IPPR

WORKING WELL
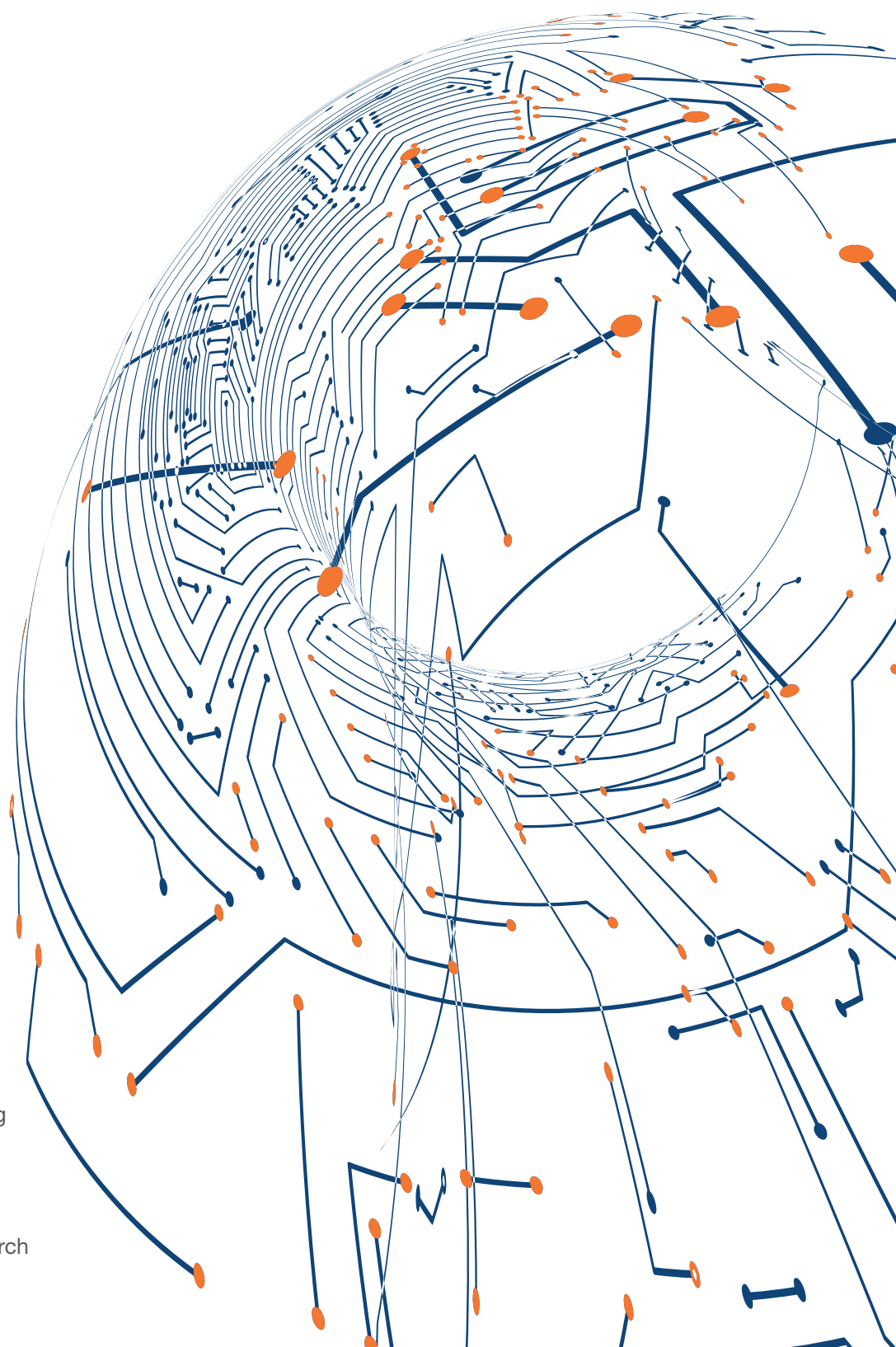## A PLAN TO REDUCE LONG-TERM SICKNESS ABSENCE

Bill Davies, Joe Dromey,
Clare McNeil, Charlotte Snelling
and Craig Thorley

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SUMMARY

60-SECOND SUMMARY

The number of people receiving sickness benefits in the UK has remained steady and stubbornly high despite fluctuations in unemployment and decades of government interventions. While the number of jobseeker's allowance claimants has risen and fallen significantly in recent years in response to demand in the labour market, the number of claimants of employment support allowance (ESA) and incapacity benefit (IB) has remained remarkably stable. Over the last two decades, levels of ESA/IB claimants have not fallen below 2.2 million and not risen much above 2.6 million.

Successive government policy (from the New Deal for Disabled People, the reform of incapacity benefit, Pathways to Work, the work capability assessment and the Work Programme) has focused on one aspect of this problem – helping people move off sickness benefits and back into work (off-flow). However, these have generally had poor results with those on sickness benefits, compared to those on jobseeker's allowance. **Over the last two decades, those who have left sickness benefits have been replaced by a steady flow of people moving from work onto IB/ESA (on-flow) which has meant that the numbers of people claiming long-term sickness benefits has remained consistently high.**

Not enough is being done to prevent people from leaving work and moving onto sickness benefits in the first place. **After 20 weeks of sickness absence, the vast majority of individuals eventually fall onto benefits. An estimated 460,000 people each year transition from work to sickness and disability benefits.** This is despite the huge cost to both government and to employers of long-term sickness. Employers pay £9 billion a year for sick pay and associated costs and the state spends £14.5 billion annually on ESA alone.

This problem can no longer be neglected by both business and the government. If the government wants to reduce welfare spending, deliver on its promise to halve the disability employment gap and build an economy that works for all, it will need to reduce the flow of people onto ESA.

KEY FINDINGS

The rise in people claiming sickness benefits because of a mental health condition is a key factor in the growth of the sickness benefit bill; such cases account for an increasing proportion of on-flow onto sickness benefits. In the year from August 1999, 31 per cent of new IB claims were due to mental health conditions. Over the same period 15 years later, this had risen to 44 per cent of new ESA claims. In May 2000, 31 per cent of all IB claimants had a mental health condition, but by May 2016 this had risen to 49 per cent of those on ESA. Tackling the increase in claims for mental health conditions must therefore be a priority for policymakers.

International evidence suggests that changing the incentives and liabilities for employers can be a powerful driver of behaviour. In the Netherlands, the government increased employers' responsibilities by lengthening the period of statutory sick pay for which they were liable. This helped incentivise employers to focus on prevention and rehabilitation, thereby reducing sickness absence rates.

Businesses in the UK are not doing enough to address this problem, and the greatest costs as a result are borne by the state. For this to change, there needs to be a major shift in incentives with greater obligations on employers to support employees to stay in work, and greater financial liabilities if they fail to do so.

The current system is failing to identify health and mental health conditions early enough, and it is not doing enough to prevent those with such conditions either from falling out of work, or moving onto sickness benefits. There are a number of problems with the sickness policy framework that need to be addressed:

- **The 'Fit Note' from GPs provides too little information about the employee's ability to work, and the necessary adaptations to the workplace that might aid a return to work.**
- **Statutory sick pay (SSP) fails to reflect today's complex and long-term health conditions that may often exceed the 28-week limit for SSP, and employees who recover after a period of more than 28 weeks do not have a right to return to their old job.**
- **The government's new 'Fit for Work' service, while good in principle, is limited in scope, struggles to engage with small to medium-sized employers who need it, and does not provide the full suite of services that employers need to help people back into work.**

RECOMMENDATIONS FOR EMPLOYERS
Additional obligations should be placed on employers so that there is a greater incentive for them to work with their employees to help keep them healthy and stay in work. However, the best employers already do this, and much can be learnt from the approach they take.

Workplace culture and practices are critical to improving the identification and management of sickness. It is in an employer's interest to guard against increased presenteeism and ensure that visible systems and mechanisms are in place to identify health problems as early as possible and ensure affected employees receive appropriate support.

Employers should encourage open dialogue in which the presence of different health conditions is not stigmatised, and ensure that employee health, wellbeing and sickness is monitored systematically to identify problems. Anti-stigma campaigns, health and wellbeing awareness training for line managers and leadership on health and wellbeing issues from senior management all have an important role to play. A growing number of employers are introducing 'wellbeing days', which can be taken at extremely short notice or on the day itself, unlike regular periods of leave which must be booked in advance. They are intended as a

means of reducing sickness absence and presenteeism by preventing the accumulation of stress and fatigue.

In addition, employers should:

- **include health and wellbeing in annual review processes and regular supervisions**
- **use sickness management software and systems to identify problems, particularly fluctuating conditions, as early as possible**
- **make greater use of flexible working practices, underpinned by a robust absence management system, and greater understanding of 'reasonable adjustments' within a mental health context.**

RECOMMENDATIONS FOR GOVERNMENT

Government must introduce a major shift in incentives with greater obligations on employers to support employees to stay in work, and greater financial liabilities if they fail to do so. It must also ensure that the sickness policy framework, notably statutory sick pay, properly reflects the nature of today's major health conditions. We recommend that the government introducec four major reforms.

1. **Establish new employer duties to engage with employees on statutory sick pay and extend SSP from 28 to 52 weeks.**
2. **Introduce 'Fit Pay' (flexible sick pay) to better reflect the nature of modern health conditions and better support employees back into work.**
3. **Pilot an expanded 'Fit for Work' occupational health service to support SMEs in particular to support employees to stay in work.**
4. **Ensure employers meet responsibilities for paying SSP.**

About this report

The empirical research presented in this report was conducted between May and September 2016, and consisted of interviews, focus groups and roundtables with people with lived experience of mental health conditions, representatives of large private sector employers, academics, representatives of mental health charities, and clinicians. The evidence and views collected were supplemented by an extensive literature review of secondary sources.

1.
CONTEXT: FROM WORK TO WELFARE

1.1 BACKGROUND

The UK labour market has, relative to many of its European neighbours, performed well since the global economic downturn (Dolphin et al 2014, Colebrook et al 2015), and more recently has delivered an employment rate without precedent in the UK (ONS 2016). Yet, for all of the relative success of recent years in delivering high numbers of jobs, there continue to be a number of groups excluded from the labour market.

The groups that face particular disadvantage in the UK, but also across many other European states, include mothers, older workers, young people, those with low skill levels, and those struggling to access or retain work due to sickness or disability. These groups face many distinct barriers, but also some that are shared. Many lack the skills needed to get by in workplaces which can be inflexible in responding to the needs of disadvantaged groups.

This research focuses on the significant number of individuals excluded from the labour market on account of being sick and disabled. The scale of the challenge posed by this group is enormous. At present, there are around 2.5 million people who are out of work and on sickness benefits, while around 400,000 people each year leave work and claim sickness-related benefits (DWP 2016a). Decades of interventions have failed to significantly shift the numbers. This is, in part, due to government focusing too heavily on helping people only when they fall out of work. Here, instead, we focus attention on helping employers and employees in supporting people before they fall out of work through sickness, as a means of preventing long-term inactivity and economic exclusion.

1.2 WHY SICKNESS MATTERS

Helping people recover from illness and manage their health conditions is a critical policy goal. Currently only 47 per cent of people with disability are in work, compared to 80 per cent of non-disabled people.

The government has set out its aspiration to halve the disability employment gap, requiring a 1.2 million boost to the employment rate for disabled people.

This will only be achieved by helping the long-term sick and disabled back into work and preventing health-related conditions leading them to leave work in the first place. It will require help for those groups who find it most difficult to access and sustain steady work in the modern labour market. As figure 1.1 shows, while three in four adults are in work, this proportion falls to under half among those with a long-term health condition,

and to one-in-three among those with mental health conditions or learning disabilities. This reflects the rising prevalence of chronic illnesses and long-term conditions in the years since statutory sick pay (SSP) was introduced in 1983. Not only are people living longer, but they are living a greater number of years with at least one chronic disability. People with long-term conditions account for 50 per cent of all GP appointments (DoH 2012a). Conditions such as these cannot be cured, but do need to be managed, As such, they will not always render someone unable to work, but will result in occasional bouts of sickness absence due to their fluctuating nature, sometimes for prolonged periods.

Only one in three people with a mental health condition or learning disability are in work
Proportion of those with a long-term health condition in work
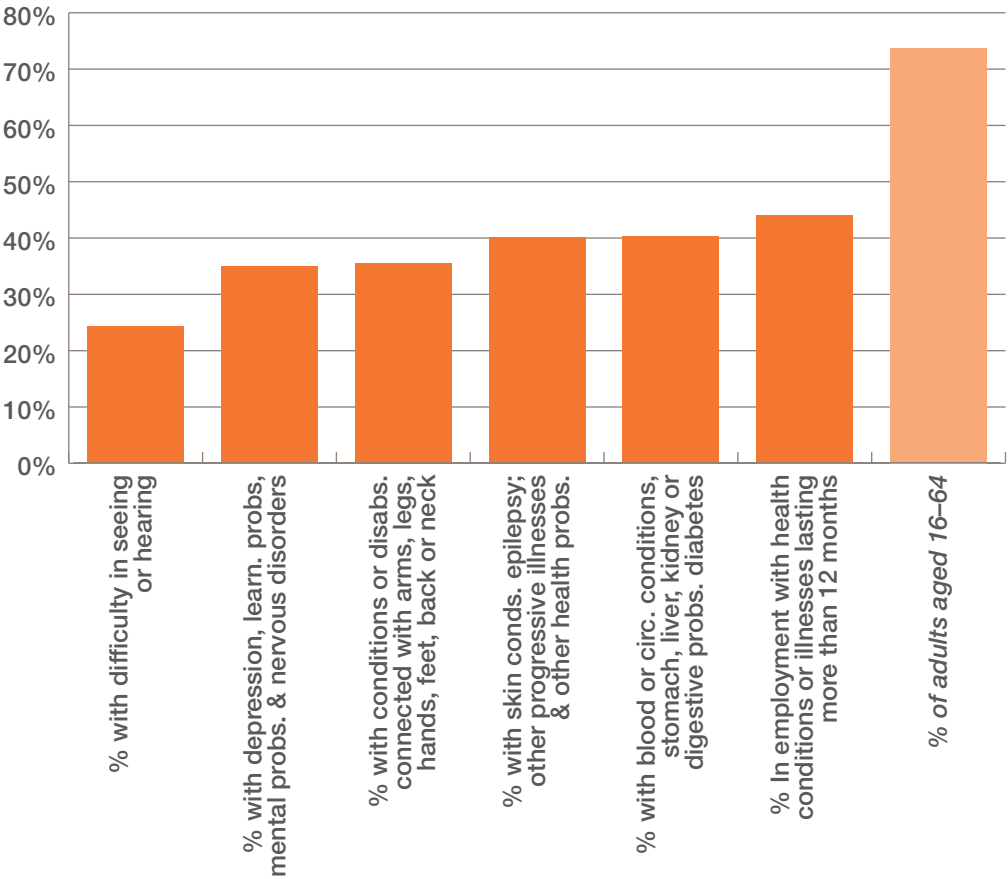
Source: Office for National Statistics, 'Labour Force Survey' (ONS 2016b)

Addressing this problem requires systemic change to how we support people who are sick when they are in and out of work: from the structure of work itself, to the culture of the workplace and hiring decisions, to the support offered to employees (both clinical and occupational), and to the systems of support for when people fall out of work.

This research focuses on a central element of this process – preventing people from falling out of work and onto long-term sickness benefits.

1.3 WHY TACKLING THE FLOW FROM WORK TO WELFARE MATTERS

Addressing this transition is fundamental, and must form a central part of a wider package of reforms.

Levels of employment and support allowance (ESA) and incapacity benefit (IB) claimants appear to have remained steady and stubbornly high despite both significant variations in labour market demand, and decades of government interventions.

While levels of jobseeker's allowance (JSA) claimants have risen and fallen significantly in recent years in response to demand in the labour market, levels of claimants of ESA and IB have remained remarkably stable. Over the last two decades, levels of ESA/IB claimants have not fallen below 2.2 million and not risen above 2.6 million.

FIGURE 1.2

Levels of ESA and IB claimants have remained remarkably stable over the last two decades, ranging between 2.2 to 2.6 million
Sickness benefit and unemployment benefit caseloads 1995–2021
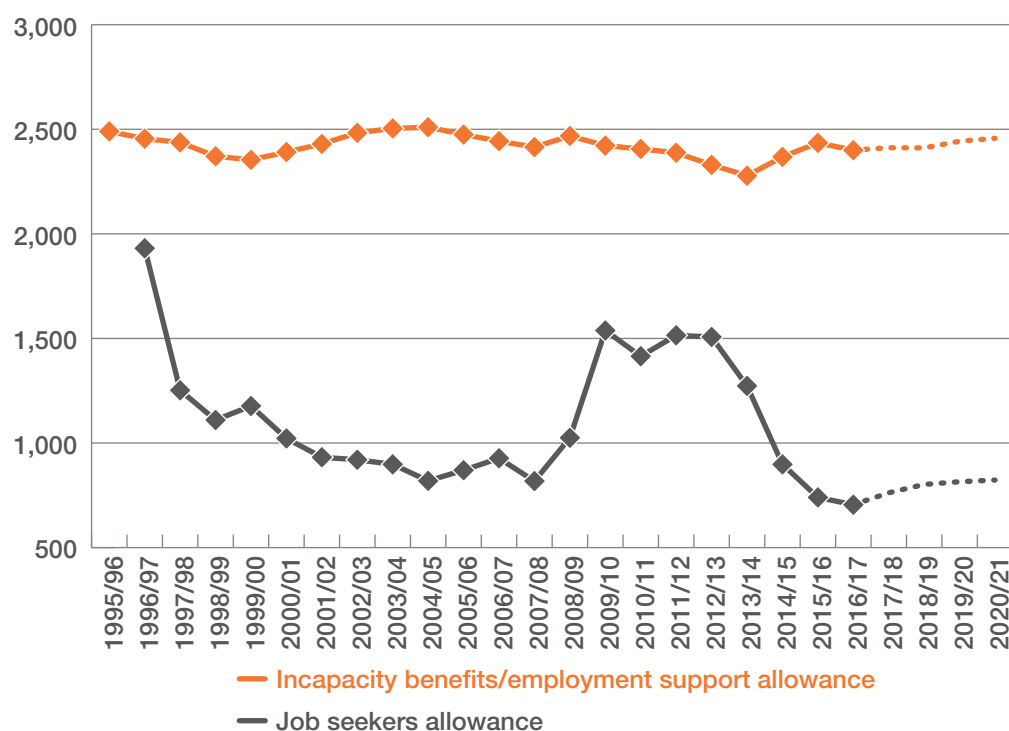
Source: IPPR analysis of Department for Work and Pensions, *DWP Statistics Tabulation Tool, 2016* (DWP 2016b)

Decades of government interventions (from the New Deal for Disabled People, the reform of incapacity benefit, Pathways to Work, the work capability assessment, Flexible New Deal, and the Work Programme) have failed to significantly reduce the numbers of people claiming long-term sickness benefits. On-flows and off-flows onto IB/ESA have remained remarkably consistent, meaning the number of people on sickness benefits has remained stubbornly high.

Despite various initiatives by different governments the number of people on sickness benefits has remained stubbornly high
Sickness benefit and unemployment benefit caseloads 1995–2021

— On-flow to employment support allowance/incapacity benefits (LHS)

— Off-flow from employment support allowance/incapacity benefits (LHS)

■ Employment support allowance/incapacity benefits stock (RHS)

Source: IPPR analysis of Department for Work and Pensions, *DWP Statistics Tabulation Tool, 2016* (DWP 2016b)[1]

Despite the huge cost to both government and to employers of long-term sickness, public policy effort has typically waited until people fall out of work before intervening. Relatively little has been done, either by government or by employers, to keep people well in work and reduce the number of people moving onto sickness-related benefits.

The government currently spends far more on welfare-to-work support for those with health and mental health conditions than it does on support to keep people with such conditions in work. The Work Programme was expected to cost £3–£5 billion over its seven years, and by December 2015 the DWP estimated that the cost had reached £2.2 billion (Dar 2016). This represents an annual spend of around £490 million. The Work and Health Programme – its successor – will have a smaller budget of around £120 million per year (Hitchcock et al 2016). Public spending on specific interventions to support people with health and mental health conditions to stay in work is tiny by comparison. The contract value for Fit for Work was £132.9 million for the life of the five-year contract, averaging just £26 million a year (Parliament 2016).

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1   We have excluded data for on-flows and off-flows from Nov 2008 to May 2013. During this period, many individuals had their claims 'migrated' from IB to ESA. The data for on-flows for this period therefore includes both new claimants, and existing claimants being transferred from the existing sickness benefit to a newer one. From May 2013, DWP began separately recording the number of ESA claims that were migrated from IB, and the number that were genuinely new claims.

As part of a broader approach to reforming the journey from work to long-term sickness benefits, public policy needs to do more to prevent the large numbers of people flowing from work to benefits.

The figures are significant. Annually, some 900,000 individuals take a prolonged period of sickness absence (for four weeks or more) and as many as 300,000 will not return to their job (DWP 2014). The number of people registering for the main sickness benefit, ESA, averages around 50,000 per month, with almost two-thirds of these individuals coming directly or indirectly (that is, after a period of sickness absence) from employment (Adams et al 2015). This means roughly 400,000 people a year moving from being in work to claiming for employment support allowance.

