

2021 EULAR points to consider to support people with rheumatic and musculoskeletal diseases to participate in healthy and sustainable paid work

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ABSTRACT

Aim As part of its strategic objectives for 2023, EULAR aims to improve the work participation of people with rheumatic and musculoskeletal diseases (RMDs). One strategic initiative focused on the development of overarching points to consider (PtC) to support people with RMDs in healthy and sustainable paid work participation.

Methods EULAR's standardised operating procedures were followed. A steering group identified six research areas on paid work participation. Three systematic literature reviews, several non-systematic reviews and two surveys were conducted. A multidisciplinary taskforce of 25 experts from 10 European countries and Canada formulated overarching principles and PtC after discussion of the results of literature reviews and surveys. Consensus was obtained through voting, with levels of agreement obtained anonymously.

Results Three overarching principles and 11 PtC were formulated. The PtC recognise various stakeholders are important to improving work participation. Five PtC emphasise shared responsibilities (eg, obligation to provide active support) (PtC 1, 2, 3, 5, 6). One encourages people with RMDs to discuss work limitations when necessary at each phase of their working life (PtC 4) and two focus on the role of interventions by healthcare providers or employers (PtC 7, 8). Employers are encouraged to create inclusive and flexible workplaces (PtC 10) and policymakers to make necessary changes in social and labour policies (PtC 9, 11). A research agenda highlights the necessity for stronger evidence aimed at personalising work-related support to the diverse needs of people with RMDs.

Conclusion Implementation of these EULAR PtC will improve healthy and sustainable work participation of people with RMDs.

INTRODUCTION

In nearly all European countries, the work participation gap between people with chronic diseases, especially those with rheumatic and musculoskeletal diseases (RMDs), and the general population persists, varying between 10% and 15%.¹ Moreover, RMDs account for up to 60% of prolonged sickness absence and work disability in the European Union and consistently rank

first or second in causes of work disability across countries.² Being age-related diseases, this burden will likely increase over the coming decades. Multiple reasons have been identified to explain the persistent work participation gap. First, despite medical advances, cure of RMDs remains elusive for most patients, and pain remains the most common symptom hampering activities and participation. Second, with population ageing, welfare systems focus on inclusive and longer participation in the work force, posing challenges to people with chronic diseases. Third, the nature of work has changed over time with more emphasis on efficiency and productivity, and little attention for vulnerable persons in society.³

To bridge the work participation gap, EULAR included in its strategic objectives that 'By 2023, EULAR's activities and related advocacy will have increased participation in work by people with RMDs'.⁴ As part of these activities, a taskforce was assembled to formulate points to consider (PtC) to support healthy and sustainable paid work participation for people with RMDs. The target audiences comprise (organisations of) people with RMDs and healthcare professionals, as well as employers, trade unions, occupational health and safety organisations, policymakers, researchers and others involved in durable work participation for people with chronic diseases such as RMDs.

METHODS

The steering committee (GRB, JWB, NB) of EULAR's Campaign on RMDs and Work convened physically in January 2020 with experts (AB, SMMV, TAS, TW) in the field and a patients' representative (DW) and decided on the protocol for the PtC. In line with the updated EULAR standardised operating procedures, two convenors (SMMV, AB), two fellows (MB, CW) and a methodologist (TAS) were appointed.⁵

This extended steering group identified six research areas where evidence would be required to inform the formulation of the PtC:

1. Is work relevant for (clinical) outcome?
2. What are barriers and facilitators to enter, maintain or return to work?

Recommendation

3. What is the effectiveness of pharmacological and non-pharmacological interventions on work participation outcome?
4. Which characteristics of the social security system are effective in entering, maintaining or returning to work?
5. How do work participation rates in people with RMDs compare with those in the general population?
6. What should employers do (or not do) to facilitate people with RMDs entering, maintaining returning to work?

