Health at work – an independent review of sickness absence

Dame Carol Black and David Frost CBE

November 2011

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Foreword

Sickness absence from work is often unavoidable, but when unduly prolonged it is wasteful and damaging – to individuals and their families, employers and our wider society.

The aims of our Review were to minimise the loss of work resulting from ill health and to find ways of reducing the burdens and costs. We have examined the actions of individuals, employers, healthcare professionals and official agencies made in response to sickness absence, and the incentives and disincentives that shape those actions. We have also examined the balance of costs that fall on individuals, employers and the State.

Simple premises have guided our deliberations. The first, not in dispute, is that for most people of working age, work – the right work – is good for their health and well-being. Second, for most people worklessness is harmful. Third, much sickness absence and inactivity follows common health conditions which, given the right support, are compatible with work – although sometimes it means a different kind of work. Fourth, there should be minimal delay in making an adequate assessment of an individual's capability to work. Last, despite best efforts, some people are too unwell or disabled to work. Their needs too should be answered adequately and promptly. We acknowledge that some of what we are proposing will put more pressure on people to return to work, but we hold that in many cases this would be in their own best interest, not just that of employers and taxpayers.

The Review has shown up weaknesses in the current system. We believe that changes should be made not only to improve its effectiveness in restoring people to work, but also its efficiency, with the prospect of considerable savings.

Doctors provide formal entry into the sickness absence system through the fit note, an opportunity to give advice on practical measures to enable return to work. Currently, however, many people are declared completely unfit. Doubtless warranted in particular circumstances, in many other cases this holds back people from work, inhibits employers from helping people return, and might not be in the employee's best long-term interest. We have, therefore, made recommendations to improve sickness certification.

We have also learnt that employers would value access to independent expert advice on the functional capabilities of sick employees, especially in longer-term and more difficult instances of sickness absence where there is great risk of people never working again. Therefore, we have recommended the introduction of an Independent Assessment Service, a new source of functional assessment and occupational health advice.

In addition, we have made recommendations on changes to the tax and regulatory regimes that we believe will serve to enhance employers' role in sickness absence management.

Ministers asked us to look at the public sector where sickness absence and its costs are greater than in the private sector. We found wide variations in practice and have made recommendations designed to bring the worst performing parts up to the standards of the best.

Some long-term health conditions, even if incompatible with an individual's current job, are compatible with different work. We have therefore recommended that the State should offer a job-brokering service.

While affirming the importance of improved certification, and early supportive intervention to help return to work, we are clear that they are not enough. For many people who remain off sick we have found wasteful delays in the steps leading to the assessment of work capability, at which a considerable proportion of claimants are found to be fit for work. This is a major problem. In response we have identified measures to improve both the effectiveness of the benefits system and its efficiency, and to remove delay.

Our Review has depended crucially on the detailed analytical work and synthesis undertaken by the Review team led by Donna Ward. They have been a mainstay of the Review. We should also like to extend our gratitude to the panel of experts, drawn from a range of disciplines, who have challenged and refined our thinking throughout the Review. We have also been fortunate to have had the benefit of opinion and expert advice drawn widely from business, trades unions and health bodies. Their contributions give us confidence in the soundness and acceptability of our conclusions and the measures we have proposed.

Dame Carol Black

David Frost CBE

Executive summary

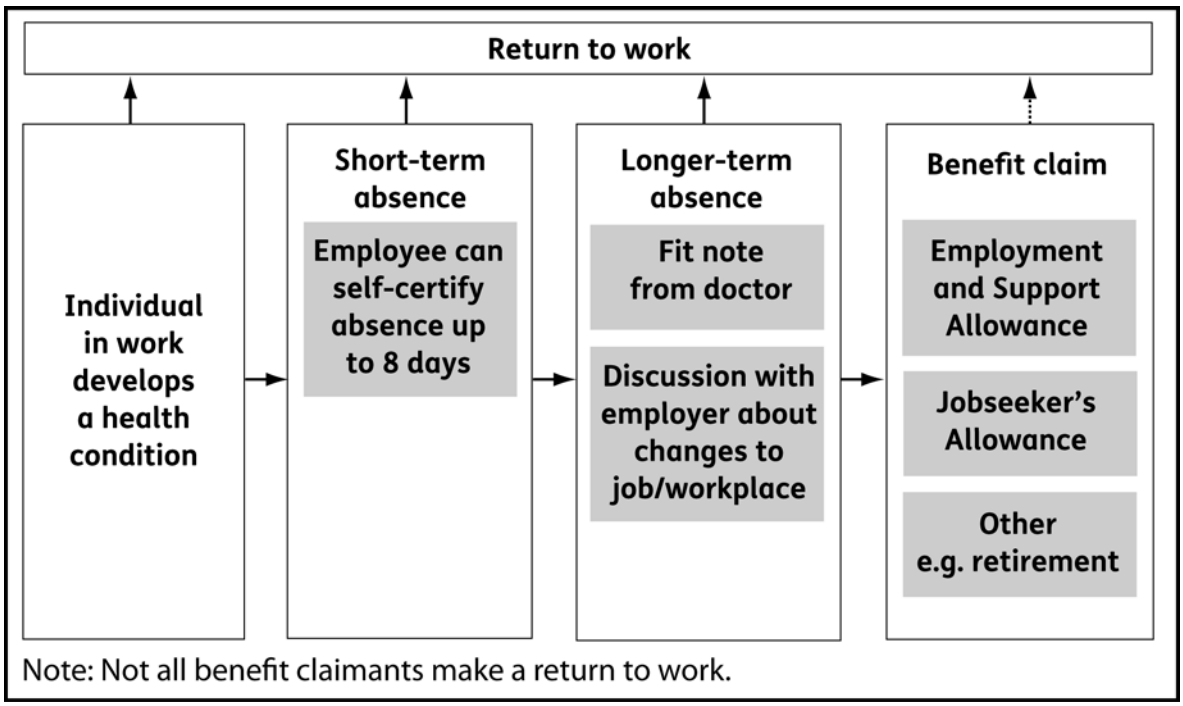
Background and purpose of the Review

1. Every year 140 million working days are lost to sickness absence, much of which ends in a swift return to work. However, a significant number of absences last longer than they need to and each year over 300,000 people fall out of work onto health-related state benefits. Before reaching this point, many have been long-term sick off work. They have become increasingly distanced from the labour market and suffer from the reduced economic, social and health status that come with being out of work. We know that the longer someone is off sick or out of work, the harder it is to get back to work, and worklessness comes at great personal and financial cost. Much absence and inactivity is due to comparatively mild illness which is compatible with work – and may indeed be improved by work.

2. This Review has been carried out to stop as many people as possible from needlessly moving away from work because of ill health, and to find ways of improving the coherence, effectiveness and cost of the existing system for managing sickness absence. We have been motivated, first and foremost, by the financial and social loss to those suffering ill health. There are also major gains to be made for employers, who pay sick pay and associated costs of £9 billion a year and for the State, which spends £13 billion annually on health-related benefits.

3. As requested by the Government, we have taken a hard look at the whole system to assess its performance and highlight any market failures or problems of unaligned incentives. The costs of sickness absence are shared between employers, individuals and the State, and all three make decisions based on a number of incentives that create the current set of outcomes and costs. Figure 1 illustrates the key stages along the sickness absence journey from employment through to eventual state benefit claim, by those who leave work.

Figure 1: Stylised journey from work to benefit claim



4. For employees, the costs of sickness absence fall on individuals, who often bear the personal and financial costs of absence, and employers, who are responsible for sick pay. For those who fall out of work due to ill health, the State bears much of the cost, and individuals and their families suffer through loss of income as well as the illness itself. Health professionals play various roles at different points in the system:

   - providing care, advice, treatment and rehabilitation;
   - certifying sickness of the employee to their employer; and
   - acting as a gateway to the benefits system.

5. In an ideal system, people who are unable to work would be swiftly identified and supported; those with conditions that are compatible with their current work would receive early treatment and support to return quickly; and those needing to change jobs would be efficiently helped back into work. Costs would be fairly distributed between employers, individuals and the State, and incentives aligned to manage these costs.

6. For some people, the current system falls well short of this ideal at every stage of the journey. Below is a summary of the key system failures which we found in the course of the Review and the policy recommendations we have made to address them. Our recommendations fall into two broad categories – those that aim to improve the efficiency of the system while people are still in work, and those that aim to improve the benefits system.

Sickness absence in work

7. Certification (normally by General Practitioners (GPs)) of sickness gives entry to the system. Employers use this as evidence of the validity of claims for sick pay and the State uses it as evidence for benefit claims. The primary role of GPs is the care and treatment of their patients and they do not have strong incentives to consider state and employer costs.

8. Employers pay £9 billion a year in sick pay and associated costs, plus the indirect costs of managing business while people are off sick. Currently, the majority of people seeking a medical certificate (fit note) are signed off as completely unfit. Unless this is addressed, employers cannot make adjustments to help people whose illness is compatible with a return to work. Solving this issue is the first crucial step in stemming sickness absence and inactivity. In longer-term and more difficult sickness cases, employers have told us that they need independent, bespoke advice, especially if they do not have their own occupational health services. Such advice could help doctors, who usually do not consider themselves expert in this area.

9. We therefore recommend that the Government should fund a new Independent Assessment Service (IAS). The IAS would provide an in-depth assessment of an individual's physical and/or mental function. It would also provide advice about how an individual taking sickness absence could be supported to return to work. It should be provided by approved health professionals, and be appropriately quality controlled. The service should usually be accessed when an individual's absence spell has lasted around four weeks.

10. This service, intended to improve the effectiveness of medical certification and encourage early positive intervention, would not replace the independent assessments which the State makes in determining entitlement to eventual health-related benefits (the Work Capability Assessment (WCA) – see below). However, we would expect the new assessment service to provide useful evidence for a state-sponsored WCA, on claims made by people who fall out of work subsequently. The State, through Jobcentre Plus, may use this new assessment to inform their advice to claimants for health-related benefits.

11. We estimate that employers would save approximately £100 million a year in sick pay costs by using this service, with an estimated increase in economic output of around £150 million a year. The State would also make savings from reduced flows onto health-related benefits and gain from the tax revenue from increased economic output.

12. The management by employers of long-term absence from work is uneven. Larger employers and those in the public sector are more likely to offer occupational health services. Higher earners are individually more valuable to employers and often have readier access to private health care. Consequently, employees who are less well paid and less qualified, and those from smaller firms, are more likely to be excluded from interventions to get them back to work. They are therefore more likely to fall onto state benefits.

13. We therefore recommend that expenditure by employers targeted at keeping sick employees in work (or speeding their return to work), such as medical treatments or vocational rehabilitation, should attract tax relief. This should be targeted at basic-rate taxpayers. We estimate that this will cost around £150 million a year, but will result in gains to employers of up to £250 million.

14. Currently, employers who experience high rates of sickness absence, can be compensated by the Government through the Percentage Threshold Scheme (PTS). However, this scheme costs £50 million a year and gives the employer no incentive to reduce absence. Therefore, we propose abolishing the PTS. This will help pay for the new service providing functional assessments described above. We also recommend that record-keeping obligations under Statutory Sick Pay (SSP) are abolished. Removing this administrative burden will save employers £44 million a year and will largely offset the cost to business of abolishing the PTS.

15. Sickness absence and its costs are greater in the public sector than the private sector. There are, however, some excellent examples of low sickness absence in the public sector, invariably associated with good management practices.

16. However, there is great variation in management and leadership across the public sector, leading to poor outcomes for some staff and bad value for taxpayers. We therefore recommend that public sector employers take immediate action to bring the worst performing parts of the public sector up to the standards of the best. This will require public sector employers to adopt the best examples of absence management displayed in both the public and private sectors. It will require board-level commitment to reducing absence (including senior managers being accountable for absence levels in performance monitoring). Halving the gap in sickness absence levels between the public sector and large private sector employers could save the taxpayer up to £800 million. We also recommend that the Government reviews occupational sick pay (OSP) in the public sector.

17. A key aim of the Review has been to increase job retention. However, some long-term health conditions are simply incompatible with an individual's current job. The State does not currently help people look for alternative jobs until they enter the benefits system. However, people off sick for a long period face a very high chance of falling onto state benefits. After 20 weeks of sickness absence, the vast majority of individuals eventually fall onto benefits. The average claimant receiving Employment and Support Allowance (ESA) costs the State £8,500 a year. Yet the State does not intervene to help such people find an alternative job until after they have become unemployed, often after a long delay.

18. We recommend that the State should offer a free job-brokering service for anyone with a sickness absence period of 20 weeks or more. Government should consider ways of allowing earlier access to the service and the implications for who should pay for it. Government should consider delivering the service as an extension of the Work Programme. We estimate that the State could save up to £300 million a year by introducing this service. The increase in economic output could be up to £800 million a year.

The benefits system

19. Around 140,000 people a year fall out of work and claim state health-related benefits without having a period of sick leave with their employer beforehand. This group has no support to get back to work and no attachment to an employer.

20. There are inefficiencies and delays in the benefits system. It takes an average of 17 weeks for people claiming ESA to be assessed and then over 60 per cent are actually found fit for work (accounting for those who successfully appeal against being found fit, the proportion found fit is still over 50 per cent). This builds an unacceptable delay into the journey to get people back to work.

21. We therefore recommend that the Government ends the ESA assessment phase altogether. People should go onto ESA only if they qualify after a WCA or as now, if they have sufficient medical evidence not to need a face-to-face WCA. This recommendation should be supported by reformed processes within Jobcentre Plus, to prevent high numbers of claimants being inappropriately directed towards ESA. We estimate that this change could save the State up to £100 million a year, with an increase in economic output of up to £300 million.

Overall impact of the proposed new system for managing sickness absence

22. We believe that the new system, reformed as we recommend, will provide a swifter and more sensible journey, from work to a period of support and back to work again, for the vast majority of people who can return to work. Complex cases will be assessed more quickly (in employment and the benefits system) and those who need financial support will get it sooner. Employers who invest in interventions will be encouraged, not penalised. Also, the State will support job search much sooner for those who need it, including, for the first time, before they fall out of work. Overall, we believe that the reformed system could save £400 million a year for employers and up to £300 million a year for the State, and boost economic output by up to £1.4 billion.

Summary of recommendations

The Review makes a number of recommendations to improve the sickness absence and benefits systems.

Supporting employees at work

1. Government should fund a new Independent Assessment Service (IAS). The IAS would provide an in-depth assessment of an individual's physical and/or mental function. It would also provide advice about how an individual on sickness absence could be supported to return to work. This service should usually be accessed when an individual's absence spell has lasted around four weeks.

2. Government should revise fit note guidance to ensure that judgements about fitness to work move away from only job-specific assessments.

3. Government should do more to improve knowledge and awareness among healthcare professionals, particularly those involved in certification, of the WCA and the benefits system generally and the importance of work for health.

4. Expenditure by employers targeted at keeping sick employees in work (or speeding their return to work) such as medical treatments or vocational rehabilitation should attract tax relief. This should be targeted at basic-rate taxpayers.

5. Existing tax relief on employee assistance programmes (EAPs), which provide information, advice and counselling on a variety of issues causing absence and/or performance problems should be retained.

6. Government should abolish PTS which compensates mainly smaller employers for very high rates of sickness absence in their organisations, but reduces incentives to manage absence.

7. Record-keeping obligations under SSP should be abolished, thereby helping to reduce employer administrative burdens.

8. Government should update its Employers Charter to address misconceptions around sickness absence management, especially legal uncertainty.

9. Government should carry out further research into the reasons behind the significant number of people claiming ill health benefits who come straight from work, especially from smaller employers, but appear not to have been paid sick pay by their employer beforehand.

10. Public sector employers should take immediate action to bring the worst performing parts of the public sector up to the standards of the best. Government should also review OSP in the public sector.

11. The introduction of a new job-brokering service to help long-term sick employees find new work (where appropriate) before they fall onto the benefits system. This service should be offered free by the State in cases of very long-term absence (at 20 weeks or sooner if the Government is convinced of the business case to do so), but should be available earlier for individuals and employers that are willing to pay for it. Government should consider delivering the service as an extension of the Work Programme.

Improving the benefits system

12. The Government should end the ESA assessment phase altogether. People should go onto ESA only if they qualify after a WCA, or as at present, if they qualify to pass directly onto ESA without a face-to-face WCA.

13. The recommendation above should be supported by changes to Jobcentre Plus' claims policies and processes to prevent large numbers of people being inappropriately directed towards ESA.

Chapter 1 – Context, institutional framework, recent trends and total costs of sickness absence

Introduction

1. Too often, ill health leads to people falling out of work altogether at great cost to individuals, their families and society. Yet many causes of absence and of inactivity due to ill health are relatively mild conditions that are compatible with work – indeed, could often be improved by work. A caring society has a responsibility to help such people return to work. Sickness absences cost the economy around £15 billion a year, predominantly in lost output. For employers, the financial costs of sick pay and other indirect costs of managing absence are estimated at £9 billion per year. The State spends £13 billion annually on health-related benefits.

2. It was to address these problems that the Prime Minister announced this independent review of sickness absence. It has been sponsored jointly by the Department for Work and Pensions (DWP) and the Department for Business, Innovation and Skills (BIS) and led by Dame Carol Black and David Frost CBE.

3. This Review builds on Dame Carol's Review of the health of the working-age population (*Working for a Healthier Tomorrow*, 2008). In their terms of reference (see Annex A), the reviewers were asked to:

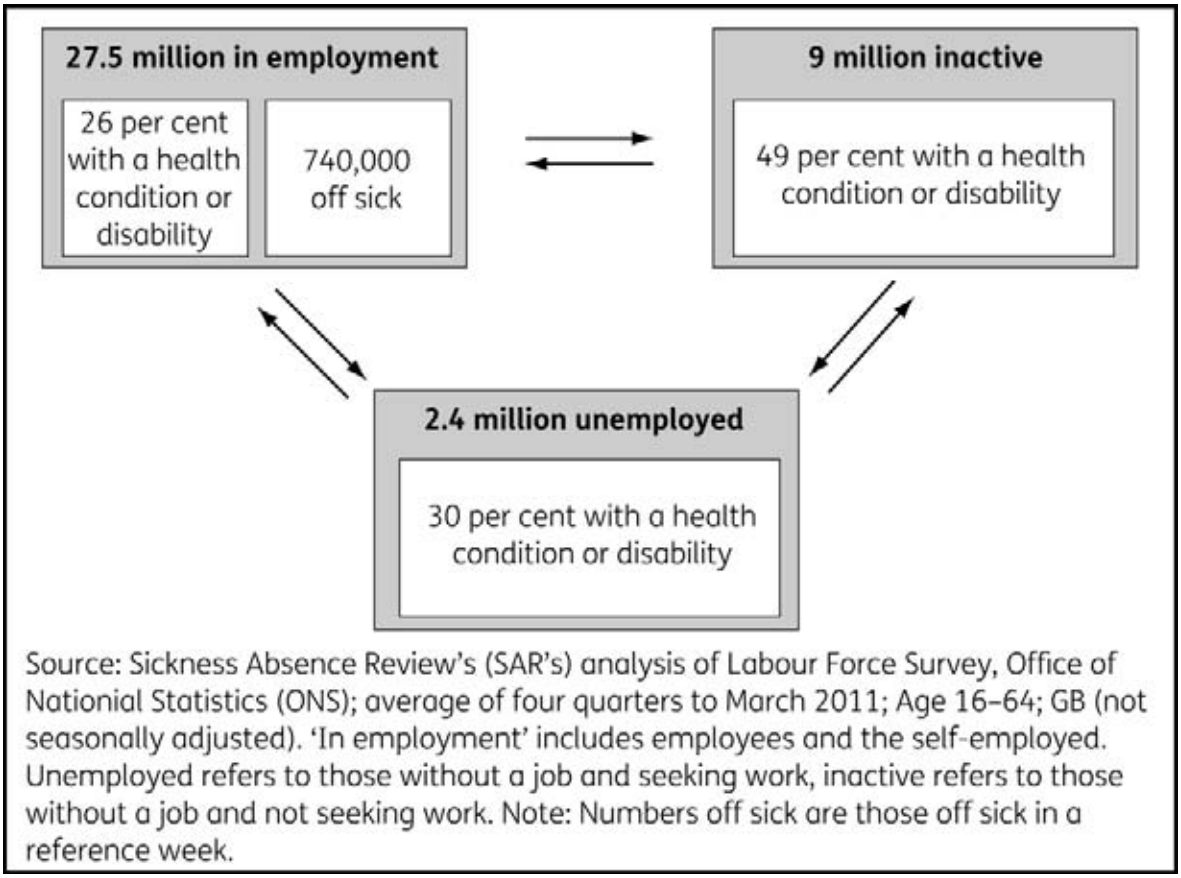
   - examine and challenge the existing system, especially the balance of costs and incentives between individuals, the State and employers;
   - assess whether the distribution of costs could be improved, in particular, whether by adjusting the current balance it may be possible to improve incentives to reduce costs overall; and
   - establish whether decision-making throughout the system is coherent and incentives aligned.

4. In summary, the aims of the Review are to find ways of reducing the number of people who fall out of work due to ill health, and ways of improving the coherence, effectiveness and cost of the system for managing sickness absence among working people.

Labour market context

5. Many people with long-standing health conditions are in work. Figure 2 shows the numbers in employment, out of employment and seeking work (unemployed), and out of employment and not seeking work (inactive), as well as the proportion of people in each group with a self-reported long-term health condition or disability. This is a moving picture – people flow between these different states.

Figure 2: Labour market status and health condition



Source: Sickness Absence Review's (SAR's) analysis of Labour Force Survey, Office of National Statistics (ONS); average of four quarters to March 2011; Age 16–64; GB (not seasonally adjusted). 'In employment' includes employees and the self-employed. Unemployed refers to those without a job and seeking work, inactive refers to those without a job and not seeking work. Note: Numbers off sick are those off sick in a reference week.

Similar symptoms, different work outcomes

Why do some people with common health conditions continue to work while others with similar conditions leave their workplace and seek a medical certificate?

One widely held view is that different economic incentives explain why some individuals with common health conditions take sickness absence and some do not. However, psychologists and researchers suggest that individuals' responses to illness are likely to be influenced by a wider combination of social and circumstantial factors[1].

[1] Bandura, A. (1997). *Self-Efficacy: The Exercise of Control*. New York: W.H. Freeman & Company.
Fear, W. J. (2007). Return to work revisited. *The Psychologist*, 22, (6), 502-503.
Giri, P., Poole, J., Nightingale, P. and Robertson, A. (2009). Perceptions of illness and their impact on sickness absence. *Occupational Medicine*, 59, 550-555.
Halligan, P. (2007). Belief and illness. *The Psychologist*. 20, (6), 358–361.
Waddell, G. and Burton, K. (2004). *Concepts of rehabilitation for the management of common health problems*. London. The Stationary Office.

These factors are critical to how individuals interpret their symptoms and think about responding to them. People consider their symptoms from different angles, for example, on the perceived cause of their symptoms: 'My back pain is caused by carrying heavy loads at work' or alternatively 'My back pain is related to wear and tear because of my age.' On the need for treatment, 'I need an operation' or in contrast 'I'll take pain killers'. On their ability to work: 'I can't work until the pain has stopped' or in contrast 'I'll have to learn to manage my pain whilst working'.

The nature of the job and individuals' experience in the workplace (for example, whether they like the job, perform it well and get on with their supervisor) will influence their decisions about their symptoms and absence from work.

Many factors and people influence an individual's sickness behaviour, for example, the responses of employers, information provided by GPs, and the views of family and friends.

Biomedical and economic factors alone cannot properly explain the different work outcomes we see for people with similar health conditions. Social factors which impact an individual's beliefs and behaviours are critical too.

6. Having a health condition need not necessarily prevent someone from working. Over a quarter of the employed population have a long-term health condition and 59 per cent of those with a long-term health condition are in work.

7. However, there are barriers to work for people with long-term health problems. Their 59 per cent employment rate compares with 77 per cent for those without a health condition, and the rate is very much lower for those with mental health conditions (between 20 per cent and 35 per cent, depending on the condition)[2]. Clearly, there is still a huge challenge in making work the norm for people with relatively mild long-term conditions.

8. This challenge will become ever more important because the population in Great Britain (GB) is both growing and ageing. The total GB population is forecast to grow by over 10 million from an estimated 60.5 million people in 2010 to 71.2 million by 2035. Over the same period, median age will increase to 42.2 years from 39.7 years in 2010. In 2035, there will be 639 dependants per 1,000 persons of working age, up from 618 in 2010[3].

9. There is evidence to suggest that the health of the population – and thus the workforce – will deteriorate in the coming decades. Levels of disease in the workforce will increase, due partly to lifestyle[4]. Coupled with an ageing workforce this represents a major challenge for the economy. It will become increasingly important to emphasise that work is compatible with less than perfect health.

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2 Sickness Absence Review analysis of Labour Force Survey, ONS; average of four quarters to March 2011; Age 16–64; GB (not seasonally adjusted).

3 ONS, National population projections, 2010-based, October 2011. Available from: http://www.statistics.gov.uk/pdfdir/pproj1009.pdf

4 Vaughan-Jones, H and Barham, L. (2009). *Healthy Work Challenges and Opportunities to 2030*. Available from: http://www.theworkfoundation.com/assets/docs/publications/216_Bupa_report.pdf

The importance of work for health

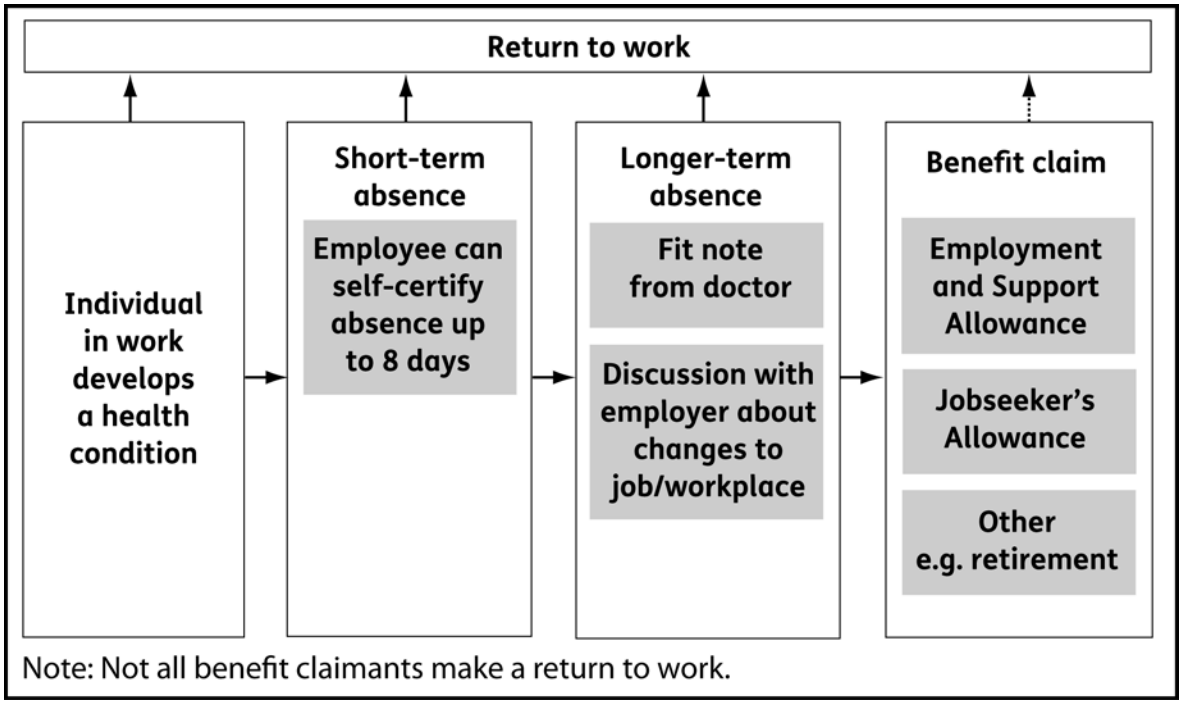
Like the 2008 Review, this Review is premised on the fact that work is good for health in most cases. Waddell and Burton's influential review *Is work good for your health and wellbeing* (2006) concluded that:

- Work is generally good for physical and mental health and well-being and can be therapeutic for people with common health problems.
- Worklessness is associated with poorer physical and mental health and well-being.
- For a small number of people (5–10 per cent), work may contribute to poor health; however, the beneficial effects of work outweigh the risks and are greater than the harmful effects of long-term unemployment and prolonged sickness absence.
- For individuals with common health conditions (mental health, cardio-respiratory and musculoskeletal condition) consensus holds that – for the good of their health – they should remain in, or return as soon as possible to, work.
- However, work should be 'good' if an individual is to maximise the net gains that work (compared to inactivity) can offer.