Mental health conditions account for the largest and an increasing proportion of new claims for ESA
On-flow of new claimants onto ESA, excluding migrated IB claims
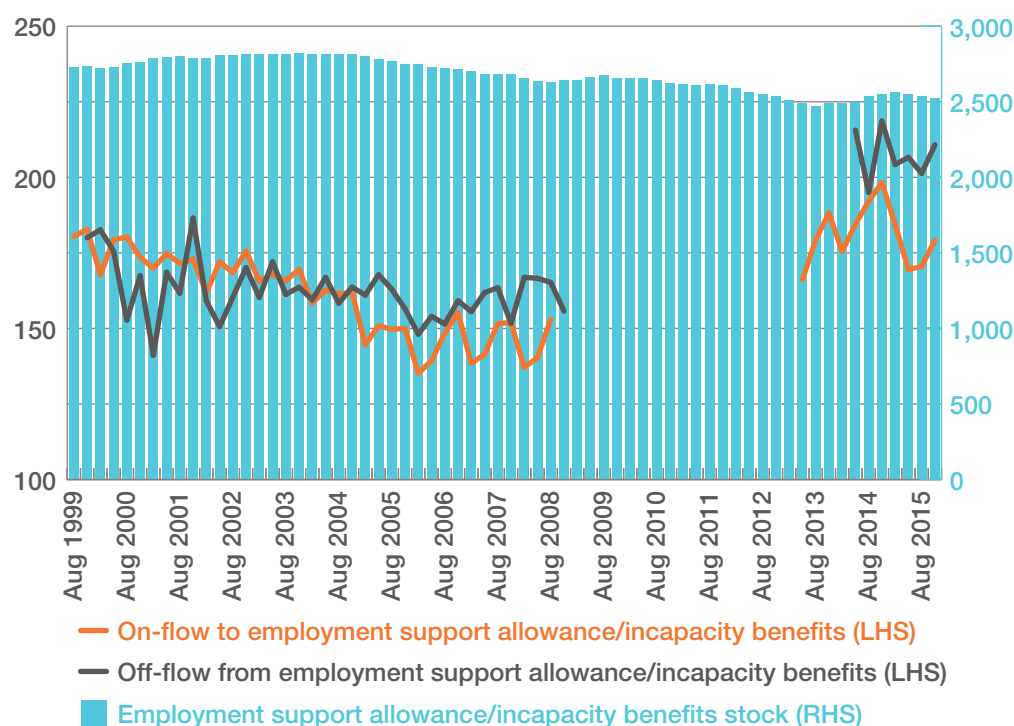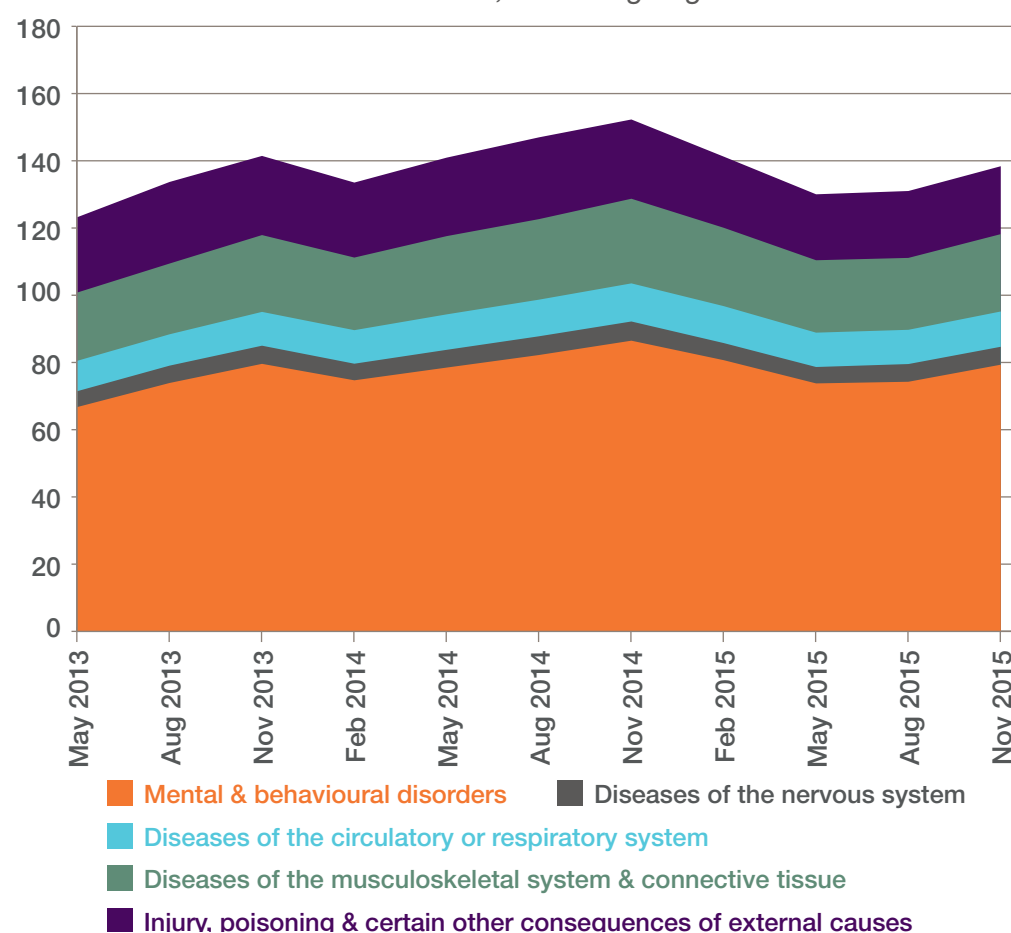

Source: IPPR analysis of Department for Work and Pensions, *DWP Statistics Tabulation Tool, 2016* (DWP 2016b)

While there is considerable variety among the types of health conditions experienced by those falling out of work, mental health conditions account for the largest proportion of any sickness category by some margin, as illustrated in figure 1.4.

The proportion of those on health-related out-of-work benefits as a result of a mental health condition has increased steadily in the last two decades. In May 2000, 31 per cent of claimants on incapacity benefit had a mental health condition, but by May 2016 this had risen to 49 per cent.

Over the last two decades the proportion of those on health-related out-of-work benefits as a result of a mental health condition has increased steadily
IB/ESA claimants and mental health conditions, quarterly
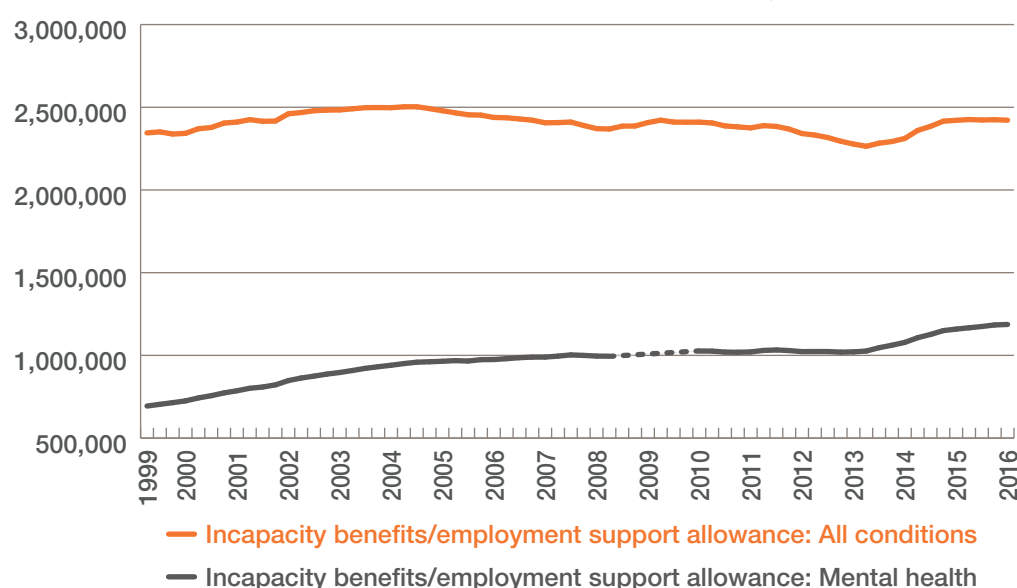
Source: IPPR analysis of Nomis, *Work and Pensions Longitudinal Study* (Nomis 2016)[2]

People falling out of work due to sickness is costly for government. ESA is currently paid at £73.10 per week for the first 13 weeks, then £102.15 a week for the Work Related Activity Group (WRAG), who are expected to seek to return to work, and £109.30 for those with more limiting illnesses or disabilities. However, from April 2017, new claimants of ESA who are placed in the WRAG group will be paid only £73.10 – the same as jobseeker's allowance claimants – a reduction of nearly £30 a week compared to what current claimants receive. The total spend on ESA in 2015/16 was £14.5 billion. As is set out in table 1.2, half of this was accounted for by people with mental health problems as their primary condition (£7.5 billion) with the second highest being those with musculoskeletal conditions (£2.2 billion) (DWP 2016c).

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2   While Nomis records data for ESA claimant numbers from November 2008, when the benefit was introduced, it does not report the condition for November 2008 to November 2009 inclusive.

TABLE 1.2

ESA expenditure by reported medical condition and phase
of claim, 2015/16

	Employment & support allowance by reported medical condition, £m, real terms, 2015/16 (2016/17 prices)	% of total ESA claimant bill, 2015/16
Mental and behavioural disorders	£7,465	51.5%
Diseases of the musculoskeletal system & connective tissue	£2,200	15.2%
Symptoms, signs and abnormal clinical & laboratory findings, not elsewhere classified	£1,359	9.4%
Diseases of the nervous system	£809	5.6%
Injury, poisoning and certain other consequences of external causes	£672	4.6%

Source: Department for Work and Pensions, 'ESA expenditure by reported medical condition and phase of claim, 2000/1 to 2015/16' (DWP 2016c)

Spending on sickness benefits in the UK increased by £1.7 billion in cash terms between 2010/11 and 2015/16, and is expected to increase by £2.4 billion compared with 2010/11 by the end of the parliament in 2020/21 (OBR 2016). The Office for Budget Responsibility (OBR) finds that the rising incidence of mental health conditions, particularly at younger ages, has been an important driver of the rising disability benefits caseload, as well as the increasing proportion of sickness benefit claims that are placed in the support group of ESA. The number of people aged under 35 on IB/ESA as a result of a mental health condition has risen from 268,000 in May 2000 to 346,000 in May 2016 (DWP 2016a).

It is also costly to employers. Estimates suggest that the sickness-related costs to employers are annually in the region of £9 billion (employers in the UK bearing the full brunt of statutory sick pay (SSP) for the 28 weeks over which it can be claimed).[3]

There is also a cost to employees. UK employees can lose out on as much as £4 billion each year in lost earnings when experiencing sickness (DWP 2014), which works out as £554 per employee each year (CIPD 2015).

More important than the financial cost, however, is the human cost. Slowing the numbers going from work to welfare due to sickness is essential for improving the health and wellbeing of the workforce. We should care about keeping people in work for many reasons, and particularly because work is, in certain circumstances and for certain conditions, actually good for people's health and wellbeing. Unemployment, on the other hand, can tend to generate, or exacerbate, poor health outcomes.

- Unemployment can be detrimental to economic wellbeing where it is associated with financial insecurity, low incomes, and a fall in social status. This can impact on issues such as diet, accommodation standards, fuel poverty, and leisure activities. In turn, the financial strain and associated disadvantage can have a significant direct and negative effect on health, and particularly mental health, where it

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3   In OECD countries, it is only the Netherlands and UK in which employers meet the costs of sick pay. Elsewhere, the state either pays in full or, more frequently, 'tops up' employer contributions.

creates stress and anxiety (Creed and Klisch 2005, Paul and Moser 2009, Fone and Dunstan 2006).

- Employment can provide daily structure, social contacts, and a sense of identity (see Jahoda 1982). These experiences can minimise the risks of developing or compounding mental health conditions, particularly those associated with depression and isolation (Carter and Whitworth 2016). Staying physically active can also be important for improving health.
- Young people experiencing unemployment can be particularly susceptible to symptoms of mental illness as a direct result of their being jobless, reporting feelings of self-loathing, panic attacks, and suicidal thoughts (Prince's Trust 2014).
- The impact of leaving employment – creating a sudden change in financial circumstances and lifestyle – and navigating the benefits system, including the work capability assessment, can generate additional anxieties (Carter and Whitworth 2016, Litchfield 2013).

Studying this phenomenon across OECD countries has led researchers to conclude that 'the worst labour market scenario for a working-age person, in terms of mental health, is to stay inactive' (Llena-Nozal 2009: 85).

Tackling sickness in the workplace is therefore critical for people's health and wellbeing, but also for delivering on the government's twin objectives of halving the disability employment gap and reducing public expenditure on welfare.

For all of the reasons above, it is worth supporting employees to stay in work as much and as far as it is in their own, their employers, and the state's best interests to do so.

2.
THE PREVALENCE AND DRIVERS OF SICKNESS IN THE WORKPLACE

In order to understand how employees, employers and the state can jointly move towards a system in which more people are supported to manage their health conditions while remaining in work, it is first necessary to consider the extent and nature of sickness in the workplace, and identify how this has changed over time. This chapter will therefore examine which groups are most at risk of developing health problems that can lead to both short- and long-term periods of sickness absence. It will then go on to explore how sickness absence rates are falling, and whether this really does point to an improvement in the overall health of the workforce, or whether it might be masking other trends and pressures that employees face in the modern labour market.

2.1 WHO GETS ILL, AND WHY?

People get sick whether they are at work or not. Sometimes work is the cause of sickness absence: from stress created in the workplace, coming into contact with people carrying illnesses, or through industrial accidents. In 2007/08, 2.1 million people were estimated to be experiencing conditions developed through, or made worse by, their work (Fit for Work 2016). On other occasions, sickness is simply an inevitable occurrence from time to time, which can arise from a wide range of circumstances often out of our control.

2.1.1 Short-term sickness

Most periods of sickness are short and typically the result of minor illnesses or short-lived physical injuries, and so are unproblematic. Data from the Office for National Statistics (ONS), for instance, shows that minor illnesses are the most common reason given for short-term sickness absence, such as common colds, followed by back, neck and muscle pain (commonly termed musculoskeletal injury) (ONS 2014).

Most periods of short-term sickness are caused by minor illnesses or musculoskeletal problems
Causes of short-term sickness, 2013
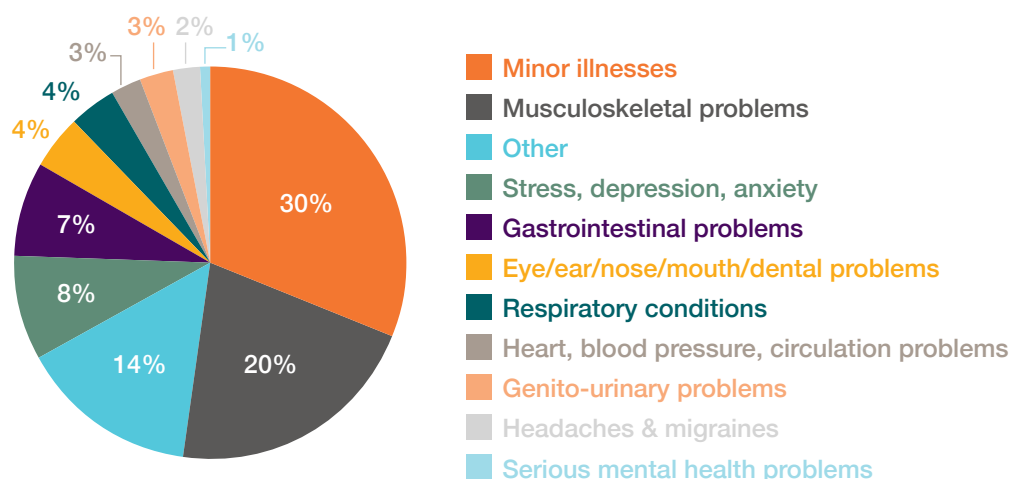
Source: ONS, 'Sickness absence in the labour market' (ONS 2014)

2.1.2 Which groups are most at risk?

However, this is not the full picture. Other drivers of short-term sickness absence are indirect – for instance, a parent taking a day off work because their child is sick or that there are problems with childcare arrangements. This has been recorded as a significant contributor to absences.
For example, 31 per cent and 34 per cent of manual and non-manual occupation employers respectively report caring responsibilities in their top five reasons for absence (CIPD 2015).

There are a number of people who are more likely than others to have time off work due to sickness.

- The distribution of sickness absence is 60 per cent women, 40 per cent men (ONS 2014).
- As a percentage of the workforce, employees in the North of England are more likely to be off sick, followed by employees in the Midlands (ibid).
- Older people aged 50–64 have the highest proportion of sickness absence of any age group (ibid).
- Employed individuals are more likely to be off sick than self-employed, and employees of larger firms more likely to be off sick than of SMEs (ibid).
- Sickness levels differ by sector. Higher than average sickness levels are recorded in public administration and in manufacturing, for example. Workers in manual occupations have, on average, 1.5 more days absent from work recorded as sickness than workers in non-manual occupations (CIPD 2015). In the public sector, health occupations experience the highest rates of sickness absence (ONS 2014).
- Research in Norway has shown that unemployed individuals who have recently returned to work have a lower probability of taking sickness

absence. Given their susceptibility to illness should be no different to other workers, researchers have explained this presenteeism by the 'disciplining effect' of unemployment (Askildsen et al 2002).

There are reasons why we might expect these patterns to emerge. Women, who tend still to dominate childcare, may take more 'indirect' sick leave to care for sick children. Jobs in manufacturing sectors may be more physically demanding than desk-based tasks, with short-term illnesses presenting more of an impairment for those involved in manual labour. And health and safety considerations are also important. For example, in certain occupations, such as in the health sector, employees can be required to take additional time off if there is a risk of passing on an infection even if physical symptoms have passed.

Smaller employers, even if inadvertently, might engender a greater sense of presenteeism, where employees continue to work despite the presence of underlying health problems, as a smaller workforce may create an environment in which sick employees are particularly reluctant to take time off in order not to let team members down. This was identified as a key reason for going into work when sick by 45 per cent of employees in a recent survey (CIPD 2013). Similarly, people who are self-employed have a personal stake in their business, creating an additional pressure to minimise time away from the workplace given its more immediate impact on personal and wider business income (and the fact that they do not receive a sick pay entitlement).

Finally, short-term sickness absence may also be misrecorded. For example, survey data illustrates that a large proportion of employees admit to taking periods of time off work for non-sickness-related matters, with 26 per cent admitting taking a day's absence for a job interview, and 32 per cent admitting to having taken a day's absence after a night out (PwC 2014). The 2015 edition of the annual CIPD survey found that 30 per cent of manual occupation employers and 23 per cent of non-manual occupation employers report 'non-genuine ill-health' as a top five cause of absenteeism in their organisations or companies (CIPD 2015).

2.2 THE REAL CHALLENGE: LONG-TERM SICKNESS

Generally, short-term sickness is not a policy problem: the losses to the individual are limited, the costs to the employer are manageable both financially and organisationally, and with SSP being paid by the employer, the costs to the state are also fairly small.[4]

2.2.1 Enhanced risk of inactivity

Sickness absence becomes a problem when these periods become protracted. This is because once people have been off sick for a while, generally for periods exceeding four weeks, their likelihood of returning to work diminishes. In 2014, 960,000 employees were off sick for more than four weeks and only two-thirds of these individuals are likely to return to work (DWP 2014).

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4   Limited to a government-funded initiative offering 'Free, expert and impartial work-related health advice via our website and telephone line' and 'Referral to an occupational health professional for employees who have been, or who are likely to be, off sick for four weeks or more.'

Once an individual moves onto ESA after being in work the cost shifts from the employer to the state, with the former responsible for paying SSP and the latter responsible for paying ESA. On top of this, the bureaucratic burden created by the administrative nature of an individual undergoing the work capability assessment (WCA) and, following this, possibly entering into the Work Programme create further demands on both the state and the individual. The chances of ESA claimants returning to work after entering into the Work Programme were weak; just 12 per cent of new ESA claimants achieved a job after two years on the programme, and only 4 per cent of former IB claimants did so. This compared to 3 in 10 JSA claimants (CESI 2015). It is, therefore, for those people who fall out of work due to ill-health where the social and economic costs can become most pronounced and long-term.

2.2.2 Causes of long-term sickness absence

The causes of longer-term absences are surveyed by the CIPD (2015). Some of these – for example, cancer or strokes (24 per cent of employers' main reason for sickness absence) – can occur suddenly and may often require a prolonged period of treatment and rehabilitation. But for others, they can emerge more gradually, and may have the potential to be managed alongside an individual continuing to work. These include other common causes of longer-term sickness absence such as stress (the main cause of absence for 26 per cent of employers), mental health conditions (16 per cent), and musculoskeletal conditions (13 per cent). It is for these groups, therefore, where particular emphasis and energies should be placed, as the potential for reducing work-related sickness and, ultimately, long-term inactivity, are greatest.

This is demonstrated by breaking down the types of health conditions experienced by ESA claimants. Forty-four per cent of new ESA claimants over the last year suffer from a mental health condition, compared to 12 per cent for those with diagnosed musculoskeletal conditions (DWP 2016b). Moreover, those with diagnosed mental health conditions are less likely to be found fit for work (and therefore more likely to be approved for ESA, rather than moved to jobseeker's allowance, than individuals with other conditions. Within this, ESA claimants with a mental health condition have a higher likelihood of being placed into the Support Group which demands minimal job search requirements. They account for 41 per cent of Support Group participants (Litchfield 2014).