The RMDs considered were inflammatory arthritis (IA) including juvenile idiopathic arthritis (JIA), osteoarthritis (OA), systemic diseases, crystal arthritis, regional or generalised musculoskeletal pain (see online supplemental appendix 1 for details). Studies on (work-related) musculoskeletal injuries and chronic low back pain were excluded, as these persons are not under chronic care of rheumatologists in most countries. After scanning the published literature, it was decided to conduct three new systematic literature reviews (SLRs). The first aimed to identify facilitators and barriers for work outcomes (research area 2), the second addressed prospective studies assessing non-pharmacological interventions (research area 3), and the third concerned studies comparing work participation outcomes in people with RMDs with the general population (research area 5). Additionally, the extended steering group decided on two surveys. The first was distributed among professional and patient organisations in rheumatology to identify recommendations/guidelines or activities (eg, self-management courses, guidelines) aiming to support work participation for people with RMDs (research area 3). The second survey was among large companies on available policies or programmes to support people with chronic diseases, specifically those with RMDs (research area 6). For remaining areas (research areas 1 and 4), non-systematic searches were the source of evidence. Online supplemental appendix 1 provides an overview of sources of evidence for each research area including the types of RMDs actually addressed in these sources, and [table 1](#) explains key terminology. Convenors and fellows were responsible for the literature searches and surveys, data extraction/analyses and data synthesis. The three SLRs will be submitted for publication.

The extended steering group convened four times to discuss intermediate results. The entire taskforce (n=25) was invited for a virtual meeting in May 2021, and included persons from 10 European countries and Canada. A wide range of stakeholders were invited including: health professionals, researchers, epidemiologists, patient representatives, consultants in management and policy communication, a politician and a representative of the European Agency for Safety and Health at Work. Participants formulated the PtC following a process of discussion and voting based on evidence from the existing and new (systematic) literature reviews and survey results (online supplemental appendices 2–5 for sources of evidence and unpublished results). Consensus was reached if >75% of the members voted in favour of a PtC in the first (or >66% and >50% in a second and third, if applicable) round.⁵ After the meeting, the level of evidence and strength of recommendation were added to each of the statements.⁶ Finally, taskforce members anonymously indicated the level of agreement (LoA) via an online survey (numerical rating scale ranging from 0=‘do not agree at all’ to 10= ‘fully agree’) emailed to participants after the taskforce meeting. The mean and SD of the LoA as well as the percentage of taskforce members with an agreement ≥ 8 are presented. Taskforce members could refrain from voting if a statement was outside their professional expertise. Based on the gaps in evidence and issues of controversy, a research agenda was formulated. The final manuscript was approved by the EULAR Council.

RESULTS

The taskforce developed and endorsed 3 overarching principles and 11 PtC ([table 2](#)).

Overarching principles

Participation in good work increases self-worth and self-esteem, economic independence and social inclusion, which generally translates into better health and well-being

Substantial causal evidence indicates that not having paid work is a predictor of comorbidities, social exclusion and mortality. Consensus exists across various disciplines that paid work

Table 1 Clarification of words as used in this manuscript

Construct	Definition
Paid work participation	The act of taking part/being involved in paid work. Comprises having (or not having) paid work but sick leave and presenteeism.
Work participation outcomes	Work status Having paid work (employee or self-employed) and reasons for not having paid work (eg, work disability). Sick leave or sickness absence Not performing/attending work due to illness while having an employment contract. Presenteeism (a) The behaviour of attending (paid) work while being ill, and/or (b) the level (i) productivity loss, or (ii) difficulty reduced ability to work when being at work with health problems.
Adverse work outcome	(Partial) unemployment (eg, work disability) and/or sick leave and/or presenteeism due to health issues.
Work participation gap*	The difference in work participation outcomes between between patients with RMDs and the general population.
Good work (decent work)	Work that is engaging, gives people a voice, treats them fairly, provides job security, helps them to progress and is accommodating for specific health and mental needs.
Work sustainability intervention (stay at work)	Intervention that aims to prevent unwanted/adverse work outcome and focuses on persons having a paid job.
Return to work intervention	Intervention that aims for return to paid work of persons currently on sick leave, work disabled or unemployed.
Work-related support	Any support contributing to work participation of people with a (chronic) disease.
Pharmacological intervention	Intervention with focus on effects of drugs/medicines.
Non-pharmacological intervention*	Intervention that does not contain pharmacological or surgical components.
Workplace intervention*	Intervention mainly executed at the workplace.
Healthcare intervention*	Intervention mainly executed in a healthcare setting.
Intersectionality	Framework for conceptualising a person, group of people or social problem as affected by a number of discrimination and disadvantages. It takes into account people's overlapping identities (eg, gender, race, sexual orientation, education, obesity) and experiences (social exclusion, stigmatisation) in order to understand the complexity of prejudices they face.