Roles, responsibilities and decisions in the current system

10. Figure 3 summarises the key responsibilities and decision-making points for individuals, employers, the State and health professionals as people move through the system from work, through sickness absence, to state benefits. Not everyone takes all of this journey – a considerable number come straight to the benefits system from work without experiencing any absence with their employer.

Figure 3: Stylised journey from work to benefit claim



Note: Not all benefit claimants make a return to work.

- **The employer** is required to provide sick pay for employees after the third consecutive day of illness. SSP is £81.60 a week, but up to 70 per cent of employees are offered more than this, particularly those working in large firms and those in the public sector[5]. Employers are not required to manage sickness absence in any particular way or to rehabilitate staff, although they must comply with disability provisions under the Equality Act (2010).
- Once individuals fall out of work due to ill health, **the State** is responsible for decisions on benefit entitlement and any conditions upon it.
- **Individuals** make decisions at different points in the journey (influenced by advice, financial circumstances, and decisions of the employer and the State, as well as their health) – to take sickness absence or not; to stay in work or to apply for benefits.
- **Health professionals** play various different roles at different points in the system. Individuals generally require certification from a doctor (usually a GP) after one week of continuous absence from work. Occupational health professionals may play a role in helping to rehabilitate employees during a period of long-term absence (but usually only if the employer pays for access to these services).

Sickness absence outcomes – current levels and trends

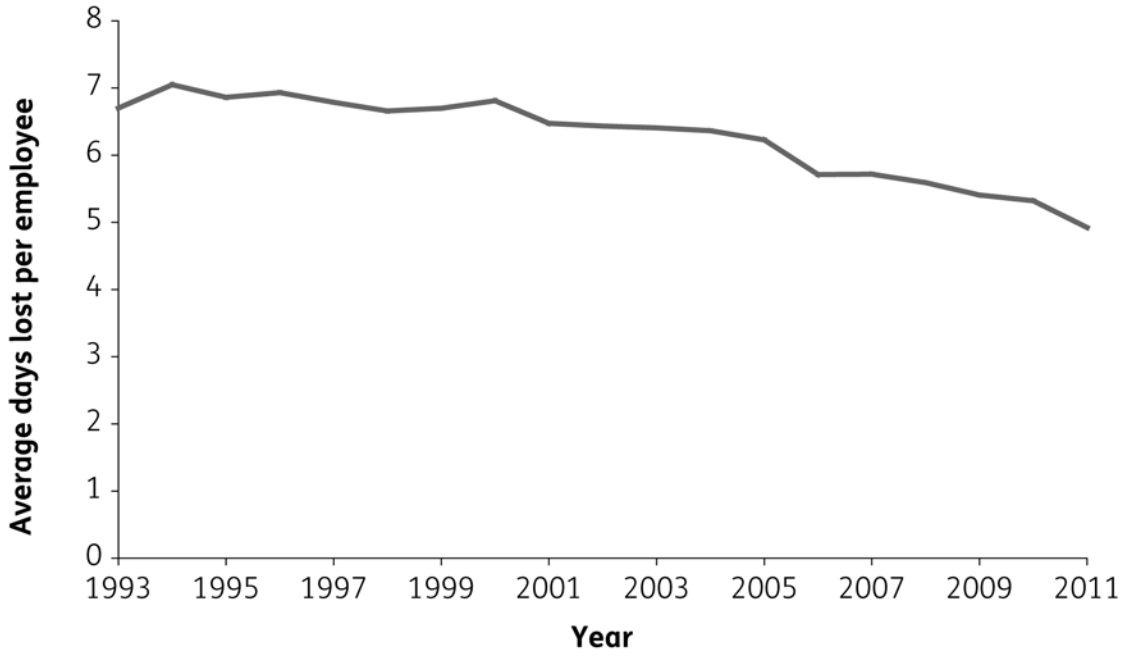
11. We estimate that there are currently 140 million working days lost per year in GB due to sickness absence[6]. This equates to 2.2 per cent of all working time, or 4.9 days for each worker each year, and is broadly comparable to many other developed countries (the United States, France, Germany and the Netherlands have similar rates).

12. Overall sickness absence has been gradually declining over recent years (see Figure 4) and employers report that they have been managing the issue more actively.

[5] Young, V. and Bhaumik, C. (2011). *Health and well-being at work: a survey of employees*, DWP Research Report No. 751.

[6] Source: SAR's analysis of Labour Force Survey, ONS; average of four quarters to March 2011; Age 16–64; GB (not seasonally adjusted). In its latest absence and workplace health survey 2011, the Confederation for British Industry (CBI) estimates nearly 190 million days were lost to absence in 2010, though this reflects their generally higher reported absence levels (due to the survey bias towards larger firms).

Figure 4: Sickness absence: average days lost by each employee each year



Source: SAR's analysis of Labour Force Survey, ONS; average of four quarters in year to March; Age 16–64; GB (not seasonally adjusted).

Work-related sickness absence

13. Most sickness absence is not caused or made worse by the workplace. Statistics from the Heath and Safety Executive suggest that only around one-fifth of working days lost to sickness absence are work related (around 22 million days due to work-related ill health and a further 4.4 million to workplace injury[7]).

Factors affecting absences and flows out of work

14. As Annex C sets out, absence levels vary greatly with individual and firm characteristics. There are also considerable differences between shorter-term absence, longer-term absence and flows out of work altogether, in terms of the health conditions people suffer at each stage and their personal characteristics. For example, both short-term and long-term absence are associated with higher levels of OSP; longer-term absence is more prevalent in the public sector and among older employees; and better employee engagement reduces all types of absence. Lower paid, lower skilled workers are more likely to take absences and to fall out of work altogether through ill health. These differences are important for understanding what policy changes could improve absence outcomes at different stages.

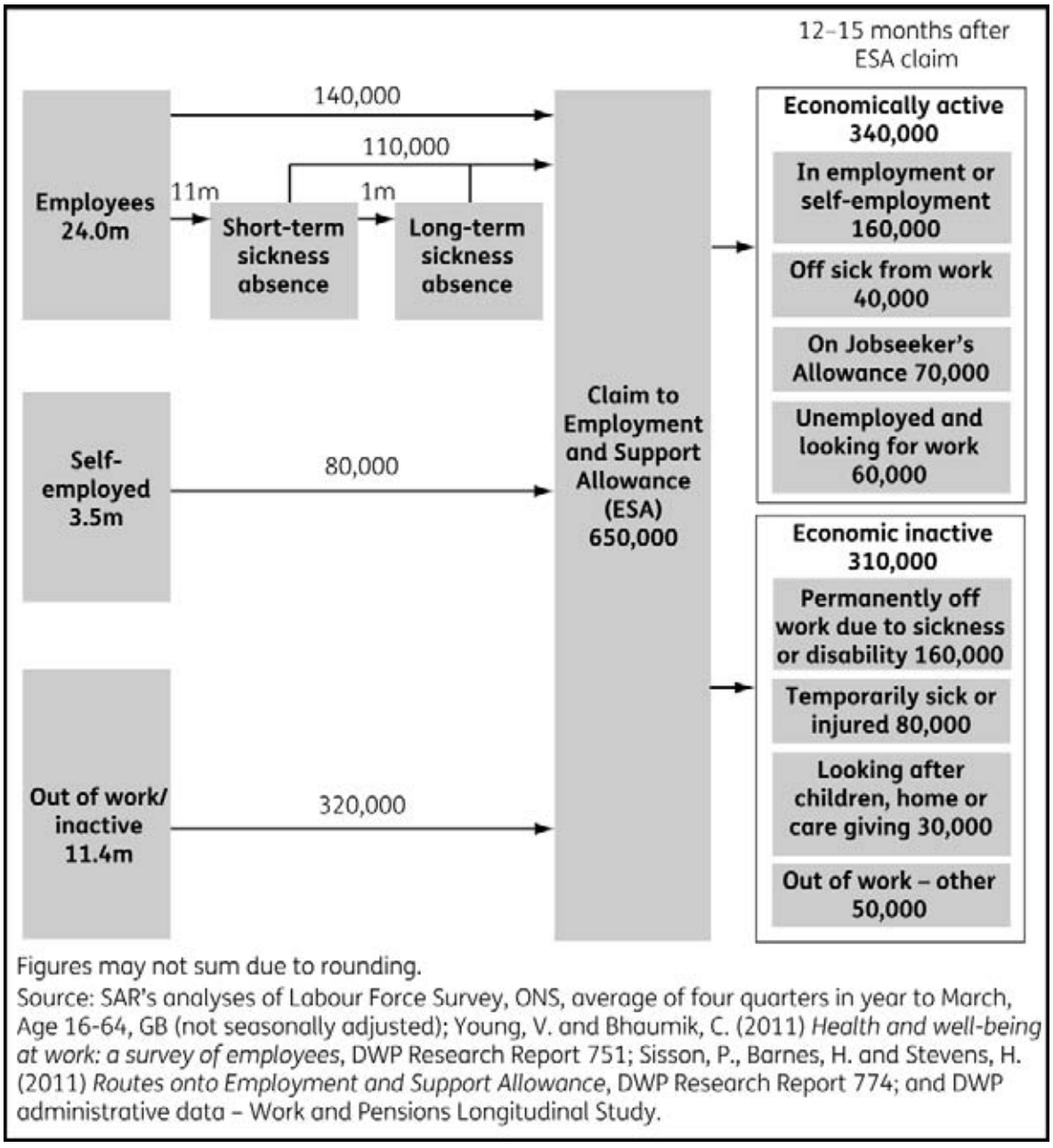
[7] The Health and Safety Executive Statistics 2010/11.

Flows out of work due to ill health

15. Each year, approximately 330,000 people flow from work on to the State's main health-related benefit, ESA. Two-thirds of claimants are male and over a third are over 50 years of age.

16. Unlike in the stylised journey above, not all ESA claimants coming from work have had a spell of sickness absence with their employer first. In fact, we have found evidence of considerable churn between employment and the benefits system for (disproportionately) lower paid people coming from smaller and medium-sized firms. Figure 5 shows the flows of people between work, sickness absence and ESA within a year.

Figure 5: Flows between work, absence and ESA



Figures may not sum due to rounding.
Source: SAR's analyses of Labour Force Survey, ONS, average of four quarters in year to March, Age 16-64, GB (not seasonally adjusted); Young, V. and Bhaumik, C. (2011) *Health and well-being at work: a survey of employees*, DWP Research Report 751; Sisson, P., Barnes, H. and Stevens, H. (2011) *Routes onto Employment and Support Allowance*, DWP Research Report 774; and DWP administrative data – Work and Pensions Longitudinal Study.

17. This shows that over half of ESA claimants coming from employment (140,000 people) actually do not have a period off sick first. This finding has been very important in understanding the current system and making recommendations. In particular, the fact that smaller firms have lower sickness absence rates (see Chapter 3) is partly explained by the flows of people straight from work onto benefits as these come disproportionately from smaller firms.

18. Because not all individuals experience the full stylised journey of Figure 3 with their employer, we have also had to think about the actual journeys made to state benefits and between different types of benefits. In particular, we had to satisfy ourselves that any promotion of greater responsibility by employers to manage sickness absence would not result in encouraging them to pass people with health conditions onto the State.

19. The fact that so many people come to state benefits without a period of paid absence in employment also means that for this group the State has a bigger role than employers in supporting them back to work. But, as Figure 5 shows, only one in four ESA claimants are back in work a year or more after making an initial claim. Therefore we needed to assess the State's efficiency in helping people with a health condition get back to work (see Chapter 6).

Data on sickness absence

20. We have drawn on a wide range of data sources to support our arguments for change. We have also considered international experiences of sickness absence (see Annex D). As we highlight throughout the report, more robust data and information on sickness absence can better inform decision-making to help employers and the State.

21. Better use could also be made of existing data and the Government should work with the academic community and the private sector to explore how to improve access to aggregated administrative data and potentially allow more linking with other data sets held elsewhere. Doing so would necessitate finding a method that continues to protect the confidentiality of personal data and complies with all relevant legislation.

Chapter 2 – Sickness certification: improving its effectiveness

Chapter 2 describes how certification[8] of ill health by a doctor is the gateway to employers' sick pay and often marks the start of a journey towards ill health benefits. This chapter seeks to enhance the changes in medical certification (particularly the introduction of the 'fit note') made following the 2008 Black Review.

For longer-term absences (four weeks or more), or difficult cases, employers and doctors (usually General Practitioners (GPs)) would welcome independent authoritative advice about what support would be most effective in returning an individual to work. This would help doctors, who usually do not consider themselves expert in this area, and employers who need advice to support their employees to return to work.

Many large companies already purchase such advice from occupational health providers. However, many medium and small employers find it difficult to access similar services because of the costs involved.

The Review therefore recommends that the Government should fund a new Independent Assessment Service (IAS). The IAS would provide an in-depth assessment of an individual's physical and/or mental function. It would also provide advice about how an individual on sickness absence could be supported to return to work. The assessment could be used by employers to help support a return to work, and by doctors to inform their advice to patients.

This service should usually be accessed when an individual's absence has lasted around four weeks, at which point there is a heightened risk of a significant spell of longer-term absence. The service should be quality-assured and provided by healthcare professionals with appropriate skills.

To build on improvements already made to certification from the fit note, the Government should also:

- revise fit note guidance to ensure that judgements about fitness to work move away from only job-specific assessments; and
- do more to improve knowledge and awareness among healthcare professionals, particularly those involved in certification, of the WCA and the benefits system generally and the importance of work for health.

[8] Formally doctors issue medical statements, however, 'medical certificates' and 'certification' better reflect real-world language and are used throughout this chapter.

22. The first stage of an individual's sickness absence journey is usually to visit their doctor to discuss their health problems, receive treatment where appropriate, and seek advice about their fitness for work.

23. Evidence of fitness or unfitness for work – most commonly provided by GPs on 'fit notes' – is pivotal to the effective functioning of the sickness absence system. Specifically, fit notes are designed to provide advice to:

    - **patients**, about whether and how their health condition affects their ability to work. A note sets out advice and practical measures that could be taken so that work remains compatible with their health or impairment and their treatment;
    - **employers**, on whether their employees' claim to sick pay is legitimate and how they could help an employee with a health condition remain in work; and
    - **Jobcentre Plus**, on who is eligible to make an initial claim for health-related benefits such as the Employment and Support Allowance (ESA).

    The fit notes also provide a means for doctors to sharpen their focus on the relationship between health and work, which is particularly important given the strong evidence about the importance of work for health.

24. Research suggests that each year around four million spells of absence are sanctioned by medical certificates, accounting annually for around 70 per cent of all working days lost to employee sickness absence[9]. Within the benefits system, each year around 650,000 people make a claim to ESA, supported by evidence provided by a doctor. This chapter examines the current functioning of the medical certification system, and asks whether doctors, their patients and employers could be better advised and supported.

Meeting the needs of employers and employees

25. Employers rely on the fit note as evidence to verify that sickness absences of over seven calendar days are justified, and to inform them when an individual is, or is expected to be, fit enough to return to work. Employers also rely on fit notes to identify those cases where an employee has a health condition which limits function, but could work if given sufficient support.

[9] Based on estimates of spells distribution from Young, V. and Bhaumik, C. (2011). *Health and well-being at work: a survey of employees*, DWP Research Report No. 751, applied to Labour Force Survey sickness absence totals.

Introducing the fit note

In April 2010, the Government replaced the old sick note with a new medical certificate known as the fit note.

Under the old sick note system, doctors had the unrealistic choice of advising their patients that they were completely fit or completely unfit for work. Such a distinction did not recognise how many people with health conditions could work with changes to workplaces or job roles. Indeed, it could aid their recovery if they did so.

As a result, many patients were signed off work completely, when with appropriate adjustments they could have been supported to return to work.

Employers were unhappy that the sick note system effectively gave doctors sole responsibility for sanctioning sickness absence. In their view, this increased absence durations and prevented them from supporting people to stay in work.

Responding to these challenges the new fit note introduced a 'may be fit' category. This allowed doctors to reach a judgement that a patient had some functional limitations, but could return to the workplace with appropriate support.

It was hoped that under a fit note system employers would be better advised on the steps they could take to help employees back to work and therefore control their sickness absence more effectively.

Doctors have largely welcomed the new fit note and often say that their practice has changed as a result.[10] Employers, however, are frustrated that the system is still not fully meeting their needs.

26. During the course of this Review we have heard from many employers, both large and small. A common theme to emerge from these discussions is that employers, of all types, do not believe that the certification system yet meets their needs.

27. They describe how, too often, sick individuals, whom they would want to support to remain in or return to work, are signed off as entirely unfit for work. They also report that too few fit notes describe an employee as 'may be fit', and when a 'may be fit' note is issued the advice given is often not as helpful as they would wish.

28. A recent survey of Department for Work and Pensions (DWP) line managers suggests that around 10 to 15 per cent of fit notes are issued containing a 'may be fit' assessment. Other large employers have reported to us that 'may be fit' assessments occur in as few as 2 per cent of cases.

[10] Hann, M. and Sibbald, B. (2011). *General Practitioners' attitudes towards patients' health and work*, DWP Research Report No. 733.

29. These early findings suggest that over 85 per cent of patients off sick for more than a week may be being certified as entirely incapable of work. Although employers may themselves wish to take steps to support individuals back to work, the medical statement 'not fit for work' hinders this process. This leaves the patient further removed from the labour market, with risk to their well-being and indeed their health in the longer term[11].

Improving the effectiveness of the fit note

30. Certificates that make firm judgements that an individual is not fit for work exert a powerful influence in the sickness-absence system. Employers feel unable to challenge such certificates and, as a result, individuals may be needlessly absent from work and potentially begin an unnecessary journey into the benefits system.

31. The fit note reforms aimed to reduce the number of such 'not fit' certificates by encouraging doctors to indicate where individuals could be supported to work with appropriate adjustments. While most employers support the intent behind the fit note, they believe that more should be done to deliver on its promise, with many more 'may be fit' certificates being issued.

32. One reason why there are relatively few 'may be fit' certificates could be that doctors mainly have in mind the tasks and requirements of an individual's specific job when they issue a fit note[12]. However, it seems that they do not consider whether the job itself or the workplace may be modified to permit the person to return to or remain in work. As a consequence, doctors can be led to be cautious and certify patients as entirely unfit, perhaps assuming that modifications to work cannot or will not be possible. Some doctors may feel that this is their duty in the short term, as the patient's advocate, despite the long-term risks to health of being out of work[13].

33. We believe that it would be better to ask doctors to consider an individual's functional capacity to return not only to their own job, but to work more generally. If the doctor considers that a person has a reasonable level of function, and could be supported to work with the help of their employer, a 'may be fit' certificate should be issued. In other cases, for example when a patient's functional limitations are such that no work is reasonably possible, a 'not fit' certificate is more appropriate.

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11 Waddell, G. and Burton, A. K. (2006). *Is work good for your health and well-being?* TSO.

12 Guidance on completing the old sick note stressed the need for doctors to consider the patient's job if they had one. Guidance for completing the new fit note does not make clear that this approach should change. As a result, the legacy of certifying whether an individual can do their job persists.

13 Waddell, G. and Burton, A. K. (2006). *Is work good for your health and well-being?* TSO.

34. Such an approach would have a number of advantages over 'job-specific' certification. It would help employers to make sound judgments about whether an early return to work can be facilitated, but the certifying doctor would not be required to have extensive occupational health knowledge about specific jobs and/or training. Employees would have a much greater chance of getting the support they needed to stay in work as they recover from, or adapt to, their health condition or impairment. This approach would also better reflect how people are assessed in the benefits system (by a Work Capability Assessment (WCA)) ensuring that individuals have a more consistent view about their fitness to work.

35. The Government has recognised that more needs to be done to ensure that the fit note fulfils its potential. In the next 12 months, the fit note in Great Britain (GB) will become electronic. This will have a number of advantages, for example, ensuring the legibility of the advice provided by the doctor. It will also mean that data about certification practice can be collected, presenting an important opportunity for audit and professional development, providing real transparency in this area of practice. For example, local health organisations could collate data to drive improvements in local practice and direct support to those who need it.

36. More fundamentally we also believe the fit-note system would be significantly strengthened if government guidance were changed to set out clearly for doctors that when issuing fit notes they should consider work in a general sense, not merely the specific job of an individual. **We therefore recommend that the Government revise fit note guidance to ensure that judgements about fitness to work move away from only job-specific assessments.**

Advising employers about supporting a return to work

37. Asking doctors to certify whether their patients are, in general, fit for work will place an onus on employers to consider whether and how they can support individuals with health conditions to return to work. In many cases, the adjustments required to support individuals to work will be obvious. In others, the available options may or may not be appropriate for an individual's or firm's circumstances. In these cases many employers will feel they need advice about the best course of action. Without it employees may needlessly remain absent from work.

38. Few GPs have the time available or the training to give such specialised advice in more complex cases. Large employers can get around this constraint by purchasing occupational health and related rehabilitation services. However, smaller employers report that they find it difficult to access similar services because of the costs involved.

39. Clearly, if sickness absence rates are to be minimised, all employing organisations should have access to expert advice on whether and how an individual can be supported to work.

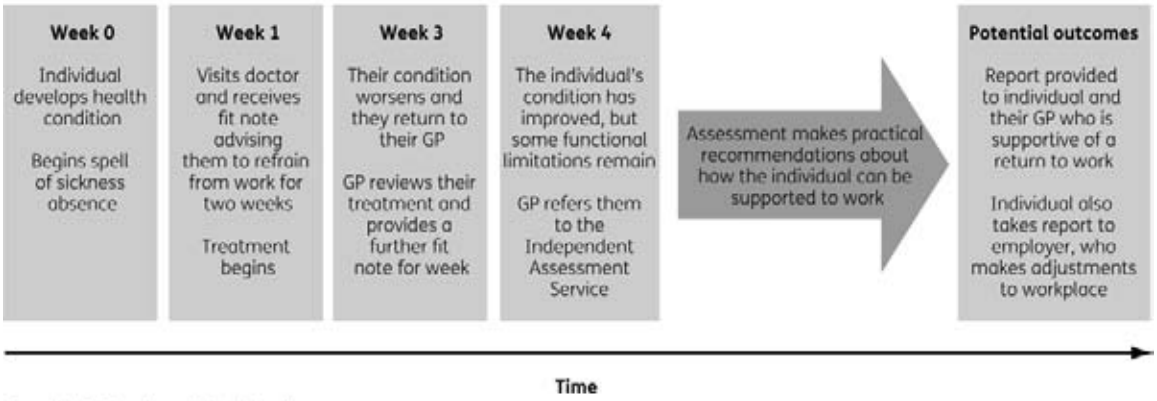
40. An IAS could provide rapid and expert fitness-for-work advice about individuals on long-term sick leave or with complex health conditions. Taking account of the individual's function, such services would offer advice about what help, if any, the individual needs to support a return to work. Where appropriate, the output of such assessments could be used as medical evidence to validate or refute a claim to sick pay.

Potential referral routes to the IAS

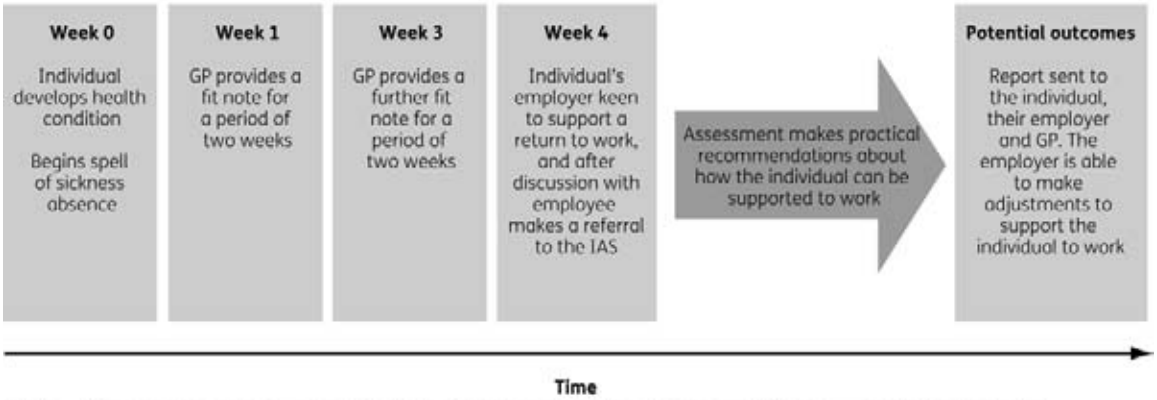
Set out below are diagrams demonstrating how individuals may be referred to the IAS. The pathways are for illustrative purposes only.

In practice, a number of scenarios are possible, for example employees may initiate a referral through either their doctor or employer.

Example 1: General-Practice-led referral



Example 2: Employer-led referral



Note: Our research suggests that absence spells of around four weeks in length present a material risk of leading to a sustained spell of absence or the individual leaving the labour market altogether. Hence it is highlighted here as an appropriate point of referral. We recognise that this might not always be the case, however.

41. Most GPs would not be expected to offer this service. We need to identify clinicians who are qualified to provide expert fitness-for-work advice and undertake functional assessments as required. As a result of discussions with professional groups, we believe that such services could draw on the expertise of, for example, appropriately skilled occupational therapists, physiotherapists, GPs and nurses, as well as occupational health professionals. Overall, the IAS would need to draw on the best services available, whether in the private or public sectors.

42. To meet the needs of all those on sick leave, the IAS would need to ensure that its clinicians have the skills, knowledge and capacity to assess both mental and physical health. Clearly, the advice provided by the service should be subject to independent scrutiny to ensure quality and consistency.