People with mental health conditions are more likely to have a recurrence of their condition. A recent study looking at the recurrence of health conditions using the Fit Note data from 68 general practices found that 22.4 per cent who were certified as suffering from a mental health condition returned to the GP within a year with another work-limiting sickness episode, with 17.4 per cent suffering from a second episode in the same diagnostic category. Patients with mental health conditions are more likely than those with any other condition to have a recurrence within the same diagnostic category (Shiels et al 2016).

On top of this, previous research has also identified the potential for this group to be vulnerable to 'parking' or 'creaming'. As a harder-to-help group, they can lose out under the outcomes-based incentive payment structure which operates within the current Work Programme, whereby

providers are incentivised to help those individuals who can be more easily placed into, and then sustain, employment (Carter and Whitworth 2015). Helping people with, often complex, mental health conditions can also sometimes require more specialist resources and skills than job search providers are equipped with, which makes providing services to this group more difficult (Newton et al 2012). The Work Programme does offer differential payments to providers according to client group, with higher levels for ESA claimants. This was intended to encourage providers to focus on this group and to offer the specialist support they need. However, the incentives do not appear to have been sufficient to make the programme a success for this group.

2.3 HEALTHY AND HAPPY EMPLOYEES? UNDERSTANDING THE FALL IN SICKNESS ABSENCE RATES

2.3.1 General trends

Compared internationally, sickness absence from work is fairly limited in the UK (OECD 2010). There are around 31.5 million people in work in the UK, and while the size of the workforce has grown in recent years, the number of days lost to sickness absence has gradually, but significantly, fallen. Between 1993 and 2013, the total number of days lost to sickness absence each year has fallen by nearly 50 million. In 1993, around 7.2 working days were lost per employee. By 2013, this had fallen to 4.4 days.

FIGURE 2.2

Although the size of the UK workforce has grown in recent years, the number of days lost to sickness absence has fallen
Total working days lost to sickness per annum (millions)

— Number of days lost due to sickness
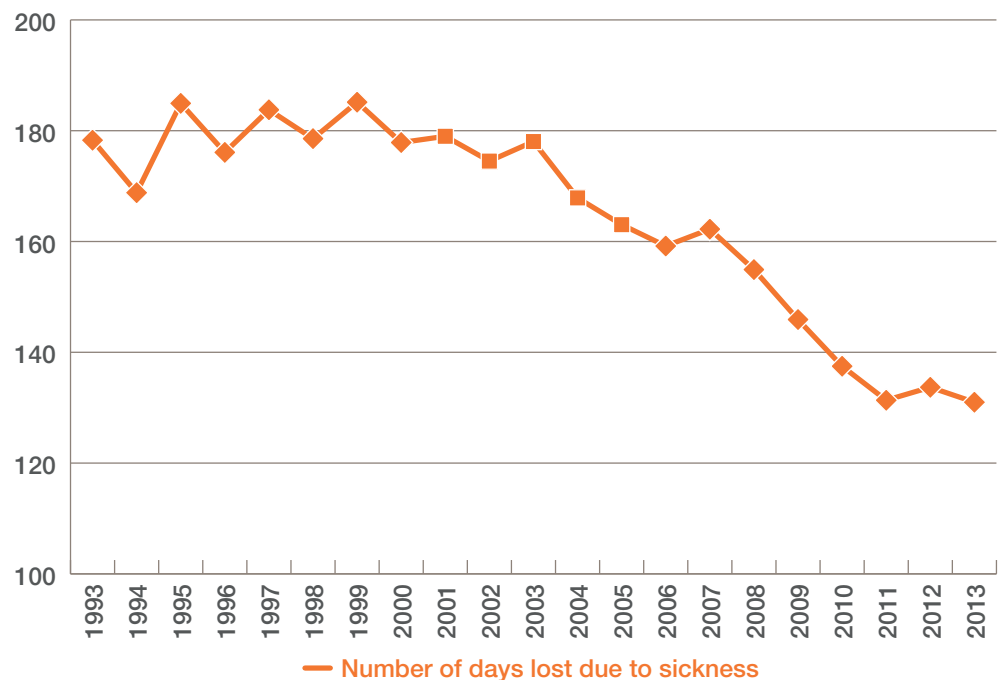
Source: ONS, 'Sickness absence in the labour market' (ONS 2014)

Despite this general trend, certain health conditions do appear to be becoming more prevalent. Survey data shows mental health- and stress-related absence is reported by two-fifths of employees, rising to half among public sector employers, and that there was an increase on the previous year (CIPD 2015). As such, a significant proportion of the workforce experiences a common mental health condition at any one time. Estimates suggest one in six British workers are affected every year by anxiety, stress or depression (TUC 2015).

The number of cases in which work significantly contributes to ill-health appears to be falling too. The number of self-reported cases of employment-related ill-health has fallen by around 20 per cent in recent years.

FIGURE 2.3

The number of self-reported cases of employment-related ill-health has fallen by around 20 per cent in recent years
Rate of workplace-related ill-health per 100k employees

Rate of workplace related ill health per 100,000 employees
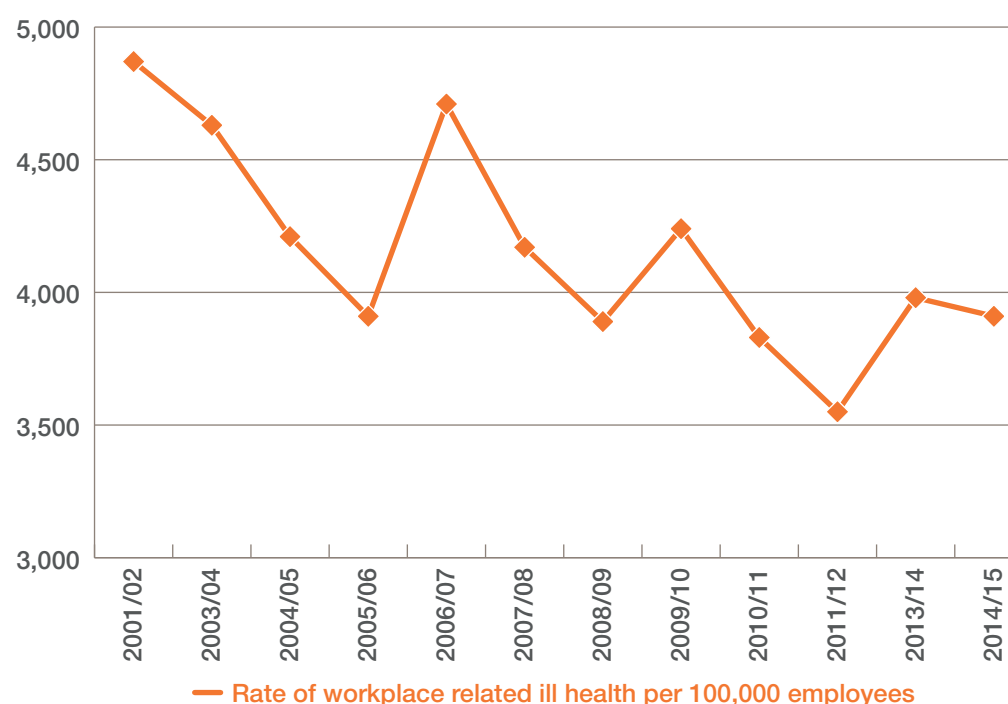
Source: Health and Safety Executive, 'Labour Force Survey', (HSE 2016a)

The number of new cases of work-related stress, anxiety and depression in 2014/15 was 234,000 – or 740 per 100,000 workers. The figures suggest that the number and rate of work-related mental health problems has remained broadly flat over the last 10 years (HSE 2016a).

2.3.2 Possible causes of falling sickness absence rates
There are no agreed explanations for why sickness rates have fallen in this way, but a number of factors are thought to have played a role.

The health of the workforce is improving in line with improvements in the health of the overall population

The health needs of the UK population are largely determined by the presence or absence of a number of lifestyle risk factors which can increase the risk of developing several predominant causes of sickness. According to the 2011 annual report of the Chief Medical Officer, 'early death and disability do not occur in isolation; they are mediated through a complex interplay of social, economic and environmental factors, as well as by individual specific determinants of health' (DoH 2012b: 194). The report identified the top eight risk factors for early death and disability in England. These were, in order of impact, as follows.

1. Tobacco use
2. Harmful alcohol use
3. High blood pressure
4. High cholesterol
5. Overweightness and obesity
6. Physical inactivity
7. Illicit drug use
8. Low fruit and vegetable intake.

There is evidence that the rates of harmful behaviours associated with many of the above risk factors are decreasing. For example, the percentage of adults in England who smoke fell from 39 per cent in 1980 to 20 per cent in 2011; and the percentage of those with raised cholesterol fell for both men (from 74 per cent to 57 per cent) and women (from 77 per cent to 61 per cent) between 1994 and 2006 (DoH 2012).

FIGURE 2.4

The percentage of adults who report multiple lifestyle risk factors is decreasing
The percentage of adults (aged 16 and over) who report the presence of different combinations of lifestyle risk factors, England, 2011

- No lifestyle risk factors
- One lifestyle risk factor
- Two lifestyle risk factors
- Three lifestyle risk factors
- Four or more lifestyle risk factors
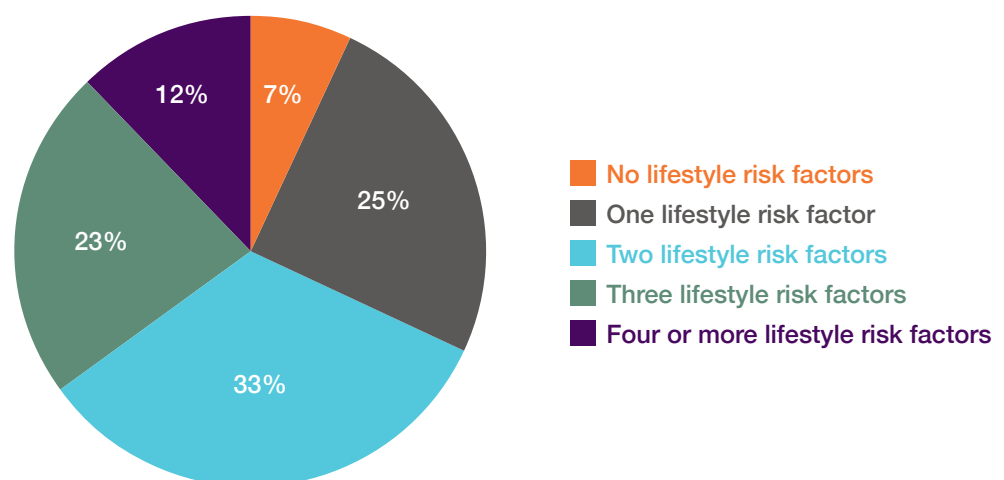
Source: Department of Health, 'Chief Medical Officer annual report 2011: volume 1' (DoH 2012b: 222)

Where individuals are exposed to multiple simultaneous lifestyle risk factors, the likelihood of succumbing to illness is multiplied. There is evidence that the percentage of adults who report multiple risk factors is also decreasing. Between 2003 and 2010, the percentage of males exposed to three or more risk factors fell from 48 per cent to 28 per cent, and the percentage of females fell from 39 per cent to 34 per cent (ibid).

The decrease in exposure to lifestyle risk factors among the wider population is likely to translate, to some extent, to improved health in the workplace, and a reduction in sickness absence.

Employers are becoming stricter in monitoring and acting on sickness absence
According to a recent survey, three-fifths of employers report using absence as a key performance indicator, with this practice being particularly common among large employers (CIPD 2015). There is some evidence to suggest that when employers do implement stricter monitoring measures, sickness absence rates are reduced (particularly in the public sector) (ibid). However, it does not necessarily follow that this will lead only to increased attendance among 'healthy' workers, and instead could lead to increased presenteeism among employees also experiencing ill-health.

More widespread job insecurity is making employees less willing to take time off due to sickness, for fear of negative repercussions
There is some evidence that insecurity at work and the fear of losing one's job is making employees less willing to take time off when they are sick.

Perceptions of insecurity have increased in recent years. The Workplace Employment Relations Study showed that the proportion of employees who were satisfied with their job security fell from 65 per cent in 2004 to 59 per cent in 2011 (van Wanrooy et al 2012).

It seems that higher levels of insecurity are influencing decisions around sickness absence. During our focus group with people who have lived experience of mental health problems in the workplace, fear of losing one's job or being demoted was identified as being a barrier to reporting sickness and taking time off (see box in chapter 3).

The evidence suggests this fear is well founded: 45 per cent of organisations surveyed report that they use sickness absence records as a criterion when making decisions on redundancy. While employers in the public sector are more likely than those in the private sector to have made redundancies in recent years (56 per cent compared to 42 per cent), the use of sickness absence records during the redundancy process is more common among private sector employers (62 per cent compared to 52 per cent) (CIPD 2014). This suggests that job insecurity has provided employees in both sectors with significant incentives to minimise the number and length of periods of absence.

Reduced rates of sickness absence are, in fact, masking growing levels of presenteeism in the workforce

While falling levels of sickness absence may appear to be positive, there is evidence to suggest that high levels of presenteeism play a significant role.

The head of the TUC, Frances O'Grady, has stated that '[t]he real health threat we face is the growing culture of presenteeism, where unwell staff are pressured into coming to work by their bosses. This can prolong illness, spread diseases and cause stress in the workplace' (TUC 2014).

Self-reported presenteeism is widespread, with 93 per cent of the workforce believing that they would go into work when feeling unwell (CIPD 2013). Similarly, a growing proportion of employers have reported an increase in the number of employees turning up to work when ill, and is now around one-third.

Presenteeism has a significant impact on productivity. Lost productivity arising from people going into work despite the presence of a mental health problem (when they are not fully healthy and may not be able to work at an optimum level) is estimated to cost the economy as much as £15.1 billion per year. There can be a further annual cost of £2.4 billion where an individual has to leave their job as a result of their condition, and replacement staff have to be recruited (Sainsbury Centre for Mental Health 2007).

FIGURE 2.5

Employers are reporting an increased incidence of 'presenteeism'
Percentage of organisations surveyed who report an increase in presenteeism over the previous 12 months (2014)
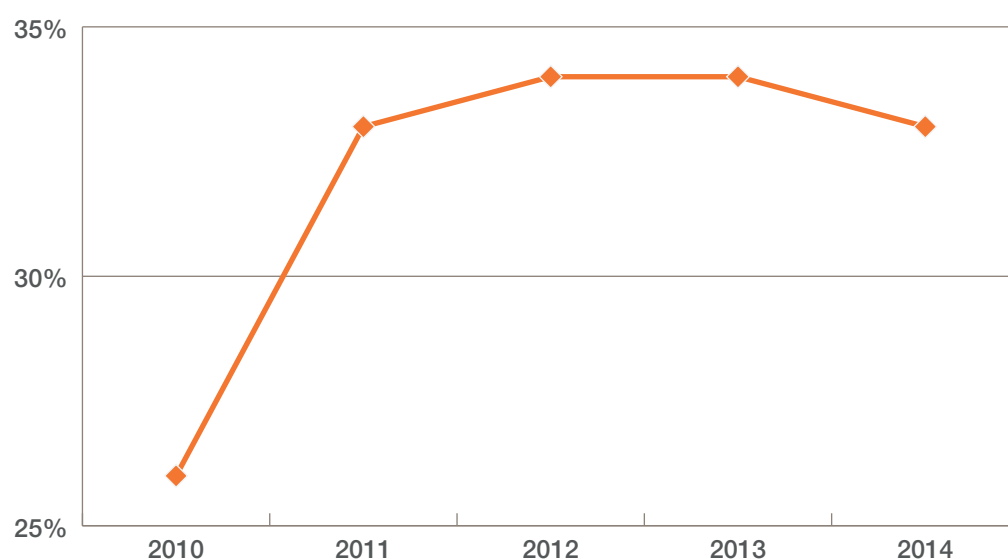
Source: Chartered Institute for Personnel and Development, *Absence management 2014* (CIPD 2014)

Presenteeism has been found to be particularly likely when a workforce is exposed to high levels of workload, stress and insecurity. For example, employers who report expected redundancies over the coming six months are also twice as likely to report an increase in presenteeism compared

to those who are not planning redundancies (49 per cent compared to 24 per cent) (CIPD 2014).

Much presenteeism is likely to refer to mild, short-term health complaints, for which continuing to go to work when ill is unlikely to be particularly problematic. Colds, headaches and the like are unlikely to have a significant effect on an employee's productivity, or pose a risk to other employees. However, presenteeism is more likely to pose significant problems to the employee, employer and government when it relates to longer-term health conditions. This is where it is likely to cause a more significant drag on productivity, and delay opportunities for recovery.

2.3.3 Comparing rates of sickness absence to rates of sickness benefit claims

While the number of sick days has fallen in recent years, there has not been an equivalent fall in the number of sickness-related welfare claimants. Latest figures show that 2.5 million people currently claim ESA or incapacity benefit, which is three times higher than the number claiming similar benefits in the 1970s (DWP 2016d). Research with ESA claimants shows that, of the 64 per cent of individuals claiming the benefit immediately following a period of employment, almost one-third (29 per cent) do not undergo a period of sickness absence, and instead transition straight from employment onto ESA (Adams et al 2015). This demonstrates how falls in sickness absence rates may in fact be masking a continuation in the level of ill-health among the working-age population.

2.4 SUMMARY

The overall picture is one of a relatively present workforce which, for the most part, is not ill but is increasingly reluctant to take time off when illness strikes. While sickness absence statistics provide grounds for optimism on the surface, questions remain over the continued prevalence of underlying health conditions among the workforce, the extent of presenteeism, and the persistently high levels of ESA claimant counts.

Sickness at work is often the result of minor illnesses that result in very short periods of absence, such as colds, migraines and flu. While it is in the interest of employees, employers and the government to reduce the incidence of these short periods of sickness absence, the predominant concern for all stakeholders should be to find ways to identify and support those at risk of going off work for prolonged periods of time.

Mental health problems are a prominent cause of long-term sickness absence. While mental ill-health is a growing problem within the wider population, now affecting one in four adults each year, three in four employees describe their mental health as good or very good (CIPD 2016). However, among those who did report having experienced a mental health problem, half have never taken time off as a result, yet only 4 per cent claim that this does not affect their performance at work (ibid). There is, therefore, a significant section of the workforce who experience mental health problems while at work, but who nonetheless do not take time off sick or seek support. This can have a negative impact both on their performance, and on their health.

Given the difficulty many experience in returning to work once on ESA, and the particularly difficult journey faced by people with mental health conditions, there is a real need to think about how people can be better supported before they end up on ESA.

It is vital for employers to maximise opportunities to identify signs of sickness as early as possible. It is vital also to provide appropriate and timely support to reduce the likelihood that emerging health problems deteriorate to the point at which they may lead to a prolonged period of sickness absence, leading potentially to an employee falling out of the labour market altogether.

Individuals with mental health conditions often report that they lack support at work, are unable to discuss their condition openly with their employer, and are not sufficiently helped by adjustments to the working environment (Adams et al 2015). It is with this in mind that the next chapter turns to consider employees' journey from being a healthy employee to a period of sickness absence. It will consider the availability and effectiveness of a range of employer-led initiatives for identifying and supporting employees with long-term health conditions, with a particular focus on mental ill-health.

3.
THE JOURNEY FROM WORK TO SICKNESS BENEFITS

The journey from being in work to claiming long-term sickness benefits is complex, and will differ widely from person to person. However, there are a range of experiences that are common among both employers and employees, and a number of common stages where intervention can occur.

FIGURE 3.1

Key points in the sickness-at-work journey

HEALTHY HAPPY EMPLOYEE
- Emerging signs of sickness
- Opportunity to intervene with EH & adjustments

ABSENT FROM WORK
- Self-certification & fit note
- Opportunity for rehabilitation

INACTIVE, CLAIMING EMPLOYMENT SUPPORT ALLOWANCE
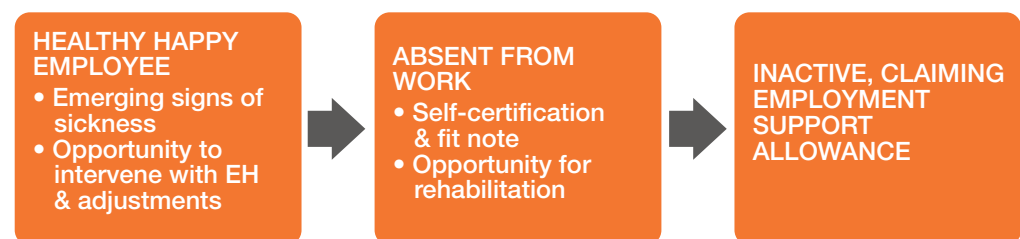
This chapter will explore several of the key points along the sickness-at-work journey. First, it will explore what employers can do to identify emerging signs of sickness among the workforce, and so maximise opportunities to intervene to support an employee's health needs and prevent them from undertaking a prolonged period of sickness absence. Second, it will then go on to consider what employers can do to support employees who *have* begun a period of sickness absence, in order to increase the likelihood of a safe and timely return to work, and decrease the likelihood of relapse.