For the full formal EULAR definition, see online supplemental appendix 1.

*Definition specific for the current PtC.

PtC, points to consider; RMDs, rheumatic and musculoskeletal diseases.

Table 2 Overarching principles and points to consider* (all statements n=21 except A: n=22)

	LoE (1–5)	SoR	LoA (0–10)	
			Mean (SD)	% with score ≥8
Overarching principles				
A. Participation in good work increases self-worth and self-esteem, economic independence and social inclusion, which generally translates into better health and well-being.			9.5 (2.0)	91
B. The aim of work-related support for people with RMDs is to optimise working life and to ensure best physical and mental health.			9.6 (0.7)	100
C. It is a shared responsibility of all members of the society to support people with RMDs to participate in healthy and sustainable work.			9.1 (1.7)	82
Points to consider				
1. Throughout their working life, people with RMDs should be supported and encouraged to enter, sustain and/or return to work.	5	D	9.7 (0.6)	100
2. People with RMDs should have timely access to health and job support to promote sustained work ability and productivity, and to prevent long-term absence.	5	D	9.6 (0.7)	100
3. Health professional organisations, policymakers, patient organisations and employers should collaborate to minimise the employment gap and optimise employment opportunities among people with RMDs.	5	D	9.6 (0.8)	91
4. People with RMDs should be supported (in the decision whether) to discuss their work-related challenges with their employer and healthcare providers.	5	D	9.4 (1.0)	91
5. Presenteeism and sickness absence can be signals for future adverse work outcomes.	2b	B	9.8 (0.4)	100
6. All aspects of the biopsychosocial framework of health have to be considered when addressing the work participation needs of people with RMDs.	2b	B	9.6 (0.8)	100
7. Disease-modifying interventions for inflammatory rheumatic diseases have a beneficial effect on work participation and are recommended to be started as early as possible.	1b*	A*	9.7 (0.6)	100
8. Non-pharmacological interventions should be considered for people with RMDs to reduce or prevent sickness absence and possibly improve work ability.	1a	A	9.6 (1.0)	91
9. Actors in the social security systems should develop and implement policies and practices to promote work sustainability and return-to-work efforts, with respect to the rights of people with RMDs.	4	C	9.3 (1.2)	82
10. Healthy workplaces and supportive attitudes of employers, managers and colleagues are essential for people with RMDs to acquire and maintain work.	4	C	9.6 (1.3)	100
11. Employers should develop and implement policies and practices to promote a workplace culture of inclusivity, flexibility and support.	5	D	9.3 (1.5)	82
*Evidence of effectiveness of disease modification comes from RA, axSpA and PsA, evidence of benefits of early versus late stems from indirect comparisons of RCTs in RA or cohorts in SpA. axSpA, axial spondyloarthritis; LoA, level of agreement; LoE, level of evidence; PsA, psoriatic arthritis; RA, rheumatoid arthritis; RCTs, randomised controlled trials; RMDs, rheumatic and musculoskeletal diseases; SoR, strength of recommendation; SpA, spondyloarthritis.				

positively contributes to mental and physical health of people with RMDs.⁷ Evidence of specific work activities having an adverse impact on health is scarce, methodologically challenging and mainly limited to OA.⁸ However, it should be recognised that performing paid work might aggravate symptoms of RMDs, and for some individuals specific circumstances might preclude healthy work participation. The taskforce emphasised the importance of ‘good work’, referring to work that is engaging, gives people a voice, treats them fairly and inclusive, provides job security and equal opportunities, helps them to progress and is accommodating for specific health and mental needs.^{9 10}

The aim of work-related support for people with RMDs is to optimise working life and to ensure best physical and mental health. The taskforce asserted work-related support has a dual aim: (1) to support people with RMDs to sustain their ability to remain employed and, if needed, to return to work after absence, and (2) to safeguard health. Work participation should not be imposed at the expense of physical or mental health. Also, after being informed about benefits and drawbacks, not participating in paid work can be a personal (informed) choice.