43. The costs of such a service are not insignificant. We estimate that each year, up to 200,000 people would gain from using the IAS. Depending on how the service is configured, it could cost around £30 million each year.

44. A number of stakeholders in the system would stand to gain from such services. Employees would be more likely to get the support they need to stay in and enjoy the advantages of work for themselves and their families. For those receiving sick pay, which is less than their usual wage, this could be highly valuable.

45. Employers will get the help they need to better control the costs of absence and keep valuable employees. We estimate that they could gain around £100 million a year through reducing the costs of absence (see Annex B).

46. The State would gain too: firstly, from fewer people claiming benefits such as ESA, and secondly, because tax revenues will increase as a result of increasing economic output. However, given that we recommend the State funds the IAS, we estimate there will be a small cost overall to the State of £10 million (see Annex B).

47. There are a number of ways to fund such services, each with its own merits. However, we believe that initially the most attractive option would be for the State to bear the cost of delivery. We reach this conclusion for a number of reasons.

48. First, the State is already intervening in this area. For example, Her Majesty's Revenue and Customs (HMRC) have for many years run an assessment service to which individuals and employers could turn if medical evidence supporting a claim for Statutory Sick Pay (SSP) was disputed. More recently, a telephone-based occupational health advice line has been launched to support small businesses to manage individual cases of absence.

49. Second, such an approach would allow the DWP, HMRC and health departments in England, Scotland and Wales to design assessment services which properly integrate with primary and secondary care services (see paragraphs 53–57 below).

50. Third, the business case for investing in such advice is persuasive. We estimate that the State would cover the costs of running such services if around 5,000 people each year were helped to remain in work rather than make a claim to benefit. An initially state-funded model would also ensure that employers, at a time of economic difficulty, retain the gains made by making greater efforts to reduce sickness absence.

51. Once the service is established and economic conditions improve, a charging model could perhaps be adopted, with employers and possibly employees being asked to make a contribution as they access the service.

52. **We recommend that the Government creates an IAS that employers and doctors could access to help support high-risk or long-term-absent employees back to work.**

How will the new IAS help?

Case study 1: John

John is a driver for a distribution company. After lifting a heavy consignment John reports a dull aching pain in his lower back that gets worse in the following weeks and he has difficulty bending down and reaching forwards.

John visits his GP and describes his symptoms and explains why he believes he is unable to undertake his current job – as it involves heavy lifting and sitting still for long periods when he is driving. John's GP refers him for physiotherapy and issues a fit note stating he is not fit for work.

John's employer recognises that undertaking his usual driving duties may be difficult while John recovers from his back problem. However, they are keen to support him to remain in work and think that his driving experience could be put to good use in their Logistical Planning Department. They talk through this option with John who is keen to take the opportunity, but he is worried that it may make his back condition worse.

John's employer encourages him to phone his local assessment service. A functional assessment ensues, considering John's symptoms and the role he has been offered during his recovery. The professional expert who undertakes the assessment assures John that staying active and returning to work will help his recovery. This is reported to John's employer and his GP. John agrees to take the position offered in logistics and returns to work.

Case study 2: Sarah

Sarah works for a small firm of solicitors. She has lived with rheumatoid arthritis for a number of years and has been able to work throughout this period. Over time her condition worsens and her consultant recommends that Sarah undergo surgery to replace both knee joints. Following the operation, Sarah undertakes a period of recuperation and rehabilitation which usually takes three to six months.

After four months, making significant progress towards rehabilitation, Sarah thinks about returning to work. However, she still has limited mobility, especially walking on slopes, and cannot climb stairs very easily. She does not believe she could complete her journey to work on public transport.

Sarah's GP wants a functional assessment and advice as to what support she would need to return to work and so refers her to the local assessment service.

There, an occupational therapist advises that returning to work would be beneficial for Sarah and sets out the support she would need, including an adjustable chair and moving her work station.

Sarah takes a copy of her assessment to her employer who agrees to make the changes suggested. Sarah also makes an application to the Government's Access to Work scheme[14] to help cover the costs of her journey to work, which for a short period she needs to make by taxi.

Accessing appropriate treatment

53. Many people with health conditions can be returned quickly to work by agreeing simple workplace adjustments with their employer. In some cases, the intervention needed to help them back to work is a treatment that would usually be offered by local health services. In other circumstances, 'social' interventions, such as debt counselling, might be needed to overcome barriers to return.

54. Usually, the healthcare professional with overall clinical responsibility would refer a patient to appropriate services. Sometimes, for a variety of reasons, this does not happen.

[14] Access to Work is a specialist disability programme delivered by Jobcentre Plus, which provides practical advice and support to disabled people and their employers to help them overcome work-related obstacles resulting from disability. Access to Work funds the support that is beyond the reasonable adjustments that employers make.

The Fit for Work Service approach

While many employees return to work quickly without additional support, for others, intervening early in a spell of sickness can speed a return to work and avoid health-related job loss. To provide this support, the 2008 Review of the health of Britain's working-age population proposed piloting a new Fit for Work Service.

A Fit for Work Service uses a case-managed, multi-disciplinary approach to providing treatment, advice and guidance for people in the early stages of sickness absence. It also recognises that sickness absence can have both medical and non-medical causes. The service can, for example, provide access to advice on financial and housing issues, and negotiation with the employer, as well as more traditional National Health service (NHS) medical services.

The Government accepted these earlier proposals and Fit for Work Services are being piloted and evaluated, with final evaluations expected in 2013. If found to be effective, these services could be rolled out across GB, giving access to appropriate work-related support to all employees.

55. The new assessment service presents an opportunity to identify such individuals and ensure that they can access the care or support they need. Most simply, this could involve signposting individuals to local provision such as debt and housing advice, or where available a Fit for Work Service (see *The Fit for Work Service approach*). Where appropriate, the service could refer people to the job-brokering service which we describe in Chapter 5.

56. In other cases, the professional conducting an assessment, acting within the scope of their practice, may offer advice that could help an individual's rehabilitation. More rarely, an assessor may conclude that a further clinical assessment could be helpful to support a return to work: for example, an underlying mental health condition may also be suspected in a patient presenting with back pain. In these circumstances, it is important that assessors liaise directly with the clinician responsible for the individual's care.

57. To deliver such an holistic service the IAS will need to work collaboratively with primary and secondary care, with public health and with the providers of services which could help return people to work. Creating such conditions should be a guiding principle for those who take forward the design of this service.

Providing appropriate advice to individuals claiming benefit

58. Each year, around 650,000 people make a claim to ESA supported by a medical certificate provided by a doctor. DWP data show that of the 840,000 claimants for ESA who undertook a WCA between October 2008 and November 2010, only around 320,000 (38 per cent) were found to have functional limitation(s) beyond the state threshold for the benefit[15].

59. Fit notes are used by these individuals as evidence that they have a health condition which limits their ability to work. As such, they act as a passport to an initial claim for ESA. However, recent DWP survey data suggest that 77 per cent of doctors believe their understanding of the benefits system is not up-to-date[16]. Given the important role that doctors play at the start of the journey towards the benefits system, and the potential consequences for patients, this clearly needs addressing.

60. We believe that given early appropriate advice and support, this journey towards inactivity and life on benefits is entirely preventable for many people. Chapter 6 explores in much greater detail how we suggest the benefits system be changed to prevent people being trapped in a slow and inefficient system.

61. **We therefore recommend that the Government does more to improve knowledge and awareness among healthcare professionals, particularly those involved in certification, of the WCA and the benefits system generally and the importance of work for health.**

15 Excludes appeals, cases closed before an assessment was completed and assessments still in progress.

16 Hann, M. and Sibbald, B. (2011). *General Practitioners' attitudes towards patients' health and work*, DWP Research Report No. 733.

Chapter 3 – Sickness absence in employment

Chapter 3 focuses on the cost and nature of sickness absence in the workplace and what might help employers reduce absence and cost.

Although there is clear evidence that early intervention helps sick employees return to work sooner, employers are often discouraged from investing in this by the tax system. To help overcome this we recommend:

- **that expenditure by employers targeted at keeping sick employees in work (or speeding their return to work) such as medical treatments or vocational rehabilitation should attract tax relief. This should be targeted at basic rate taxpayers.** Some companies already voluntarily provide private medical treatment and/or private health insurance for at least some of their workforce to reduce absence, but many more are discouraged from doing so as it is treated as a taxable benefit in kind; and
- **that tax relief on Employee Assistance Programmes (EAPs) be retained.** We have found these services can be very effective in tackling absence by providing information, advice and counselling on a variety of issues causing absence and/or performance problems. Existing tax relief on EAPs has been under threat, but we are convinced that there is real value in these programmes.

The Review has highlighted the complex nature of sickness absence in smaller firms. Although they have lower absence, their staff, when they experience ill health, are more likely to move straight to the benefits system. Government should carry out **further research into this issue** and the extent to which, if at all, this is non-compliance by small and medium-sized enterprises (SMEs) in paying Statutory Sick Pay (SSP).

Furthermore we recommend that the Percentage Threshold Scheme (PTS) be abolished. Although it compensates employers for higher-than-average sickness absence, it fails to promote attendance management. **We also recommend that record-keeping obligations under SSP are abolished.** Removing this administrative burden will largely offset the cost to business of abolishing the PTS.

Employers can reduce sickness absence directly through good management and early intervention. We highlight the importance of:

- **proper measurement of absence and a better understanding of its cost;**
- **promoting management best practice** – including how to deal with the growing problem of stress and mental health conditions; and
- **better and more accessible guidance** to help employers understand the law on sickness absence. **We recommend the Government updates its Employers Charter to address misconceptions about sickness absence management.**

The costs of sickness absence to employers

62. Employers bear much of the cost of sickness absence while employees are still in work. However, success in managing sickness absence varies greatly between employers. This chapter identifies barriers to employers controlling absence costs more effectively and puts forward recommendations to overcome them.

Background – employers, employment and the industrial sector

63. There are currently 27.5 million people in employment in Great Britain (GB), made up of 24 million employees and 3.5 million self-employed[17]. The public sector, discussed in greater detail in the next chapter, employs almost six million people.

64. There are over 1.1 million private sector employers in GB. The vast majority of them are small: 97 per cent have 50 or fewer employees and almost 83 per cent have fewer than ten employees. However, most employment is concentrated in medium or large firms: almost half work in large firms employing over 250 people and most of these in firms with 500 or more employees. Smaller employers account for just over a third of all those in work in the private sector.

Table 1: Distribution of private sector employers by size in GB

Firm size	Enterprises with employees (000s)	Share of employers (%)	Share of employment (%)
Micro (1–9 employees)	941	82.2	18.4
Small (10–49 employees)	168	14.7	17.4
Medium (50–249 employees)	30	2.6	14.9
Large (250+ employees)	6	0.6	49.3
Of which more than 500 employees	**3**	**0.3**	**43.6**
Total	1,145	100	100

Source: Department for Business Innovation and Skills, *Business Population Estimates for the UK and Regions 2011*.

[17] *Labour Market Statistics*, September 2011. Office for National Statistics.

65. Sickness absence varies greatly among employees and between employments of different types. Analysis of the data indicates that this appears to be due to a combination of: employee characteristics and demographics; the presence and scope of occupational sick pay (OSP); management practice; and the degree of employee engagement.

Statutory Sick Pay and Occupational Sick Pay

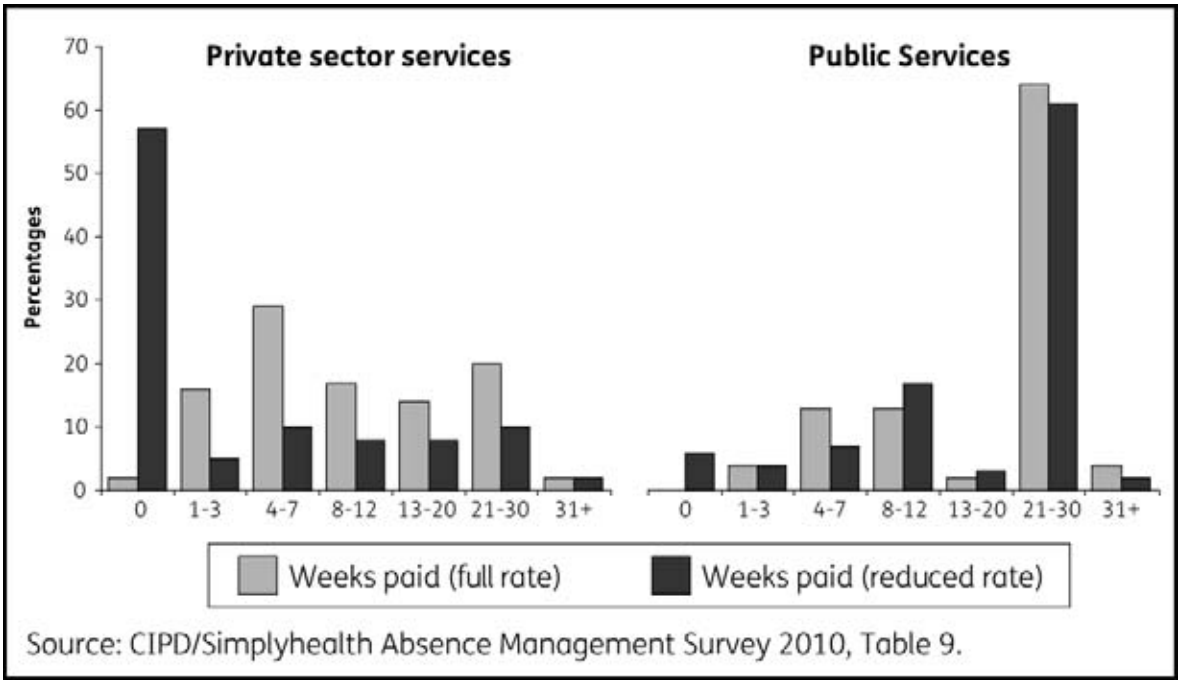
66. Since 1983, the responsibility for the direct financial costs of sickness absence has gradually been transferred from the State to employers. Employers are obliged to pay SSP of up to £81.60 per week for up to 28 weeks, though only from the fourth consecutive day of absence.

67. Although SSP sets a minimum for employers, in medium-sized and larger organisations the basic SSP provisions appear to have little impact on the sick pay actually offered. Around half of employers – covering up to 70 per cent of employees – are much more generous and offer OSP often at full pay and usually from the first day of absence. We estimate that SSP places an obligation of around £1.5 billion on employers, but on top of this employers voluntarily pay an additional £6.9 billion in OSP.

68. The generosity of OSP varies a great deal between firms and tends to be much more favourable in the public sector (as Figure 6 shows). The median duration of OSP at full pay in the public sector is 26 weeks; in the private sector it is eight weeks.

69. We have also considered the obligation for employers to provide 28 weeks SSP. We recognise that the likelihood of an employee returning to work after such a long spell of sickness absence is low. However, our recommendation for a new job-brokering service will help address this (Chapter 5). On balance, having considered the current balance of responsibilities between employers, individuals and the State, and the likely impact of our recommendations, we have concluded that the 28-week period for SSP should not be changed.

Figure 6: Duration of OSP provision in the public and private sectors



70. A number of studies[18] suggest a causal link between high sickness absence and generous OSP. Where an employee can be off on full pay, there is no financial incentive to be at work. Furthermore, paid sick leave can often be seen as an entitlement, to be used up each year in a similar way to annual leave. This may be an unintended consequence of OSP policy. Throughout the Review, though, employers have emphasised their commitment to OSP to support those employees who are ill or injured and need time to recover to make a successful return to work.

Sick pay and SMEs

71. Overall, long-term absence tends to be much lower in SMEs. One of the reasons is likely to be lower levels of OSP among SMEs, making it less attractive for employees to take sick leave (and increasing the attractiveness of state benefits in long-term sick cases). However, set against this, a disproportionate number of people come from SMEs onto ESA without first going onto sick pay. Further research will be required to investigate how small firms manage their sickness absence obligations and whether state resources could be better targeted.

[18] Frick, B. and Malo, M. (2008). *Labour market institutions and individual absenteeism in the European Union: the relative importance of sickness benefit systems and employment protection legislation*; Osterkamp, R. and Röhn, O. (2005) *Being on Sick Leave – Possible Explanations for Differences of Sick-leave Days Across Countries*, Ifo Working Paper No. 19.

72. As SSP policy has evolved, there has been greater assistance for SMEs. In 1991, a Small Employers Relief (SER) scheme was introduced allowing SMEs to claim 100 per cent of SSP costs from the State after the sixth week of absence. All other employers could reclaim only 80 per cent of the cost. In 1994, the SER rules were relaxed to allow cost recovery after four weeks and the threshold increased making more employers eligible. At the same time, SSP cost recovery for other employers was abolished.

Percentage Threshold Scheme

73. In 1995, the PTS was introduced instead of SER, offering a rebate to employers experiencing higher-than-average levels of sickness absence[19]. Used mainly by small business this costs the State around £50 million each year[20].

74. But the PTS does nothing to encourage employers to reduce absence and there have been calls to abolish it[21]. The current arrangements for dealing with sickness absence in smaller firms are clearly not optimal. Smaller firms do face particular pressures, but much greater focus on tackling absence is needed, rather than the State simply reimbursing some of the cost. Other recommendations put forward by this Review will help smaller – as well as larger – businesses to address sickness absence. **We do not see any justification for retaining the PTS and recommend that it be abolished.** The savings that result from this change will help pay for the new service providing functional assessments described above.

Administrative burdens

75. Employers also bear considerable administrative costs in relation to SSP, mainly around the requirement to maintain records for three years of all sickness absence lasting for four days or more[22]. The provision is required to ensure a record is available for SSP compliance checks by Her Majesty's Revenue and Customs (HMRC) and to support claims under the PTS scheme. The record is also useful in case of a dispute. This regulation also requires employers to maintain a record of all SSP payments associated with these spells of sickness. This costs private business an estimated £44 million a year[23].

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19 An employer qualifies for PTS if the total SSP paid is more than 13 per cent of the total gross National Insurance Contribution (NIC) liability in that month. Any payments over and above this level can be recovered from the State.

20 In 2009–10, over 90 per cent of claims were from smaller firms and averaged less than £500 per claim.

21 See for instance Report of the Statutory Sick Pay Review Working Group and the Ministerial response, available at: http://www.dwp.gov.uk/publications/policy-publications/review-ssp.shtml

22 Regulation 13 of the Social Security Statutory Sick Pay (General) Regulations 1982.

23 Department for Work and Pensions (2006), *Administrative Burdens of Regulation*.

76. **As much of the three-year record-keeping requirement under SSP can be related to PTS we recommend that this associated administrative burden is also scrapped.** Businesses should be able to rely on their own existing record-keeping arrangements, which are vital to managing and costing absence properly.

Overcoming barriers to managing sickness absence

77. According to a recent Confederation of British Industry (CBI) survey[24] the long-term decline in sickness absence (highlighted in Chapter 1) is largely due to better management practice: closer appropriate employer-employee contact during absence, return-to-work plans, and good records. Adopting the right management practices can have a powerful effect on returning an employee to work quickly. Outlined below are a number of areas on which employers, some of whom do not currently follow best practice, could focus to improve their management of absence.

Recording sickness absence and monitoring its cost

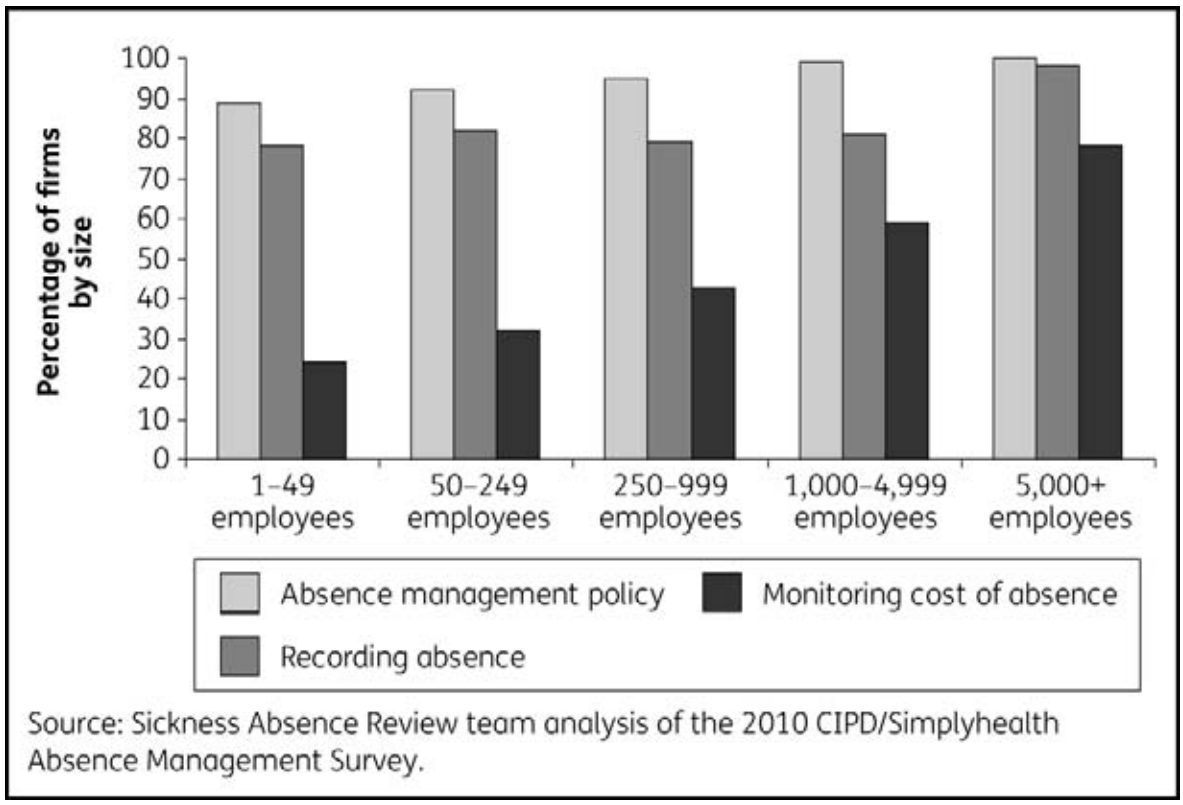
> *The provision of accurate, timely and accessible information is the cornerstone of a successful absence policy. Without good data, managers have no grasp of what they are trying to control. The saying 'You can't manage what you can't measure' applies directly to absence control.*
>
> *National Audit Office*[25]

78. Although most employers – large and small – have absence management policies and systems for recording absence, the degree to which firms actually monitor the costs of sickness absence varies significantly. Only half of businesses do this and the proportion is even lower in smaller firms (see Figure 7).

[24] Confederation of British Industry (2010), *On the path to recovery: absence and workplace health survey 2010*, Confederation of British Industry.

[25] National Audit Office (2004), *Current thinking on managing attendance – a short guide for HR professionals*.

Figure 7: Absence management practice by firm size



Source: Sickness Absence Review team analysis of the 2010 CIPD/Simplyhealth Absence Management Survey.

79. Even where absence records are kept, many organisations still have problems because of inaccuracy or inadequacy of the information collected[26]. Relatively few actually use the information to improve absence management procedures, and only one in five measures the financial costs and lost productivity[27]. A greater focus on good quality and consistent absence data, combined with better understanding of the true costs of absence, would help organisations focus efforts on tackling the problem. Early and appropriate interventions would speed recovery and return to work, thus justifying the investment. Line managers and Human Resources departments should make greater use of existing online tools that help calculate the cost of absence[28].

How employers tackle sickness absence

80. Half of organisations have a sickness absence target and a similar proportion benchmark absence performance against other employers. Return-to-work interviews and trigger mechanisms to review attendance are seen by employers as being effective in tackling short-term absence[29].

[26] XpertHR, (2010). *Compiling, maintaining and using absence records: the 2010 IRS survey.*
[27] Aviva, (2011). *The fifth Aviva Health of the Workplace Report*.
[28] For instance the National Institute for Clinical Excellence (NICE) has a business case tool to help employers calculate the costs of long-term absence and the benefits from intervention.
[29] The 2010 CIPD Absence Management Survey in partnership with Simplyhealth.

81. Occupational health input was cited as being most effective in tackling long-term absence. Conversely, lack of access to occupational health – especially among smaller businesses – has been consistently cited as a significant barrier to good sickness absence management (see Table 8 in Annex C). Our recommendations for a new Independent Assessment Service (IAS) are in part designed to overcome this barrier.

82. The way sickness absence is managed by immediate line managers is a key factor. Organisations that train them appropriately are more likely to achieve a decrease in absence[30].

83. One of the strongest messages we have received throughout the Review is that some employers still lack confidence in dealing with absent employees, from both a management and a legal perspective.

84. Excellent guidance to help employers tackle sickness absence already exists, notably through the Advisory, Conciliation and Arbitration Service (Acas)[31] and the National Institute for Clinical Excellence (NICE)[32] (see Figure 8). These emphasise the importance of intervening early, maintaining contact with employees and holding exploratory interviews, training line managers and considering graded interventions to help people back to work.

85. Not all employers use this guidance as evidence shows awareness and take-up remain low. Recent Department for Work and Pensions (DWP) research[33] shows that only 15 per cent of organisations were aware of the NICE public health guidance. Awareness was even lower in the private sector and among smaller businesses[34] and actual usage was lower still.

86. The challenge, therefore, is to ensure that best practice becomes embedded in organisational approaches to absence management. There has been a proliferation of sources of information and guidance, risking inconsistencies even from government sources. The recent programme of migrating business-facing content onto a single website (www.businesslink.gov.uk) has addressed some of these issues, but there is still more work to be done. The latest government initiative, to create a single platform for both citizens and business by autumn 2012, will improve communications further.

30 EEF, *Sickness Absence and Rehabilitation Survey 2011*.
31 For instance Acas Advisory booklet on *Managing attendance and employee turnover*, available at: www.acas.co.uk/index.aspx?articleid=1183
32 NICE (2009), *Management of long-term sickness absence and incapacity for work: quick reference guide*, available at: www.nice.org.uk/nicemedia/live/11779/43546/43546.pdf
33 Young, V. and Bhaumik, C. (2011). *Health and wellbeing at work: a survey of employers*, DWP Research Report No. 750. Fig 7.1.
34 *ibid* Table 7.1.

Legal uncertainty

87. Employers have also reported uncertainty about the rights of employees and employers in respect of sickness absence[35]. This ranges from concerns about communicating with an employee who is off sick, to dismissing an employee because their health condition means they are no longer able to do their job. A small number of employees do not want to remain with their current employer and the way forward for both parties to end the relationship is not always clear. Concerns over 'getting it wrong' lead to a lack of confidence in dealing with sickness absence issues in an effective and straightforward way. The fear of being taken to an employment tribunal and the potential financial penalties can be considerable. Employers are particularly nervous about the link between long-term sickness absence and their potential obligations under the Equality Act, especially as compensatory awards for discrimination, including disability discrimination, are uncapped. Employer feedback during the Review has also highlighted problems arising from the ban on pre-recruitment health screening.

88. In the specific area of sickness absence it is important that guidance should be as clear as possible. Employers should also set out and explain clearly in their absence management policy documentation the processes they intend to follow, and ensure that employees are familiar with the process.