3.1 EMERGING SIGNS OF SICKNESS: OPPORTUNITIES FOR IDENTIFYING HEALTH PROBLEMS AT WORK

Identifying early signs of sickness can often be straightforward, such as when symptoms are clearly visible and difficult to conceal. However, while the reporting and identification of physical illness within the workplace can be relatively straightforward, identifying mental health problems can be a particular challenge.

There are a number of routes through which mental health problems can be identified in the workplace. The people with lived experience of mental ill-health in the workplace who took part in our focus group identified several groups who are

potentially well placed to identify mental health problems in the first instance:

- colleagues
- line managers/supervisors
- HR staff
- the employee themselves.

There are, however, barriers to each of these groups being able to identify mental health problems effectively, and so help people to access the support they need. Research by Adams et al (2015) found that while people who spoke to their employer about their health condition generally found the discussion helpful, people with experience of a mental health condition who then transferred onto ESA were less likely to have spoken to their employer about their health than people who had experienced a physical health condition. Their survey of ESA claimants found one-third of respondents with experience of a mental health condition had not discussed it with either their line manager or HR. This compares to only 20 per cent among respondents with experience of a musculoskeletal condition. Men have been found to be less likely to report their condition to their employer than women (Sissons et al 2011).

The complexity of mental ill-health creates a challenge for employers trying to create an environment where workers can more easily discuss their health concerns with colleagues, line managers or HR staff who might be able to help them access support.

Barriers to identification of mental health problems in the workplace

Our focus group identified the following barriers to self-reporting and identification by other groups in the workplace:

- stigma/prejudice/discrimination/negative attitudes
- lack of awareness of symptoms
- lack of training on how to raise issues around mental health
- stressful work culture in which mental health problems can become 'normalised'
- lack of policies and procedures on mental health
- fears of losing one's job, or being demoted
- a perception that employers cannot provide the help needed.

Raising awareness and breaking down stigma

A major barrier to the self-identification of mental health problems at work is stigma. Where an employee recognises that their mental health may be deteriorating, they are less likely to report and act on it if they consider their workplace to be ignorant, dismissive or even hostile to issues around mental health.

According to Mind (2015), 'Too often employees are scared to tell their manager about a mental health problem and so problems can spiral.' This is supported by survey data, in which just 38 per cent of employees

believe their organisation has an inclusive environment for being open about mental health (CIPD 2016).

Further survey data shows how negative perceptions of colleagues with mental health problems can affect opportunities for career progression (NatCen 2016). One-third of respondents claimed that someone's medical history *should* affect their chances of gaining promotion, while just 8 per cent of respondents believed that people with schizophrenia would be as likely as others to gain promotion, rising to 17 per cent for people with depression.

When stigma around mental ill-health has the potential to affect an individual's career and relationships with colleagues in this way, it is clear why having an initial conversation about mental health, even with a trained line manager, is consistently found to be problematic.

Initiatives such as 'Time to Change' have sought to help employers raise awareness and break down the stigma that can prevent people from seeking early support. Run by the mental health charities Mind and Rethink Mental Illness, Time to Change provides resources and information by which employers can develop their own anti-stigma activities. By signing the Time to Change 'pledge' to end mental health discrimination, employers receive support to develop an action plan to get employees talking about mental health.

A number of smaller, more targeted anti-stigma campaigns have also emerged in sectors identified as being potentially more vulnerable to prejudice against mental ill-health. For example, the City Mental Health Alliance – made up of a collection of businesses in the City of London who want to prioritise the mental health of their employees – launched *This is Me: In the City* in 2016, which aims to encourage employers to record video messages telling their own stories of experiencing mental health problems at work.

Improving understanding of causes and symptoms
A lack of understanding of mental health conditions among the workforce can lead those who experience them while at work to refrain from disclosing their condition and seeking help, due to fear of a negative reaction from colleagues.

According to forthcoming research from the Equality and Human Rights Commission, people with mental health conditions value understanding from their colleagues as a top priority when thinking about health at work. Improved understanding among colleagues is not only important as a way to increase the likelihood of self-identification of problems, but also because it increases the number of other people (such as line managers and colleagues) who may be able to spot that someone's mental health is deteriorating.

Mental Health First Aid England provides educational training to individuals and workplaces in order to help build knowledge of the signs and symptoms of a range of common mental health conditions. The approach is explicitly modelled on first aid for physical health, and so is intended to provide workplaces with some internal capacity to identify and understand mental health conditions and help signpost

colleagues to appropriate support. The course has been delivered to over 100,000 people in England.

Some employers also encourage some members of staff to become 'mental health champions'. These are often, but not exclusively, people who have themselves experienced mental health problems at work, and who can provide a further layer of more expert support and advice (although they will not necessarily possess clinical expertise). For example, the Deloitte mental health champions scheme now has 20 members.

Both mental health first aid and champion schemes benefit from providing an internal referral route, which exists outside the traditional line management structure. This can be invaluable where the emergence of mental health problems, such as stress and anxiety, are linked to poor workplace practices and potentially a breakdown in the relationship between line manager and employee. It can also be important where these are exacerbating issues that have emerged outside of the workplace.

FIGURE 3.2

Building layers of mental health awareness in the workplace

ADVANCED TRAINING & SUPPORT
(e.g. mental health champions programme)

BASIC TRAINING PROVISION
(e.g. line management, & Mental Health First Aid)

RAISING AWARENESS & BREAKING DOWN STIGMA
(e.g. Time to Change)

Reporting problems

Employers should recognise that, while it is important to provide as many opportunities to identify problems in the workplace as possible, many employees will prefer to talk to someone from outside the workplace. Employers should therefore ensure that they are able to provide employees with a means to report a mental health problem which exists outside the workplace structure altogether.

There are a number of free and confidential phone lines, run by charities such as Mind, the Mental Health Foundation and the Depression Alliance, which employers should ensure are visible to the workforce. The advice and support provided by an employee opting to get in touch with an expert phone line could help them to take the first steps towards raising issues with management or colleagues.

Monitoring sickness and wellbeing

Finally, where systems are in place to monitor both staff wellbeing and periods of sickness absence, this can help to identify more complex, fluctuating conditions. These are likely to result in shorter, more regular

periods of absence, rather than singular, extended periods. For example, in 2008 new IB claimants were found to be more likely to report that their condition fluctuated over time if they had a mental health condition, compared to those with a physical condition (Irvine 2009).

Most employers monitor sickness absence among their workforce, with larger organisations, especially those in the public sector, the most rigorous in recording and acting on sickness absence. The CIPD found that:

> *'Almost all organisations surveyed (94 per cent) have a written absence/attendance management policy. Even among very small organisations (one to nine employees) nearly three-quarters (72 per cent) have a written policy.'*
> CIPD 2015

SMEs are less well equipped to monitor sickness absence. The CIPD's finding is reinforced by a recent survey in which around one-third of SME managers or HR professionals suggested that their organisation lacks an adequate system for managing and recording sickness absence (Ellipse 2015). This was echoed by employees of SMEs: 39 per cent of whom suggested that their employer did not manage their sickness system well, while one quarter suggested that they didn't think their employer knew about the full number of sick days they had taken (ibid).

In order to help them identify and support employees who have fallen ill, or are at risk of falling ill, it is not sufficient for employers to merely have a mechanism for recording periods of sickness absence. They must also ensure that, alongside the monitoring of absence, data is used and collected in a systematic way. If employers don't know when or why people are taking time off, it can be more difficult to identify when someone's health may be deteriorating, and so address health problems as they emerge.

Figure 3.3 shows what employers do with the data they collect on sickness absence. It shows how a majority of employers do use the data they collect to help inform different business activities. There are, though, some basic tools that can be used by both large employers and SMEs to help ensure that sickness and wellbeing is monitored in an effective way, and that the data collected is used to help prevent sickness and support those who do fall ill.

Wellness action plans (WAPs) are an employee-led practical tool that can be used to help inform conversations between line managers and employees about the requirements of maintaining wellness at work, and provide the framework through which health and wellbeing can be monitored over time. Reviewing WAPs can be easily integrated into supervision meetings and one-to-ones, and can include review of sickness absence.

FIGURE 3.3

While a majority of employers use the data they collect to help inform different business activities, there are some basic tools that can help ensure that sickness and wellbeing is monitored in an effective way
What employers do with their absence data, 2015 (base 471)
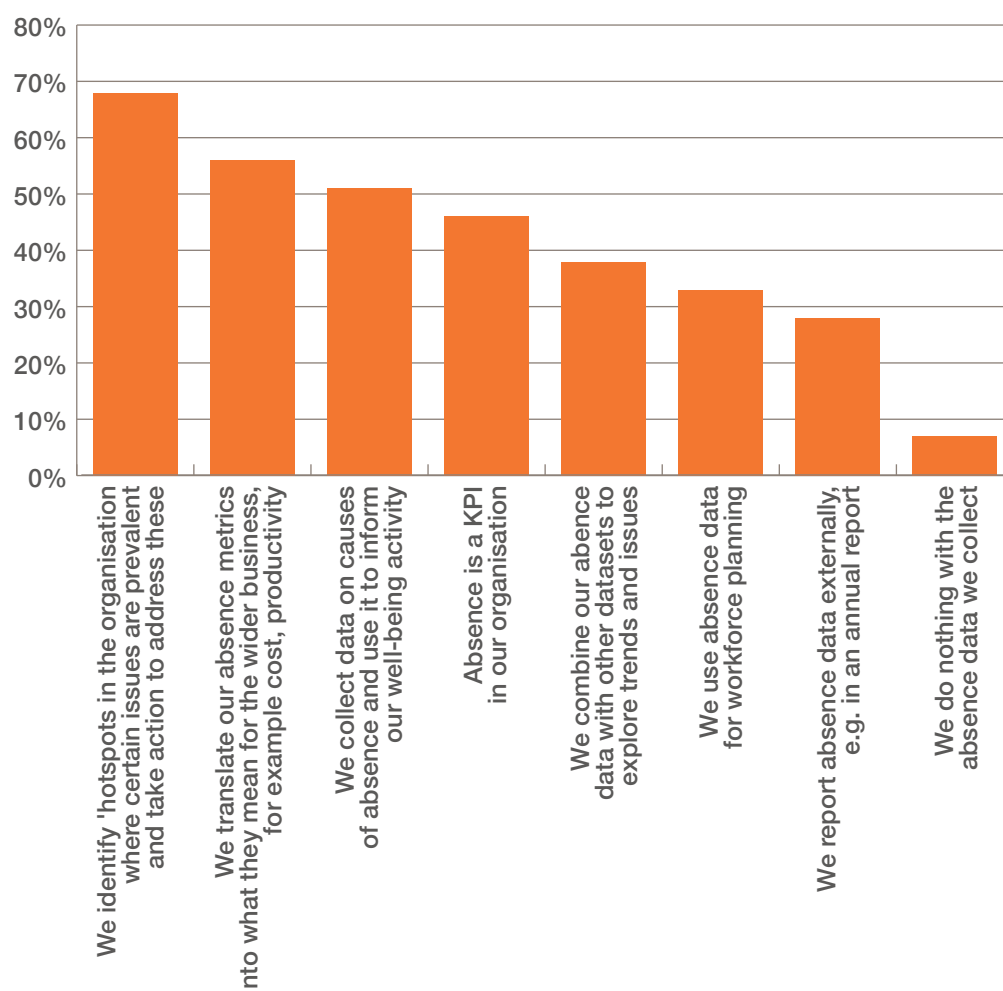
Source: Chartered Institute for Personnel and Development, *Absence management 2015* (CIPD 2015)

Return-to-work interviews after each individual period of sickness absence are relatively common across different labour market sectors. However, the rigour with which they are carried out can vary dramatically. The use of coding tools such as the Sickness Absence Reporting Tool (SART) developed by the Health and Safety Executive can provide a more detailed means of recording the details of a period of sickness absence during a return-to-work interview. Particularly for SMEs, which largely lack a sophisticated internal HR function, collecting and coding information in a systematic way can help to minimise the risk that patterns in sickness absence are overlooked due to differences in the way that information is recorded.

3.2 ABSENCE FROM WORK: HELPING EMPLOYEES GET BETTER

Employer-led services to help employees with health problems who are returning from a period of sickness absence are extremely patchy. Part of the reason for the inconsistent availability of employer-led health support is that the role of the employer in the sickness absence system has largely failed to be articulated in policy terms. With the exception of the requirement to make reasonable adjustments to the workplace under the Equalities Act and the requirement to provide statutory sick pay to eligible workers, what services employers make available to employees with health problems is largely determined by employers themselves.

There are a number of tools employers can use to help unwell employees get better, including:

- stress management training
- occupational health services
- employee assistance programmes (EAPs) and counselling
- specialist mental health support (including counselling services, CBT and IAPT)
- reasonable adjustments (including options for a phased return to work).

3.2.1 Stress management training

What is it?

Stress at work is best understood as arising due to a complex mix of factors that can be positive as well as negative. As such, it's presence does not have an absolute correlation with mental health problems, and there should not be an automatic assumption that stress requires some form of treatment. The severity and duration of stress matter. According to Steadman et al (2015), 'though a short period of stress may be a normal part of working, prolonged stress can become more serious, contributing to the development of both physical and mental health conditions, or worsening existing health conditions.'

Work-related stress affects a significant proportion of the workforce. In 2015/16 stress accounted for 37 per cent of all work-related illness, and 45 per cent of all working days lost due to sickness absence (HSE 2016b). Similarly, 44 per cent of survey respondents report that their work is 'stressful' or 'very stressful' (Steadman et al 2015). Self-reported prevalence of work-related stress is highest among professional occupations, females, and people working in large organisations (HSE 2016b).

Stress management training can be made available by employers to help employees understand the root causes of work-related stress and develop strategies and techniques to manage it effectively. This can reduce the likelihood stress impedes on an individual's mental health or productivity levels.

How common is it?

There is a disconnect, though, between the proportion of the workforce who encounter stress in the workplace and the proportion who can access stress management training in the workplace, the availability of which remains limited. It is estimated to be accessible to just one-third

(31 per cent) of employees overall, and far fewer in small, private sector firms (Steadman et al 2015).

Is it effective in reducing long-term sickness?

The effectiveness of employer-led programmes and strategies to reduce work-related stress is contested. Despite reporting that making stress management courses available can help employees to handle stressful situations and prevent them from arising in the first place, the Royal College of Psychiatrists has argued that there is 'no firm evidence that stress management techniques reduce the prevalence of common mental illness or of sickness absence' (RCP 2008).

However, more recent work has found that courses for employees based on self-guided, internet-based stress management techniques *can* improve health across a number of metrics, including reductions in feelings of stress and anxiety. They did not, however, find any reduction in employee absenteeism (Ebert et al 2016).

3.2.2 Occupational health services

What is it?

Occupational health services can be delivered either in-house or via a contractor, and are aimed at improving the health of the workforce by reacting to and preventing work-related illness. The services are delivered largely by private sector providers, although the NHS Health at Work scheme is also available for employers to purchase. After a health concern has been identified, an employee can be referred to the occupational health service, which will usually then undertake assessment of the employee's need, before working with them over a number of sessions to begin to resolve issues and improve their health.

The Black and Frost review (2011) identified the role of occupational health as central to supporting employees back into work.

> *'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.'*
> Black and Frost 2011

Because occupational health provision usually entails a strong line of communication between the health practitioners and line managers or HR, there is a perception that it allows employees' health issues to be addressed more quickly than may be the case were they left to independently navigate public services. During our workshop with large employers, there was a strong view that where employees cannot access occupational health and so instead enter mainstream NHS services via their GP, periods of sickness absence can be longer. This was echoed in the Black and Frost review, in which employers reported that occupational health services allow them to avoid the need to await the views of GPs, who can lack the time, expertise in employment, and understanding of the business needed to provide appropriate and timely advice.

A further benefit of occupational health provision is that it can provide more accurate diagnostics of health problems within the context of a particular workplace, due to a more sophisticated understanding of that workplace. Occupational health services can therefore also play an important role in identifying the adjustments in workplace practices, culture or physical environment that are needed to help improve employees' health.

How common is it?
Occupational health services are among the most common types of health support available in the workplace, particularly among larger employers with access to more financial resources. According to the 2014 Health and Wellbeing at Work Survey, half of employees (51 per cent) interviewed reported they had access to occupational health services. Among employers whose workforce exceeded 250 employees, this rose to two-thirds (65 per cent) (Steadman et al 2015). This represents an upward trend in recent years. Between 2011 and 2014, the proportion of employees reporting access to occupational health had grown by 13 percentage points (ibid).

Given that occupational health is usually determined by an employer's (rather than an employee's) willingness to pay for the service, access is related to the size and profitability of the employer, with smaller firms much less likely to provide employees with access to occupational health services. Access among employers with between 1 and 50 employees is estimated to be just 21 per cent (ibid).

Interestingly, ESA claimants are less likely to have had access to occupational health services. A recent DWP survey identified that as few as one-third of claimants had access to occupational health (Adams et al 2015). This is likely to be due to the fact ESA claimants disproportionately come from the lower-paid end of the labour market, and from smaller firms or agencies.

Does it help reduce long-term sickness?
There is some evidence that occupational health services help people experiencing musculoskeletal conditions to manage their health more effectively. Randomised control trials have found that employees who receive specialist consultations with a physician and physiotherapist focused on teaching skills to cope with their condition, tend to return to work more quickly than those treated in primary care (NICE 2009).

Occupational health is less effective at helping the significant proportion of individuals joining the ESA caseload who have mental health conditions. This group requires a more complex approach to supporting employee health than is traditionally available via occupational health, which is largely designed so as to identify and administer appropriate treatment for physical conditions (RCP 2009).

3.2.3 Employee assistance programmes (EAPs) and counselling
What is it?
Employee assistance programmes (EAPs) are employee benefit programmes which are intended to help employees understand and manage personal problems which have affected, or have the potential to affect, their

health and work performance. EAPs generally have low barriers to entry, with employees able to refer themselves into the service confidentially. They generally include an initial assessment, a short-term counselling intervention from an independent source, and a referral service to external provision where this is deemed appropriate. They aim to provide an easily accessible psychological support service, which can help to unpick both work-related and non-work-related problems in a holistic way.

How common is it?
It is estimated that more than 8 million employees in around 5,200 organisations in the UK have access to EAP services, but that just 5–10 per cent of those with access actually go on to use the service, leading to fears that they can often be underpublicised and underutilised (Rick et al 2012). Like occupational health services, EAPs are more available to employees of larger organisations compared to SMEs.

Is it effective in reducing long-term sickness?
A recent study found that EAPs can lead to improvements in both employees' psychological wellbeing and sickness absence rates (ibid). There was found to be significant variation between organisations in terms of whether these improvements occur.

These findings are supported by those of similar studies that have examined the effectiveness of workplace counselling (not restricted to that provided by EAPs). More than 90 per cent of employees who access workplace counselling are estimated to be highly satisfied with the service they receive, would use the service again if necessary, and would recommend it to colleagues. Workplace counselling interventions have also been found to reduce both symptoms associated with common mental health problems and sickness absence rates in the majority of those who access them (McLeod 2010).

Where they are implemented effectively, EAPs can be part of a proactive approach to preventing and actively managing sickness absence. While they should not be seen as a replacement for more specialist forms of intervention for diagnosed mental health conditions, they are able to play an important role in improving health outcomes for employees.

3.2.4 Specialist mental health support
What is it?
Where mental health conditions are identified in the workplace, many employers face a real challenge in helping affected individuals, together with health professionals, to identify appropriate workplace support.

The two most common mental health conditions are depression and anxiety disorders. Common mental health conditions experienced in the workplace could be caused or exacerbated by life events outside of work, or work-related events and pressures, or a combination of the two. Among employees rating their mental health as 'poor', only 7 per cent say this results solely from problems at work, 54 per cent saying it is due to a combination of problems at work and problems outside of work, and 37 per cent saying problems outside of work were the exclusive cause.

So, while most employees cite problems at work, only a small minority see these as the exclusive cause for their poor mental health (CIPD 2016).[5]

There has been a long-term increase in the prevalence of common mental health conditions such as depression and anxiety among the wider UK population. According to the 2007 adult psychiatric morbidity survey, the number of adults in England who meet the criteria for one common mental health condition increased from 15.5 per cent to 17.6 per cent between 1993 and 2007 (NHS Information Centre for Health and Social Care 2009).

For those mental health conditions that are directly work-related, workload pressures have been identified as being the predominant factor, followed by interrelationships at work and changes at work (HSE 2016b). For work-related depression and anxiety, understanding the nature of the work-relatedness and putting in place strategies to reduce the pressures felt by the individual are central to health outcomes improving and sickness absence rates falling. Occupational health provision, EAPs and counselling can play an important role here.