It is a shared responsibility of all members of the society to support people with RMDs to participate in healthy and sustainable work. Work participation is a complex outcome, influenced by multiple factors at the individual, social, societal and environmental level that are interconnected and that involve different people and professionals. To improve the sustainability of work participation, it is essential to recognise persons at risk, including intersectionality that considers multiple aspects of a person’s identities and experiences that can make some individuals at greater risk of discrimination and disadvantage. It is also critical to ensure that all relevant persons and organisations collaborate. Support can vary from appreciation of a person’s work commitment to informal help or formal policies and practices to accommodate healthy work.

Points to consider

Throughout their working life, people with RMDs should be supported and encouraged to enter, sustain and/or return to work. RMDs can occur across the life course and influence career opportunities. When RMDs develop at young age (eg, JIA), the choice of professional education and first job may influence future employment prospects.^{11–13} When an RMD affects older persons, the disease can interfere with age-related challenges to

maintain paid work.^{14 15} Moreover, needs of patients can vary by the stage of the RMDs.¹⁶ In early phases, patients might be more concerned with uncertainty and fluctuations of the disease. In later phases, irreversible limitations or accumulating comorbidities might be more bothersome.^{17–19} For each phase, support by knowledgeable persons should comprise (1) general or preventive actions or policies that can benefit all people with RMDs (eg, stay-at-work programmes in the healthcare system or at the workplaces), and (2) person-tailored support for those at increased risk of or experiencing adverse work outcome (eg, occupational advice/support/accommodation).

People with RMDs should have timely access to health and job support to promote sustained work ability and productivity, and to prevent long-term absence

People with RMDs on long-term sickness absence or on work disability benefits have lower chances of successful return to work.² It is thus important to promote work participation and support work ability while still in paid work.⁷ This requires early identification of persons at risk followed by support tailored to the person's needs.^{20,21} While this is a shared responsibility of several stakeholders, healthcare providers could play a more active role in screening for those at risk and initiating timely support.²² Current management recommendations and standards of care in RMDs overall lack too often explicit statements on the need for work-oriented care in clinical practice (online supplemental appendix 3.1).

Health professional organisations, policymakers, patient organisations and employers should collaborate to minimise the employment gap and optimise employment opportunities among people with RMDs

Collaboration among stakeholders is essential to increase employment opportunities for people with RMDs. Relevant parties should (1) agree on common goals and principles regarding 'healthy and sustainable work', and define the specific responsibilities of each stakeholder; (2) consider national as well as local context (healthcare, social security, employment systems and labour market); and (3) monitor effectiveness and safety of practices and interventions in order to increase knowledge on effective and efficient work-related support.²³

People with RMDs should be supported (in the decision whether) to discuss their work-related challenges with their employer and healthcare providers

People with RMDs are best positioned to recognise when sustainable work participation is at risk. However, they might need encouragement/guidance (a) in their decisions whether and when to share information—for example, disclose their disease with their workplace leader (eg, supervisor, human resource manager) - in the context of legislation on this issue and (b) how to formulate their needs to any relevant stakeholders. Healthcare providers can play an important role in this process. If needed, interactions among patients, healthcare providers and employer groups should be facilitated, allowing a shared decision and actionable treatment plan. It is essential patients feel safe to communicate.

Presenteeism and sickness absence can be signals for future adverse work outcomes

There is accumulating evidence that presenteeism and/or recent sickness absence are strong predictors of long-term sick leave and that long-term sick leave is a strong predictor of future work disability.^{22 24 25} Both predictors should be an indicator—also in clinical care—to start support processes to maintain healthy and sustainable work participation.