89. Further action should also be taken to help dispel some of the myths about what an employer can or cannot do in managing sickness absence. The Institute of Directors already produces a very helpful briefing setting out clearly and concisely employers' legal obligations[36]. We recommend the Government also updates its Employer's Charter[37] to address misconceptions around sickness absence management. Government digital channels such as businesslink.org.uk would also be an effective means to promote myth-busting.

90. From a wider perspective there are also areas of employment law that clearly impact on employers' management of sickness absence. Through the Employment Law Review and Red Tape Challenge, government is currently considering many of these issues. We believe this stock-take of employment law provides an excellent opportunity to address some issues related to sickness absence and we therefore urge the Government to consider the following to help employers tackle sickness absence further:

35 Federation of Small Business, 2006, Health matters: the small business perspective.
36 Institute of Directors, Sickness issues and SSP, Directors' Briefing. www.iod.com/MainWebSite/Resources/Document/HR23SICK.pdf
37 available at http://www.bis.gov.uk/assets/biscore/employment-matters/docs/e/employerscharter.pdf

- Employment law should be modified to make it easier for both employers and employees to end an employment relationship, where the parties could negotiate a financial settlement, but where neither would be judged to be at fault. Compromise agreements are already regularly used by employers, but these can be costly. Therefore we would like to see the introduction of a new, more efficient route where sums paid are laid down in law. In the context of sickness absence we believe this could help in cases where an employer is unable to make a reasonable adjustment, or where the employee is assessed as conditionally fit for work, but does not want to return to their current employer. This route would help firms and employees reach a swift settlement, without risks and indirect costs for the business. There are clear links here with our recommendation for a new job-brokering service (Chapter 5).
- The Government should look at options around the use of a 'protected conversation' to allow employers the chance to have an honest, without prejudice conversation[38] with their staff about their condition. The current regulatory framework means many firms take a very risk-averse approach to the detriment of both the business and the employee.
- We fully support the work undertaken through the Red Tape Challenge Equalities theme to consider the impact of equalities legislation on employers and their recruitment approach. We would call for the ban on pre-employment health questionnaires to be reconsidered. Guidance should also be published to help firms in this area of the recruitment process.
- The Government is already looking at the issue of compensation for discrimination awarded by employment tribunals. We recognise there are legal constraints to capping discrimination awards. However, the Government should do more to raise awareness of the reality among both employers and potential claimants. That is, that significantly large awards are in fact few and far between and very few claims actually reach tribunal[39].

Wider staff management initiatives

91. As a number of reports and studies[40] demonstrate, there is a link between high levels of employee engagement or worker commitment and lower sickness absence. In the public sector, in every case where absence had been tackled and reduced, one consistent factor was the willingness of senior managers, starting at Board level, to acknowledge the problem and take action. Good management is vital in improving attendance, spreading a good working culture and changing habits.

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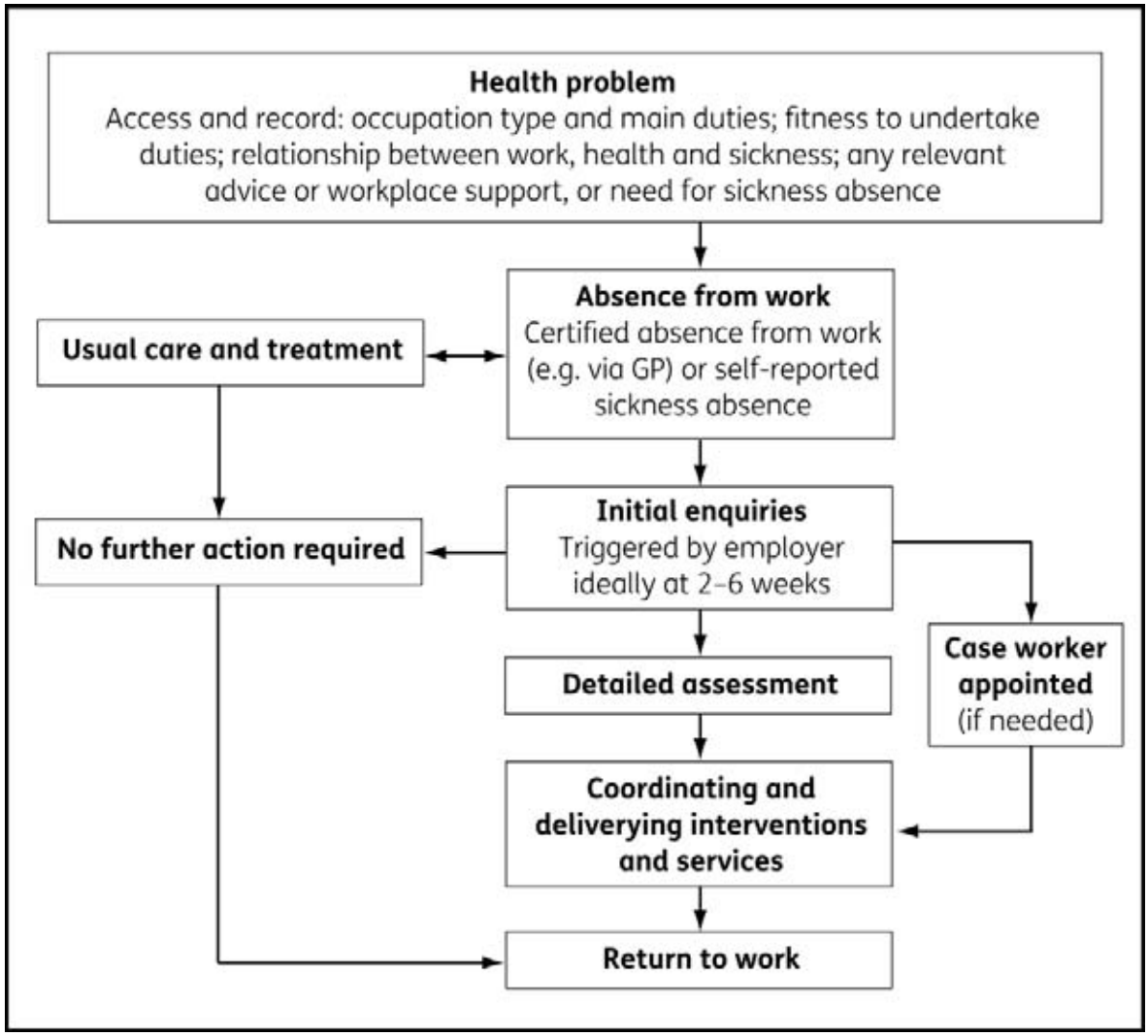
38 Without prejudice conversations are only legally valid when a dispute has already arisen.

39 Ninety per cent of all discrimination awards were for less than £40,000 ion 2010–11. Source: Employment Tribunals and EAT Statistics, 2010-11, Ministry of Justice, HM Courts and Tribunals Service, 1 September 2011.

40 Mcleod, D. and Clarke, N. (2009). *Engaging for success: enhancing performance through employee engagement*, Department for Business Enterprise and Regulatory Reform; Oxford Research, 2011, *Links between quality of work and performance*, European Foundation for the Improvement of Living and Working Conditions; West, M. *et al.* (2011). *NHS Staff Management and Health Service Quality; Results from the NHS Staff Survey and Related Data*, Aston Business School.

92. Organisations offering flexible working also report lower absenteeism[41], as it helps achieve better work-life balance and manage some of the pressures that currently can lead to non-health-related absence. Further research on the complementary effects of such initiatives is desirable.

Figure 8: NICE Guidance – Pathway for managing long-term or recurring short- or long-term sickness absence



Incentivising early health interventions

93. The nature of the intervention required will depend on the underlying cause of sickness absence. Longer-term absence (of more than four weeks), which accounts for 40 per cent or more of working time lost, tends to be due to musculoskeletal disorders, common mental health problems and medical conditions such as cancer, diabetes, heart disease or stroke.

[41] Haywood, B. *et al.* (2007), *Third Work-life Balance Employer Survey: Main Findings*, Department for Business Innovation and Skills Employment Relations Research Series No. 86.

Return to work and the importance of early intervention

94. Most employees who suffer from these conditions do make a successful return to work (see Table 2). At least four out of five of those suffering from musculoskeletal injuries and back pain return to work, while for those with stress and other mental ill health problems return rates – of the order of 75–80 per cent – are only slightly lower.

Table 2: Return to work rates after absence of four weeks or longer

	Musculoskeletal injuries	Back pain	Stress	Mental ill health	Acute medical conditions	Other conditions
% return	85	82	80	75	66	78

Source: The 2011 CIPD Absence Management Survey in partnership with Simplyhealth.

95. Recognising this, employers can then focus their efforts on trying to help sick employees return to work sooner. The evidence, discussed further below, shows that early intervention can make a significant difference here.

Musculoskeletal disorders

The concept of early intervention is central to vocational rehabilitation, because the longer anyone is off work, the greater the obstacles to return to work and the more difficult vocational rehabilitation becomes. It is simpler, more effective and cost-effective to prevent people with common health problems going on to long-term sickness absence.

Waddell, Burton & Kendall, Vocational Rehabilitation – What works, for whom and when?

96. Dame Carol Black's 2008 Review highlighted the importance of early intervention. There is now further comprehensive evidence that early interventions in the form of vocational rehabilitation are effective in getting people back to work[42], especially for those employees with common musculoskeletal disorders.

97. Therefore there is a strong business case for vocational rehabilitation, where common health problems are prioritised and return-to-work is a key outcome measure. Crucially, vocational rehabilitation depends on work-focused healthcare and accommodating workplaces[43].

[42] Waddell, G. *et al.* (2008). Vocational Rehabilitation; *What works, for whom, and when?* Department for Work and Pensions.

[43] *ibid*.

Stress and mental health disorders

98. Stress and mental health disorders are one of the biggest causes of long-term absence and, according to a number of business surveys, are on the increase as a reason for absence. It is estimated that each year one in six workers in England and Wales is affected by anxiety, depression and unmanageable stress[44].

99. 'Stress' itself has become a major issue in the workplace. The fact is that excessive pressure – driven by workplace or other external factors – can lead to stress. This can then become harmful and lead to other mental health issues such as anxiety or depression[45].

100. Mental health disorders generally are still poorly understood by both employers and the public at large. Often they are regarded as a taboo subject and a key challenge is to change attitudes and destigmatise these issues[46]. Employees are reluctant to disclose mental health issues at work[47], many fearing being thought less capable and at greater risk of dismissal. The evidence does bear this out to some extent[48].

101. Much more needs to be done to overcome this stigma. Although the vast majority of managers say they would be happy discussing mental health issues with an employee, most organisations still have no formal policy on stress and mental health[49].

102. There are encouraging examples of organisations that, having recognised the problem and introduced initiatives to tackle it, have reduced mental health-related sickness absence[50]. Employers can learn a great deal from these.

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44 Populus poll for Mind of 2,006 adults in employment in England and Wales between 25 and 28 February 2011, and 4–6 March 2011.

45 Mindful Employer, *What is Mental Ill Health? Introduction to Diagnoses, Treatments and Recovery.*

46 Eighty-five per cent of people think that people with mental illness experience stigma and discrimination. NHS The Information Centre, *Attitudes to Mental Illness – 2011 Survey Report*.

47 Forty-three per cent of people say they would feel uncomfortable talking to their employer about their mental health – NHS The Information Centre, *Attitudes to Mental Illness – 2011 Survey Report*.

48 One in five of those who had disclosed a mental health problem had been sacked or forced out of their jobs – Mind, Populus poll for Mind of 2,006 adults in employment in England and Wales 2011.

49 Shaw Trust (2010), *Mental Health: Still the Last Workplace Taboo?*

50 See for example; *British Telecom – managing mental health* at http://www.dwp.gov.uk/health-work-and-well-being/case-studies/bt-mental-health/; Case study John Binns, Deloitte, Mind, 2011, *Taking care of business: employer solutions for better mental health at work; EDF Energy's upstream approach to stress management*, available at http://www.bitc.org.uk/document.rm?id=9439

103. This Review also commends the excellent work done by Mind[51], the Health and Safety Executive (HSE)[52], NICE[53], Mindful Employer[54] and others to bring this subject to the fore and help employers develop strategies to manage mental health-related absence more effectively. These strategies increase focus on promoting well-being in the workplace, tackling work-related mental health problems (including training line managers) and supporting employees. As the Mind campaign recognises this is often about a change in attitude rather than a cost.

Barriers to early intervention: Tax disincentives

104. The tax system can discourage employers from investing in early medical intervention even when they see its advantages. A recent survey by Aviva showed that 39 per cent of employers said tax incentives would encourage them to invest more in health initiatives[55]. Unless the intervention is for a work-related illness or injury – and 80 per cent of sickness absence is not work-related – it is classed as a benefit in kind for the employee. The cost of treatment is liable to tax at the employee's marginal tax rate. The employer also has to pay NICs[56]. In practice it is often the employer who ends up paying both, adding considerably to the original cost of treatment.

105. Not only does this disincentive risk delaying treatment and getting the employee back to work, but there is also a wider impact of lost productivity. The discouragement of early intervention is particularly clear in the more marginal cases – for instance, lower earners at risk of long-term absence and, later, dependency on state benefits.

Employee assistance programmes

106. EAPs have expanded in recent years to become one of the most common employee benefits offered by organisations. Usually provided by a third party, they mainly provide a telephone-based or, if necessary, face-to-face service offering information, advice and counselling on a variety of issues (including debt, workplace conflict and stress, factors often associated with non-health-related absence). Survey evidence and employer input into this Review have shown how valued EAPs are and how effective they can be in helping prevent and tackle absence. They are also relatively inexpensive to provide[57].

107. EAPs currently attract tax relief, though the recent report from the Office for Tax Simplification[58] recommended that this be abolished. However, we have found that EAPs have an important role to play in helping to keep sickness absence lower than it otherwise might be. **We therefore recommend that tax relief on EAPs be retained.**

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51 Mind, *Taking care of business campaign*.
52 Health and Safety Executive, *Management Standards for Work-related Stress*.
53 NICE, *Promoting mental wellbeing through productive and healthy working conditions*.
54 Mindful Employer, *Charter for Employers*.
55 Aviva, (2011). *The fifth Aviva Health of the Workplace Report.*
56 At a further 13.8 per cent.
57 In the region of £9–£12 per employee per year – XpertHR (2009), *Employee assistance programmes: the 2009 IRS survey*.
58 Office for Tax Simplification, (2011). *Review of Tax Reliefs Final Report*.

Private medical treatment/insurance

108. Employers report delays in access to publicly-provided health treatment as a barrier to getting sick employees back to work. Median waiting times are around four and eight weeks respectively for outpatient and inpatient National Health Service (NHS) treatment and one in 20 are waiting up to 16 weeks and 22 weeks in each case[59]. If a sick employee is absent until treatment is available this can represent a significant loss of working time.

109. Almost two out of every five companies surveyed by EEF said that at least one member of staff had received private medical treatment either paid for directly by the company or through private medical insurance[60].

110. Excluded from the list of EAP services that are granted tax relief by HMRC is employer expenditure on medical treatment, whether purchased directly or through private medical insurance. Private medical insurance is often provided as part of a recruitment package for more senior staff (often covering their families too). The latest available data for 2007–08 show that around half of the 2.3 million recipients of employer expenditure on private medical and dental products were higher rate taxpayers. In total, these benefits-in-kind were worth £1.5 billion and two-thirds of this was for higher earners[61].

111. We do not consider it appropriate to seek tax relief for all recipients of private medical treatment or insurance. Employers are likely to purchase these employee benefits for higher-earning staff regardless of the tax rules.

112. However, we believe there is a case for offering tax relief for private medical treatment or insurance for lower earners, for whom the decision by the employer to invest in treatment is likely to be more marginal. Under the current system, tax liability applies once the employee earns above a limit of £8,500, which effectively excludes most employees from tax relief. The limit was last set in 1979 – today's equivalent would be almost £34,000[62]. As lower earners are at greater risk of long-term absence and of flowing onto state benefits, we feel there is a strong case for offering tax relief for private medical treatment or insurance to all basic rate taxpayers, to help incentivise employers to intervene. To qualify for tax relief, the benefit would have to be clearly targeted at helping the employee return to work. It would therefore exclude wider health treatments and be limited to the employee only. **We therefore recommend that expenditure by employers targeted at keeping sick employees in work (or speeding their return to work) such as medical treatments or vocational rehabilitation should attract tax relief. This should be targeted at basic-rate taxpayers.**

113. Relieving basic rate taxpayers should result in a net gain overall. We estimate there would be an initial direct fall in tax receipts of around £150 million. However, we estimate employers will gain by around £250 million a year through reductions in lost output as sick employees return to work sooner. These cost-savings estimates are set out in Annex B.

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59 Department of Health, *NHS Referral to Treatment (RTT) Waiting Times Data, July 2011*.
60 EEF, *Sickness Absence and Rehabilitation Survey 2011*.
61 HMRC, *Expenses and benefits statistics*, table T4, May 2011.
62 Office for Tax Simplification, (2011). *Review of Tax Reliefs Final Report*.

114. There is also an important link here with the IAS (discussed in Chapter 2). If our recommendation on tax relief is accepted by government an IAS intervention at four weeks could be even more effective. Such an assessment might recommend early intervention with some health-related expenditure, which an employer could be more willing to finance in a favourable tax regime.

Case study 3: Early active rehabilitation study of a Financial Times/Stock Exchange index of 100 main share (FTSE 100) company

Between November 2007 and December 2008, Bupa undertook an Early Active Rehabilitation (EAR) programme at an FTSE 100 company. The company had 38,000 employees in the UK. The aim was to provide private medical care for early intervention to assist UK-based employees back to work on full duties where an illness or accident prevented this and there was delay in investigations and/or treatment normally provided by the NHS.

To be eligible for referral to EAR, employees had to have been absent from work and on an NHS waiting list with any underlying medical condition whether work-related or not. There also had to be a cost-saving to facilitating private treatment with the assumption that in 80 per cent of cases the employee would make a successful return to work.

Of the 700 closed EAR cases identified over the period, the study analysed 338 where full and robust data were available. Almost half of these were for musculoskeletal disorders (MSD) and a further 40 per cent were for mental health disorders (MHD). The study found that EAR waiting times for both conditions averaged around one and a half weeks, compared with average NHS waiting times of 15 weeks for MSDs and 21 weeks for MHDs. Across all cases, total days lost to waiting times fell by 92 per cent. The financial savings were significant too. Based on the wage costs of the absent employee and the cost of medical treatment, the company saved £1.75 million by using EAR, a reduction of 39 per cent on the estimated cost without intervention.

Insurance for vocational rehabilitation

115. Private medical insurance is often a bundled product, covering a wide range of possible medical interventions. A separate product focusing primarily on vocational rehabilitation, a much-needed and often neglected intervention, could be a more targeted instrument to speed return to work. Insurance premiums in this case would be lower – estimated to be between £70 and £100 per employee per year.

116. As now, employers would be free to choose whether or not they purchase this type of insurance. However, recognising the advantages of early intervention they could be further incentivised to do so by an alternative approach to the tax treatment of this expenditure.

117. The Office for Tax Simplification (OTS) recently recommended that HMRC and HMT further review, with its help, the role of a de minimis limit on benefits provided to the employee by the employer[63]. Under a de minimis limit, benefits provided by the employer that fall below a certain value, say £100 or £250 for each employee each year, would be exempt from tax. There may be an opportunity to consider including the cost of a targeted vocational rehabilitation insurance as part of a wider de minimis limit on employee benefits[64]. Although the OTS recognises this might result in administrative complexity for employers, we do encourage the OTS to investigate this issue further in its work on the current OTS Small Business Tax Simplification review.

118. We have also considered the role of other types of insurance (see Annex E). Various stakeholders have suggested that increasing the take-up of Income Protection (IP) insurance in particular could significantly reduce the costs of sickness absence. This insurance provides an invaluable income to employees who have exhausted sick pay and whose health condition continues to prevent them from returning to work. It can also help employers manage sickness absence through the provision of return-to-work services. This also creates direct savings for the State as people receiving an income from an IP policy will be eligible for reduced income-related state benefits. However, the return-to-work support that usually comes as part of an IP policy will generally not be available to lower-paid employees. This significantly reduces the attractiveness of IP for employers.

119. Overall, the insurance industry clearly has an important role in managing sickness absence. However, the market for income protection is well established and we do not think there is a strong case for the State to intervene to drive greater coverage. Further detail is set out in Annex E.

63 Office for Tax Simplification (2011), *Review of Tax Reliefs Final Report.*
64 *ibid.*

Chapter 4 – Public sector absence

Public sector absence

Ministers asked us to consider sickness absence in the public sector which is, on average, one and a half to twice that of the private sector and, with six million employees, this has a significant impact on the economy. There are no definitive figures, but we estimate the total wage cost of public sector absence to be in the region of £4.5 billion a year.

On average, sick pay in the public sector is more generous than in the private sector, an important consideration for public sector workers. However, the cost of these schemes to the employer and the taxpayer is considerable. **We recommend that Government conducts a review of public sector occupational sick pay (OSP).**

There is a wide variation in levels of sickness absence between public sector employers, even those who offer the same services and who operate the same OSP schemes.

There have been many previous studies of sickness absence in specific parts of the public sector. Many employers demonstrate what can be done to improve attendance and there are plenty of guidelines for employers to follow. We want all employers to aim for the present upper quartile performance and publish an account of what they are doing to make this happen.

We recommend that public sector employers take immediate action to bring the worst performing parts of the public sector up to the standards of the best. This will require public sector employers to adopt the best examples of absence management displayed in both the public and private sectors. It will require Board-level commitment to reducing absence, and the recognition and reward of senior manager should include being accountable for absence levels.

Background – the public sector landscape

120. The public sector accounts for around 20 per cent of the total workforce in Great Britain (GB). Education and the National Health Service (NHS) each employ around 1.5 million people, and public administration around 1.1 million, of which 490,000 work in the civil service[65].

[65] Public sector employment Q1 2011, Office for National Statistics (ONS) (year to March 2011; aged 16 and over; GB, not seasonally adjusted). Note that the latest figures on public sector employment by industry are unavailable for GB so United Kingdom proportions were applied to the GB total (Labour Market Statistics, ONS, September 2011).

121. There are many different roles and working environments within the public sector. The public sector covers such diverse roles as hospital consultants, nurses, teachers, prison officers, planning officers, refuse operators, and many more. There is also a wide variety of working environments with many public-facing roles directly serving the community, including healthcare, custodial and educational settings.

122. There are also a significant number of separate public sector employers, each offering their own terms and conditions and taking a multitude of approaches to absence management. Different terms and conditions within each workforce, often represented by more than one union, make negotiating any change a complex process. Some parts of the public sector are also undergoing significant change, with business units either amalgamating or being broken down into smaller autonomous units, for example Primary Care Trusts (PCTs) and the Academy/Free Schools programme.

123. This complex landscape makes it difficult to compare and contrast sickness absence across the public sector. However, it also allows for a differentiated approach, using focused change where needed, but allowing those who are managing attendance well to continue with their own successful policies.

Sickness absence levels in the public sector

124. Although overall sickness absence has fallen over the last decade, it remains higher in the public sector than in the private sector (on average seven days compared with four days each year[66]). Public sector sickness absence therefore accounts for a disproportionately large share of all absence in the economy, as 20 per cent of workers account for over 30 per cent of all absence and probably an even higher proportion of sick pay, given the more generous terms.

125. The majority of public sector employees work in large organisations (500 or more employees) and research suggests that absence is generally higher in large organisations in public or private sectors[67].

[66] Sickness Absence Review analysis of Labour Force Survey, ONS; average of four quarters to March 2011; aged 16–64; GB (not seasonally adjusted).

[67] Young, V. and Bhaumik, C. (2011). *Health and well-being at work: a survey of employees*. DWP Research Report No. 751.

126. Higher sickness absence in the public sector is also partly explained by the profile of the workforce:

- it employs more older people and women, both of whom tend to have higher rates of sickness absence which is also more likely to be long term;
- it is more likely to employ staff with a long-standing health condition[68] who are more likely to go off sick and to have longer average time off work; and
- it has a much more unionised workforce[69] and tends to offer more generous sick pay arrangements.

127. In this Review, we have not conducted in-depth comparisons between the public and private sectors. Instead, we have sought to learn from best practice in both sectors.

The costs of public sector sickness absence

128. There are no definitive figures but we estimate the cost of public sector absence to be in the region of £4.5 billion a year in wage costs.

Health causes of absence in the public sector

129. In common with the private sector, longer-term absence in the public sector tends to be due to musculoskeletal disorders, common mental health problems and medical conditions. The public sector is facing the considerable challenge of rising levels of stress as reported in a recent survey of public sector staff[70]. Stress is, for the first time, the most common cause of long-term sickness absence for both manual and non-manual employees and 50 per cent of public sector respondents reported an increase in stress-related absence. The amount of organisational change and restructuring has been identified as the number one cause of stress at work.

130. According to data produced by the Health and Safety Executive, the risk[71] of work-related stress, depression and anxiety is highest in the public sector. Those working in health and social work are almost twice as likely as the average worker to suffer. The risk is also higher than average in public administration and education (see Figure 9). Mental health problems accounted for almost 4.6 million of the 7.9 million days lost to work-related illness or injury in the public sector in 2010-11.

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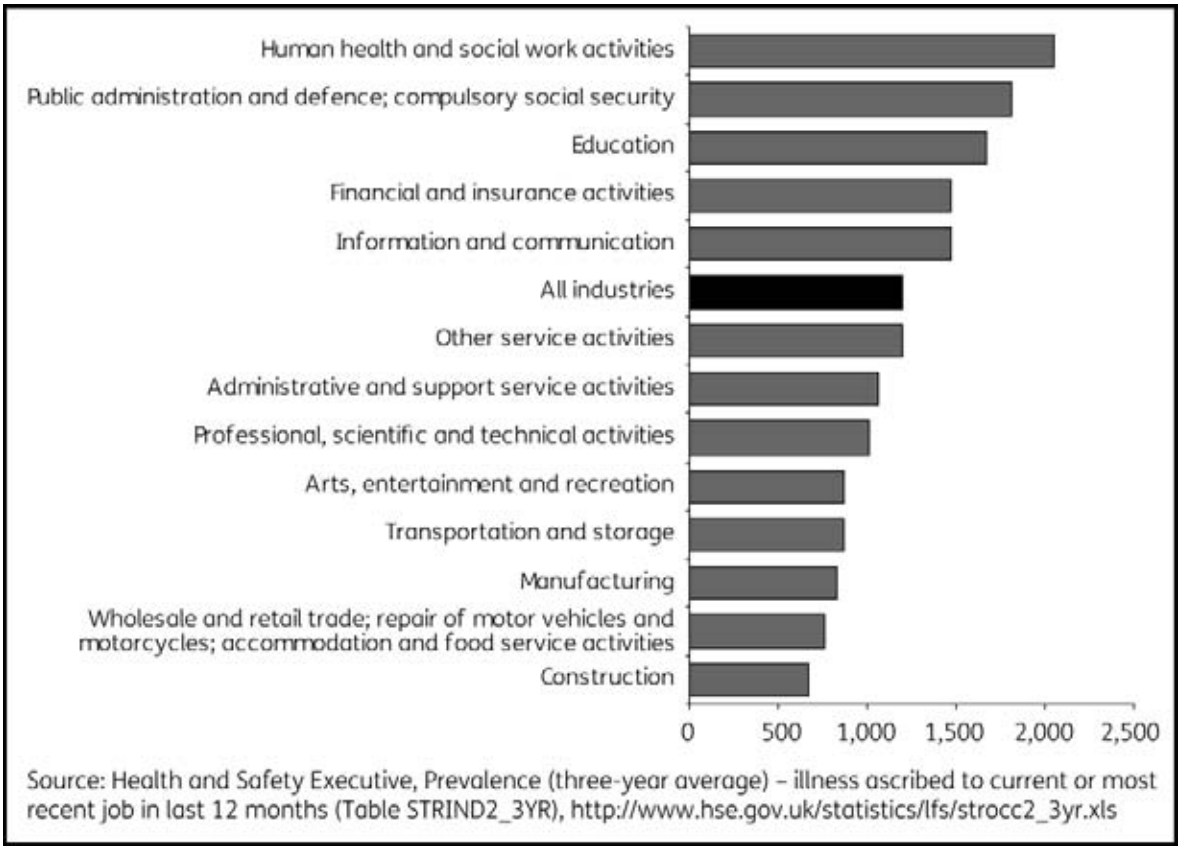
68 Twenty-eight per cent compared to 26 per cent in the private sector – Sickness Absence Review analysis of Labour Force Survey, ONS; average of four quarters to March 2011; aged 16-64; GB (not seasonally adjusted).