FIGURE 3.4

Workload pressures are the predominant factor for employees with directly work-related mental health conditions
Breakdown of mental ill-health cases reported to THOR-GP according to precipitating event (aggregate across 2013–2015)
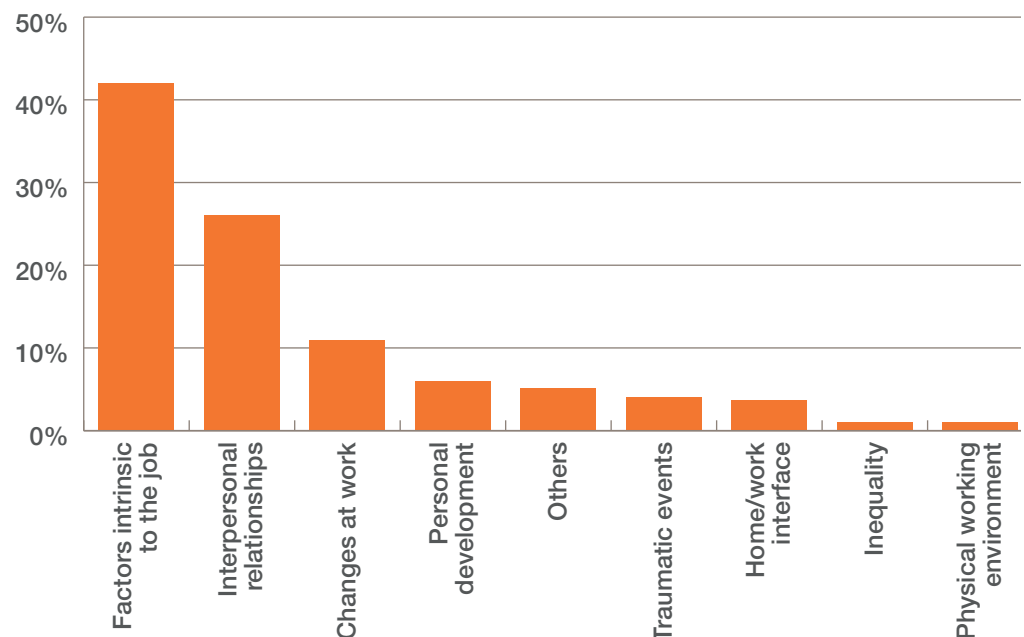
Source: Health and Safety Executive, *Work related Stress, Anxiety and Depression Statistics in Great Britain 2016* (HSE 2016b)

For common mental health conditions which have an impact on an individual's ability to work, but which may not be predominantly work-related in terms of their cause, directing an employee to more specialist forms of mental health support may also be appropriate. However, while occupational

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5   Two per cent responded 'Don't know'.

health provision is becoming more widespread, there is no evidence that this is also the case for employer-initiated specialist mental health services. This is despite evidence that their use, alongside other changes to workforce practices, is widely recognised as being helpful in increasing the probability of an individual returning to work.

In recent years, there has been a national drive to significantly increase access to cognitive behavioural therapy (CBT) – a therapeutic, talking therapy intervention usually delivered over an eight-week period for people with depression and anxiety disorders. CBT is largely delivered through the Improving Access to Psychological Therapies (IAPT) service introduced in 2007. By providing the option of employment advice alongside clinical treatment, IAPT aims to intervene as early as possible to help people return to work from a period of sickness absence.

IAPT teams are able to refer people accessing the service to employment assistants (EAs) where that person is in employment and is considered to potentially benefit from specialist employment advice. Employees can be referred into the EA service by GPs and employers, as well as via IAPT teams. EAs are able to provide practical advice to help employees deal specifically with work-related problems that they are experiencing, and which are raised during psychological therapy sessions.

An evaluation of EA pilots that were run between 2009 and 2011 found the problems that prompted IAPT service users to seek employment advice were often associated with relationship difficulties with their managers and colleagues, the reorganisation of work and difficulties managing workloads (DWP 2013).

How common is it?
Despite the growing evidence of its effectiveness, the extent of specialist mental health support available through the workplace is inconsistent. Steadman et al (2015) found that the provision of independent counselling and advice was available to only a minority (39 per cent) of employees, and that accessibility had not increased between 2010–2014.

There is evidence that the lack of availability of specialist mental health support means that employees' mental health needs often go unmet. According to Steadman et al (ibid), employees with a mental health condition were more than twice as likely to report unmet need compared to those with physical health conditions (22 per cent compared to 10 per cent).

Employees who move onto sickness benefit as a result of a period of absence are significantly less likely to have accessed employer-led health services than the average worker. Just one in five (18 per cent) ESA claimants have accessed independent counselling and one in three (33 per cent) have accessed occupational health services (ibid).

How effective is it in reducing long-term sickness?
There is strong evidence demonstrating the effectiveness of specialist mental health support in preventing relapse for people with depression and anxiety disorders. A study by the Royal College of Psychiatrists (RCP 2008) found that CBT can help people with common mental disorders return to work after a period of sickness absence, although

the time-limited nature of courses of treatment was considered unhelpful by some. Evidence demonstrating that CBT combined with employment support can increase the number of people on sick pay and benefits convinced the government to support widening access (DoH 2011).

Similarly, the 2013 evaluation of the IAPT EA pilots found widespread service-user satisfaction, with 89 per cent reporting that they would recommend the service to others, and 58 per cent reporting that their work-related problems had been fully or partially resolved. Of those who had returned to work after sickness absence, 26 per cent said they would not have returned so soon without the employment advice they received. Of those who were on sickness absence when they started seeing the EA, 63 per cent were attending work when they stopped seeing their adviser (DWP 2013). It was not possible to conclude the extent to which this would have happened with access to IAPT treatment alone. However, given that employed IAPT service users who were referred for EA had worse mental health than the IAPT service users who did not see EAs, it is reasonable to conclude that the combination of psychological therapy and employment advice was particularly effective in helping them return to work after sickness absence.

CBT can, then, be used as part of a wider rehabilitative effort aimed at improving employee's health outcomes and bringing about a return to work. But in order to maximise the chance that clinical interventions are effective, employers must also ensure that they are complemented by regular managerial contact with the employee, and not offered in isolation. This gives clinical interventions the best opportunity to unpick both individual- and organisation-level drivers of poor mental health.

While CBT and counselling can be effective with the majority of common mental health conditions experienced in the workplace such as stress, anxiety and depression, they are less likely to be effective in dealing with more severe and enduring conditions. In cases such as these, the employer should assist the employee in accessing the necessary clinical support.

People with schizophrenia for example tend to have far lower rates of employment. It has been estimated that between 30 and 50 per cent of people living with schizophrenia in the UK are capable of working (Marwaha and Johnson 2004). For this group, the employer will need to be engaged so as to manage periodic periods of sickness absence together with the employee, and ensure that potential barriers to the employee returning to work are overcome.

3.2.5 Returning to work: Reasonable adjustments
What is it?
If sickness absence is managed effectively, perhaps involving a combination of clinically effective health interventions and regular contact with a line manager or HR staff, the likelihood of an employee returning to work is enhanced.

In anticipation of a return to work, employers should consider making reasonable adjustments to the workplace. For employees who are legally captured by employment discrimination law (such as those classified under the Equality Act 2010), the employer is legally required to provide

reasonable adjustments to the workplace so that the individual can continue to work.[6] This is most commonly associated with alterations to the physical work environment, although employers should also consider the potential need for alterations in workplace practices (such as a period of flexible working or reduced hours).

How common is it?
Despite this, there is significant variation in the extent to which reasonable adjustments are actually implemented. According to a recent survey of employees with a health condition or recent period of sickness absence, 39 per cent reported having no adjustments made by their employer as a result of their sickness and subsequent return to work (Steadman et al 2015). Survey data also shows that the provision of workplace adjustments for ESA claimants is similar to that for non-claimants, with around 59 per cent of the former having experienced efforts from their employer to make at least one adjustment (Adams et al 2015).

Where adjustments are made, the most common are thought to be: permitting employees to take time off at short notice (to attend appointments, for example); permitting employees to work flexible hours, or undergo a phased return to work; and permitting employees to change the nature of their daily tasks (Steadman et al 2015).

But there are also risks. As flexible working entitlements have become more widely enjoyed, a phenomenon of 'leavism' has also emerged whereby individuals can work around their conditions using flexi-time and annual leave. Flexible working can provide an opportunity for employees to balance work with the demands of a health condition, be it short or long term, and so is often considered a form of reasonable adjustment. However, as with presenteeism, it has the potential to lead employees to continue to work during periods where a more prolonged and total absence from work may be more appropriate for their long-term health and work prospects.

Does it help reduce long-term sickness?
Employees report that adjustments have the potential to make a real impact on their ability to continue to work. Thirty per cent of people aged over 50 who leave employment for reasons of sickness and disability report that they would not have left had adjustments been made to their duties or work environment (MacInnes et al 2014).

For the predominant causes of long-term sickness, implementing reasonable adjustments to the workplace can be particularly important. For employees with musculoskeletal conditions, employers should go beyond providing health interventions such as physiotherapy. According to the Health and Safety Executive:

> 'Altering a task, equipment or the workload an individual faces can significantly reduce the risk of [musculoskeletal conditions] reoccurring … Often the costs of any adjustment

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6   The Disability Discrimination Act (DDA) 1995 was repealed and replaced by the Equality Act 2010 for all workplaces in the UK, with the exception of Northern Ireland where the DDA still applies.

are outweighed by the longer term benefits of getting the employee back to work early.'
HSE 2016b

Similarly, there is often a need to implement reasonable adjustments for employees returning to work after a period of sickness absence brought about by the presence of a mental health condition. An employee with a mental health condition that affects day-to-day activities in a non-trivial way is considered disabled under the Equality Act, and so is legally entitled to reasonable adjustments. This could include things such as one's ability to use public transport during rush hour, or sitting in a certain part of an office, for example. It is also required that the condition has lasted for at least 12 months, or is expected to last 12 months. An employee is covered by the law if they met these criteria in the past, but have since recovered.

Research has shown that both ESA claimants and non-claimants with mental health conditions are less likely than those with physical conditions to feel that their employer had been supportive or that the adjustments to the workplace offered or made enhanced their ability to stay in work (Adams et al 2015). This could reflect a lack of understanding among employers of mental health conditions, or how mental health can be improved and protected through changes to working practices.

There is also evidence that employees who access counselling and discuss their condition with their employer are actually more likely to access ESA without a preceding period of sickness absence than those who do not (ibid). This suggests that some employers may be encouraging long-term detachment from the labour market for those with mental health conditions rather than considering use of a period of sickness absence to put in place adjustments that may support a quicker return to work.

There is, therefore, a continued lack of recognition among many employers about the benefits of implementing adjustments to the workplace for employees with mental health conditions, and an apparent lack of willingness to implement changes where need is identified.

3.3 SUMMARY

Despite real advancements in the availability and quality of employer-led initiatives aimed at supporting employees with long-term health conditions, it remains the case that particular groups are still disproportionately likely to miss out on the support they need. People living with mental health conditions, people working for SMEs, and people working casual hours or for employment agencies continue to be denied the access to support that is available to others in the labour market. The result is that these groups continue to be overrepresented among those who experience long-term sickness and inactivity. Where an individual falls into more than one of these three categories, the likelihood of their health condition leading them into inactivity is enhanced further.

It remains the case that not all employers record sickness absence, let alone do something with the information they record. Even when monitored, the services offered may be limited. Mental health support in particular (and an organisational culture in which employees feel able to identify and discuss it) remains in its infancy in many parts of

the labour market. An examination of services such as occupational health and employee assistance programmes show how their availability does not appear to be growing quickly enough to meet the scale of the challenge posed by sickness in the workplace. While the implementation of reasonable adjustments for people with more complex (particularly mental) health conditions is improving, it remains patchy, meaning many people continue to be denied the support they need.

While there are core groups of employees who continue to be denied access to the support that could potentially improve their health and work outcomes, it is important to recognise that there are limitations to what employers (particularly SMEs) can achieve given the current weaknesses of the wider policy framework. It is with this in mind that the next chapter turns to examine the different policy initiatives that have been introduced to help reduce long-term sickness absence and health-related inactivity.

4.
CURRENT POLICY AND THE TENSIONS PREVENTING REFORM

The systems of support for employees with health conditions have improved in recent years, including through the growth of occupational health support and the establishment of the 'Fit for Work' service. However, there remain problems with the system at large, including with the provision of both financial support to employees, and practical support to help them manage their condition. While the previous chapter highlighted examples of best practice among employers, there is more that public policy can do to ensure that a greater number of employers go on to actually implement them, and to identify where the state can act to fill in the gaps and resolve the evident tensions in the system. This chapter addresses each of these in turn.

4.1 FINANCIAL SUPPORT FOR WHEN PEOPLE GET SICK

When employees get ill, in most cases they are able to access financial support from their employer for a limited time period. Public policy provides a safety net for employees through mandatory sick pay, but many employers offer more generous benefits to their employees.

The provision of contractual sick pay (or occupational sick pay [OSP]) above the minimum legal limit is a widespread employee benefit. The Black and Frost review found:

> '*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.*'
> Black and Frost 2011

Separate research for the DWP found that 48 per cent of employers surveyed paid all or some of their staff occupational sick pay, and of those that did, most (93 per cent) started paying OSP at 100 per cent of workers' salaries (Young and Bhaumik 2011).

The proportion of firms offering their employees OSP varied widely by he size of firms. Large firms were very likely to offer it (88 per cent) compared with 71 per cent of medium and only 47 per cent of small employers (ibid).

There is also variation according to sector, with public sector employers more generous in their provision of occupational sick pay than those in the private sector. According to the Black and Frost review, 'The median duration of OSP at full pay in the public sector is 26 weeks; in the private sector it is eight weeks' (Black and Frost 2011).

A survey of employers for the DWP found that the majority (68 per cent) hold their occupational sick pay at the same level throughout the period during the employee's entitlement, compared to some 23 per cent of employers who reported varying the rate.

4.2 DOES GENEROUS FINANCIAL SUPPORT ENABLE RETURN TO WORK?

There are obvious advantages to providing contractual sick pay to employees, not least in recognising their value to the workforce, and ensuring that they are not plunged into financial hardship which could potentially exacerbate other problems, such as debt or anxiety. However, the design of sick pay systems in the workplace, and their generosity, requires careful consideration.

While around half of employers provide occupational sick pay, a review by the Economist Intelligence Unit of 17 countries' sick pay regimes found the UK to be, on average, less generous than most. The UK's rate of salary compensation averaged 15 per cent of salaries, ahead only of Ireland and Portugal (EIU 2014).

At the more generous end of the spectrum are full salary compensation schemes. Germany operates a system where, for a period of time, full pay is mandatory – that is, an employee's salary must be fully or partially maintained for a specified period. Other countries operate the full pay model too, including Austria, Finland, Norway and Belgium (OECD 2010). While the upfront costs to employers may be the same, their generosity differs significantly. Germany demands full pay for the first six weeks, for instance, while in Finland it is only the first nine days, though in reality most employers pay full salary for the first one or two months (ibid).

A second model is a reduced salary scheme, which is also common among OECD states. For example, in Poland 80 per cent of the worker's salary must be paid for the first 33 calendar days, and in Spain sickness benefits are paid at 60 per cent of salary from the 4th to 15th day of absence (ibid).

While these international models may prevent sharp falls in income, and are thus more generous to the employee, the time period they cover tends to be shorter than in the UK, and therefore may fail to support employees with longer-term conditions, or conditions with longer recovery periods. By being shorter, but more generous, the total cost burdens of paying sick pay may be similar. For example, were UK employers mandated to operate a German-style regime at 100 per cent salary, based on average weekly earnings of £504, an employer would pay around £3,024 over six weeks, compared with the current cost of 28 weeks' SSP of £2,464.

There is evidence that more generous sick pay schemes tend to be associated with higher levels of sickness leave. Research conducted in Germany, where the federal government legislated to raise the equivalent SSP from 80 per cent of worker salaries to 100 per cent for the first six weeks, illustrates the challenge. This change led to the length of periods of sickness absence increasing by on average one day (or 20 per cent) (Ziebarth and Karlsson 2013). Such findings were supported by research in Finland, which identified a strong correlation between the extent of salary replacement and levels of sickness absence (Bockerman et al 2014). In some cases this may be as a result of reduced preseneetism, with employees merely taking time off when they need it, and while they recover. In some cases, employees may be taking more leave than is necessary.

There is, therefore, a tension for employers. More generous schemes can help protect employees when they fall ill and while they recover. They may help reduce presenteeism, and they could be an attractive benefit for employees. However, they can encourage employees to take longer periods of sickness absence than is necessary. Employers need to consider these factors when deciding on their sickness absence schemes.

4.3 SUPPORTING EMPLOYEES WHO DO NOT RECEIVE OCCUPATIONAL SICK PAY

Statutory sick pay (SSP) refers to the legal obligation of an employer to pay an employee a minimum income of £88 per week for up to six months during periods of sickness absence. The costs of this are completely absorbed by the employer.

An individual who is in work (and who is not self-employed), is legally entitled to receive SSP as long as they: have done at least one day's work for their employer; are sick for four full days or more in a row (including non-working days); earn on average more than £112 per week (before tax); and follow their employer's rules for accessing sick pay.

To receive SSP, an employee must do the following.
1. Tell their employer straight away that they're sick and can't work.
2. Let their employer know what the first day of their illness was, even if it was a non-working day.
3. Confirm their illness in writing (this is called 'self-certification') – they'll need to do this within seven days of telling the employer that they're sick.[7]
4. Get a doctor's note if they're sick for longer than seven days (called a Fit Note) and they have been asked by their employer to present one – the seven days includes any days when the employee wouldn't normally be working.

SSP is the minimum employers are expected to pay their employees for the 28 weeks of sickness absence, but, as outlined above, many pay more.

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7   Adams et al (2015) report that despite the self-certification option for up to seven days, 70 per cent of ESA claimants are likely to have been required to supply a Fit Note, and within this 55 per cent had to do so within the self-certification period.

While employers who pay SSP only are in the minority, individuals who end up on sickness-related benefits are disproportionately likely to only have received SSP when in work. A recent survey of employment support allowance claimants reported that among respondents who received some form of sick pay, 66 per cent received SSP only, 15 per cent received a combination of SSP and OSP, and 13 per cent received OSP only (Adams et al 2015) This may well be the result of the type of work ESA claimants were previously employed in, and the nature of the firms they worked for.

More troubling is the finding that many individuals, particularly those within probationary periods, on temporary contracts, or employed as agency staff, report not being aware of their SSP entitlements. Over one-third (35 per cent) of employees on ESA had not received sick pay during their latest period of absence prior to claiming ESA (ibid). There appears to be a widespread lack of understanding around employment and sickness rights, particularly among low-income groups and the contingent labour market, as well as many examples of incorrect practices being adopted by employers (whether knowingly, or not) (ibid).

The survey by Adams et al (2015) also revealed that, as well as low awareness, there appears to be significant numbers of people moving onto ESA because they were told that they were not eligible for statutory sick pay. A third of ESA claimants surveyed (35 per cent) who did not receive sick pay reported that their employer had informed them that they were not eligible. Of this group:

- 55 per cent said this was because they were employed on a probationary period, temporary contract or as an agency worker
- 36 per cent said this was because they worked variable or part-time hours.

The contingent labour market appears to be particularly problematic, as demonstrated by the following finding from the survey:

> *'Those employed via an agency as opposed to directly by an employer were significantly more likely to state contractual reasons as to why they were not eligible for sick pay (82 per cent compared to 47 per cent). However, this is inconsistent with government guidance on SSP, and may suggest that employers have been incorrectly withholding SSP from agency workers.'*
> Adams et al 2015

The lack of understanding on the part of both employees and employers with regards to obligations to pay statutory sick pay once entitlement rules have been met is something that clearly needs to be addressed – not least because where unscrupulous employers fail to do their legal duty, the state ends up picking up the tab through benefit payments.

4.4 DOES THE CURRENT DURATION OF STATUTORY SICK PAY AID RETURN TO WORK?

Currently, employees are eligible for statutory sick pay for up to 28 weeks of sickness absence.

There is international evidence that increasing employer contributions to sick pay and lengthening the period of protection can help reduce sickness absence. In the 1980s, employers in the Netherlands only had financial liability for sick pay for a few weeks. This was progressively increased to one year and then two years. This led to a decline in absence rates. As the OECD has observed, 'increasing employer co-payments can be an effective strategy in tackling high absence rates' (OECD 2010).

4.5 DO LOW LEVELS OF STATUTORY SICK PAY AID RETURN TO WORK?

An important first reflection is that the existence of any statutory sick pay regime is a positive thing, and one that should not be taken for granted. A review of OECD countries identified at least four developed states that operate no statutory sick pay system at all, allowing employers to pay nothing to their workers if they become sick (OECD 2010.

Equally, there are many countries where the sick pay system is considerably more miserly than in the UK, both in terms of the legal coverage of support, and length of time that an employer must pay their employees. Especially on the latter point, the UK's system appears comparatively generous even against the most advanced economies and welfare states (see ibid).

The floor level for statutory sick pay in the UK – £88 – is very low relative to average weekly earnings and indeed some out-of-work benefits. Where, in August 2016, average weekly full time earnings were £504 per week, SSP was the equivalent of 17.4 per cent of average earnings (ONS 2016). Although individuals on sustained periods of SSP are also entitled to in-work universal credit, which can support housing costs and tax credits and so top up this low level of pay, it is paid in arrears, meaning that SSP recipients are likely to be plunged into hardship fairly quickly. This is particularly true of those working only part-time, whose SSP entitlements will be lower still. For example, if the employee qualifies for SSP having met the complex eligibility criteria, and only works three days per week, their SSP entitlement will reflect that, and be set at £53 per week.

The labour market literature would suggest that keeping entitlements low should incentivise returning to work as quickly as possible (see for example Ljungqvist and Sarjent 1998), and this is supported by the OECD which clearly sets out how generous sickness regimes encourage longer rates of absence, and eventual flow onto disability benefits (OECD 2010). However, this is to be balanced against the impact of low entitlements on employees who fall sick.

Statutory sick pay and behaviour change – the Netherlands
In 1967, the Dutch government established a disability insurance programme that combined two existing schemes: one for work-related diseases and injuries, and another for other disabilities.