All aspects of the biopsychosocial framework of health have to be considered when addressing the work participation needs of people with RMDs

Consistent with the biopsychosocial model of human functioning, factors associated with work outcomes comprise not only physical and mental health impairments, but also personal and environmental factors.^{26–28} These contextual factors can be barriers as well as facilitators, and are of special interest if they are modifiable. To facilitate a comprehensive needs assessment of patients in relation to work outcomes, the International Classification of Functioning and Health for Vocational Rehabilitation can be considered.²⁹ In people with RMDs, limited physical function (and/or disease activity in case of IA) is the strongest disease-related predictor of adverse work outcomes. Lower education, higher age, female gender and work-related factors (such as physically demanding jobs, job autonomy and social security system) are contextual factors that have repeatedly been associated with adverse work outcomes.^{30–34}

Disease-modifying interventions for inflammatory rheumatic diseases have a beneficial effect on work participation and are recommended to be started as early as possible

In IA, there is high-level evidence that disease-modifying drugs have moderate to large beneficial effects on sick leave and presenteeism.^{35–39} In people with established rheumatoid arthritis (RA) and axial spondyloarthritis (axSpA), the majority of people who are work disabled will not return to work. However, among patients with early RA and axSpA, some data indicate early remission translates in employment rates that come closer to the general population.^{40–42} While this latter evidence comes exclusively from recent studies in RA and axSpA, the taskforce was in agreement that timely disease modification could have similar beneficial effects on work outcome in patients with other RMDs.

Non-pharmacological interventions should be considered for people with RMDs to reduce or prevent sickness absence and possibly improve work ability

Clinical and methodological heterogeneity in non-pharmacological studies hamper clear conclusions about the effectiveness of non-pharmacological interventions for work sustainability and return to work in case of absence/sick leave.^{43 44} Our literature review showed small but significant beneficial pooled effect sizes of non-pharmacological interventions for work status, sick leave and presenteeism. Effects seemed somewhat stronger in people with RMDs compared with persons with unspecified pain disorders, especially for sick leave. Beneficial effects have been observed for both single-component (eg, information/education) or multiple-component (eg, education/information combined with physical exercise training and workplace visits/adaptations) interventions, in populations with or without risk factors for adverse outcome at baseline and for interventions executed at the workplace, in a healthcare setting or in a combined healthcare–workplace setting. Heterogeneity suggests tailoring of non-pharmacological work-related support to the individual's needs, with an essential role of context.⁴⁵

Actors in the social security systems should develop and implement policies and practices to promote work sustainability and return-to-work efforts, with respect to the rights of people with RMDs
Compared with people with RMDs living in high-income countries, those living in countries with lower healthcare expenditures and lower economic prosperity (gross domestic

product) are less likely to be employed and more likely to experience sickness absence. However, they report less presenteeism despite worse disease.^{46–49} Characteristics of the social security systems vary importantly across countries. Examples include eligibility and criteria for compensation (eg, years employed; type of employment; type/severity of impairment), level of income substitution and role of rheumatologists in disability assessment. While policies in social security organisations *within countries* can have important effects on overall employment/work disability, *across countries* none of these characteristics is consistently associated with differences in employment or work disability rate in RA.⁵⁰ Some evidence suggests that systems requiring vocational rehabilitation before granting work disability have higher employment rates among people with chronic diseases.^{50–53} Of note, persons with RMDs who face long-term sickness absence or work disability often feel stigmatised along the process towards recognition of work disability. This is less so for persons within Scandinavian social security systems.^{52–54} Taken together, the findings call for system changes at different strands and various executive levels of the social security system, with priorities that can differ by region/country.