69 Trade union density in the public sector in GB is 56 per cent compared to just 15 per cent in the private sector. Achur, J. (2010). *Trade Union Membership 2010*. Department of Business Innovation and Skills.

70 The Chartered Institute of Personnel and Development in partnership with Simplyhealth. (2011). *Absence Management Annual Survey report 2011*.

71 Measured by the prevalence rate – the number affected for every 100,000 workers. Prevalence is the estimated number of people with a work-related illness at any time during the 12-month reference period. It includes the full range of illnesses from long-standing to new cases. The prevalence rate is the estimated prevalence divided by the population at risk of having a work-related illness.

Figure 9: Prevalence rate of work-related stress, depression or anxiety by sector



Source: Health and Safety Executive, Prevalence (three-year average) – illness ascribed to current or most recent job in last 12 months (Table STRIND2_3YR), http://www.hse.gov.uk/statistics/lfs/strocc2_3yr.xls

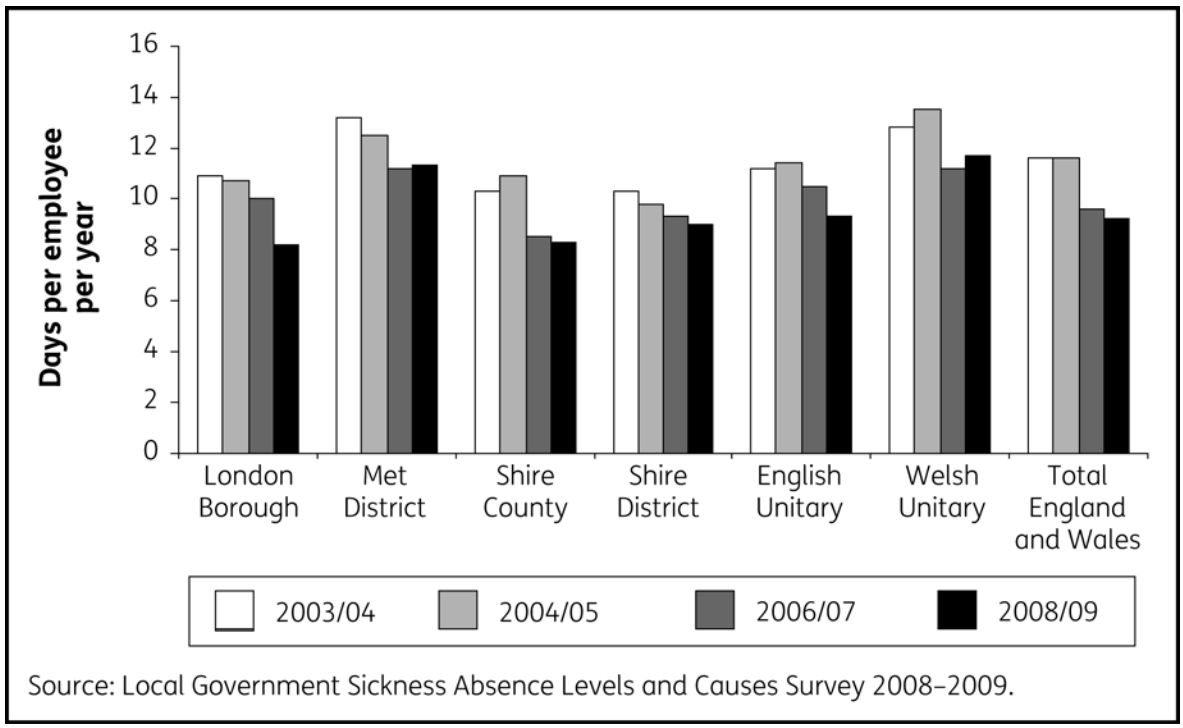
Variations in public sector absence management

131. There is considerable variation in absence rates between different parts of the public sector and different types of employee within each area. Teacher absence shows wide variation across council areas[72]. The council with the highest rate had 10.6 days, while the lowest recorded only two days for each teacher[73]. Differences between council areas are associated with council type, geography and levels of deprivation, but this variation is not enough to explain the variability of sickness absence levels.

132. The picture for local government is not as clear as we would like, as the last centrally co-ordinated survey[74] covered 2008/09 and achieved a 40 per cent response rate. However, it still provides clear evidence of variation across councils (see Figure 10).

[72] Audit Commission. (2011). *Managing Staff Absence and Cover, Better value for money in schools*. Audit Commission.
[73] 2008 data was used for this analysis.
[74] Local Government Sickness Absence Levels and Causes Survey 2008–2009.

Figure 10: Local authority sickness absence levels by authority type



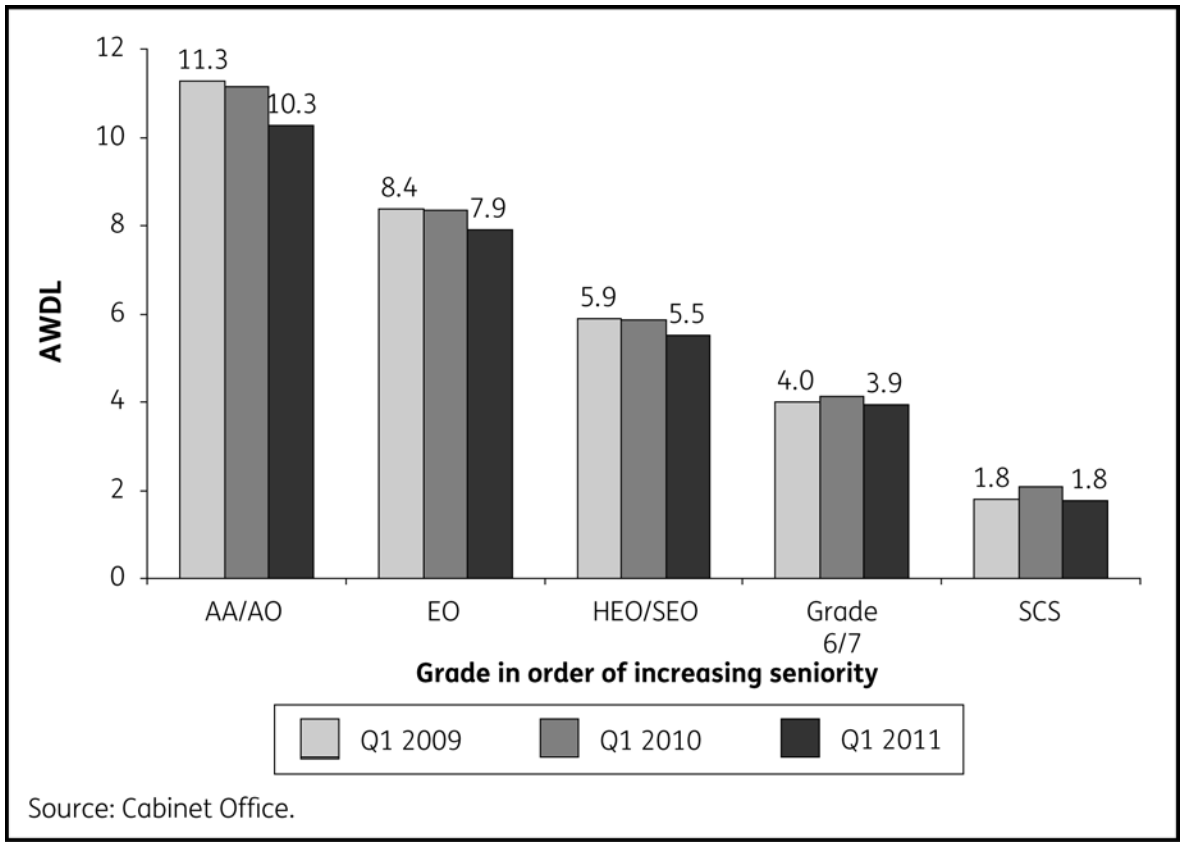
Source: Local Government Sickness Absence Levels and Causes Survey 2008–2009.

133. Average working days[75] lost (AWDL) also vary between Civil Service departments, from 3.2 days at HM Treasury to 12.1 days in the Northern Ireland Office. The overall Civil Service AWDL has fallen from 10.1 days (1999) to 8.2 days (Q1 2011) and is now at its lowest reported figure since 1999.

134. Absence varies considerably by Civil Service grade too, with AWDL falling as seniority increases (see Figure 11). The Whitehall study of British civil servants, begun in 1967, has already established an inverse association between social class, as assessed by grade of employment, and mortality from a wide range of diseases. This is consistent with evidence from the wider public sector (Civil Service and NHS) where absence rates are considerably higher in the more junior grades, although these too have exhibited a downward trend in recent years.

[75] Year ending 31 March 2011 (Q1 2011).

Figure 11: Civil Service AWDL by grade, Q1 2009, Q1 2010 and Q1 2011



Source: Cabinet Office.

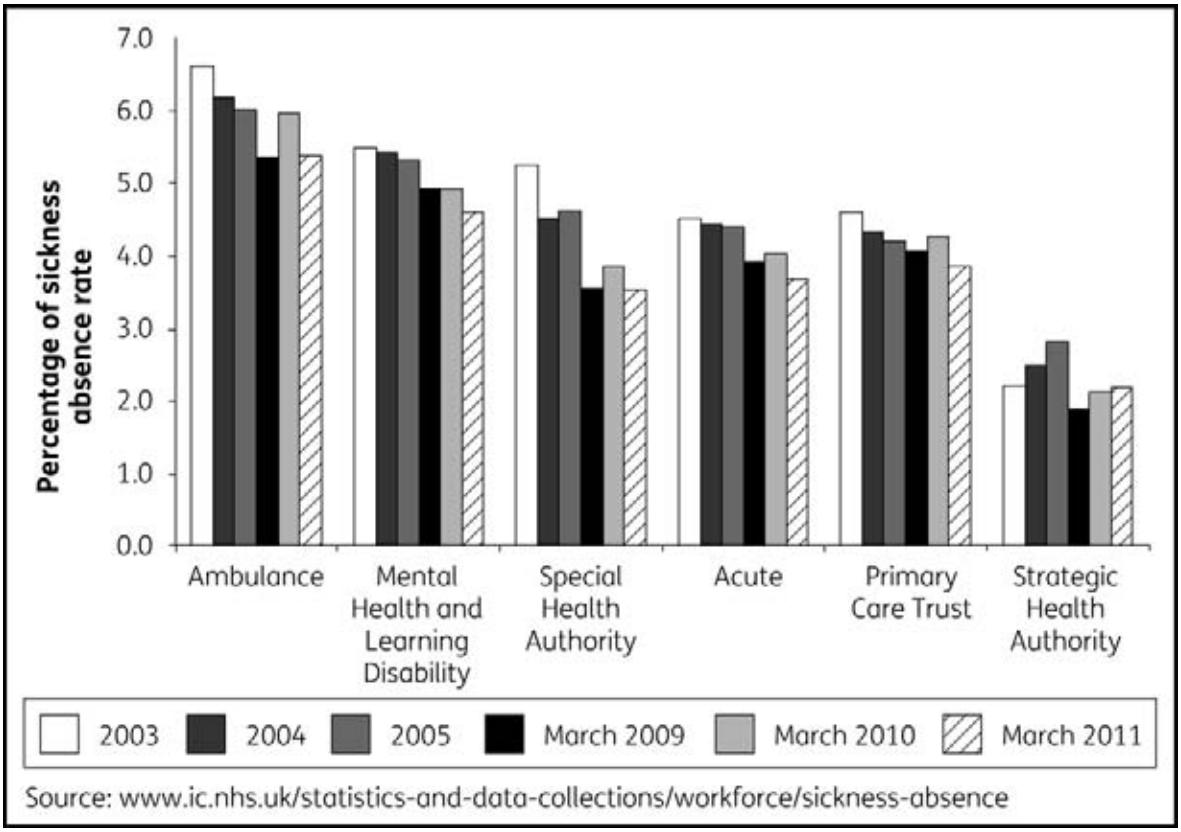
135. Sickness absence in the NHS varies significantly. Sickness absence data in the NHS are presented in terms of percentage of working time lost. Different NHS workforces have markedly different absence rates (see Figure 12). Ambulance staff have the highest aggregated sickness absence rate (6.3 per cent) followed by healthcare assistants and other support staff (6.21 per cent). By contrast, nursing, midwifery and health visiting learners had the lowest rate (1.05 per cent) followed by medical and dental staff (1.21 per cent). Generally, NHS absence rates have fallen in recent years, particularly in those job areas exhibiting above-average absence.

136. Sickness absence in the NHS also varies by region. It is highest, on average, for PCTs and trusts in the North East Strategic Health Authority (SHA) area and lowest in the London SHA area. It ranges from 1.6 per cent to 6.8 per cent nationally[76].

137. Overall, a number of different factors contribute to the variation in sickness absence rates, including local differences in deprivation and grade mix (the proportion of staff at each pay grade and staff group).

[76] Using data collected from all local NHS organisations by the NHS Information Centre for Health and Social Care between July 2009 and June 2010.

Figure 12: NHS absence by organisation type



Case study 4: Good practice – Driver and Vehicle Licensing Agency (DVLA), Swansea, Wales

In 2005 average working days lost at the DVLA reached 14 days per person at an annual cost of £10.3 million. In response a strategy was developed to move from a culture of 'illness' to one of 'wellness'. The strategy began with getting the basics right as follows:

- developing more detailed management information to target specific issues and identify 'hotspots';
- reviewing policies and procedures with guides and top tips to support staff and managers;
- introducing more robust management of long-term cases including earlier referral, keeping in touch during absence and proactive rehabilitation, including adjustments and phased return to work;
- improving the capability of line managers by developing and delivering a new training course that subsequently won a National Training (Wales) Award;
- introducing corporate objectives on attendance for staff and managers.

DVLA now has more than 200 additional staff in work each day compared to 2005 and improvements have been recorded in both accuracy and customer service targets. DVLA has also recorded consistent increases in levels of staff engagement. By March 2011, sickness had almost halved to an average of 7.1 days per person and saving more than £5 million per annum in absence costs.

Reducing the cost of sickness absence

138. On average, OSP in the public sector is more generous than in the private sector, and is an important employee benefit for public sector workers. The number and range of employers across the public sector has precluded a detailed assessment of each OSP scheme. However, the cost of these schemes to the employer and the taxpayer is significant. Further research is needed to see whether the public sector OSP schemes are effective and provide best value for the employer and the taxpayer. **We therefore recommend that the Government conducts a review of public sector OSP.**

139. Many of the good examples of relatively low absence occur in parts of the public sector that share a centrally-specified OSP regime (that is a centrally-negotiated scheme for all employers within that sector), for example NHS employers, and the scheme for teachers and civil servants. Such a wide variation between employers who administer the same OSP rules would suggest that it is not the scheme but its management that impacts on absence levels. This supports our view that management buy-in on good practice and implementation across all staff on all sites is critical.

Case study 5: York Teaching Hospital NHS Foundation Trust

At the beginning of 2008 York Teaching Hospital NHS Foundation Trust was losing 5.5 per cent of total working time to sickness absence. This amounted to an annual cost of £3.7 million. With full backing from the Board, the Trust introduced a pilot project in February 2008 to tackle this. So far, the Trust has invested over £160,000 in a multidisciplinary team working in partnership with hospital managers and trades unions to help sick employees return to work. This multidisciplinary team includes input from specialist nurses, physiotherapy, counsellors, clinical psychologists and Human Resources (HR). Over this period the Trust has achieved significant reductions in sickness absence. By January 2011 absence rates were down to 3.8 per cent and are currently around three per cent. Long-term absence has also fallen significantly – by 72 per cent for those off for four weeks or longer and 77 per cent for those absent for three months. Measured on a full-time equivalent basis there are now 54 more staff available to work. Direct savings in pay costs are almost £1.2 million per year with additional savings from the reduced need for bank and agency staff.

140. The problem of high sickness absence in the public sector has been recognised for some time. In 1998 and 2004 there were major public-sector-wide reviews seeking to help employers address the problem:

- Cabinet Office. (1998). *Working Well Together.*
- Health and Safety Executive. (2004). *Managing Sickness Absence in the Public Sector – A joint review by the Ministerial Task Force for Health, Safety and Productivity and the Cabinet Office.*

141. Both reports challenged the public sector to reduce days lost to sickness absence by 30 per cent. To help employers achieve this both reviews set out a wide range of measures that would significantly reduce absence if successfully implemented. A common feature of these and subsequent reports has been the requirement for a sustained commitment to reducing absence from managers at the highest levels.

142. Since the publication of these two Reviews we are encouraged to see that some public sector employers have significantly reduced their levels of absence. However, this has not been achieved consistently. A number of other reports have focused on specific parts of the public sector such as:

- Cabinet Office. (1999). *Managing attendance in the public sector: Putting best practice to work*, Her Majesty's Government.
- Boorman, Dr S. (2009). *NHS Health and Well-being. Final Report*. Department of Health. This report found that NHS organisations that prioritise staff health and well-being performed better, in terms of quality, patient satisfaction, staff retention and sickness absence.
- Local Government Group. (2010). *Health, Work and Well-being in Local Authorities.*
- Audit Commission. (2011). *Managing sickness absence in the NHS, Health briefing, February 2011*.

143. This latter report demonstrated the link between absence rates and levels of local deprivation. Just as the Whitehall studies have shown, the factors behind sickness absence can be complex. These suggest, to some extent, deeper-rooted problems which will take time to address. However, we also believe there is much the public sector could be doing now from a management perspective to help reduce sickness absence.

144. While we recognise there is now much good practice and guidance for employers to follow in the public sector, there is still too much unexplained variation in sickness absence between employers of the same type. Some employers have demonstrated what can be done to improve attendance while many others have yet to take effective action. The previous chapter highlighted what employers should be doing and where to go for help and guidance. We therefore consider that all public sector employers should aim for the present upper quartile performance and publish an account of what they are doing to make this happen and to ensure any results are sustainable. We believe the Government should set a timetable for this.

145. **We recommend that public sector employers take immediate action to bring the worst performing parts of the public sector up to the standards of the best.** This will require public sector employers to adopt the best examples of absence management displayed in both the public and private sectors. It will require Board-level commitment to reducing absence and the recognition and reward of senior managers should include being accountable for absence levels.

146. As described at the beginning of this chapter, there are reasons why levels of sickness absence may differ between the public and private sectors. However, we do not accept that this explains all of the gap. Just halving the gap between public and private sector absence would save the taxpayer around £800 million per year. We believe this is achievable by adopting a renewed and consistent approach to absence management.

Case study 6: NHS Lanarkshire

In May 2008, NHS Lanarkshire implemented a unique sickness absence management service called Early Access to Support for You (EASY). EASY supplements existing absence policies and enables communication between the absentee and their line manager.

Three major changes were made:

- Contact with absent staff on days one, three and ten.
- From day one staff are made aware of a range of support services, including physiotherapy, HR advice, occupational therapy and counselling.
- At day 10, a referral to occupational health (previously day 28) and, dependent on need, assignment of a case manager who can offer non-clinical support.

Sickness absence rates have since decreased from a high of 6.84 per cent in January 2008 to 4.84 per cent in January 2011, before reaching a record low of 3.70 per cent in July 2011.

EASY has contributed to both efficiency savings and direct savings through reductions in bank and overtime costs. NHS Lanarkshire has also experienced an increase in productivity and staff available to deliver critical frontline services.

NHS Lanarkshire has moved from the worst performing large Scottish mainland Health Board to the best in this time period.

Chapter 5 – Extending access to back-to-work support and facilitating job changes

Support is not always readily available to help people with health-related problems remain in work. In a significant minority of cases, absent employees will only be returned to work if they are able to change jobs and employer. Early evidence suggests that in 10–20 per cent of cases of long-term absence (50,000 to 100,000 cases a year) a change of employer is the best solution. These cases are disproportionately likely to enter the benefits system, and this likelihood increases with length of absence. Under the current system, the State does not intervene to help people find jobs until they have left the labour market altogether and usually after a long delay. These are individuals who need support and advice to make such a move.

The Review recommends that the State should offer a job-brokering service for anyone with a sickness absence period of 20 weeks or more. Government should consider ways of allowing earlier access to the service and the implications on who pays for earlier access.

The average fiscal cost to the State of claimants coming to the Employment and Support Allowance (ESA) is around £8,500 each year. In comparison, we believe the job-brokering service would cost the State less than half this amount (between £2,000 to £3,000 for each person). The service could be delivered as an extension of the Work Programme.

We estimate the State could save up to £300 million a year by introducing this service. The increase in economic output could be up to £800 million a year.

147. Over the course of a year around 11 million working people will become sick or ill and need time off work to recover. Most will recover quickly and return to work within a few days, but some one million go on to be absent from work for more than four weeks. Long-term absence is costly for individuals, employers, taxpayers and the overall economy, and entails increased risk of ultimate job loss.

148. While many employees return to work quickly without additional support, for others, intervening early in a spell of sickness can speed their return.

For some people the best solution is to change employer

149. For a person experiencing a bout of sickness absence, the primary aim of both the employee and their employer should be a return to their job as soon as possible. In some cases this may involve working with an employer to accommodate new needs by making suitable adjustments and ensuring support is available for this, for example through Access to Work. In others this could require a move to a new set of duties altogether, for example a manual worker moving to a less physically active role.

150. For other people, their health and long-term work prospects would be best served by a change of employer. This change could involve a move to a similar job in another organisation if, for example, an individual's stress-related health condition arose from an irreconcilable difficult relationship with their current employer. For others this will involve both a change of employer and a change in duties. A number of support organisations use a return-to-work hierarchy in the following order:

- Same employer, same duties.
- Same employer, different duties.
- Different employer, same duties.
- Different employer, different duties.

151. Early evidence from the Fit for Work Service and Improving Access to Psychological Therapies employment advisor pilots suggests that the long-term health and work prospects of between 10 per cent and 20 per cent of their clients would be best served by a change of employer.

152. For an individual with a health-related condition, changing employer can be particularly difficult, especially if they are already taking long-term sick leave. So, without support, a typical journey would include a long spell on sick pay before eventually moving out of work and onto state benefits. The next step would then, ideally, be a return to the workplace, but we know that this is unlikely (or likely to take longer) for an individual who has been out of work for such a long time. This could be over six months for a person who has exhausted Statutory Sick Pay (SSP) before moving completely out of work.

153. A more positive journey for such an individual would be to change employer before they fall onto state benefits. These individuals (recently at work, still attached to an employer) are relatively close to the labour market and so have a much greater chance of moving to a new job and avoiding state benefits altogether.

154. Unsurprisingly, the longer a person receives sick pay, the more likely they are to fall out of work altogether. If absent at 20 weeks, the vast majority of employees will eventually go on make a benefit claim. Yet the State does not intervene for at least eight further weeks (once SSP is exhausted). In some cases this could be even later if an individual applies for ESA (see Chapter 6).

The advantages from changing employers

155. Facilitating a move from one employer to another without a potentially long period out of work would be good for:

- the employee's health, wellbeing and finances as they spend less time out of work;
- the employer, as they would save money on sick pay and could more quickly replace a member of staff who has become poorly matched to their job;
- the State, as it would save money on benefits;
- a more efficient and better functioning labour market; and ultimately,
- the economy overall.

156. As an example, for each ten week, say, reduction in time spent out of work, we estimate this would lead to savings of:

- at least £800 in sick pay that would otherwise be paid by the current employer; and
- around £4,000 in lost earnings for an individual earning the UK average salary of £26,000.

157. Overall savings are likely to be much higher than this as they will also include the avoidance of lost productivity and the reduced likelihood of the employee falling onto state benefits.

158. While this adds up to potentially significant savings across the economy, these gains are spread between the different parties involved. This points towards limited incentives for any individual party to act alone and suggests the need for state intervention in the form of a subsidised job-brokering service to help these individuals change employers.

A job-brokering service

159. Once it becomes apparent that, even with additional support, an employee taking sickness absence will not be returning to work for their current employer, the employer effectively has two options:

- to dismiss the employee on health grounds; or
- to continue to pay sick pay until the employee's eligibility runs out.

160. We know that many employers choose the latter of these two options and are prepared to continue paying sick pay in such circumstances. This could be seen as an extension of the willingness of employers to offer their employees more than the statutory minimum, and to consider issues such as wider employee engagement ahead of short-term cost savings. Either way, between these two stark options, a third, intermediate option would be to access a voluntary job-brokering service that would support these individuals to change employer.

161. While accessing this service we would expect the employee to continue receiving sick pay from their current employer until their eligibility runs out. At this point, if they have not found another job, they would then most likely move onto the benefits system as at present. Given this ongoing relationship between the employer and employee, it is important that both have complete clarity over the employee's intentions.

162. The type of support would be similar to that currently being made available by organisations such as Jobcentre Plus, Work Programme providers and other third sector providers. The kinds of support would include:

- working with employment advisers to identify what is stopping the individual from remaining with their current employer;
- developing a job-change action plan that reflects the needs of the individual;
- a skills audit and access to relevant training opportunities; and
- practical help to access job vacancies.

Access to the service

163. Given the importance of early intervention, employees should have access to this service as soon as is practicable, once it becomes apparent that, given their health-related problem, they would gain from a change of employer. The service should also seek to limit access by healthy employees who simply wish to change job, or by employers who may wish to use the service to divest themselves of an employee who is poorly matched to their job.

164. However, directly identifying the individuals who would gain most from the service (and those who should not be accessing the service) using the types of information readily available to the State is impracticable. To address this we propose that access to the service be limited to those employees who meet the following criteria:

- Both the employee and their current employer must agree to this intervention. Both parties must be fully aware of the employee's intentions and be clear about the ongoing nature of their relationship.
- The employee should have been absent for a set number of weeks to limit the risk of high dead-weight costs. This could be 20 weeks, say, as at this point it is highly likely that the employee will eventually claim state benefits.
- The employee should have either been assessed as being 'may be fit for work' (but have been unable to find appropriate work with their current employer) or have been directed to this service by a health professional, possibly as part of the new Independent Assessment Service (see Chapter 2).