The state-funded programme had generous benefits – replacing 80 per cent of salary – and relatively easy access. This led to a rapid expansion, and spending on the programme reached 4 per cent of GDP in 1980, over three times the OECD average.

When initial restrictions on eligibility introduced in the early 1980s failed to reduce costs, the Dutch government in 1996 made employers responsible for the costs of sickness benefits and extended their duration. In 1998, experience ratings were introduced in order to make the cost on individual employers reflect levels of sickness absence at the organisation.

In 2002, the Gatekeeper Protocol was introduced which placed significant requirements on Dutch employers to rehabilitate and accommodate sick workers. This includes conducting an assessment of prognosis, developing a return-to-work plan, appointing a case manager, and providing a set of prescribed occupational health services. Dutch employers have to engage a company doctor to evaluate sickness reports and refer workers to specialist support. Where return to work is not possible, employers are required to explain why, and to support the worker into suitable alternative employment.

In 2004, the period for which employers are responsible for providing sick pay and rehabilitation support was extended to two years.

The reforms can be seen as highly successful in some respects. There have been significant declines in spending on sickness and disability. Spend on sickness benefits and disability pensions declined from 6.5 per cent of GDP in 1980 to 2.9 per cent in 2011. There has been a decline in sickness-absence rates, with the rate of short-term work absence down 25 per cent, and disability insurance caseloads also falling 25 per cent.

However, there have also been some negative developments associated with the reforms.

- Declining employment among disabled people – whereas one in two people with disabilities were in work in 2000, this had fallen to one in three by 2014. Unemployment among disabled people tripled over the same period. Some have suggested that this decline in the disability employment rate was the result of greater reluctance on the part of employers to hire people with disabilities or health problems as a result of the greater liabilities placed on them for supporting employees who become sick in work.

- Increase in temporary employment – initially, benefits for workers on temporary contracts were funded collectively, rather than by individual employers. There was a large increase in temporary employment following the introduction of the reforms, which has been seen as being in part driven by a desire by some employers to limit their liabilities. The Dutch government has recently closed this loophole and made employers responsible for covering the costs of benefits for temporary staff too.

Source: Fultz 2016

4.5 THE RIGHT TO RETURN TO WORK

Currently employees who are on SSP have a right to return to their previous job if and when they recover. However, once the SSP period of 28 weeks has been completed, employees do not have a right to return to work.

Employees who recover after a period of 28 weeks' sickness face a difficult situation. They are not entitled to return to their old job, which may have been filled or absorbed within the organisation, and their employer may be wary of taking them back in case they face a relapse. It may also be difficult for an individual to secure alternative employment given their recent prolonged gap in their work history, and the fact that their health may not be fully recovered.

This contrasts with the protection offered to mothers who take maternity leave. Mothers have a period of statutory maternity leave of 52 weeks, of which 39 weeks are paid. The mother has the right to return to work at any point during that 52-week period, and is protected by law from unfair dismissal during the period.

4.6 IN-KIND SUPPORT FOR EMPLOYERS: FIT NOTES, FIT FOR WORK AND ACCESS TO WORK

As well as mandating the level of sick pay to which employees are entitled, the state also provides support and advice services, targeted particularly at those employers that lack the in-house capability and expertise to provide the necessary support to employees.

4.6.1 The Fit Note
What is it?

The state's involvement in the sickness absence process generally begins with advice from GPs through the Fit Note, which is designed to a) encourage GPs to focus more closely on the extent to which an individual's sickness limits their ability to work, and b) to help provide guidance to employees and employers about the adjustments to the workplace that might be needed. For instance, beyond determining whether an individual is fit for work or otherwise, the note includes options by which the GP can recommend a graded return to work, altered hours or duties, and workplace adaptations.

Given that this is required as proof of sickness, and consequent eligibility for SSP after seven days of continuous absence, it should help inform the employer of the basic changes that might be necessary to help manage an employee's health condition, and make adjustments to bring them back into the workforce (much as the advice from an employer occupational health service would).

Despite the fact that doctors have been fairly positive about the role of the Fit Note in supporting return to work (Hann and Sibbald 2013), with 60 per cent believing that it increased the frequency with which they recommended a return to work to help patient recovery, this does appear to have been from a very low base.

Does it aid return to work?

A review of the Fit Note by Nottingham University found that just 6.7 per cent of those collected from employers participating in the study had the option for 'return to work' selected (Coole et al 2015). This finding was reinforced by the Black and Frost review, which found that, in a study of line managers, just 10 to 15 per cent of Fit Notes were 'may be fit notes', and this fell to as little as 2 per cent of Fit Notes in some large organisations (Black and Frost 2015). According to the research from Nottingham University:

> *'An important finding was that "may be fit" notes would usually not be considered [by GPs] until after one or more "not fit" notes. If this is the case, there is a risk that opportunities are being missed to help employed patients avoid any sickness absence by using the "may be fit" option more proactively i.e. to draw an employer's attention to where preventative action could be taken.'*
> IEOH 2015[8]

Employers we spoke to as part of this research also argued that the content of Fit Notes are fairly limited in their advice, and that advice often does not take account of the nature of the affected employee's work. A recent survey (EEF 2014) found that more companies disagreed (45 per cent) than agreed (16 per cent) that the advice given by GPs about employees' fitness for work had improved.

The extent of advice given by GPs on the Fit Note does appear to be influenced by a wide range of factors, including: who they thought was likely to read the note; how it would be interpreted; whether the Fit Note was written for other reasons than ill-health; the GP's desire to maintain a certain relationship with the patient; a perceived lack of confidentiality in the workplace; their [the GPs] own beliefs and attitudes about what was 'safe' to disclose; and the method of completion (IEOH 2015). The more proactive employers we spoke to through the course of this research would therefore follow up with GPs to discuss the employees condition and seek further advice. However, it is clear that smaller employers may particularly struggle to find the time to do this, and that all employers are likely to run into some of the challenges listed above.

It is also fair to say that expectations of GPs in relation to giving occupational health advice may be too high. The GPs primary concern and expertise is in relation to the patient's health and wellbeing. As such, even if they recognise the value of good employment as a part of a patient's recovery, GPs may not be best placed to provide the more extensive advice needed to aid the return to work.

Equally, if the notes are to support employers, not only may they require more detail earlier, but they might also be used to better signpost individuals to available support. At present, while government guidance signposts GPs to wider employee support (such as Fit for Work – see section 4.6.2), the Fit Note does not include an option to signpost the employee to Fit for Work if the discussion with the GP has revealed

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8   Though 76 per cent of doctors agree that they feel obliged to give sickness certificates for reasons that are not strictly medical (Hann and Sibbald 2013).

that the employee does not have access to occupational health or other support services at work.

At a time when around one-quarter of employers (24 per cent) believe the Fit Note has not accelerated return to work for employees (compared to 40 per cent that believe otherwise) (EEF 2014), it seems clear that there is some way to go in improving the Fit Note system for both employers and employees, particularly in directing employers and employees to effective support services.

4.6.2 Fit for Work

What is it?

After several years of piloting, the Fit for Work service was formally introduced in 2015, replacing numerous previous schemes. The service is intended to support employers in reintegrating the long-term sick back into work, especially the significant minority who lack access to employer occupational health services, by offering 'focused return-to-work support' for employees during periods of long-term sickness absence (periods exceeding four weeks). It also offers a direct, confidential advice service to employers, irrespective of whether they have an employee referred to the Fit for Work service or not. The system is voluntary – an employer or GP can refer an employee to Fit for Work to receive support, but the employee can opt out. An employee cannot, though, self-refer.

Where referred by a GP, employees are contacted within two working days by a case manager, after which they receive a 'holistic biopsychosocial assessment'. The case manager seeks to identify the obstacles preventing the employee from returning to work, and works with them to agree a 'return-to-work plan' designed to address each obstacle and enable a safe and sustained return to work. Assessments generally take place over the phone, with few face-to-face interviews throughout an employee's interaction with the service (BMA 2016). This has raised some concerns over the accuracy of some assessments.

This return-to-work plan aims to reflect the assessment and set out work-focused advice and recommendations which have been discussed with the employee to help them return to work more quickly and safely. The plan is sent via email or post (where appropriate) to the GP, the employee and the employer (subject to the employee's consent), and can therefore act as a replacement for the Fit Note.

Finally, as part of a return-to-work plan, the employer can claim up to £500 back in tax where meeting the costs of making adjustments.

Does it aid return to work?

It is probably too early to say whether the Fit for Work service will have an impact on the propensity of individuals to return to work rather than move onto out-of-work benefits. However, given the evidence that the absence of intervention after four weeks significantly reduces the chance of an individual returning to work, a service that does offer effective interventions to those groups who would otherwise not receive them is, in principle, a good thing.

The pilots of the Fit for Work service, on which the current model is broadly based, offer a reasonable proxy for understanding what the effects and limitations of the programme might be, given limited evidence in relation to the performance of the scheme so far. In surveying participants during the pilots' second and third years, roughly three-quarters (76 per cent) said that the pilot had helped them return to work and just 22 per cent said that it had not (Hillage et al 2015). The following quote from the evaluation of the pilots highlights both the potential benefits of the service as well as the limitations of the evaluation:

> 'The evidence from the fit note data collection exercise in the Manchester, North Staffordshire and Leicester pilots throws some positive light on this issue. In two out of the three areas, clients returned to work sooner on average than the control group of all fit note recipients in the same area, taking into account a four-week lead time before clients took up the service. It should be noted that these two groups are not matched other than in their initial absence period: the 'fit note population' control group would include a range of people for whom the pilots would not be appropriate, and differences between the two groups (for instance in motivation to work or socio-economic conditions) may account for some of the difference in outcomes.'
> Hillage et al 2015

For all of the service's potential, the pilots identified issues that are likely to be pervasive under the current Fit for Work service structure. For example, the pilots struggled to attract clients from SMEs, despite SME employees being intended as the service's primary client group. The evaluation identified a number of factors which contributed to the underrepresentation of SME employees among the pilot's client base, including SMEs not considering sickness a priority until it occurred (and thus not responding to marketing) and GPs not differentiating between individuals who had in-house support available and those who did not (ibid).

Going forward, the service therefore needs to increase its exposure to employers. The service also needs to be able to communicate more effectively about what exactly it offers to employers and employees, given that there appears to be a degree of misunderstanding about what the service currently offers. Government guidance states that:

> 'Fit for Work will complement, and not replace, existing occupational health services provided by employers. It will fill the gap in support that currently exists and will especially benefit those employers who currently have limited in-house occupational health services.'
> HM Government 2016

However, the British Medical Association has warned that this is misleading, and that, despite the intention to provide support to organisations that lack occupational health support for their employees, the current service does not really offer occupational health support at all (despite this being a feature

of several pilots), but rather was limited to providing a rather basic service of return to work advice (BMA 2016.

This is a real concern. Given the evidence of a significant gap in the provision of occupational health services to help people return to work, particularly among smaller employers, the Fit for Work service would appear to be falling short of what could, and arguably should, be provided.

In principal, the £500 tax break associated with the provision of 'return-to-work plans' could be used to help employers fund occupational health support themselves, but there is no data on knowledge, or take up, of the tax break available. Indeed, occupational health support and counselling services will often exceed £500. As a result, it might be sensible to forge a stronger connection between Fit for Work service, and the Access to Work support system.

4.6.3 Access to Work
What is it?
A further return-to-work support available to employees and employers is the Access to Work programme. Access to Work pays for work-based assistance, adaptations and support to enable people to take up and retain paid work, and is aimed at funding adjustments that it would be considered 'unreasonable' to expect an employer to fund, and which extend beyond those required by the Equality Act 2010.[9]

Does it support people to remain in work?
Introduced in 1994, Access to Work has been described as the government's 'best kept secret' (Sayce 2011) and has helped hundreds of thousands of disabled people to stay in work. The service has proven remarkably popular with both employers and employees. According to a 2009 evaluation of the programme:

> *'Customers and employers were generally very happy with the amount and quality of support that had been put in place by [Access to Work]. Customers who received ongoing support from [Access to Work], for travel to work or support workers for example, were most likely to report high levels of satisfaction.'*
> Dewsen et al 2009

According to the most recent figures, Access to Work has helped 104,620 people since April 2007 and provided an estimated net benefit to the Treasury of £1.48 for every £1 spent (Sayce 2011). In 2010/11, Access to Work assisted 38,840 people at an average cost of £2,900 per person (Cooke et al 2015). The types of services provided through Access to Work vary widely, and include things such as taxis to and from work, workplace adjustments and specialist equipment. However, the proportion of the programme's overall spend that is directed towards support for employees with mental health conditions is very low. It is estimated that, in 2013/14, this accounted for only 4 per cent of the overall budget, signalling that there is a real challenge in promoting

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9   Disability Discrimination Act 1995 in Northern Ireland.

use of Access to Work for employees with mental health conditions (Mind 2014).

Connecting Access to Work with the Fit for Work service would therefore be a logical step to offer employees and employers further assistance in supporting people to remain in the workplace and manage health conditions in an effective way. Indeed, where a need is identified through the Fit Note, the Fit for Work service could prescribe changes to the work environment through financial support from Access to Work.

4.7 SUMMARY

While public policy has come a long way in recent years, with government taking a more active role in supporting employers and employees in managing sickness in the workplace, the extent of public sector involvement in the provision of support – through the Fit Note, Fit for Work and Access to Work – remains too limited to be fully effective. Expanding the scope and reach of these programmes does, though, demand government to confront a number of tensions which it is necessary to take into account if reforming sickness policy is to complement, rather than displace, existing employer activities.

1. Increased state provision of occupational health services will help employers to retain staff, but may result in in-house occupational health becoming less common (or even disappearing from some sectors altogether).

2. Changing labour market regulation to force employers to retain staff who are long-term sick will reduce on-flow onto out-of-work benefits, but conversely may also reduce ESA off-flow by making employers more wary of hiring those with long-term health conditions.

3. Statutory sick pay offers some employees an insufficient time to recover. Increasing the duration of SSP would allow for more employees to recover and return to work, as well as strengthening incentives for employers positively to engage their staff. However, it may also negatively affect hiring decisions and encourage absence.

4. The state stepping in to help cover the costs of sickness benefits and services may limit negative labour market impacts (by de-risking hiring decisions and increased rates of absence), but this would come at a much greater cost to the state, and may reduce employer provision.

Managing these tensions will require government to carefully consider the range of possible effects when setting the extent of support available to employees and employers. An effective system requires the incentives placed on the employer, employee and the state to be balanced against one another and directed towards the same objective: a safe and speedy return to work. The final chapter sets out a number of recommendations for both how employers and government policy can act to meet this objective for the greatest possible number of employees.

5.
RECOMMENDATIONS
HELPING EMPLOYEES REMAIN IN WORK

In assessing the gaps in the systems of support available to employees with long-term health conditions, we have identified several key areas which must be tackled if we are to reduce the rate at which people fall out of work and onto long-term sickness benefits. In particular, there is a need to encourage an open dialogue about sickness, so that conditions can be identified early; to provide proper support for individuals when sickness is identified; and then ensure systems of support are available for people when they do go off sick, even if these cannot always be provided in-house by the employer themselves.

5.1 THE CORE CHALLENGES

The current system for sickness-related inactivity is failing employers and employees, and needs significant reform at each stage of the sickness at work 'journey'.

1. Early identification and in-work interventions.
2. Sickness absence management.
3. Return to work.
4. Ongoing health and wellbeing support.

Key challenges include:

- A general lack of understanding among employers of many health conditions, particularly mental health conditions, often leading to stigma, a culture of silence, and limited thinking on possible reasonable adjustments. One-third of individuals with experience of a mental health condition have not discussed the issue with their employer.

- Support for employees remains limited. Only half of employees have access to occupational health support through their employer, with fewer still among SMEs. Counselling provision is even lower – just 40 per cent of employees have access to counselling services through their employer. This is despite evidence showing that both occupational health and counselling (such as that made available through employee assistance programmes) can improve health and return-to-work outcomes.

- When off sick, the Fit Note places too much emphasis on medical diagnoses at the expense of an individual's work-based capability. Only around 1 in 20 Fit Notes suggest employees may be fit for a graded return to work. An overreliance on GP judgement can also delay processes whereby further appointments may help to establish a more accurate diagnosis than is possible through self-certification.

- Statutory sick pay (SSP) can be too short to help employees who experience health conditions that may require longer-term periods of treatment or recovery. This may lead to employees who could recover if given more time, instead falling out of work and moving onto ESA.
- Awareness of support among employees and employers remains weak at the low-paid end of the labour market. Understanding of SSP eligibility is often lacking, particularly for temporary and agency workers, as is knowledge of the Fit for Work service, which has the potential to provide additional support where employees do not have access to in-house occupational health.
- An employee who becomes sick often has to deal with numerous different systems and actors, which all too often do not communicate effectively with each other, or work towards the same ends.

In an 'ideal' journey, early identification, interventions and adjustments will minimise sickness absence, as will ongoing organisation-wide health and wellbeing programmes for all employees **(in-work)**. Where a period of sickness absence is unavoidable, however, alternative support mechanisms are needed **(out-of-work)**. Given these distinct stages, our recommendations are targeted at both employers (practice-based, with government support) and government (policy-based).

There is a particular need for strengthened systems of in-work and out-of-work support for employees with mental health conditions. The incidence of these conditions is high and increasing, their impact on individuals and the wider labour market is significant, and there is a continued lack of understanding and specialist support among employers.

In-work: healthy workplaces and early interventions
Workplace culture is critical to improving the identification and management of sickness. The evidence shows that there is considerable reluctance among employees to discuss their health conditions in the workplace with people who have the potential to help them access support, such as line managers or HR staff. Creating a culture in which self-identification and colleague-identification of health conditions is fundamental. This is particularly true for employees with mental health conditions, which remain highly stigmatised in the workplace.

First and foremost, employers need to encourage open dialogue in their workplaces about health conditions. There are a range of best-practice examples in this report that highlight potential ways forward, in particular for mental health, including **the promotion of anti-stigma campaigns, health and wellbeing awareness training for line managers and others, including Mental Health First Aid and mental health 'champions' schemes,** to create a more open work culture. We highlighted a **range of ways in which companies can encourage leadership on health and wellbeing issues**. For instance, companies could encourage senior staff to be open about their health conditions in order to create an environment permissive of discussion of workplace health, and to indicate to employees that having a health condition need not be a barrier to in the workplace.

Encouraging dialogue alone may not, though, be enough. It is also important that employers monitor rates of sickness systematically to identify the extent of health problems within their workforce, enabling them to put in place any appropriate adjustments to workplace practices and the physical working environment.

5.2 RECOMMENDATIONS FOR EMPLOYERS

We therefore make the following recommendations to employers.

- **Include health and wellbeing in annual review processes and regular supervisions**, to provide space for individuals to assess their own health and to identify potential issues early. This could be achieved through, for example, increased use of wellness action plans (WAPs). As described in chapter 3, WAPs are an employee-led tool used to help inform conversations between line managers and employees about the requirements of maintaining wellness at work, and can be included into supervision and reviews of sickness absence.

- **Use sickness management software and systems to identify problems, particularly fluctuating conditions, as early as possible.** Various online software is available to help employers of any size monitor sickness absence, and can be used to trigger conversations with employees.

- **Make greater use of flexible working practices, underpinned by a robust absence management system, and greater understanding of 'reasonable adjustments' within a mental health context.** To discourage presenteeism and remove the stigma associated with sickness absence, employers could introduce a 'wellbeing days' scheme.

Wellbeing days

Wellbeing days can be introduced as part of a subset of an employees' annual leave entitlement, granting between two and four wellbeing days per year. Their central feature is that they can be taken at extremely short notice or on the day itself, unlike regular periods of leave which must be booked in advance. They are intended as a means of reducing sickness absence and presenteeism by preventing the accumulation of stress and fatigue.

A growing number of employers are reporting the benefits of incorporating such a scheme into their flexible working procedures. For example, UK property firm Lendlease reported increased engagement and retention since employees were encouraged to take a wellbeing day once per quarter in order to de-stress. These should exist alongside employer-led systems to monitor the wellbeing of employees, and identify when there may be potential for deterioration in employee's health. The loss incurred by a days lost work will be significantly outweighed by the avoidance of a future possible period of prolonged sickness absence.

5.3 RECOMMENDATIONS FOR GOVERNMENT

As much as employers can do pre-emptively, the role of the state in reducing levels of sickness absence is a critical part of the process, yet its participation is often too little and too late.

Public policy support in this space may be an irrelevance to large employers, who often see the benefit of intervening early and have the resources to be able to provide occupational sick pay schemes, in-house occupational health, and, in some cases, in-house GPs and onsite counselling services. However, it is not realistic to expect this level of employer-led services to be available to the majority of private sector employees, particularly those working for smaller employers, the self-employed, or those in short-term contracts or in agency work. Indeed, **this research has identified that as little as half of all employees have, at the point of getting sick, access to either occupational health or counselling support, despite evidence that both can shorten periods of absence by helping the employee to manage their health condition and the employer to make any necessary adaptions**. What is more, where these services are not provided, government often ends up picking up the costs through claims for sickness benefits.

There is, therefore, clearly a role for the state in ensuring that employers are taking a proactive role in helping to support employees to remain in work. There is also a need for public policy to provide employers with further support to help them retain employees with health conditions and prevent, wherever possible, on-flow onto out-of-work benefits.