Healthy workplaces and supportive attitudes of employers, managers and colleagues are essential for people with RMDs to acquire and maintain work

Qualitative and quantitative research among people with RMDs provides substantial evidence on the facilitating role of attitudes of colleagues, supervisors and employers in healthy and sustainable work.⁵⁵ Therefore, the taskforce calls upon all persons working with people with RMDs to adopt an understanding attitude and to implement active support for persons with RMDs in periods or circumstances when support is needed. Ensuring ‘good work’ is an essential basis for a culture of inclusiveness.

Employers should develop and implement policies and practices to promote a workplace culture of inclusivity, flexibility and support. To achieve impactful improvement in career perspectives and sustainable work participation of people with RMDs, the taskforce highlighted the need for workplaces that are inclusive for people with chronic disease and are flexible in accommodating to the needs of people with RMDs. These needs typically differ between individuals and across jobs and may vary over time. Employers have the legal duty to ensure safety and equality at work. To develop and implement desired policies and practices, employers and their organisations should align with other stakeholders such as unions and disability managers/occupational physicians, and account for national and regional needs, opportunities and regulations.

Research agenda

Several knowledge gaps emerged during evidence collection in the six research areas and were reinforced in the final taskforce meeting. Gaps pertained to defining and measuring ‘healthy and sustainable’ work participation, defining and measuring ‘good work’, dealing with intersectionality, methodological issues of designing work intervention studies, the need for high-quality evidence on (cost-)effectiveness of work interventions and policies, and the need for clear implementation strategies (table 3).

DISCUSSION

Finding paid work, maintaining sustainable work, pursuing a career and if applicable re-entering the labour market are

as relevant for people with RMDs as for those in the general population. A taskforce of 25 experts in the field of work participation formulated 11 statements with the ultimate aim to close the persistent work participation gap of people with RMDs compared with the general population and optimise working life for people with RMDs. Not providing people with RMDs the support to gainfully participate in the labour market will result in socioeconomic exclusion of this population, potentially resulting in poor health and inequities.⁵⁶

Though some of the statements are based on evidence of systematic review of scientific papers (PtC 7 and 8), other statements have a low level of evidence and rely on expert opinion (PtC 1–4). Therefore, the guidance statements have been formulated as ‘points to consider’ rather than recommendations. Statements with lowest level of evidence (1–4 and 9–11) received still a high level of agreement and inspired the research agenda, specifically on the question what constitutes ‘good work’ for people with RMDs, what is the role of healthcare professional in supporting work and which specific policies and practices for social security systems and employers are successful in achieving sustainable work. Also, response to our surveys was low and likely those with attention for work participation were more likely to respond. Initiatives revealed through the survey can be inspirational for other societies/companies. Researchers should engage in evaluation of such practices.

The PtC recognise the complexity of work participation, as people’s background, health impairments and experiences intersect with cultures, institutions, and systems. To enhance healthy and sustainable work, the actors involved—from people with RMDs and their healthcare providers to policymakers—are called upon to take responsibility to enable the right for paid work and the right for just and favourable conditions of work.⁵⁷ Importantly, staying in work should never be at the expense of disease control. The PtC further emphasise the role of prevention (eg, acting upon early signs that work support is needed, designing healthy workplaces), the need to consider health as well as context, and alignment of care and support for individual people with RMDs across the settings (healthcare, employers and labour organisations, social security). The key to success is implementation of policies and practices that have shown to be safe and effective for each part of the work participation chain.

A vast amount of research evidence points to the decisive role of the workplace in sustainable work for vulnerable persons. While several terms and definitions have been proposed on what constitutes ‘good work’, a generally agreed upon and (wherever possible) evidence-based working definition is highly needed. Overall, work that helps people to progress, treats them fairly, provides job security, and has the culture and resources to be accommodating and flexible for specific health and mental needs has been identified as good work.^{9–10}

A limitation of this project was the sparse literature in some specific RMDs. However, the general principles as revealed from the frequently studied diseases (RA, SpA, systemic lupus erythematosus) are likely generalisable to other RMDs, with an exception for the role of disease modification where evidence comes exclusively from IA. When specific evidence for types of RMDs will become available in the future, updates of the current PtC could be considered. However, such evidence should also become part of the disease-specific management recommendation. Second, although the PtC were not externally validated, the participants constituted experts in the field of work participation at the national and international level. Finally, participants could