165. By offering the service in this way, the State would be providing support for employees before they enter the benefits system. The main rationale is that these people have developed barriers to moving jobs because of their ill health and, without help, are at high risk of never returning to any employment. Further consideration will be needed to see how this service fits into the wider suite of return-to-work support on offer to all job seekers.

Earlier access to the service

166. By intervening earlier than 20 weeks into a period of sickness absence, the service would be more likely to help people find new jobs much more quickly and easily. We believe that this is worth further investigation.

167. However, earlier access would raise a number of difficult issues, for example the challenge of effectively identifying those in need of the service and the risk of employees without health conditions attempting to gain access to the service to help them change jobs. There would also be a greater need to ensure that the employer and employee both agree to the use of this service and that the employer has had time to consider job modifications and other roles in the organisation.

168. With earlier access to the service, the employer could be asked to contribute to funding, given the potential gains they will make, for example:

- around £400 plus other direct costs[77] for each five weeks of SSP saved (or significantly more if paying OSP); and
- productivity gains from being able to replace an employee who is not well matched to their job.

169. The level of potential savings depends on how long an employee would have spent receiving sick pay. The longer the absence, the greater the 'sunk cost' and the lower the potential savings. So, employers would have greater incentive to pay for the service early in a period of absence, but less incentive as sick pay eligibility is slowly exhausted.

170. The level of contribution from employers would depend on the overall cost of the service balanced against their potential gains. As we recommend access being voluntary, these contributions would also need to be kept low enough not to bar access, but high enough to reduce moral hazard and make a worthwhile contribution to costs.

171. Using the Work Programme as a benchmark (see *The Work Programme model* below), we could expect employers to pay a 'joining fee' of below £400 for each individual referred to the service. For some individuals, the State could also pay a longer-term 'bonus' when they remain in the new job for an agreed period (say two years). Further modelling of the costs, savings and relative risks in this system is needed to identify the most appropriate charging schedule.

The Work Programme model

172. There are potential advantages to be brought to the job-brokering service by following a Work Programme model. This programme, designed to address the problems of those already in the benefits system, gives people the one-to-one support they need to return to, and remain in, work. There are obvious similarities between these two services.

173. At the heart of the job brokering service is the need to deal with complicated, multi-factorial problems that are best addressed in an individualised manner. This is especially relevant for those with a number of (possibly non-medical) causes for their sickness absence. The Work Programme has been set up so that providers also have flexibility to innovate, matching their support to the needs of the individual. We believe that the additional job-finding flexibility offered by this Work Programme model could enhance the job-brokering service and lead to more effective results.

[77] Supplementary costs to employment, such as National Insurance Contributions, pension contributions etc.

174. Some people will have acute health-related problems that may be solved once and for all by an intervention. Many others have fluctuating conditions resulting in intermittent sickness absence. There is a need for continuing support to help them and others with long-term conditions to stay in work. A model based on the Work Programme model could address this need by rewarding providers for keeping people in work for at least two years.

175. The Work Programme also brings in the private and voluntary sectors who can take on responsibility for intensive case management and for providing tailored help for individuals. Work Programme providers are taking a case-managed, holistic approach to supporting people back into work, incentivised by payment by results.

176. In considering the roll-out of job-brokering services, we recommend that the Government should consider lessons from these complementary approaches and how they could work together to provide more comprehensive return-to-work support, replacing the existing patchwork of public, private, and voluntary provision.

177. The multi-provider nature of the Work Programme model allows it to be readily scalable to meet these sorts of new demands. Initial soundings suggest that providers could be interested in expanding their role to this area.

178. **We therefore recommend that the Government considers providing this service through an extension of the Work Programme.**

179. Overall, we estimate the State could save up to £300 million a year by introducing this service. The increase in economic output could be up to £800 million a year.

Chapter 6 – The benefits system

Chapter 6 deals with problems in the benefits system. The main focus of the Review has been to keep people in work (with their original or an alternative employer) and reduce the numbers flowing onto benefits each year. However, in any functioning labour market there will inevitably be flows in and out of work. Therefore efficiency of the benefits system, once someone reaches it, is of critical importance in ensuring a swift return to work where possible, and appropriate and timely support where not.

This Review has uncovered a number of inefficiencies in the benefits system, in particular in the administration of the Government's main health-related benefit, the Employment and Support Allowance (ESA). These inefficiencies are slowing down return to work and preventing people capable of working from doing so.

Our two main concerns with the ESA system, both of which prolong detachment from the labour market, are:

- the length of wait before a Work Capability Assessment (WCA) is carried out to decide whether a claimant is indeed eligible for ESA; and
- the large proportion of claimants for ESA who are, in fact, found 'fit for work'.

These two problems together mean that more than a half of all claimants coming from work to ESA sit in the waiting 'assessment phase' for long periods with no conditionality or support to find work, and are ultimately found fit for work after a WCA[78]. This is hugely wasteful and clearly demonstrates that the 'assessment phase' is not serving its intended purpose.

We therefore recommend that the assessment phase for ESA should end altogether and people should go onto ESA only if:

- **they qualify after a WCA**; or
- **as at present, they qualify to pass directly onto ESA without a face-to-face WCA.**

This recommendation should be supported by reformed processes in Jobcentre Plus to prevent high numbers of claimants being inappropriately directed towards ESA. In addition, Jobcentre Plus should ensure that the face-to-face WCA is carried out as soon as possible. This will mean that those in greatest need will gain much swifter access to full rates of ESA. We estimate that these changes would save the State £100 million a year, with an increase in economic output of around £300 million.

[78] This allows for fit-for-work decisions confirmed on appeal.

180. Over 300,000 people flow from work onto ESA each year, with a similar number coming from inactivity or other benefits. The main focus of the Review has been to keep people in work with their original or an alternative employer, thus improving their well-being and that of their families and reduce the numbers flowing onto benefits each year, thus combating the long-term ill-effects of worklessness.

181. However, in any functioning labour market there will inevitably be flows in and out of work. Therefore, the efficiency of the benefits system once someone reaches it is of critical importance in ensuring a swift return to work where possible, and appropriate and timely support where not. A number of inefficiencies in the benefits system have been uncovered in the course of this Review, in particular in the administration of the Government's main health-related benefit, ESA. These inefficiencies are slowing down return to work and potentially preventing people capable of working from doing so.

Background to ESA

182. ESA is one of the two main benefits available for people of working age, alongside Jobseeker's Allowance (JSA). JSA supports those seeking employment, while ESA is intended to support people who are unable to do any work due to illness or disability.

183. For most people, entry onto ESA begins with an 'assessment phase' of up to 91 days. During this time, individuals undergo a WCA which determines whether they are unfit for work. Others, such as those with a terminal illness, automatically qualify for ESA without having a face-to-face WCA.

184. The WCA starts with a questionnaire that asks a claimant how their illness, condition or disability affects their ability to complete everyday tasks. The questionnaire and any supporting medical evidence and information are assessed by an approved healthcare professional. If this professional decides that the Department for Work and Pensions (DWP) needs more information to make a decision, they will recommend a face-to-face medical assessment.

185. This assessment will decide whether the claimant is indeed entitled to ESA. If a claimant is found unfit for work, he or she will be eligible to receive additional ESA benefits (including higher payments) through being assigned to either a Work Related Activity Group (WRAG) or Support Group (SG) for a period of time until a further WCA. Individuals in the WRAG are required to access work-related activity to help them prepare for employment. Those in the SG are not expected to undertake such activity, but can volunteer to do so. Claimants found fit for work will lose their entitlement to ESA. At this point they may move onto JSA. There is, however, scope for a claimant to appeal their fit for work decision and remain in the ESA assessment phase awaiting the outcome.

Problems with the ESA system

186. During the course of the Review we have found two main problems with the ESA system, both of which prolong detachment from the labour market. These are the length of the assessment phase and the number of claimants who are ultimately found to be fit for work.

The length of the assessment phase before a WCA is carried out

187. During the 91-day assessment phase, individuals do not access support from Jobcentre Plus to help them return to work. Neither are any active labour market measures or conditions placed upon their continued entitlement to benefit. Thus, the assessment phase has become a largely unconditional temporary benefit in its own right.

188. The assessment phase timing was originally designed to give claimants ample time to collate evidence and to reduce demands on WCA providers, since many individuals withdraw their claim before 91 days. However, the average actual waiting period before a decision on entitlement is made by a WCA is 128 days[79]. Indeed, around two-thirds of WCA decisions have not been made 91 days into a claim.

189. For many individuals this further prolongs detachment from the labour market. For example, if a claimant had been receiving sick pay at work for 28 weeks and went through the full assessment phase of ESA, the period of time they would be detached from the labour market without any access to return-to-work support, is at least 41 weeks. There is strong evidence that this can cause and/or exacerbate adverse health outcomes[80].

190. During this extended period, Jobcentre Plus generally does not engage with customers. For example, 81 per cent of claimants for ESA make initial contact with Jobcentre Plus but only 54 per cent have contact with Jobcentre Plus again in the subsequent 12 months. In comparison, 99 per cent of JSA customers have some contact with Jobcentre Plus in the 12 months from the start of their claim[81].

79 http://statistics.dwp.gov.uk/asd/asd1/adhoc_analysis/2011/assessment_phase_duration.pdf

80 Waddell and Burton. (2006). *Is work good for your health and well-being?*

81 Williams, B. *et al.* (2011). *Developing an online service: Customer research into the benefits and likely uptake of Automated Service Delivery (Jobseeker's Allowance).* DWP Research Report No. 734.

The large number of claimants on the ESA assessment phase who are, in fact, fit for work

191. The length of the assessment phase is a serious problem, because most people who enter it are, in fact, subsequently found fit for work yet have spent a long time without return-to-work support. Over 1.3 million people have claimed ESA from its launch in October 2008 to November 2010. Of those who underwent a WCA, 62 per cent were found fit for work. Once found fit for work, some people appeal this decision. Taking account of the outcomes of these appeals, the total proportion of people found fit for work is still around 53 per cent.

192. The fact that so many people enter the assessment phase inappropriately appears to be a combination of:

- a mis-match between a General Practitioner's medical certificate (the usual entry criterion for this phase) and the all-work in-depth functional WCA; and
- the ease with which Jobcentre Plus directs people who say they have a health condition towards this benefit (see *The role of Jobcentre Plus* below).

193. In Chapter 2 we explored medical certification and how to make it more effective, with several recommendations which will align more closely certification practices with an eventual WCA.

The role of Jobcentre Plus

194. We understand that some people will be unable to work for a variety of health-related reasons. However, we are convinced that people do not have to be 100 per cent fit to be able to work and indeed, 26 per cent of people in employment have a long-term health condition. Equally, people who are out of work and not 100 per cent fit should, in many cases, be looking for work. Given the potential barriers these people face in securing a new job, it is important that they receive appropriate return-to-work support alongside a benefit claim.

195. Around half of new JSA claimants leave the JSA register within three months and three quarters within six months, with the majority returning to work[82]. Return to work rates for ESA claimants are much lower. Of those ESA claimants currently found fit for work, recent research has shown that 33 per cent were in work when they were re-contacted between 12 and 15 months after their initial claim. For those placed in the WRAG or SG the rate was around half this at 17 per cent[83].

[82] www.nomisweb.co.uk

[83] Sissons, P., Barnes, H. and Stevens, H. (2011). *Routes onto Employment and Support Allowance*. DWP Research Report No. 774.

196. Although the characteristics of JSA and ESA claimants may be different and some ESA claimants may be harder to help, it is clear that leaving people on benefits for longer with no conditionality can only reduce their employment chances as well as wasting taxpayers' money and, above all, human potential. It is, therefore, vitally important that people receive the most appropriate benefit for their circumstances.

197. One of the key differences between ESA and JSA is that when people claim JSA they declare through a Jobseeker's Agreement that they are:

- available for employment; and
- actively seeking employment.

198. This could lead to a misconception that one needs to be 100 per cent fit to claim JSA. However, we note that these declarations can be adjusted on the grounds of ill health by, for example, restricting the type of job and number of hours a claimant agrees to work, and Personal Advisors can refer customers to support to help them return to work.

199. In some cases, when individuals leave their employment voluntarily, or are dismissed due to misconduct, they may have their benefit payments stopped for a period of between 1–26 weeks, the average being around 13 weeks. However, if an individual left employment because a health condition prevented them from continuing in their job, such sanctions may not apply and they could claim JSA in the normal manner.

200. For those who would gain from working, a JSA claim is clearly preferable to the current lack of support available to individuals on the ESA assessment phase. As access to benefits begins with a claim, it is important that people are guided to make an initial claim for the most appropriate benefit for them.

201. However, a recent DWP survey shows that the enquiries to Jobcentre Plus least likely to give satisfaction are queries about benefit eligibility. Furthermore, the customers most dissatisfied with Jobcentre Plus service are ESA customers.

202. Around 70 per cent of all claims to ESA are made over the telephone, through Jobcentre Plus customer service advisors, and Jobcentre Plus staff will often advise and assist people to claim ESA when they encounter individuals with a health condition or disability. DWP research shows that 80 per cent of claimants were made aware of ESA by someone else and most individuals (56 per cent) found out about ESA from Jobcentre Plus staff. Most claimants felt that the information they were given about ESA was incomplete, vague and confusing. This research has also shown that many people claiming ESA do not understand it, with only 32 per cent realising that it is a health-related benefit, while only three per cent understand that it has a work element[84].

203. Furthermore, an individual can claim ESA without any checks being made that they understand the implications of claiming this benefit and whether alternative benefits, such as JSA, may be more suitable.

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[84] Barnes, H. *et al.* (2010). *Employment and Support Allowance: Findings from a face-to-face survey of customers*. DWP Research Report No. 707.

204. When considered against the high number of WCA 'fit for work' decisions, this suggests that Jobcentres can and should do more to help people claim the benefit that is most appropriate for them. This is of particular importance for those people with health conditions who would gain from a return to work, but are less likely to do this when claiming ESA. These people are missing out on the return to work support that would be available if they were to claim JSA, albeit with the necessary restrictions on conditionality to reflect their health condition.

205. In addition to Jobcentre Plus, health professionals play a role in helping people gain access to benefits, principally through the provision of fit notes. Our earlier recommendation (see Chapter 2) was that knowledge and awareness of the benefits system by health professionals be improved, with particular reference to the WCA. The Government may wish to consider further the relationship between access to ESA (usually through the WCA) and the new Independent Assessment Service proposed in Chapter 2.

Recommendations

206. Having reviewed the evidence, we believe that the ESA assessment phase is not fulfilling its intended purpose. It has become an additional benefit with no conditionality that people remain on for long periods and then mostly are found fit for work by a WCA. Many people churn between JSA and ESA each year. In doing so they no longer have to look for a job and so, unsurprisingly, are very unlikely to find work and leave the benefits system.

207. We therefore recommend that the assessment phase for ESA should end altogether and people should go onto ESA only if:

- **they qualify after a WCA**; or
- **as at present, they qualify to pass directly onto ESA without a face-to-face WCA.**

208. This recommendation should be supported by reformed processes in Jobcentre Plus, to prevent high numbers of claimants being inappropriately directed towards ESA. Jobcentre Plus will also need to be much more efficient at getting people to a WCA because, otherwise, genuinely sick people will be left on JSA for long periods and this is clearly unacceptable. We estimate that these changes would save the State £100 million a year, with an increase in economic output of around £300 million (see Annex B).

209. By removing the assessment phase and using the WCA as the only gateway of entitlement to ESA, we can greatly reduce needless periods of detachment from the labour market, while those that do qualify and enter the WRAGs or SGs can access support much sooner. Any increase in the volume of WCAs should be more than offset by a decrease in claims to ESA from the outset.

210. As part of the welfare reforms, the Government is planning to introduce a new means-tested benefits system called Universal Credit (UC). It will replace current means-tested versions of out of work benefits including JSA and ESA. The principles of our recommendations remain relevant under this new system and should be considered and carried through into the design principles of UC.

Chapter 7 – Conclusions

211. During the course of the Review, we have explored how the current sickness absence system could be changed to help people stay in work, reduce costs and contribute to economic growth. We have uncovered a number of major problems and inequalities in the way in which individuals, employers and the State manage ill health and work. As a result, sickness absence levels are too high, our employers are less competitive in the global market and individuals with health conditions are inappropriately denied the advantages of work.

212. We have identified the problems that need to be addressed if this needless waste is to be reduced. The most important of these are as follows:

213. For those in work:

- a medical certification process that does not always meet the needs of employers and employees, and should be more effective;
- people with health conditions too often do not receive appropriate early support to remain in work, especially those with common mental health conditions;
- a lack of access for employers to independent advice on the functional capabilities of staff who are off work sick, and what adjustments could help them return;
- inequalities in the provision of necessary services, such as vocational rehabilitation and occupational health, so that many lower paid employees and/or those coming from smaller firms receive little support to stay in work;
- higher incidence of sickness in the public sector, with great variability in management and leadership across the sector, leading to poor outcomes for some staff and bad value for taxpayers;
- people, usually lower paid or lower skilled people, churning between (usually) smaller employers and the benefits system, without a period of sickness absence with their employer first.

214. For those falling out of work:

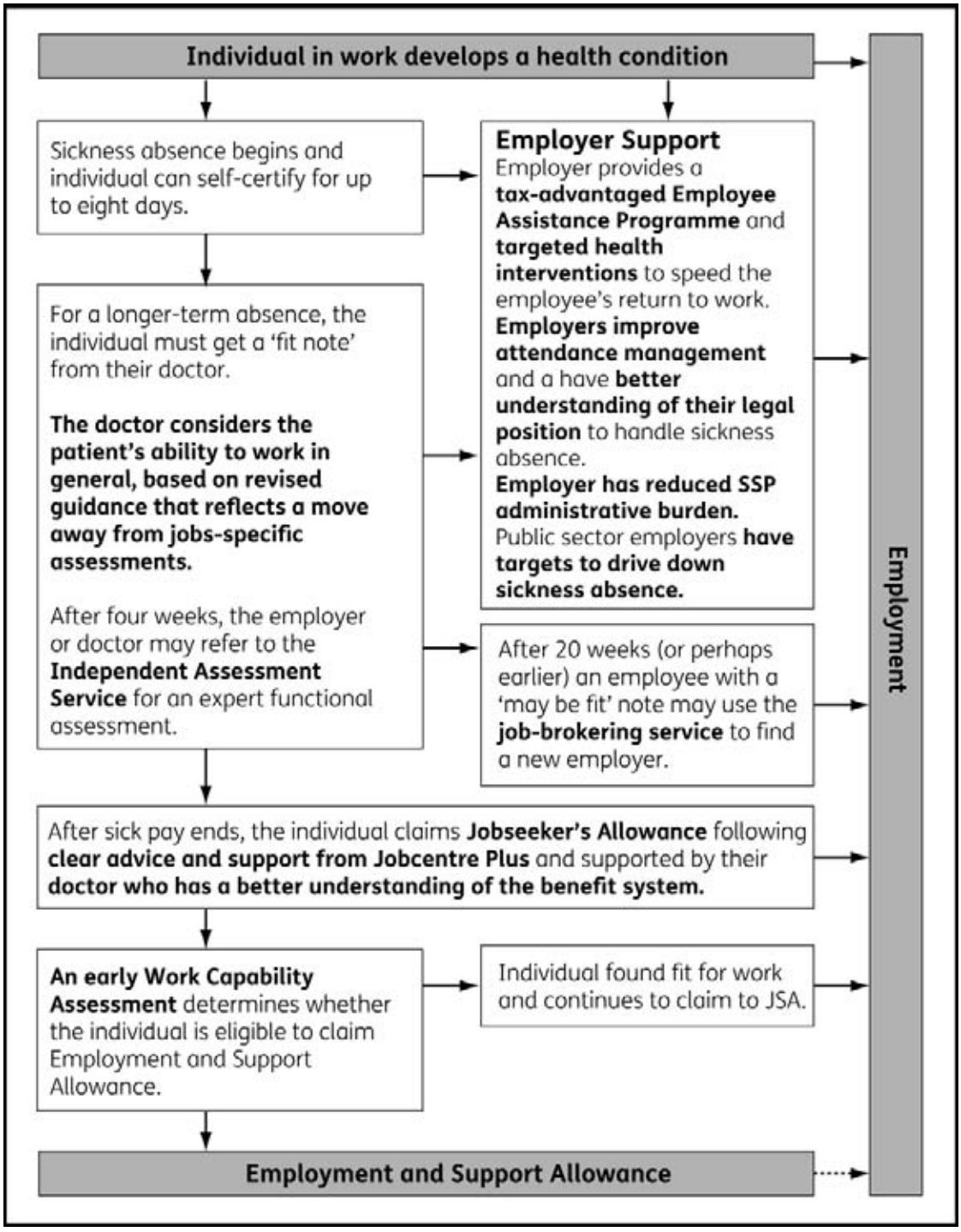
- most people who make a claim for ESA do not go on to qualify, but spend a long time in the assessment phase with no conditions and little support to seek work;
- people well enough to work, but who need to change jobs before they return, get no help from the State until they have left their current employer.

215. These individual problems conspire to create a system which is failing, a system which pushes people away from the labour market towards inactivity; which fails to invest in support for those that need it; and which adds significant cost to business at a time of economic difficulty.

216. The problems have been caused, primarily, by unclear or diffuse incentives in the system. For example, the State gains from employers investing in absence management, but the design of the tax and benefits systems has not fully taken this into account. Employers gain from the State dealing with unemployment efficiently and from employees proactively looking after their own health, but this is not always recognised. Health professionals usually do want to support people back into work, but in individual cases, acting as the patient's advocate in the short term, it can seem easier or kinder to sign a person off as sick.

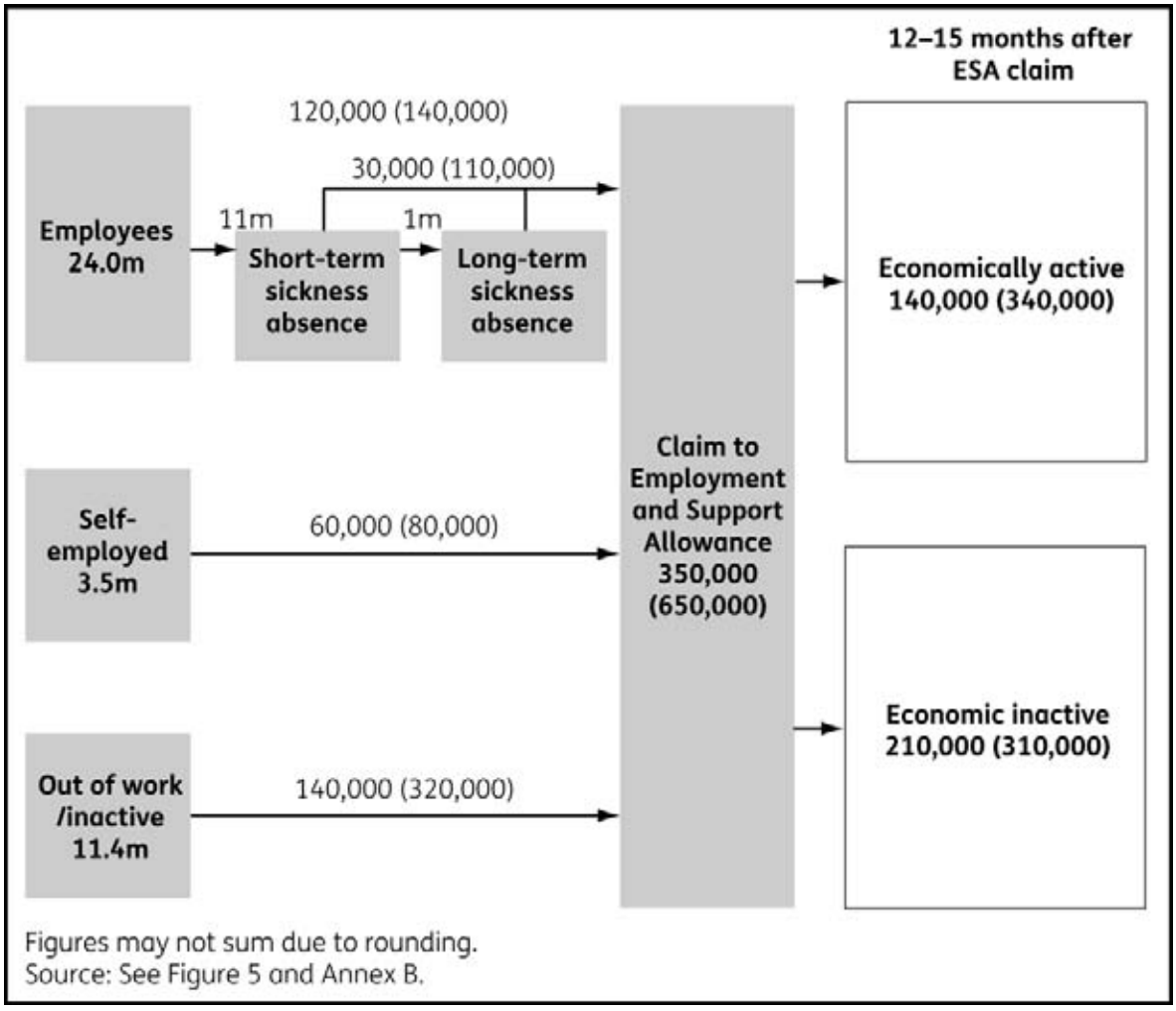
217. Importantly we believe that these barriers to success can be overcome. In this Review we put forward an important yet fiscally modest set of recommendations which we believe, if adopted, could have a transformative impact on the system as a whole. These recommendations will have an impact right across the sickness absence journey, supporting individuals with health conditions to work (see Figure 13).

Figure 13: A new stylised journey from work, through sickness absence, and back to work



218. The recommendations could result in reduced flows of people from work to absence and ESA (see Figure 14). Overall, we believe this could save £400 million a year for employers, up to £300 million a year for the State and boost economic output by up to £1.4 billion.

Figure 14: Flows between work, absence and ESA post recommendations (pre recommendation flows in parentheses)



219. The over-arching aim of all of the recommendations in this Review has been to increase labour market attachment, realign incentives and improve decision making. We believe the new system will provide a swifter and more sensible journey from work to a period of support and back to work again, for the vast majority of people who can return.

Annex A – Sickness absence review: terms of reference

1. The Review will have the following aims:

   - to explore how the current sickness absence system could be changed to help people stay in work, reduce costs and contribute to economic growth;
   - to examine whether the balance of these costs are appropriately shared between the state, individuals and employers;
   - to make tangible recommendations for system change; and
   - to ensure that recommendations for change are consistent with promoting private sector growth and minimising burdens on business and in particular small- and medium-sized businesses.