To the credit of successive governments they have introduced a number of initiatives intended to support both employers and employees to manage sickness at work. However, these have not been effective in significantly reducing the numbers of people flowing onto sickness benefits from work.

The current Fit for Work offer is too limited (in spite of positive pilot evidence (DWP 2015)), and is underused. **We therefore recommend new statutory duties for employers to engage with employees on statutory sick pay and an incrementally expanded public service offer through the Fit for Work service to help employers and employees manage sickness absence effectively.**

Altogether we recommend four major reforms:
* **establish new employer duties to engage with employees on statutory sick pay and increase statutory sick pay from 28 to 52 weeks**
* **introducing 'Fit Pay' (flexible sick pay) to better reflect the nature of modern health conditions**
* **pilot an expansion of the Fit for Work service to increase the scope and the offer of services available to employers and employees, and its effectiveness**
* **ensure employers meet responsibilities for paying SSP**.

Reform 1: Establish new employer duties to engage with employees on statutory sick pay and increase statutory sick pay from 28 to 52 weeks

The best employers will keep in regular contact with their employees to help them return to work. This helps to keep employers up to date with the employee's health, it can ensure the employee still feels valued by the employer, and it can allow for steps to be put in place to support the employee return to work. However, too few employees currently receive structured support from their employer to help them back into work.

A new system of incentives and support should therefore be introduced to help employees and employers plan for a return to work after a period of sickness absence. These would place greater obligations on employers to support a return to work, and greater opportunities for employees to engage. This should include the following steps:

Step 1. Agree a plan after four weeks' absence
After an employee is absent from work through sickness for four successive (or cumulative) weeks, **employers should be responsible for working with them to develop a plan for helping them return to work.**

The agreed **return-to-work plan should be developed with the employee, using any necessary advice from their GP or the Fit for Work Service.**[10] **Any plan should be co-signed by the employee**, with a short description of any agreed adjustments and supportive measures, and sent to DWP for record keeping. These plans would differ from the current return-to-work plans that form part of the Fit for Work scheme as they would be mandatory for employers with over 50 employees, underpinned by a statutory duty, and they would set out shared responsibilities between employer and employee. This should not initially be compulsory for small employers with fewer than 50 employees as they are less likely to have a professional HR function.

In order to incentivise employers to offer this support, any **failure to submit the completed plan to DWP should result in an increased employer liability for payment of statutory sick pay.** In such cases, the employer's liability to pay SSP should increase from 28 to 52 weeks where the employee fails to return to work.

Step 2. Regular catch-ups
Regular catch-ups between employers and employees are key to ensuring the consistency and quality of return-to-work support. This should ideally happen on a monthly basis, and should include a review of progress from both the employer and employee, along with updates according to any further steps that both have agreed are necessary.

If the employee feels that the employer has failed to deliver the necessary support, they should be able to refer themselves to the Fit for Work service for additional support.

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10   The role of the GP in this system would simply be to assess whether, based on the employee's condition, it is appropriate for the employer to be in regular contact. The nature of some mental health conditions will mean that four-weekly contact is not appropriate. But in most cases regular discussions between employer and employee will be feasible and mutually beneficial.

Step 3. Half-year review

Ideally, the steps taken above will bring the employee back into the workforce as their health improves, and as adjustments to the workplace are made. However, where the return-to-work plan has failed to achieve this, the employer and employee should meet at the six-month point, in order to review progress, discuss what further steps can be taken, and any further support needed.

The individual should also be required to meet with their GP in order to assess whether a return to work in the following six months would be feasible.

If it is clear that the individual is unlikely to return to their workplace, despite the best efforts of the employer and employee, then employment should cease with the individual applying for employment support allowance. However, if there is a realistic possibility of recovery, they should be eligible to continue receiving statutory sick pay.

Extend the existing statutory sick pay regime from 28 to 52 weeks. Many employees who fall ill require a significant period of time to recover as we have shown. This period will often exceed the 28 weeks that SSP is currently provided for.

In order to maximise the opportunity for a successful return to work, **SSP should be extended to 52 weeks, and the employer should be obliged to keep the post open for the employee, with a 'right of return' to their old job.** This would provide a longer time for employees to recover and to return to work, with the support of their employer. By providing a longer gateway period, it could increase the number of employees who will return to work and reduce the number going into the ESA system.

Where the employer has developed a return-to-work plan with their employee and submitted it to DWP, they should be partially reimbursed by DWP for the costs of the additional SSP from week 28 to 52. This could be at the equivalent cost of the ESA assessment rate for this 24-week period, thereby providing no additional cost to the state. It would represent an additional cost to the employer of £358 across the 24-week period, acting as a small incentive for the employer to continue to support the employee return to work.

The individual would continue to receive statutory sick pay from their employer, but would be eligible to apply for other benefits, such as the housing element of universal credit.

Where the employer has not conducted a return-to-work plan with the employee, they should be liable for the full cost of SSP for the period. This would represent an additional cost of up to £2,122.80, and would act as a powerful incentive for employers to carry out a return-to-work plan, and to support employees in the early stages of a sickness absence to recover and return to work. Small employers with fewer than 50 employees should initially be exempt from this additional liability.

In the case where an employer is found to be liable for the additional 24 weeks of SSP, this would represent a saving to the state of £2,282.50 compared to the costs of ESA for that initial period.[11] We estimate that every year 105,000 people move onto ESA having fallen out of work at a medium or large employer, and having received sick pay for 28 weeks. If employers do not fulfil the minimum requirement of developing a return-to-work plan in two in five cases, the saving to the state in terms of reduced on-flow to ESA would be £96 million a year.[12]

The path of possible interventions would, therefore, appear as is set out in figure 5.1.

FIGURE 5.1

Recommended journey for employees suffering from health/mental health condition

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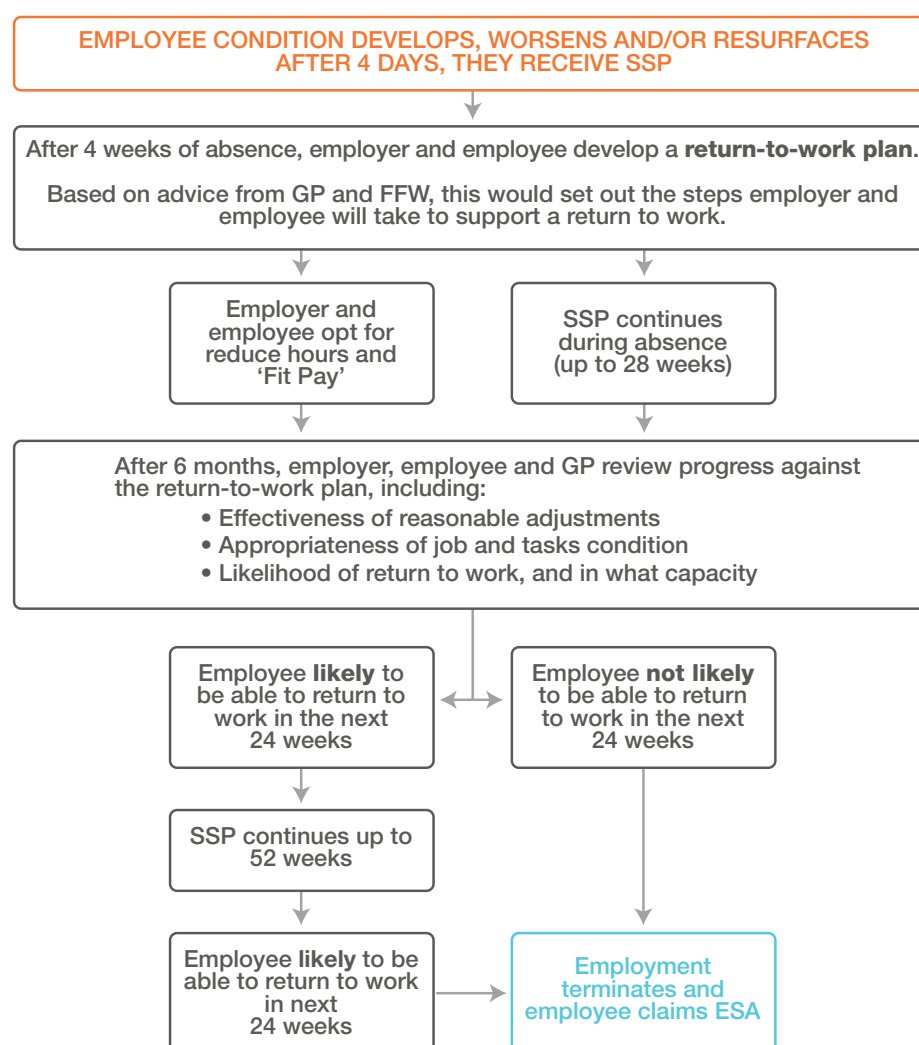
11   This is the cost of 13 weeks on the initial rate of ESA £73.10 and 13 weeks on the current WRAG rate of ESA £102.50

12   There are 600,000 new claims for ESA each year with 45 per cent doing so following a period of paid sickness. This represents around 270,000, with the mean duration of sickness leave preceding ESA claim being 22.6 weeks. Assuming three out of four of these periods of sickness last the full 28 weeks, 202,500 people claim sick pay for 28 weeks before moving onto ESA. Roughly half of these have come from medium or large employers (>50 employees), totalling 105,000 people each year.

Reform 2: Introduce 'Fit Pay' to better reflect modern health conditions and to reduce flow onto ESA

Statutory sick pay was designed for a society facing a different set of major illnesses. Due to the changing nature of conditions it no longer fully achieves its original intended purpose of ensuring people do not lose income because they are unable to carry out a day's work. It is also the case that the six-month limit on receipt of SSP can cause some people to move onto sickness benefit simply because of the design of the current system and as a result of a lack of proper support, rather than because they are unable to work on a long-term basis. The proposals outlined below address both of these issues.

In the time since the introduction of SSP in 1983, the predominant health trend in the UK, and across developed countries, has been the rising prevalence of chronic illnesses and long-term conditions. Not only are people living longer, but they are living a greater number of years with at least one chronic disability. In 2010, musculoskeletal conditions and mental health disorders together made up over half of all years lived with disability (YLDs). YLDs due to major depressive disorders increased by 9 per cent between 1990 and 2010, while those due to lower back pain increased by 12 per cent over the same period (Murray et al 2013).

Conditions such as these cannot be cured, but do need to be managed, As such, they will not always render someone unable to work, but will result in occasional bouts of sickness absence due to their fluctuating nature, sometimes for prolonged periods. For example, sickness benefit claimants are more likely to report that their condition fluctuates over time if they had a mental health condition, compared to those with a physical condition (Irvine 2009).

Currently, SSP is paid only to employees who are out of work as a result of illness.

The health benefits of appropriate work for certain health conditions are well proven (Waddell and Burton 2006). For some individuals, rather than stopping work completely, it may be better to reduce hours for a limited period of time. This may help the individual to better manage their condition and to recover more quickly, while maintaining contact with the labour market.

We propose that the DWP should **introduce 'Fit Pay' (flexible sick pay) alongside statutory sick pay to address this. Fit Pay would allow people to stay in work but to reduce their hours while receiving an income-smoothing replacement benefit for the hours they were unable to work**. The employer would be responsible for paying Fit Pay, as they are for paying SSP. The non-working days would be paid at a pro-rata SSP rate of £88 per week, up to a maximum of four days, for a maximum period of 28 weeks, the current period for which employees are entitled to SSP. As with SSP, employers could of course choose to pay above the standard rate and offer more generous schemes as an employee benefit.

Fit Pay: An example

Employee A is working full-time on a salary of £18,000. They are suffering from anxiety and depression which is affecting their ability to work. They would like to continue in work, but are unable to continue with their current duties.

Having consulted their GP they agree with their employer to move from full-time to two days a week. They would be eligible for:

2 days of their salary pro-rata	*£600.00/month*
3 days of Fit Pay	*£229.97/month*
Total	**£829.97/month**

Employee A would be better able to manage their condition, and would maintain contact with their employer and with the labour market.

The employer would face a cost of £229.97 a month for Fit Pay, on top of the pro-rata salary cost. Over the maximum 28 weeks this would represent a maximum total cost of £1,485.96. However, this is lower than the cost they would face if the worker was off work on SSP for the same period; £2,477. If the employer had a sick pay scheme more generous than SSP, the saving would be greater. The employer would also retain contact with the employee, and would have less of a need to backfill to cover their work.

Employee B was working full-time on a salary of £15,000. They develop severe anxiety which prevents them from continuing with their role. Employee B ends up on statutory sick pay.

After eight weeks out of work, employee B's condition has improved partially. Having consulted their GP, employee B agrees with their employer in one of their regular catch-ups to attempt a phased return to work.

Employee B starts by working three half days a week, with modified duties, for a period of four weeks. They would be eligible for:

1.5 days of their salary pro rata	*£86.54/week*
3.5 days of Fit Pay	*£62.92/week*
Total	**£148.46/week**

The arrangements are reviewed after four weeks. Employee B and their employer agree to move up to four days a week for a further four weeks.

4 days of their salary pro rata	*£230.77/week*
1 day of Fit Pay	*£17.69*
Total	**£248.46**

After completing the agreed four-week period, the employee and employer agree to return to their previous full-time hours.

This would allow employees to maintain limited connection with the workplace while being compensated for the days they were unable to work. For employers, the cost burden would be lower than full-time payment of SSP or OSP and would also enable them to retain some working hours from their employee where appropriate.

Eligibility for Fit Pay would need to be determined by the GP. This new measure should be reflected in a new version of the GP Fit Note. Currently, the Fit Note offers two options:
• not fit for work
• fit for work taking account of the following advice (followed by space for GP recommendations).

Where a GP determines that reduced working hours combined with Flexible SSP would be better for their patient than leaving work entirely, they should be able to recommend this as a third option.

In cases where the GP has recommended this option, employees would have a right to request Fit Pay, in a similar way to the right to request flexible working. An employer should be able to refuse an application only if they have a good business reason for doing so. It is reasonable to expect that the majority of such requests will be accepted; the vast majority of requests for flexible working are already accepted, and although Fit Pay involves a cost to employers, it may be preferable to cover this rather than SSP and occupational sick pay if an employee goes off sick.

Offering this additional option – with limited financial support for employees to stay in work but on reduced hours – could help reduce the proportion of employees who are signed off as not fit for work.

Reform 3: Staged expansion of the Fit for Work service to improve the offer to employees and small businesses

Small employers (those with fewer than 50 staff), are less likely to have a professional internal HR function. They should therefore be initially exempt from the potential liability for paying SSP for an extended period if they do not offer employees sufficient report to return to work when they fall ill.

However, half of all employees work in small organisations, and these small employers are less likely to offer the sort of additional and specialist support that can help employees recover and return to work. So in the longer term, the aim should be to expand the requirement to produce a return-to-work plan for SMEs too, as well as the liability to pay for SSP to up to 52 weeks should they not do so.

Given that many small employers will lack the funds or capacity to provide in-house health support and return-to-work services for their employees, and in recognition of the limited additional burden on small employers, the new duties will need to be matched with a more comprehensive Fit for Work service offer.

The Fit for Work service should operate as a hub to support the delivery of return-to-work plans that employers and employees have developed

together with a GP, and fund and provide support services that smaller employers are unable to offer themselves.

One of the key gaps in SME provision is the offer of occupational health and counselling support, something that the Fit for Work service is yet to fully offer, despite evidence that both of these can assist returns to employment.

In order to offer the extent of support that is necessary, for SMEs in particular, the government should **introduce a pilot project extending the remit of Fit for Work to providing full sickness support for smaller employers**. This offer should include:

- a centre of knowledge for employers seeking advice (as is currently the case) and for employers seeking to understand best practice, as well as more practical support such as the provision of sickness monitoring software
- onsite occupational health facilities accessible to employees of SMEs
- access to counselling services
- the opportunity to draw down Access to Work funding to support reasonable adjustments to the workplace
- employment support to help people to find alternative work where they are unable to return to their current employment.

The new approach should be piloted in a city-region, with small employers in the region being offered additional support through the expanded local Fit for Work service, but also subject to the additional conditionality to undertake a return-to-work plan. The local pilot would demonstrate whether a more comprehensive Fit for Work service would be more effective than the more limited service currently being delivered, ahead of a potential national rollout.

The piloted service should be offered free to small employers with fewer than 50 employees, where coverage of occupational health and counselling is very limited. For medium-sized firms, it could be offered at cost price or at a discounted rate, and for larger firms it could be offered at a commercial rate, with profits reinvested in the service. This is set out in table 5.1.

TABLE 5.1

Expanded Fit for Work pilot

	Small employers (1–49 employees)	Medium-sized employers (50–249 employees)	Large employers (>250 employees)
Proportion of total employees	48%	12%	40%
Employee reported availability of independent counselling	12%	28%	52%
Employee reported availability of occupational health	21%	35%	69%
Proposed eligibility for expanded Fit for Work service	Free	Cost price/ discounted rate	Commercial rate

Source: Department for Business, Innovation and Skills, 'Business population estimates for the UK and regions 2016' (BIS 2016), Steadman et al, *Health and wellbeing at work: survey of employees* (Steadman et al 2015)

Larger employers currently meet the bulk of the costs in supporting their employees to return to work after a period of sickness absence, and would be expected to continue to do so in future.

Should the pilot be rolled out, providing an expanded support offer to smaller employers and their employees would represent an additional immediate cost to the state. However, the cost to the state of intervening to help someone to remain in work is often far below the costs involved in the provision of long-term sickness benefit. The Fit for Work pilot costs ranged from £500 to £2,500 per participant. Yet the cost of employment support allowance per claimant per year is around £5,300, and half of ESA claimants also claim housing benefit, at an average cost of £5,098 per year.

The Fit for Work pilots helped 72 per cent of participants into work. Of these, 49 per cent said they returned to work more quickly than they would have, with 10 per cent saying they would not have returned to work without the support. Assuming the same results with the 430,000 employees of small businesses who face a month of sickness absence each year, this could mean 152,000 are supported back into work quicker than they would have been, and therefore spending less time on sick pay or out-of-work benefits. It could also represent 31,000 fewer employees moving on to ESA each year, equivalent to a 5.2 per cent reduction in the total on-flow.

If the provision of an enhanced Fit for Work service can help to stem the flow of individuals onto out-of-work and sickness benefits, then the cost savings to government would be significant.

Reform 4: Ensure employers meet responsibilities for paying SSP
Evidence suggests that many employers are avoiding their responsibilities for paying SSP by incorrectly telling employees they are not eligible. In one survey of ESA claimants carried out for DWP, three in 10 (28 per cent) of those claiming the benefit moved from work to ESA without receiving any sick pay. Of these, one-third (35 per cent) said that their employer had told them they were not eligible, with those in the contingent labour market being disproportionately likely to be denied SSP. This represents one in 10 of all ESA claims each year, or 70,000 claimants. This is despite the very limited eligibility criteria for SSP. It is therefore possible that many of these claimants were actually entitled to SSP (Adams et al 2015).

This is a serious cause for concern. First, employers who do not pay SSP are passing on a significant cost to the state, as these individuals will most likely have to claim ESA or other out-of-work benefits. This could represent a cost to DWP of as much as £174 million per year in ESA alone. Second, employers who unfairly avoid paying SSP have less of an incentive either to prevent sickness in the first place, or to support sick employees to return to work. This can incentivise irresponsible practices that could come at a cost both to employees' health and to public finances.

Currently, if an employee is not entitled to SSP, their employer should send them an SSP1 form informing them of why they are not entitled to it. If the employee believes they have been unfairly refused SSP, and if they have not received an SSP1 form, they can request one. If the

employee still believes they are entitled to SSP, they can appeal to HMRC statutory payment disputes team to make a decision. In the event that the employee is found to have been entitled to SSP, the employer can appeal. If the appeal is unsuccessful, they can then take the case to an employment tribunal. This process is both lengthy and complex, and it relies on the employee both having knowledge of her or his entitlements, and being willing to pursue the process to enforce their rights. If an employer is found to have unfairly denied a statutory payment, they are liable only for the payment the employee was entitled to, with no further sanction. Where employers are found to have underpaid the national minimum wage, they are liable to repay not just any unpaid wages but also a financial penalty equal to 100 per cent of their wages. The system for SSP therefore suffers from weak incentives to ensure that employers fulfil their responsibilities, and limited sanctions when they do not. Individuals are asked if they have received an SSP1 form on applying for ESA, but if they have not, they are told only to ask their employer, leaving the onus on the individual.

The DWP should conduct further research to examine the extent of non-payment of SSP. **Where an individual moves from work onto ESA, and where they say on the application that they were not eligible for SSP, Jobcentre Plus should require the employer to prove why this was the case.** This would involve producing the SSP1 form, or their own documentation explaining why the employee was not eligible. However, **in cases in which the employee was found to have been eligible for SSP, but denied it by the employer, the employer should be required not just to provide SSP to their employee, but also fined the equivalent of a year's SSP – £4,511**. This would also allow Jobcentre Plus to identify and take action against employers who are found to be serially avoiding paying SSP, with evidence suggesting this may be particularly common among agencies.

This would ensure that employers are not able to derive a financial advantage by denying an employee their right to SSP. It would disincentivise employers from avoiding their responsibilities for SSP, and would reduce the cost to the state from employees who go on to claim ESA or other out-of-work benefits. It would also ensure that employers are incentivised to make meaningful efforts to prevent sickness absence, and to support employees who do fall sick to return to work.