Recommendation

Table 3 Research agenda originating from knowledge gaps identified during the literature searches and confirmed by the discussion among members of the taskforce

Research topic	Justification
<i>Healthcare</i>	
How to train/guide persons with RMDs to start a conversation with HCP, supervisor or employer to discuss health-related problems at work?	Employers and healthcare professionals might not always be aware of a person's specific work limitations. Communication might be a first step towards problem recognition and solutions, but requires thoughtful preparation.
How can healthcare professionals accurately identify persons with RMDs at risk of adverse work outcomes?	Prediction and risk stratification tools for adverse work outcome have been developed in general working populations, but have not been validated in people with RMDs.
Which non-pharmacological interventions are effective in (subgroups of) persons with RMDs?	Current evidence on effectiveness of non-pharmacological interventions (including workplace and community interventions) showed high heterogeneity. Efficiency of interventions will benefit from more accurate inclusion/stratification.
How can we implement (and finance) work-oriented care in clinical practice? Should work-related care be a quality indicator?	Screening, risk stratification, interventions and monitoring of work participation should be implemented by general practitioners, medical specialists and other healthcare professionals. Limited resources for prevention should not hinder timely work-oriented care.
<i>Workplace</i>	
Which features of work constitute a healthy workplace for people with RMDs, and which features are harmful for RMD-related health outcomes?	Features of work can comprise type of work, tasks within a job (including autonomy and flexibility), physical environment, regulations (including salary, job and social security) and culture of workplaces (eg, support from colleagues, accommodations).
What are the needs (eg, policies, financial) and responsibilities of employers to support people with RMDs in healthy and sustainable work?	Most employers don't have specific knowledge and skill to support people with RMDs and limited finances are in place to encourage employers to implement limited policies on this issue.
<i>Outcome assessment and monitoring</i>	
How do we define 'healthy and sustainable work' and how can we measure this?	How can we combine different perspectives on work participation outcomes (patient, caregivers, workplace and societal)? Are short-term measures appropriate surrogates for long-term outcomes? Clearly, continuation of work should not go at the expense of health.
How can we improve real-world data collection of work outcomes of persons with RMDs?	Measures of work participation should be routinely collected as part of (1) clinical data/information and (2) research projects which include working-age adults. Encourage the development of 'big data' that integrate data variables at level of the patients, their working and living environment, healthcare and social security system and national policies are required to fully understand efficiency of intervention.
<i>Policies on healthcare, social security and labour organisation</i>	
What is the role of intersectionality in (closing) the work participation gap?	Individuals in a society experience discrimination and disadvantage on the basis of a multitude of factors. Social inequality in employment occurs along several axes that intersect and need to be studied and acted upon appropriately.
Which policies support sustainable work for patients with RMDs?	Governments are interested in policies to enhance sustainable and healthy work participation, especially in an ageing population. Evidence on this issue is scarce, and methodologically challenging to generate.
What is the cost-effectiveness of various interventions that could help to close the work participation gap?	High-quality care is not only effective but also efficient. As one of the aims of work-related care is to reduce the financial burden of health-related productivity costs, work-oriented policies and care should be affordable. What is the return on investment of interventions including policies?
How can work policies be financed?	Silos in budgets between healthcare and labour policies should not hinder health-oriented policies at the workplace.
<i>Collaboration</i>	
How can we improve collaboration between professional organisations, policymakers, patient organisations and employers?	Shared goals, consistent communication and aligned policies/systems are essential to achieve optimal work participation.
How can we implement evidence-based practices, interventions and policies?	If practices/interventions have proven to be effective, (de-)implementation will be the key to achieve impact in individuals and society.
HCP, healthcare provider; RMDs, rheumatic and musculoskeletal diseases.	

abstain from voting if they felt a statement was outside their professional expertise.

In conclusion, considering and implementing these EULAR PtC are a shared responsibility and should improve healthy and sustainable work participation of people with RMDs.

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