2. The Review will therefore consider:

   - radical and wide-ranging options to achieve these changes over the medium and long term;
   - other international models and their context, such as that in Holland, where the State has successfully reduced its costs;
   - whether any recommendations made will work as well for those with mental health conditions as they will for other health conditions;
   - how any options fit with the Coalition Agreement and other agreed Government priorities including: promoting private sector growth, One-in One-out, the Big Society agenda, and the Employment Law Review;
   - how any options put forward may work in practice and the potential impact of any changes on employers, businesses (by business size) and labour demand;
   - the costs and administrative burdens on businesses by business size (micro, small, medium and large);
   - the savings and costs to Government of any proposed changes; and
   - the impact on the devolved administrations.

3. In making recommendations, the Review will also consider whether there are wider lessons that can be drawn about how the state supports people who return to work quickly rather than remaining on Statutory Sick Pay. It will examine the Industrial Injuries Disablement Benefit (IIDB) scheme, which provides state compensation for people who have had 'no fault' illness or injury as a result of their employment[85].

[85] Once the Review was underway it was apparent that our considerations and recommendations which would focus on preventing needless sickness absence, would have very limited applicability to the IIDB scheme.

Annex B – High-level costs and savings

1. This Annex provides more information on the estimated costs and benefits of the recommendations presented in the main report. We make some assumptions about how behaviour might change if our recommendations were implemented and these are recorded here. Further detailed modelling of the recommendations will be required in accordance with the final decisions on how to implement them.

2. We also expect that the recommendations as a whole should lead to significant positive behavioural effects and associated cost savings, for example, for the health system, which have not been allowed for in these estimates. We have only included here the benefits accruing from the specific policy recommendations and so have not accounted for, for example, the gains we think the public sector could make from reducing sickness absence to the levels of large private firms (as set out in Chapter 4).

3. Note that the estimates below are based on a 'steady state' world once the recommendations have been implemented and some of the changes, for example around claims for ESA, have been embedded. However, we do not expect there to be significant set-up and early years' costs which would significantly change these overall estimates.

Independent Assessment Service

4. We assume that around 200,000 of those employees who have a sick leave period of more than four weeks will go through the assessment process. For these people a reasonable assumption is that their overall sickness absence is reduced by an average of 20 per cent.

Costs and benefits

5. This new service is expected to cost the State around £30 million a year. We do not envisage that there will need to be significant additional set-up costs.

6. We estimate additional tax revenue of around £20 million as a result of more people remaining in work, leading to an overall net cost to the State of around £10 million. There are also likely to be savings from fewer people making claims for health-related benefits, although these have not been included in any calculations.

7. The reduction in average sickness levels described above means that employers could gain by up to £100 million each year in reduced costs. For the economy as a whole, the net economic benefit is estimated to be up to £150 million.

Job brokering

8. It is thought that around 100,000 people a year have a sickness spell of 20 weeks or more, by which time there is a very good chance they will enter the benefits system.

Costs and benefits

9. Assuming that the job-brokering provider (for example, a Work Programme provider) is paid £2,400 for a successful outcome (for example, £2,000 plus a £400 joining fee), the maximum net cost to the State could be up to £40 million.

10. As a maximum, the net fiscal benefits from reduced benefit payments and increased tax revenue could be £300 million. This would be associated with a maximum increase in economic output of around £800 million and a potential gain to employers of up to £50 million in terms of reduced costs from sick pay. This upper estimate allows for the expectation that some people will opt to use the service before 20 weeks of absence.

The Employment and Support Allowance system

11. We estimate that the recommendations on improved certification, job brokering and the Employment and Support Allowance (ESA) will lead to a reduction of approximately 50 per cent in claims to ESA. This is derived from data on the numbers of claimants that are currently found fit for work or who close their claim – 60 per cent of whom are assumed to be deterred by the early Work Capability Assessment (WCA) and other policy changes and no longer apply for ESA.

Costs and benefits

12. The net savings to the State from these changes are drawn from the benefit savings from fewer people on ESA, the administrative savings from fewer net WCAs as a result of fewer claims and an increase in tax revenue from having more people in employment. We estimate that this totals around £100 million.

13. More people in employment are estimated to increase overall economic output by approximately £300 million.

Tax incentives

Costs and benefits

14. We estimate that providing tax relief for basic rate taxpayers on employers' expenditure on health initiatives would result in an immediate direct cost of about £150 million to the Exchequer, based on current tax receipts on benefits in kind, although this will be offset by some additional tax revenue from more people in work.

15. The overall savings to business are estimated to be in the region of £250 million. This is based on our best estimates of the numbers of firms likely to change their behaviour as a result of these changes and the proportion of employees affected.

16. We recognise that there may be some overlap here with the savings accruing from the introduction of the Independent Assessment Service (IAS) hence have used conservative estimates in both cases.

17. For the economy as a whole, the increase in output from people being in work rather than off sick is estimated to be around £100 million.

Statutory Sick Pay – administrative burdens and the Percentage Threshold Scheme

Costs and benefits

18. The proposed abolition of the Percentage Threshold Scheme (PTS) can be expected to lead to direct fiscal savings to the State of around £50 million each year. It can be expected to reduce levels of sickness absence with associated benefits to employers, economic output and tax revenue, although abolition could potentially have a minor impact on firms' hiring practices. We have only incorporated the direct fiscal costs in our calculations.

19. Additionally, employers will save in the region of £40 million from our proposal to abolish the administrative burdens associated with Statutory Sick Pay.

Table 3: Estimated impact of measures (£m pa)

	Fiscal	Employers	Economic
IAS	-10	+100	+150
Job brokering	Up to +300	Up to +50	Up to +800
ESA system	+100		+300
Tax incentives	-150	+250	+100
PTS	+50	Up to -50*	
Total	Up to +300	Up to +400	Up to +1,400

* This offset comes from the associated reduction in administrative burdens.

Annex C – The current context

1. This Annex sets out some of the more detailed analytical work that informed the Sickness Absence Review and is not contained elsewhere in the report.

Working-age population

2. Total employment among those aged 16 to 64 in Great Britain (GB) is currently around 27.5 million, of which 3.5 million are self-employed.

Table 4: GB population by work status (millions)

	Working-age population	Employed	Unemployed	Inactive
England	33.6	23.8	2.0	7.7
Wales	1.9	1.3	0.1	0.5
Scotland	3.4	2.4	0.2	0.8
Great Britain	**38.9**	**27.5**	**2.4**	**9.0**

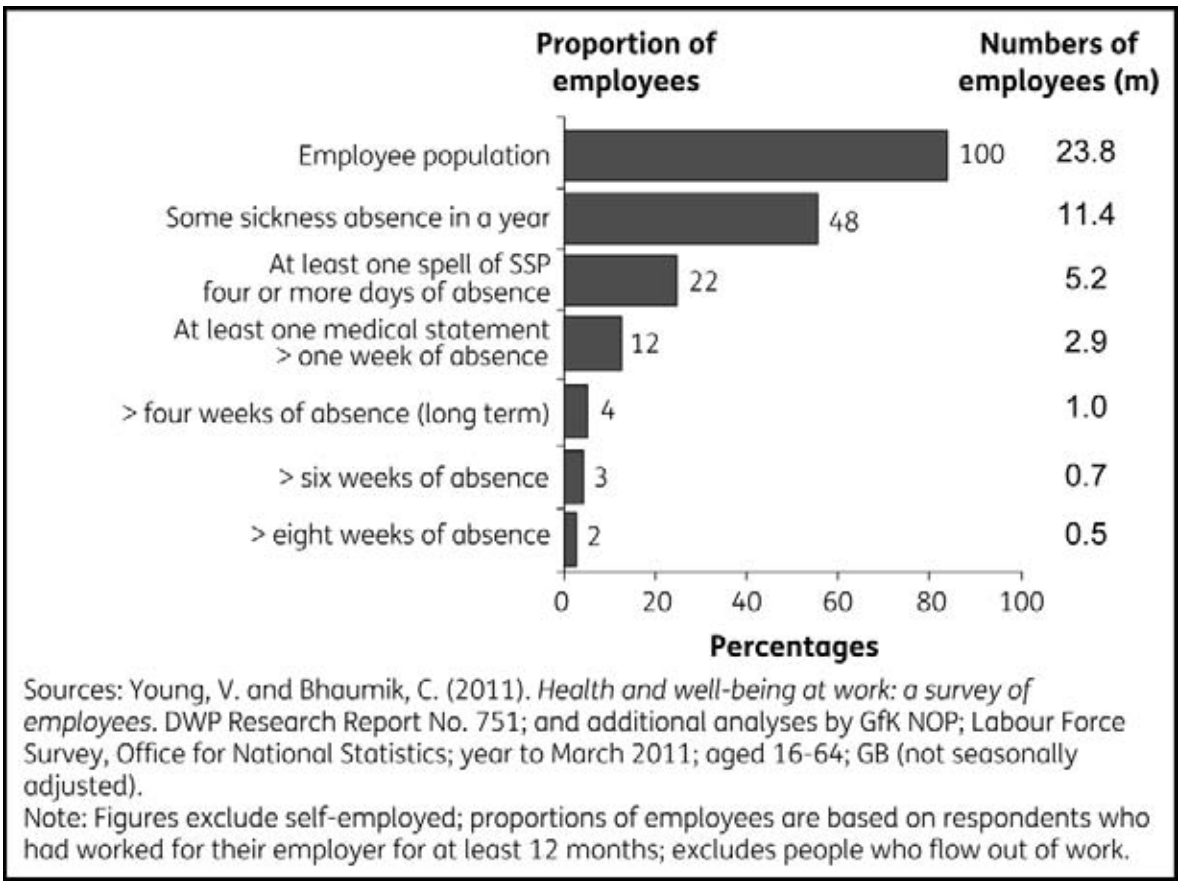
Source: Labour Force Survey, Office for National Statistics, year to March 2011; aged 16–64; GB (not seasonally adjusted).

Incidence of sickness absence

3. Sickness absence data for employees indicate that although large numbers of people experience some absence in a year (48 per cent of all employees), only a small minority (four per cent or one million employees) experience long-term absence of more than four weeks.

4. Around one in five employees have one or more spells of absence of four or more days where Statutory Sick Pay (SSP) may have been payable. Just over ten per cent have one or more spells of absence of over one week where a medical statement or 'fit note' may have been required.

Figure 15: Incidence of sickness absence (employees only)



Sources: Young, V. and Bhaumik, C. (2011). *Health and well-being at work: a survey of employees*. DWP Research Report No. 751; and additional analyses by GfK NOP; Labour Force Survey, Office for National Statistics; year to March 2011; aged 16-64; GB (not seasonally adjusted).
Note: Figures exclude self-employed; proportions of employees are based on respondents who had worked for their employer for at least 12 months; excludes people who flow out of work.

Characteristics associated with sickness absence

5. Levels of sickness absence vary with (though are not necessarily directly explained by) a number of factors and characteristics. Among them are age, gender, skill and wage level, sector, size of firm, sick pay regimes (that is, payment of occupational sick pay) and existence of a trades union.

6. Higher sickness absence is associated in general with the factors and characteristics below, although we should be cautious in drawing firm conclusions as a number of factors are inter-related, potentially contradictory or picking up similar effects:

- older workers;
- women;
- those with a long-term health condition;
- the public sector;
- larger firms;
- public administration and health/social work sectors;
- the existence of a trades union;
- part-time workers;

- those earning £15,600 to £20,799 per annum;
- those who are paid at their normal rate of pay for the first seven days of absence; and
- those in elementary/unskilled occupations.

Table 5: Incidence of any sickness absence and mean number of absence days, by individual characteristics and health status (employees only)

	Percentage of employees with any sickness in last 12 months (%)	Average (mean) number of days of sickness in last 12 months* (days)
Total	**48**	**4.9**
Age		
16–24	58	3.7
25–34	54	4.6
35–44	49	4.7
45–54	42	4.3
55+	41	7.6
Gender		
Male	45	4.1
Female	52	5.7
Suffer long-term health condition		
Yes	55	7.7
No	44	3.4

Sources: Young, V. and Bhaumik, C. (2011). *Health and well-being at work: a survey of employees*. DWP Research Report No. 751; and additional analyses by GfK NOP.
* Figure includes zero/no days of sickness absence.
Note: Calculations are based on respondents who had worked for their employer for at least 12 months.

Table 6: Incidence of any sickness absence and mean number of absence days, by employment characteristics (employees only)

	Percentage of employees with any sickness in last 12 months (%)	Average (mean) number of days of sickness in last 12 months* (days)
Sector		
Private	44	3.5
Public	54	7.2
Establishment size		
Small (1–49)	44	4.3
Medium (50–249)	52	5.5
Large (250+)	53	5.8
Industry		
Manufacturing/utilities	51	4.9
Construction	42	3.2
Retail/wholesale/hotels	41	4.4
Transport/communication	41	3.3
Finance/business	50	3.8
Public administration	59	8.4
Education	44	4.4
Health/social work	58	6.5
Other service industry	48	7.3
Trades union presence at work		
Yes	52	5.8
No	42	3.9
Hours worked per week		
Part time (Up to 30 hours)	49	6.4
Full time (30 hours or above)	48	4.5

Annual income (after tax and National Insurance)		
Up to £10,399	45	4.7
£10,400–£15,599	52	6.3
£15,600–£20,799	52	6.6
£20,800–£31,199	54	5.0
£31,200+	42	2.7
Sick pay		
Do not get sick pay	44	3.2
Paid at normal rate for first seven days of absence	52	5.8
Occupation		
Managers and senior officials	41	3.0
Professionals	51	4.1
Associate professional/ technical	59	6.6
Administrative and secretarial	46	4.5
Skilled trades	45	4.0
Personal service	48	5.7
Sales and customer service	50	5.0
Process, plant and machine operatives	41	3.7
Elementary	45	7.7

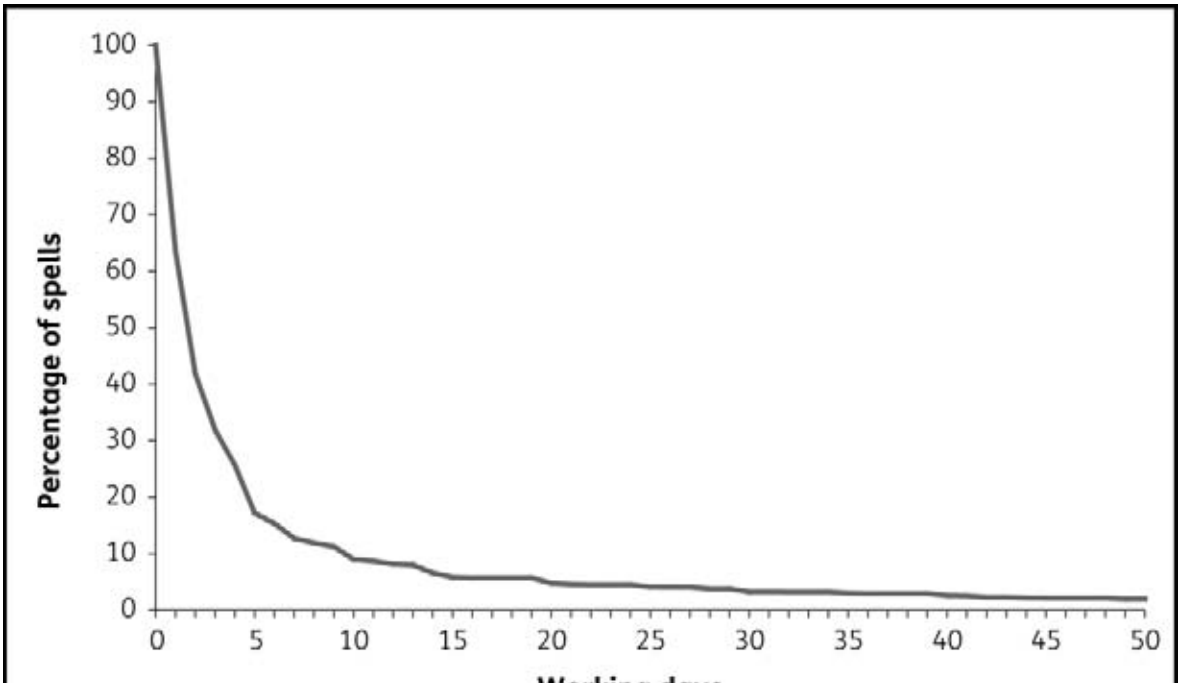
Sources: Young, V. and Bhaumik, C. (2011). *Health and well-being at work: a survey of employees*. DWP Research Report No. 751; and additional analyses by GfK NOP.
* Figure includes zero/no days of sickness absence.
Note: Calculations are based on respondents who had worked for their employer for at least 12 months.

Short-term and long-term sickness absence

7. There are considerable differences between short-term absence of up to one week and long-term absence of more than four weeks. These differences are important for understanding what policy changes could improve absence outcomes at different stages.

8. Overall, it is estimated that over 80 per cent of all sickness absence spells are short term. Long-term absence makes up only around five per cent of all spells, but almost half of total working days lost (see Figure 16).

Figure 16: Absence spells (employees only)



Source: SAR's analysis of data from Young, V. and Bhaumik, C. (2011). *Health and well-being at work: a survey of employees*. DWP Research Report No. 751.
Note: Calculations are based on respondents who had worked for their employer for at least 12 months.

Short-term absence

9. Not surprisingly, for absences of up to one week most firms (90 per cent) reported minor illnesses (colds, flu, sickness and diarrhoea) as being the most common cause. This was followed by back pain (six per cent). For absences of between one and four weeks, minor illnesses were again cited by around a third of firms. This was followed by 'problems associated with joints or muscles', 'stress/anxiety/depression' and 'back pain', each mentioned by around ten per cent of firms[86].

10. The vast majority of people experiencing a short-term episode of sickness absence return to work without moving to long-term absence or falling out of work.

Long-term absence

11. The main causes of long-term absence identified by firms were 'problems associated with joints or muscles', 'stress/anxiety/depression', 'back pain' and 'cancer-related illnesses', each mentioned by between ten and 15 per cent of firms[87].

[86] Young, V. and Bhaumik, C. (2011). *Health and well-being at work: a survey of employers*. DWP Research Report No. 750.
[87] Young, V. and Bhaumik, C. (2011). *Health and well-being at work: a survey of employers*. DWP Research Report No. 750.

12. For longer-term sickness absence:

- the main health causes are musculoskeletal and mental health conditions, followed by surgery and cancer;
- absentees are more likely than all employees to be aged 55 or over, and much more likely to suffer from a long-term health condition;
- absentees are more likely to work in the public sector; and
- their firm is more likely to pay OSP.

13. Around four out of five employees on long-term absence do eventually return to their jobs. The chances of return to work are greater for those with musculoskeletal problems (85 per cent) than for mental health conditions (75 per cent) or acute medical conditions (66 per cent)[88].

Box 2: Sickness absence statistics

There are few reliable sources for sickness absence statistics in GB. Where firms pay SSP (after an employee is absent for more than three consecutive days) they are obliged to keep a record. They are not, however, required as a matter of course to submit this information to the government (unless claiming a rebate under the Percentage Threshold Scheme (PTS)) so the government does not hold a complete record of payments made under SSP.

Various organisations conduct well-known surveys of sickness absence (including, for example, the Confederation of British Industry (CBI), the Chartered Institute of Personnel and Development (CIPD) and the Engineering Employers Federation. While useful, these typically have relatively small samples and are not necessarily representative as they are carried out with their members only. They also rely heavily on employers having accurate records, which a significant number do not.

The principal sources we have used, therefore, are the Labour Force Survey (LFS) and a recent DWP-commissioned survey of employees (Young, V. and Bhaumik, C. (2011). *Health and well-being at work: a survey of employees*. DWP Research Report No. 751). While these do not necessarily cover everything in the other surveys and are employee self-reported rather than reported by employers, both have reliable sampling and design, and are representative of the GB population as a whole. They also have large samples and high response rates, thus minimising selection bias. We have used the LFS for historical time-series data. It is the only survey to cover both employees and the self-employed. We have used the *Health and well-being at work: a survey of employees* for issues requiring more detailed information.

The two surveys provide similar, but not identical, results for the same period (the LFS suggests an average of 5.6 days for each employee in 2009, while the *Health and well-being at work: a survey of employees* produces a lower figure of 4.9 days). The CBI and CIPD estimates for working days lost are slightly higher.

88 CIPD. (2011). *Absence management: annual survey report 2011*.

Employers and sickness absence

Occupational sick pay

14. While firms are legally obliged to pay SSP, many also choose to pay occupational sick pay (OSP) over and above the minimum requirements. Practices vary across sectors, by firm size and within firms (where employees may have different entitlement to, or rates of, OSP according, for example, to their length of service or position in the firm).

15. A recent representative survey of over 2,000 employers found that 43 per cent of all firms pay OSP to all of their employees, with large firms, public sector employers and those in the financial and public administration/education sectors more likely to do so. Almost 90 per cent of large firms pay OSP to some or all of their employees compared with only 47 per cent of small firms.

Table 7: Payment of OSP (percentage of employers)

	Yes for all employees (%)	Yes for some employees (%)	No (%)	No fixed policy on OSP (%)	Not had to pay OSP (%)	Don't know (%)
All	**43**	**5**	**40**	**11**		**1**
Firm size						
Small (2–49)	42	5	41	11		
Medium (50–249)	51	20	24	4		1
Large (250 or more)	69	19	8	3		1
Sector						
Public	54	2	34	10		
Private	41	5	41	12		
Industry						
Manufacturing/ utilities	43	9	36	11		1
Construction	34	5	46	15		
Retail/wholesale	34	5	50	10		1
Hotel and restaurants	20	5	61	14		
Transport/ Communication	49	6	34	11		
Finance/ business	57	5	26	11		

Public administration/ education	52	2	45			1
Health/social work	47	4	46	2		1
Other service activity	39	6	39	11	3	2

Source: Young, V. and Bhaumik, C. (2011). *Health and well-being at work: a survey of employers*. DWP Research Report No. 750 and additional analyses by GfK NOP.

Other provision of sickness-related employee benefits

16. There are a number of ways in which firms deal with the consequences of sickness absence or try to prevent it in the first place. They are usually linked to a wider 'package' of employee benefits.

17. Again, the size of the establishment makes a difference, reflecting a combination of the perceived problem and the access to and affordability of the services available. Table 8 shows the provision of occupational health services and private medical insurance by firm size.

Table 8: Provision of occupation health services and subsidised private medical insurance (in the last 12 months)

Organisation size	Access to occupational health services (% of employers)	Subsidised private medical insurance (% of employers)
Small (1–50)	11	18
Medium (51–249)	46	53
Large (250+)	79	61
All	13	20

Source: Young, V. and Bhaumik, C. (2011). *Health and well-being at work: a survey of employers*. DWP Research Report No. 750 and additional analyses by GfK NOP.
Note: These may not be provided to all employees in the organisations.

Costs of sickness absence

18. The cost to the economy of sickness absence is estimated at around £15 billion.[89] This comprises loss of production or output and other resource costs associated with sickness absence including the value of time spent on sickness absence management and healthcare costs. Other costs to society such as loss of quality of life or well-being ('human costs') are not included in the estimate.

[89] Please note that this figure is not directly comparable with the cost of sickness absence to the economy figure (£10 billion) in Dame Carol Black's Review of the health of Britain's working-age population. The latest figure includes wider costs to employers and the health system arising from sickness absence. Note that this is not the same as the total cost of all working-age ill health, which the Review of the health of the working-age population estimated to be over £100 billion.

19. Sickness absence affects employers, workers and the Government (taxpayer). For employers, there are the costs of sick pay (SSP and OSP), essentially payment of wages/ sick pay in exchange for no output. There are also associated costs of managing sickness absence and costs of staff turnover. For individuals, there is a loss of earnings. For the Government, there are the costs of treating people who are sick, as well as foregone taxes.

Table 9: Costs of sickness absence (2010)

Cost component	2010 (£ billion)
SSP	1.5
OSP	6.9
Other sickness absence costs	0.5
Total employers	8.9
Total employees – Loss of earnings	3.2
Total self-employed – Loss of earnings	1.0
Foregone taxes	1.7
Sick pay (PTS)	0.1
Healthcare	0.2 – 0.4
Total Government	1.9 – 2.1
Lost production	14.4
Other employer sickness absence costs	0.5
Healthcare	0.2 – 0.4
Total economy	15.0 – 15.3

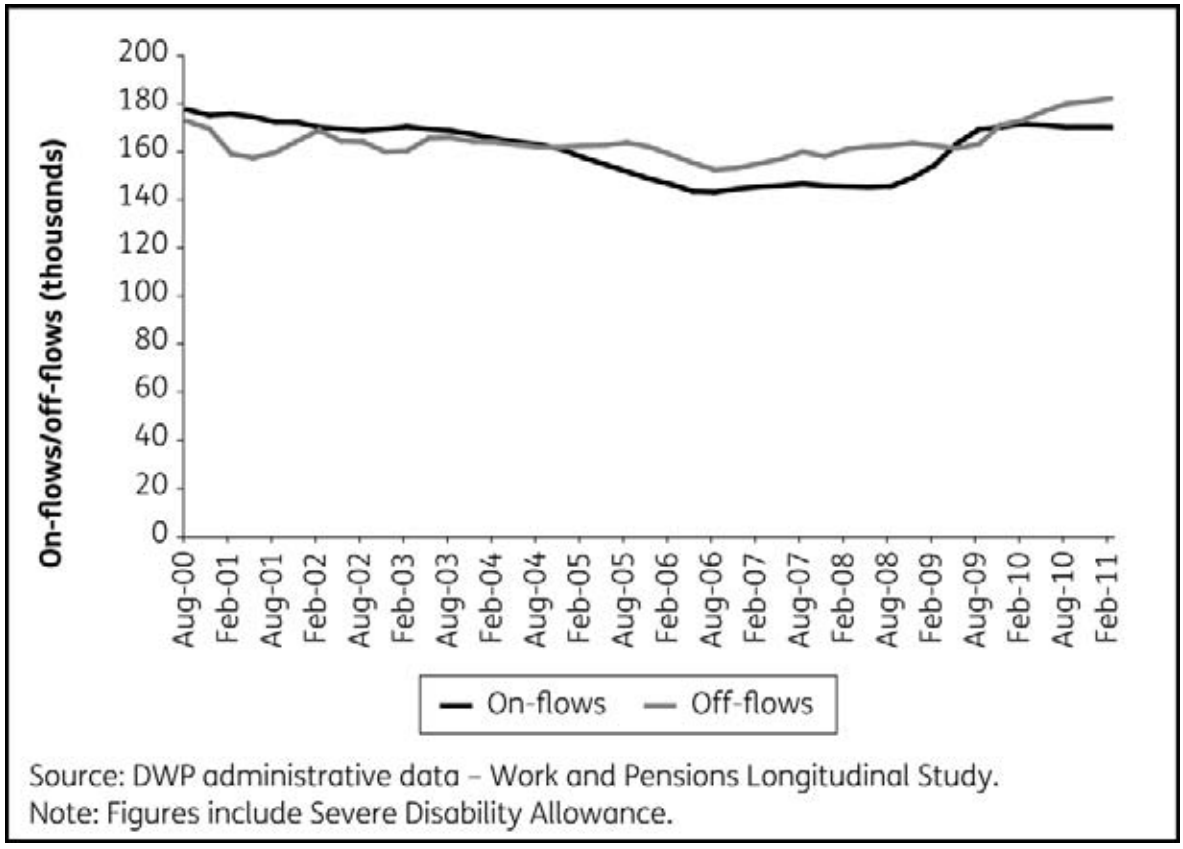
Source: SAR calculations based on Young, V. and Bhaumik, C. (2011). *Health and well-being at work: a survey of employers*. DWP Research Report No. 750; Young, V. and Bhaumik, C. (2011). *Health and well-being at work: a survey of employees*, DWP Research Report No. 751; LFS; Annual Survey of Hours and Earnings Fujiwara, D. (2010). *The Department for Work and Pensions Social Cost- Benefit Analysis framework: Methodologies for estimating and incorporating the wider social and economic impacts of work in Cost- Benefit Analysis of employment programmes*. DWP Working Paper No. 86.