Finally, the ESA cut should be reversed and SSP should be increased. From April 2017, new ESA claimants placed in the Work Related Activity Group will receive only £73.10 a week, nearly £30 lower than they currently receive. This change is expected to save DWP £640 million a year by 2020/21.

This would represent a significant reduction in support for people who often face significant work-limiting disabilities or health problems. As it affects only new claimants, it may deter existing claimants from seeking to return to work, as they would be eligible for significantly less support if they subsequently fell out of work due to a recurrence or worsening of their health condition.

However the current system actually provides a perverse incentive for those who are off work for more than 13 weeks to move from SSP to ESA. Currently SSP is £15 higher than the adult JSA rate, but £17 lower than the ESA WRAG rate. While the incentives for individuals on SSP to go onto ESA are weak during the 'assessment phase'[13] (which pays JSA equivalent for the first 13 weeks), for those unlikely to return to work within 13 weeks, the financial incentives to move onto ESA are stronger, as illustrated by figure 5.2.

FIGURE 5.2

The current system provides a perverse incentive for those who are off work on SSP for more than 13 weeks to move to ESA
SSP (standard) and part-time (3 days per week) and ESA (WRAG) and ESA (Support Group) rates over period of receipt, 2016
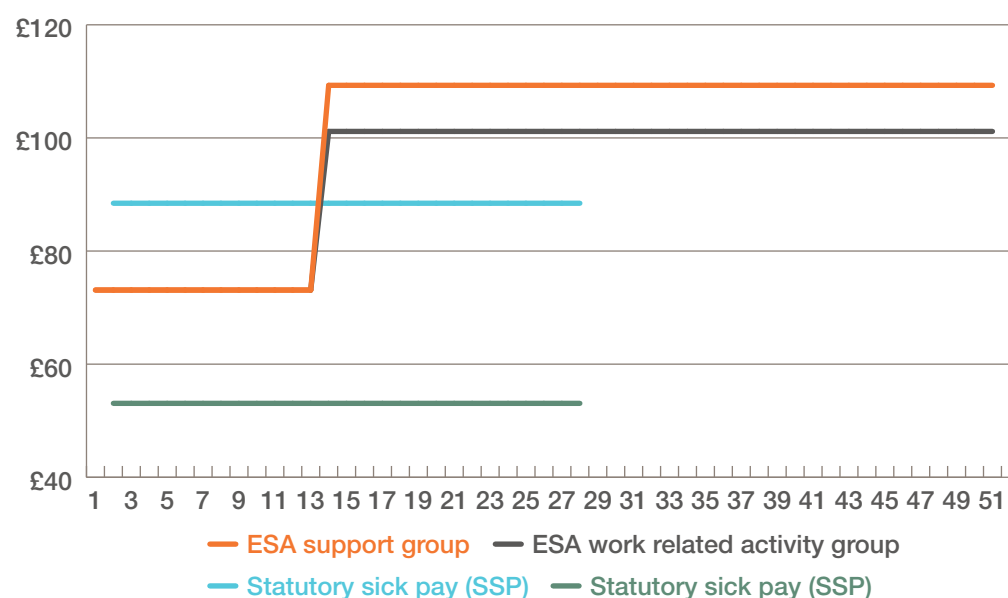
Source: IPPR calculations

For illustrative purposes, the following table sets out the cumulative basic rates for SSP and ESA by specific points in time (assuming a 13-week waiting period for an ESA decision).

TABLE 5.1

Cumulative rates of SSP and ESA

	ESA (W)	ESA (SG)	SSP	SSP PT
After 13 weeks	950	950	1,061	637
After 26 weeks	2,278	2,371	2,211	1,327
After 52 weeks	4,934	5,213	2,388	1,433

Source: IPPR Calculations

13   The assessment phase is a period where the individual is assessed, usually via a work capability assessment, on whether they are entitled to full employment support allowance, and lasts around 13 weeks.

A logical change to eliminate these incentives might therefore be to raise SSP to at least the current levels of ESA. This would remove the perverse incentive to transfer onto ESA, and ensure that employees are better protected when they are ill. It would also serve to strengthen the incentives on employers at the bottom end of the labour market to prevent employees from becoming sick, and to take reasonable measures to support them back in to work when they are unwell. This change would cost employers paying only SSP as little as £350 over the 28 weeks.

Reversing the cuts to ESA and increasing the generosity of SSP would, therefore, help to better protect those who fall sick, reduce the incentives for employees to flow onto sickness benefits, while also increasing the incentives for employers to more hastily return their employees to work.

Even if the cuts to ESA were not reversed, there would be a strong argument for increasing SSP. Doing so would increase the incentive for employers both to take reasonable action to prevent sickness, and to support employees back to work when they do fall ill. Increasing SSP – which is lower than sickness protection in nearly every comparable country – would also ensure that employees are better protected when they fall ill.

REFERENCES

Adams L, Oldfield K, Riley C, Duncan B and Downing C (2015) *Understanding the journeys from work to Employment and Support Allowance (ESA)*, Department for Work and Pensions. https://www.gov.uk/government/publications/understanding-the-journeys-from-work-to-employment-and-support-allowance

Askildsen JE, Bratberg E and Nilsen ØA (2002) 'Unemployment, labour force composition and sickness absence: A panel data study', IZA DP no 466

Black C and Frost D (2011) *Health at work – an independent review of sickness absence*, Department for Work and Pensions. https://www.gov.uk/government/publications/review-of-the-sickness-absence-system-in-great-britain

Bockerman P, Kanninen O and Suoniemi I (2014) *A kink that makes you sick: the incentive effect of sick pay on absence*, IZA DP no 8205. http://ftp.iza.org/dp8205.pdf

British Medical Association [BMA] (2016) 'Fit for Work Scheme - Guidance for GPs'.

Carter E and Whitworth A (2015) 'Creaming and parking in quasi-marketised welfare-to-work schemes: designed out of or designed in to the UK Work Programme?', *Journal of Social Policy*, 44(2): 227–296

Carter E and Whitworth A (2016) 'Work activation regimes and well-being of unemployed people: rhetoric, risk and reality of quasi-marketization in the UK Work Programme', *Social Policy and Administration*. http://onlinelibrary.wiley.com/doi/10.1111/spol.12206/full

Centre for Economic and Social Inclusion [CESI] (2015) *Work Programme Statistics: Inclusion Analysis*. http://www.learningandwork.org.uk/sites/niace_en/files/resources/Work%20Programme%20statistics%20-%20Inclusion%20analysis.pdf

Chartered Institute for Personnel and Development [CIPD] (2013) *Employee Outlook: Focus on employee well-being*. http://www.cipd.co.uk/hr-resources/survey-reports/employee-outlook-focus-well-being.aspx

Chartered Institute for Personnel and Development [CIPD] (2014) *Absence management 2014*. https://www.cipd.co.uk/knowledge/fundamentals/relations/absence/absence-management-surveys

Chartered Institute for Personnel and Development [CIPD] (2015) *Absence management 2015*. http://www.cipd.co.uk/hr-resources/survey-reports/absence-management-2015.aspx

Chartered Institute for Personnel and Development [CIPD] (2016) *Employee Outlook: Focus on mental health in the workplace*. https://www.cipd.co.uk/knowledge/culture/well-being/outlook-mental-health

Colebrook C, Cory G, Dolphin T, Doyle P, Fox Carney D, Hatfield I, McNeil C, Pontin G and Stirling A (2015) *European jobs and skills: a comprehensive review, 2015*, IPPR. http://www.ippr.org/publications/european-jobs-and-skills-a-comprehensive-review-2015

Cooke G, Pennycook M and Stirling A (2015) *Promoting contribution: boosting employment opportunity for all*, IPPR. http://www.ippr.org/publications/promoting-contribution-boosting-employment-opportunity-for-all

Coole C, Drummond A, Watson P, Nouri P and Potgieter I (2015) *Getting the best from the fit note: Investigating the use of the statement of fitness for work,* University of Nottingham. https://www.iosh.co.uk/~/media/Documents/Books%20and%20resources/Guidance%20and%20tools/Getting%20the%20best%20from%20the%20fit%20note%20full.pdf?la=en

Creed P and Klisch J (2005) 'Future outlook and financial strain: testing the personal agency and latent deprivation models of unemployment and well-being', *Journal of Occupational Health Psychology*, 10(3): 251–260

Dar A (2016) 'Work Programme – Background and Statistics', House of Commons Library. http://researchbriefings.files.parliament.uk/documents/SN06340/SN06340.pdf

Department for Business, Innovation and Skills [BIS] (2016) 'Business population estimates for the UK and regions 2016', statistical release, 13 October 2016. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/559219/bpe_2016_statistical_release.pdf

Department of Health [DoH] (2011) *Talking therapies: A four-year plan of action*. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213765/dh_123985.pdf

Department of Health [DoH] (2012a) *Long-term Conditions: Compendium of Information*, 3rd edition. https://www.gov.uk/government/publications/long-term-conditions-compendium-of-information-third-edition

Department of Health [DoH] (2012b) *Chief Medical Officer annual report 2011: volume 1*. https://www.gov.uk/government/publications/cmo-annual-report-2011-volume-one-on-the-state-of-the-public-s-health

Department for Work and Pensions [DWP] (2013) *Evaluation of employment advisers in the Improving Access to Psychological Therapies programme (RR826)*. https://www.gov.uk/government/publications/evaluation-of-employment-advisers-in-the-improving-access-to-psychological-therapies-programme-rr826

Department for Work and Pensions [DWP] (2014) 'A million workers off sick for more than a month', 10 February 2014. https://www.gov.uk/government/news/a-million-workers-off-sick-for-more-than-a-month

Department for Work and Pensions [DWP] (2015) 'Fit for Work guidance'. https://www.gov.uk/government/collections/fit-for-work-guidance

Department for Work and Pensions [DWP] (2016a) 'Work Programme statistics', *DWP Tabulation Tool*. http://tabulation-tool.dwp.gov.uk/WorkProg/tabtool.html

Department for Work and Pensions [DWP] (2016b) *DWP Statistics Tabulation Tool, 2016*. https://www.gov.uk/government/collections/dwp-statistics-tabulation-tool

Department for Work and Pensions [DWP] (2016c) 'Benefit expenditure and caseload tables, 2015'. https://www.gov.uk/government/publications/benefit-expenditure-and-caseload-tables-2016

Department for Work and Pensions [DWP] (2016d) 'Quarterly statistical summary: May 2016'. https://www.gov.uk/government/statistics/dwp-statistical-summaries-2016

Dewson S, Hill D, Meager N and Willison R (2009) *Evaluation of Access to Work: Core Evaluation*, Department for Work and Pensions. http://www.employment-studies.co.uk/resource/evaluation-access-work-core-evaluation

Dolphin T, Gottfried G, Raikes L, Slim A and Thompson S (2014) *European jobs and skills: a comprehensive review, 2014*, IPPR. http://www.ippr.org/publications/european-jobs-and-skills-a-comprehensive-review-2014

Ebert D, Heber E, Berking M, Riper H, Cuijpers P, Funk B and Lehr D (2016) 'Self-guided internet-based and mobile-based stress management for employees: results of a randomised controlled trial' *Occupational and Environmental Medicine*. http://oem.bmj.com/content/early/2016/02/16/oemed-2015-103269

Economist Inteligence Unit [EIU] (2014) *Out of the Office: A review of workplace absenteeism in Europe*. https://www.eiuperspectives.economist.com/sites/default/files/Out%20of%20office_WEB.pdf

Ellipse (2016) *Sickness absence risk and attitudes in UK SMEs*. https://www.ellipse.co.uk/sickness_absence_report

Fit for Work (2016) *Common causes of absence at work*. http://fitforwork.org/employer/preventing-absence/common-causes-of-work-absence/

Fone D and Dunstan F (2006) 'Mental health, places and people: a multilevel analysis of economic inactivity and social deprivation', *Health & Place*, 12(3): 332–344

Fultz E (2016) *Disability insurance in the Netherlands – A blueprint for US reform?* http://www.cbpp.org/research/retirement-security/disability-insurance-in-the-netherlands-a-blueprint-for-us-reform

Hann M and Sibbald B (2013) *General Practitioners' attitudes towards patients' health and work, 2010–12*, Department for Work and Pensions. https://www.gov.uk/government/publications/general-practitioners-attitudes-towards-patients-health-and-work-rr733

Health and Safety Executive [HSE] (2016a) 'LFS - Labour Force Survey - Self-reported work-related ill health and workplace injuries: Index of LFS tables'. http://www.hse.gov.uk/statistics/lfs/index.htm

Health and Safety Executive [HSE] (2016b) *Work related Stress, Anxiety and Depression Statistics in Great Britain 2016*. http://www.hse.gov.uk/statistics/causdis/stress/

Hillage J, Williams M, Marvell R, Shiels C, Gabbay M, Weston J and Humphreys I (2015) *Evaluation of the 2010-12 Fit for Work Service pilots: final report*, Department for Work and Pensions. https://www.gov.uk/government/publications/fit-for-work-service-pilots-2010-to-2013-final-evaluation-report

Hitchcock A, Pickles C and Riggs A (2016) *Work and Health Programme: Levelling the playing field*, Reform. http://www.reform.uk/wp-content/uploads/2016/07/Reform-Work-Health-EMBARGOED-0001-13_07_2016.pdf

HM Government (2016) *Fit for Work Guidance*. https://www.gov.uk/government/collections/fit-for-work-guidance

Hogarth T, Hasluck C, Gambin L, Behle H, Li Y and Lyonette C (2013) *Evaluation of Employment Advisers in the Improving Access to Psychological Therapies Programme*, Department for Work and Pensions. https://www.gov.uk/government/publications/evaluation-of-employment-advisers-in-the-improving-access-to-psychological-therapies-programme-rr826

Irvine A (2009) 'Managing mental health and employment', *Occupational Health at Work*, 6(1): 17–21. https://pure.york.ac.uk/portal/en/publications/managing-mental-health-and-employment(2ca37404-5a6a-43a0-9ffc-781aeaf06766).html

Jahoda M (1982) *Employment and unemployment: a social-psychological analysis*, Cambridge University Press

Litchfield P (2013) *An independent review of the work capability assessment – year four*, Department for Work and Pensions. https://www.gov.uk/government/publications/work-capability-assessment-independent-review-year-4

Litchfield P (2014) *An independent review of the work capability assessment – year five,* Department for Work and Pensions. https://www.gov.uk/government/publications/work-capability-assessment-independent-review-year-5

Ljungqvist L and Sargent T (1998) 'The European Unemployment Dilemma', *Journal of Political Economy*, 106(3): 514–550

Llena-Nozal A (2009) 'The effect of work status and working conditions on mental health in four OECD countries', *National Institute Economic Review*, 209(1): 72–87

MacInnes T, Tinson A, Gaffney D, Horgan G and Baumberg B (2014) *Disability, long-term conditions and poverty*, New Policy Institute. http://npi.org.uk/publications/income-and-poverty/disability-long-term-conditions-and-poverty/

Marwaha S and Johnson S (2004) 'Schizophrenia and employment - a review', *Social Psychiatry & Psychiatric Epidemiology*, 39(5): 337–349

McLeod J (2010) 'The effectiveness of workplace counselling: A systematic review', *Counselling and Psychotherapy Research*, 10(4): 238–248.

Mind (2014) *We've got work to do: transforming employment and back-to-work support for people with mental health problems*. http://www.mind.org.uk/news-campaigns/news/get-people-with-mental-health-problems-off-mainstream-back-to-work-schemes-says-mind/#.WCG7YVWLTcs

Murray C, Richards M, Newton J et al (2013) 'UK Health Performance: findings of the Global Burden of Disease Study 2010', *The Lancet*, 381(9871): 997–1020. http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)60355-4/abstract

NatCen (2016) *Attitudes to mental health problems and mental wellbeing: Findings from the 2015 British Social Attitudes survey*, Public Health England. http://www.bsa.natcen.ac.uk/latest-report/british-social-attitudes-33/mental-health.aspx

NHS Information Centre for Health and Social Care (2009) *Adult Psychiatric Morbidity in England - 2007, Results of a household survey [NS]*. http://content.digital.nhs.uk/pubs/psychiatricmorbidity07

National Institute for Health and Care Excellence [NICE] (2009) *Workplace health: long-term sickness absence and incapacity to work*. https://www.nice.org.uk/guidance/ph19

Newton B, Meager N, Bertram C, Corden A, George A, Lalani M, Metcalf H, Rolfe H, Sainsbury R and Weston K (2012) *Work Programme evaluation: Findings from the first phase of qualitative research on programme delivery*, Department for Work and Pensions. https://www.gov.uk/government/publications/work-programme-evaluation-findings-from-the-first-phase-of-qualitative-research-on-programme-delivery-rr821

Nomis (2016) *Work and Pensions Longitudinal Study*. https://www.nomisweb.co.uk/query/select/getdatasetbytheme.asp?theme=35&subgrp=Work+and+Pensions+Longitudinal+Study+%28WPLS%29

Office for Budget Responsibility [OBR] (2016) *Welfare Trends Report 2016*. http://budgetresponsibility.org.uk/wtr/welfare-trends-report-october-2016/

Office for National Statistics [ONS] (2014) 'Sickness absence in the labour market'. http://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/labourproductivity/articles/sicknessabsenceinthelabourmarket/2014-02-25

Office for National Statistics [ONS] (2016) *UK Labour Market: October 2016*. http://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/bulletins/uklabourmarket/latest

Office for National Statistics [ONS] (2016b) Labour Force Survey, dataset, accessed via Nomis. https://www.nomisweb.co.uk

Organisation for Economic Cooperation and Development [OECD] (2010) *Sickness, Disability and Work: Breaking the Barriers: A Synthesis of Findings across OECD Countries*. http://www.oecd.org/publications/sickness-disability-and-work-breaking-the-barriers-9789264088856-en.htm

Parliament (2016) 'Fit for Work Programme:Written question – 33649'. http://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2016-04-12/33649/

Paul K and Moser K (2009) 'Unemployment impairs mental health: meta-analyses', *Journal of Vocational Behavior*, 74(3): 264–282

Pricewaterhouse Coopers [PwC] (2014) 'One in three Brits have pulled a sickie – costing business £9bn a year, according to PwC research', blog, 2 July 2014. http://pwc.blogs.com/press_room/2014/07/one-in-three-brits-have-pulled-a-sickie-costing-business-9bn-a-year-according-to-pwc-research.html

Prince's Trust (2014) *Youth Index 2014*. https://www.princes-trust.org.uk/help-for-young-people/news-views/youth-index-2014

Rick J, Carroll C, McGregor M, Bessey A, Squires H and Tighe C (2012) *Systematic review of the effectiveness and cost effectiveness of employee assistance programmes*, Institute of Work Psychology, University of Sheffield. http://www.bohrf.org.uk/downloads/index.html

Royal College of Physicians [RCP] (2008) *Mental Health and Work.* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/212266/hwwb-mental-health-and-work.pdf

Royal College of Physicians [RCP] (2009) *Long-term sickness absence and depression detection 2009 – round 1*. https://www.rcplondon.ac.uk/projects/outputs/long-term-sickness-absence-and-depression-detection-2009-round-1

Sainsbury Centre for Mental Health (2007) 'Mental health at work: developing the business case', policy paper no 8. https://www.centreformentalhealth.org.uk/mental-health-at-work

Sayce L (2011) *Getting in, staying in and getting on: Disability employment support fit for the future*, Department for Work and Pensions. https://www.gov.uk/government/publications/specialist-disability-employment-support

Shiels C, Gabbay M and Hillage J (2016) 'Recurrence of sickness absence episodes certified by general practitioners in the UK', *European Journal of General Practice*, DOI: 10.3109/13814788.2016.1156083. http://www.clahrc-nwc.nihr.ac.uk/media/Info%20Hub/Recurrenceofsickness.pdf

Sissons P, Barnes H and Stevens H (2011) *Routes onto Employment and Support Allowance*, Department for Work and Pensions. https://www.gov.uk/government/publications/routes-onto-employment-and-support-allowance-rr774

Steadman K (2015) *Health and wellbeing at work: survey of employees*. https://www.gov.uk/government/publications/health-and-wellbeing-at-work-survey-of-employees

Trades Union Congress [TUC] (2014) 'Fall in sickness absence proves there is no such thing as a "sickie culture"'. https://www.tuc.org.uk/workplace-issues/health-and-safety/fall-sickness-absence-proves-there-no-such-thing-%E2%80%98sickie-culture%E2%80%99

Trades Union Congress [TUC] (2015) *Mental health at work: A young workers' guide*, TUC. https://www.tuc.org.uk/young-workers/mental-health-work-young-workers%E2%80%99-guide

van Wanrooy B, Bewley H, Bryson A, Forth J, Freeth S, Stokes L and Wood S (2012) *The 2011 Workplace Employment Relations Study First Findings*. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/336651/bis-14-1008-WERS-first-findings-report-fourth-edition-july-2014.pdf

Waddell G and Burton A (2006) *Is work good for your health and wellbeing.* https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214326/hwwb-is-work-good-for-you.pdf

Young V and Bhaumik C (2011) *Health and well-being at work: a survey of employees (RR751): full report*, Department for Work and Pensions. https://www.gov.uk/government/publications/health-and-well-being-at-work-rr751

Ziebeth N and Karlsson M (2013) 'The effects of expanding the generosity of the statutory sickness insurance system', *Journal of Applied Econometrics*, 29(2): 208–230