Health-related benefits

20. Employment and Support Allowance (ESA) replaced Incapacity Benefit (IB) and Income Support paid on the grounds of incapacity for new claims from October 2008. Since then, 1.5 million new claims have been made to ESA (up to February 2011), with 650,000 made in the year to February 2011. The current caseload stands at 630,000 (February 2011). The caseload on incapacity benefits (including Severe Disability Allowance) stands at 2.0 million (February 2011).

21. Over the last ten years, flows onto IB (and, since 2008, ESA) have been fairly consistent between 600,000 and 700,000 a year. As the figure below shows, off-flows have been of broadly similar level.

Figure 17: IB/ESA flows 2000-2011 (four-quarter rolling average)



Source: DWP administrative data – Work and Pensions Longitudinal Study.
Note: Figures include Severe Disability Allowance.

Characteristics of ESA claimants

22. In the year to February 2011, claimants to ESA were predominantly male and between the ages of 25–49.

Table 10: ESA claimant on-flow by gender – year to February 2011 (000s)

	Gender		
	Male	Female	All
On-flows	369.13	285.37	654.50
Proportion	56%	44%	100%

Source: DWP administrative data – Work and Pensions Longitudinal Study.

Table 11: ESA claimant on-flow by age – year to February 2011 (000s)

	Age			
	Under 25	25–49	50 plus	All
On-flows	115.14	367.59	171.75	654.48
Proportion	18%	56%	26%	100%

Source: DWP administrative data – Work and Pensions Longitudinal Study.

Medical condition of ESA claimants

23. Over a third of ESA claims were for mental and behavioural disorders, the most common of all health conditions. This was followed by 'injury, poisoning and certain other consequences of external causes' (14 per cent) and musculoskeletal conditions (13 per cent).

Table 12: ESA claimant on-flow by health condition – year to February 2011 (000s)

	On-flows	Proportion
Mental and behavioural disorders	239.93	37%
Injury, poisoning and certain other consequences of external causes	93.84	14%
Diseases of the musculoskeletal system and connective tissue	87.47	13%
Diseases of the circulatory system or respiratory system	37.14	6%
Diseases of the nervous system	19.36	3%
Other	176.73	27%
All	654.48	100%

Source: DWP administrative data – Work and Pensions Longitudinal Study.

Duration on benefit

24. It is probably too early to fully understand the duration on ESA. However, the current ESA caseload shows that over a third have been on ESA for one year or more.

Table 13: ESA caseload duration of current claim – February 2011 (000s)

	Caseload	Proportion
Up to three months	150.48	24%
Three months up to six months	109.82	17%
Six months up to one year	146.2	23%
One year up to two years	183.3	29%
Two years up to five years	41.56	7%
All	654.48	100%

Source: DWP administrative data – Work and Pensions Longitudinal Study.

25. Looking at IB cases, Table 14 shows for the existing IB caseload, three-quarters have been on the benefit for five years or more.

Table 14: IB caseload duration of current claim – February 2011 (000s)

	Caseload	Proportion
Up to two years	43.7	1%
Two years and up to five years	461.0	23%
Five years and over	1,481.2	75%
All	1,985.92	100%

Source: DWP administrative data – Work and Pensions Longitudinal Survey.

Flows out of work and onto health-related benefits

26. Survey data indicate that approximately 330,000 people flow from work onto ESA each year. Two-thirds of claimants are male and over a third are over 50.[90]

27. Table 15 sets out the findings from recent research on the previous employment of those coming from work onto ESA. This shows that this group is likely to:

- have been working in relatively low-skilled jobs (about 80 per cent of all those flowing from work to ESA fall into the semi/unskilled, skilled trade, or administrative, personal service or sales categories compared to 55 per cent of all people in work);
- disproportionately, come from smaller- and medium-sized employers (around a third of those coming from an employer were working for a large firm; whereas around half of all employees work for large employers in the public or private sectors);
- disproportionately, come from self-employment (over one-quarter of people coming from work said they were self-employed, but only around one in eight working people are self-employed);

[90] Barnes, H., Sissons, P. and Stevens, H. (2010). *Employment and Support Allowance: Findings from a face-to-face survey of customers.* DWP Research Report No. 707.

- tend to be relatively low-paid – nearly a third earn less than £10,000 and around three-quarters were earning less than £20,000 per year, but in the population as a whole, just under half earn less than £20,000.[91]

Table 15: Previous employment, by gender, 'from work' group claiming ESA (%)

	Men	Women	All
Sector			
Private sector	88	67	81
Public sector	11	30	18
Charity/voluntary sector	[1]	[3]	[1]
Occupation			
Managerial, professional and associate professional	16	25	19
Administrative, personal service and sales	7	47	21
Skilled trades	36	[4]	25
Semi-skilled and unskilled	41	23	35
Firm size			
Micro (1–9 employees)	15	14	15
Small (10–49 employees)	11	18	14
Medium (50–249 employees)	13	14	13
Large (250+ employees)	22	31	25
Do not know	6	6	6
Self-employed	32	18	27
Type of contract			
Permanent	81	92	85
Temporary, seasonal or casual	10	5	8
Fixed term	6	3	5
Other non-permanent	3	1	2
Annual earnings			
Less than £10,000	21	48	30
£10,000 to £19,999	46	40	44
£20,000 to £29,999	23	7	17
More than £30,000	11	[5]	9

Source: Sissons, P., Barnes, H. and Stevens H. (2011). *Routes onto Employment and Support Allowance*. DWP Research Report No. 774.

[91] Annual Survey of Hours and Earnings, 2010.

28. The most common health condition that ESA claimants coming from work suffer from is musculoskeletal disorders, followed by mental health conditions. This contrasts with ESA claimants overall, where the most common condition is mental ill health. ESA claimants coming from work are more likely to have recently developed the condition than those not coming from work. Nearly a third of individuals coming from work reported that they were awaiting treatment of their health condition 12–15 months after their initial ESA claim.

Table 16: Health characteristics of ESA claimants from work

	% ESA claimants coming from work
Main health condition	
Musculoskeletal	41
Mental health	26
Long-term/systemic condition	20
Other	10
Do not know	3
Whether main condition is mental or physical	
Physical	72
Mental	28
Single or multiple conditions	
Single	35
Multiple	65
Has fluctuating condition	
Yes	42
No	56
Onset of condition	
Recent (2008/2009)	49
Long term (2003 or before)	22

Source: Sissons, P., Barnes, H. and Stevens H. (2011). *Routes onto Employment and Support Allowance*. DWP Research Report No. 774.

Outcomes

29. Table 17 shows the outcomes, in percentages, for ESA claimants at the point they were interviewed (approximately six to nine months after their initial claim). As can be seen, similar proportions of those from work and not from work were found unfit for work and ended up in the Work Related Activity Group (WRAG) or Support Group (SG) although these comprised only around 20 per cent of the total. Over two-thirds of those flowing from work to make a claim for ESA were either found fit for work at a Work Capability Assessment (WCA) or their claim was closed or withdrawn (for example, because their health condition improved, they found a job, they were deterred by the process etc).

Table 17: WCA outcomes for the work and non-work groups

	Origin: from work	Origin: from non-work	Total
Claim group			
SG	7	6	6
WRAG	15	15	15
Fit for work	38	41	40
Closed/withdrawn	31	25	28
In progress	9	13	11
Total	**100**	**100**	**100**

Source: Barnes, H., Sissons, P. and Stevens H. (2010). *Employment and Support Allowance: Findings from a face-to-face survey of customers*. DWP Research Report No. 707 plus SAR's analysis of dataset.

30. It is important to note that a number of people appeal against the decision made following a WCA. DWP administrative data showed that around 40 per cent of those found fit for work appealed against that decision and of these about 40 per cent had the decision overturned. In Table 17 some people will have already appealed (and may therefore be in a different group to their original one). Some others may be in the process of appealing, although this should not have a significant impact on the overall distribution above (the most likely outcome is that a small proportion of those in the fit for work category may shift to the WRAG).

31. A recent survey of ESA claimants found that those who had originally come from work were more likely to be back in work when followed up six months later (approximately 12–15 months after their claim). However, as Table 18 shows, only around a third were actually back in work. Of the remainder, nearly a third reported themselves to be temporarily or permanently sick. This is a self-reported measure of main economic status and may cover a variety of circumstances (and may be interpreted in different ways by the survey respondent). The rest are otherwise out of work, for example unemployed (whether or not they were claiming Jobseeker's Allowance (JSA)), caring for family members or otherwise inactive.

Table 18: Destinations 12–15 months after claim for the work and non-work groups (%)

	Origin: from work	Origin: from non-work
In work	44	18
In employment or self-employment	35	15
Off sick from work	9	3
Out of work	56	82
In receipt of JSA	6	17
Permanently sick	22	26
Other (unemployed, carer, other inactive)	28	40

Source: Sissons, P., Barnes, H. and Stevens, H. (2011). *Routes onto Employment and Support Allowance.* DWP Research Report No. 774 plus SAR's analysis of dataset.
Note: Figures do not sum due to rounding.

Annex D – International experiences of sickness absence

1. We have closely studied each element of the British system to consider whether it can be improved. However, as was proposed in this Review's terms of reference, we have found it very helpful to consider the experiences of other countries in arriving at our recommendations.

2. There have been a number of previous attempts to describe a taxonomy of sickness and disability systems.[92] However, these have suffered from being overly specific to the extent of making false distinctions. We think that it is more important to focus on whether the costs of sickness absence are borne more by employees, employers or the State, as this then helps to highlight who has the greatest incentives to act to reduce sickness absence, and whether these incentives can be improved.

3. The first category of sickness absence systems are those that follow a **'libertarian'** approach, where the individual employee is responsible for providing their own sick pay and rehabilitation services. The key examples of this approach are the United States of America (USA), Canada and Australia. In these countries there is very little support from the State in the form of benefits or regulation for sickness absence (although compensation for work-related injuries is often paid from federal or local funds). In many instances, employers provide sick pay as part of a wider package of employee-benefits.

4. However, these employee-benefits tend to be provided only for more productive employees. Those at the bottom end of the pay scale, with little human capital, tend to be excluded from employee-benefits because they can be more easily replaced. For those who have a long-term disability, there is often a state benefit that can be paid after an assessment is made of need. The amount of the benefit is normally fixed at some base level, with income-related top-ups for those in very poor households.

5. At the opposite end of the scale are the Nordic countries. Here, sick pay is generally paid by the **State** and is often based on previous and potential future earnings (although employers often have to pay this for the first week or two). During the sick pay period, which may be up to two years, employers generally cannot dismiss their employees for any reason. There is some important variation between the three largest countries: Finland, Sweden and Norway, which is described briefly below.

    - **Sweden** is the most statist of the trio, with a fixed payment of 80 per cent of salary paid by employers for the first 14 days and by the Government thereafter, up to a year. Over this year, the State makes a number of assessments of ability for work, progressing from 'own work' to 'any work'.

[92] See, for example, Bambra, C. (2011). Health inequalities and welfare state regimes: theoretical insights on a public health puzzle. *Journal of Epidemiol Community Health*, v.65, pp. 740-745.

- In **Norway** the system is a little more flexible, with the amount of sick pay being determined by the extent to which working capacity has been affected, from 100 per cent down to 20 per cent. Although Norway and Sweden both have long-term disability benefits which are based on earnings, eligibility for Norway's system is based on social insurance contributions and is actively designed for those who are expected to be able to return to work.
- **Finland** is significantly less statist in its approach, with a model which largely relies on a state-run insurance scheme, rather than a state-administered and gated benefit. The Government, employers and employees contribute to the insurance scheme, and it is used to pay for both sick pay and rehabilitation and associated treatment. Also, Finnish employees receive no sick pay until the tenth day of their absence, unless their employer offers its own sick pay.

6. As a final example, the **Netherlands** has a rather unusual system in that it places more of a burden on **employers** than any other country. This is not to say it is less statist than Sweden or Norway, but rather that the State places a regulatory and financial burden on employers by mandating them to pay the sick pay of their employees for the first two years (at least 70 per cent of earnings). Employers also get penalised if they either do not show due diligence to the rehabilitation process or if the State thinks too many of their employees are still not back at work after two years.

7. All three of these approaches have their own advantages: a libertarian system works well for those who are part of it; a statist system can provide a good safety net for all; and an employer-based system can potentially internalise sickness costs very well.

8. However, the downsides of these three approaches are clear: a libertarian system excludes many of the most poorly paid; a statist system places significant cost on the actor least able to alleviate the problem, the State; an employer-based system encourages doing the bare minimum and also results in high-risk individuals struggling to find employment.

How does the British system compare internationally?

9. Great Britain has a mixed approach to sickness absence. Although employers in theory bear the cost of Statutory Sick Pay (SSP), the cost itself is not very high[93]. Barriers to dismissal are relatively low (although it should be noted that dismissing someone specifically to avoid paying SSP is illegal). Employers are therefore obliged to bear little cost or accountability for sickness absence, albeit many employers choose to pay more in occupational sick pay (OSP) than the statutory obligation.

[93] £81.60, around 20 per cent of average weekly earnings, Office for National Statistics, February 2011.

10. Until an employee makes a claim for the Employment and Support Allowance (ESA), the State has very little to do with those on sickness absence, save for their General Practitioner probably providing a fit note. Although an employee will almost certainly have had contact with public health services during their absence, there are no strict rules about health services focusing on return to work or communicating with employers. The State therefore bears quite a significant cost from sickness absence, in terms of medical costs and costs of ESA benefits. However, the State has given itself very little accountability, in the sense that very little is done by the State to prevent sickness absence resulting in medical and ESA costs.

11. Employees on higher earnings potentially bear a significant cost from prolonged sickness absence, as even with the additional benefits to which SSP and ESA give a passport, they could be significantly worse off. However, this cost can be avoided if their employer pays OSP, or they take out insurance. Employees therefore bear a significant cost from sickness absence because, unless they are very low paid (or, equivalently, work part time), they live in a similarly libertarian system as those in the USA, Canada and Australia – if they care about having a reasonable income while off sick then they have to find an employer who pays OSP, or purchase their own personal insurance.

12. The overall impression is therefore that the British sickness absence system is most similar to the libertarian models of the USA, Canada and Australia, albeit with a slightly firmer safety net in the form of ESA (and to a certain extent, Jobseeker's Allowance), and tighter restrictions on dismissing people during SSP periods. Although the scale of public social spending in the United Kingdom is closer to that of the Nordic countries than the USA, Australia and Canada[94], it interacts with employers much less, making it much more distant from the active labour market, in particular for those on ESA.

Case study of the Netherlands

13. The Netherlands has been held up as a good example of how to incentivise the reduction of the impact of sickness absence. The current system has been introduced progressively between 1999 and 2006, motivated by significantly rising numbers of people claiming long-term disability benefits. As mentioned above, employers are liable for up to two years of sick pay, at 70 per cent of previous salary. Alongside this, there is a strict, state-enforced schedule for the employer and employee to discuss return to work:

    - By week six: the employer must pay for an independent occupational health physician to assess the employee's ability to do their own job.
    - By week eight: they must agree a rehabilitation plan (known as the **Gatekeeper Protocol**).
    - Every six weeks, up to 91 weeks: monitoring of rehabilitation.
    - After this, if their capability for work is assessed by the state to be less than 65 per cent, then they transfer to the state-administered benefits system (**WGA** or **IVA**, depending on limitation).

[94] Organisation for Economic Co-operation and Development, 2008.

14. The WGA and IVA benefits are funded by employer contributions. If the number of employees flowing onto the benefits rises above a threshold, employers' contributions are increased.[95]

15. The risk of expenditure on sick pay has stimulated the development of a large insurance market for employers to insure against paying sick pay. This has mobilised significant resources towards health screening and preventative measures to reduce individual health risk and also to return back to work those who do get sick.

16. However, the enforcement of the Gatekeeper protocols on employers has led to a tendency for employers managing their rehabilitation processes to prioritise ticking the right boxes, rather than genuinely trying to return someone to work.[96]

17. A recent evaluation of the Dutch system[97] has looked at the impact of these measures on the number of people claiming long-term disability benefits. The evaluation looks at two of the most major reforms:

    - Experience rating and private insurance.
    - The Gatekeeper protocol.

Experience rating

18. This is where employers' premiums which they pay to private insurance companies go up if the costs of their (former) employees' disability benefits increase, that is, too many people are flowing from a firm onto long-term disability benefits. Koning (2004)[98] found this reform reduced disability benefit inflow by 15 per cent. De Jong, Thio and Bartelings (2005)[99] found a four per cent reduction. Van Sonsbeek finds a 13 per cent reduction.

Gatekeeper protocol

19. Employers and employees were mandated to make a rehabilitation plan which was reviewed by the Dutch Social Affairs Ministry at regular intervals over the two-year sick pay period. De Jong, Thio and Bartelings (2005) found this reduced benefit inflow by 15 per cent, but could be as high as 33 per cent. Van Sonsbeek endorses this view by finding a reduction of 22 per cent.

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95 Otherwise known as 'experience rating'.

96 Sprueewers, D. (2011). Managing Director of the Netherlands Centre of Occupational Diseases.

97 van Sonsbeek, J. M. (2011). *Estimating the long-term effects of recent disability reforms in the Netherlands*, VU University, Amsterdam Working Paper: https://editorialexpress.com/cgi-bin/conference/download.cgi?db_name=IIPF66&paper_id=156

98 Koning, W. P. C. (2004). *Estimating the Impact of Experience Rating on the Inflow into Disability Insurance in the Netherlands*. CPB Discussion Paper 37.

99 Jong, Ph. de, Thio, V. and Bartelings, H. (2005). *UWV als poortwachter. Fase III: WVP en de instroom in de WAO*. Ape, September 2005, in van Sonsbeek (2011).

20. The evaluation found that the combined effect of the above two measures and tightening the examination criteria together reduced the long-run forecast disability benefit caseload by 50 per cent.

The Dutch system for the UK?

21. Although the Dutch system has clearly been successful in terms of preventing people from progressing from sickness absence to long-term disability benefits, there are a number of factors which limit the applicability of the model to the UK:

    - The possibility of potential employees being disadvantaged through being higher risk would go against the message of the Disability Discrimination Act and make life more difficult both for employers and those with health conditions.
    - The British economy is currently emerging from a recession. Part of the Government's plan for recovery is to stimulate small and medium-sized businesses. Placing a burden of this scale on them would clearly not help.

22. The Dutch reforms were introduced to a system that already involved employers paying contributions towards long-term disability benefits. There was, therefore, already a psychological link for employers between their current workforce and disability benefits. No such link exists in the UK. Although employers pay National Insurance for their employees and this is technically supposed to support the welfare system, there is no link in employers minds to disability benefits. Applying the Dutch reforms to the UK would therefore involve a significantly larger cultural shift for employers than in the Netherlands.

Annex E – An insurance-based approach to reducing sickness absence

We have examined proposals that overall sickness absence costs could be significantly reduced by extending the use of sickness-absence-related insurance cover. Various stakeholders have suggested that increasing the take-up of income protection (IP) insurance in particular could significantly reduce the costs of sickness absence. This insurance can provide an invaluable income to employees who have exhausted sick pay and whose health condition continues to prevent them from returning to work. As a result, State costs can be reduced as people receiving this income will be eligible for a reduced rate of income-related state benefits.

The principal mechanism for reducing the levels of long-term sickness absence would be the application by insurers of best practice in returning individuals to the workplace. Indeed, we have learnt much from the insurance industry about best practice in supporting people to return to work.

While those on higher incomes potentially have much to gain from IP insurance, the overall use of insurance to improve return-to-work rates appears to be a more limited solution. For example, return-to-work interventions for those on lower incomes are unlikely to be cost effective for insurers to provide.

Broader coverage of insurance would also extend sickness absence obligations (and costs) for employers at a difficult time, potentially increasing employer wage bills by at least 1.5 per cent to five per cent. This compares to current costs of meeting Statutory Sick Pay and occupational sick pay (OSP) of around one per cent of pay bill.

Overall, the insurance industry clearly has a place in helping employers manage sickness absence. However, the insurance market for IP is well established and we do not think there is a strong case for the State to intervene to drive greater coverage.

1. In Chapter 3 of this report we have recommended that Government should offer employers tax relief on expenditure on interventions that prevent sickness absence or help absent employees back to work more quickly. These interventions can also be made available through some insurance products.

2. A number of submissions to the Review argued that the private insurance industry could play a more significant role in covering individuals and employers for the costs of sickness absence. It has been put to us that increasing take-up of such insurance products in the United Kingdom (UK) would have a number of significant advantages[100].

[100] Wind-Cowie, M. (2011). *Of mutual benefit personalised welfare for the many*, DEMOS.

3. The key argument used in favour of expanding the insurance market is that insurers have very clear incentives to keep employees healthy and, if sick, to speed their return to work. This is apparent in the return-to-work services offered by insurers to individuals in need of support.

Insuring employees against loss of income

4. Most people receive sick pay when they are off work recovering from an illness. However, sick pay will only be paid for a fixed length of time (often six months) after which it will stop. This can be very difficult to manage for those people who need much longer to recover as it can lead to a substantial fall in their income.

5. To guard against this, people can be covered by IP insurance which will pay them a proportion of their pre-sickness income once they no longer receive sick pay. This income is paid on top of any state benefits to which they are entitled. Some employers purchase this insurance for their employees and, in doing so, extend employee health-related benefits beyond sick pay alone.

6. At present, around 11 per cent of UK workers are covered by an IP policy[101] – with coverage skewed towards higher earning executives. Group Income Protection (GIP) provided by an employer makes up over 70 per cent of this total[102].

7. For those employees who rely on these payments, IP is undoubtedly invaluable. There are also a number of other issues that both support and undermine the case for extending the use of IP insurance.

8. For example, IP insurance can offer more than just income replacement. This is because insurers will have a keen interest to keep people in work and reduce the length of any sickness absence. Consequently, insurers offer other services such as access to occupational health and have developed some very interesting condition management support to help people return to work quickly. These are clearly valuable for employers who choose to take out IP insurance, helping them maintain a healthy workforce.

9. These services are generally readily available to those in higher-paid professions. For people on lower incomes, and consequently at higher risk of flowing out of work, this sort of additional help is unlikely to be cost effective for the insurer to provide.

10. Similarly, for individuals on higher incomes, moving onto the levels of income offered by state benefits can be difficult to manage, making clear the value of IP insurance. However, individuals on lower incomes will already receive relatively high income replacement rates from state benefits and so would have little to gain from this insurance.

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[101] Legal and General. (2010). *Saving money raising quality: Ideas for Britain's welfare system*.
[102] Legal and General. (2010). *Saving money raising quality: Ideas for Britain's welfare system*.

11. Set against the potential advantages of insurance in getting people back to work, offering IP can also increase sickness rates as it reduces the cost to the employee of being on long-term sick leave, thus increasing moral hazard. Similarly, an issue that has been raised at our stakeholder meetings is the risk of firms using GIP being less willing to employ 'at-risk' individuals. This is a notable aspect of the heavily insurance-led system in the Netherlands, where individuals with a pre-existing health condition find it difficult to enter the labour market.

12. For employers, GIP can be used as part of the package offered to attract and retain staff and to improve employee engagement[103]. Premiums paid by employers for GIP can also be experience rated, meaning that they are linked to the extent to which they draw on the policy. This provides a feedback loop between higher absence rates and higher costs, making the cost of sickness absence more transparent and encouraging employers to reduce their sickness absence levels. Research[104] on the use of experience rating in the Netherlands has found that it may reduce disability benefit inflow, thus providing a further, indirect, advantage of compulsory insurance.

13. For the State, it has been argued that greater use of IP insurance could reduce spending on income-related benefits. It is very difficult to estimate the size of these savings as they depend on the full behavioural impacts of any policy changes. However, given the expected costs to business of broadening IP insurance coverage, we would not expect savings to the State to outweigh the corresponding costs to business.

The cost of insurance

14. The cost of IP insurance varies according to the type of cover on offer, the characteristics of the people covered and, where an employer is buying cover, the characteristics of their company.

15. The insurance industry currently covers around 11 per cent of employees at a rough cost of around 1.5 per cent of an employer's wage bill[105] though this coverage is not uniform. There is currently only limited market penetration in some significant sectors, including small and medium-sized enterprises and employees in low-paying and low-skilled jobs who are at higher risk of taking long-term sickness absence. This suggests potentially much higher costs than at present where the market is more limited to large employers and lower risk individuals.

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[103] Engineering Employers Federation Sickness Absence Survey 2010.

[104] van Sonsbeek, J. M. (2011). *Estimating the long-term effects of recent disability reforms in the Netherlands*. VU University, Amsterdam Working Paper: https://editorialexpress.com/cgi-bin/conference/download.cgi?db_name=IIPF66&paper_id=156
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[105] Legal and General. (2010). *Saving money raising quality: Ideas for Britain's welfare system*.

16. Therefore while the cost of insurance currently on offer is estimated to be 1.5 per cent of an employer's wage bill[106] – this will be higher, possibly up to five per cent of wage bill, for those employing more manual and high-risk occupations. This compares to current costs of meeting sick pay obligations of around one per cent of an employer's wage bill.

Insuring employers against sick pay costs

17. We have also considered the scope for employers' directly insuring against sick pay liabilities. There is currently little or no sickness absence insurance market in the UK providing this cover. This is partly because employer liabilities for sick pay are relatively low, something that is particularly relevant for those employers who offer the statutory minimum cover. Larger employers will be in a position to self-insure against the more generous OSP that they choose to offer. Once this period of sick pay has been exhausted, the employer can then legitimately pass longer-term costs to the State.

18. There are also limited incentives for the insurance industry to supply this type of insurance. There would be little profit to be made in covering such low costs/risks. Furthermore, even if this type of cover was available, it would only be cost-effective for insurers to provide very low-cost return-to-work services. Some services such as the national Occupation Health Advice-line are already available to employers. So even if there were a market for covering the costs of short-term absence, it would probably do little to reduce levels of sickness absence.

19. Therefore, rather than considering the implications of widening employer cover against sick pay liabilities, we focused on the possibility of extending the use of insurance which protects employee incomes (as above).

Main conclusion

20. Overall, the insurance industry clearly has a place in helping employers manage sickness absence. However, this includes relatively high costs for employers and the potentially limited coverage of return-to-work support for those on lower incomes. As the insurance market for IP is well established, we do not think there is a strong case for the State to intervene to drive greater coverage.

[106] Legal and General. (2010). *Saving money raising quality: Ideas for Britain's welfare system*.

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