

Health and the Working Age Population

There is a renewed focus on health and work. The impact of an ageing workforce is an important part of this.

What happens to our health and work experience in mid life tends to set the pattern for well-being in later life. It is for this reason that TAEN and Help the Aged are working on the demographic dimensions of the health and work agenda.

In October 2005 the Government set out a *Health, Work and Well-being* strategy. There are also major changes planned for Welfare to Work programmes. A key theme is the role work can play in improving health, reducing health inequalities and offering better opportunities. The focus is on what people can do rather than on what they cannot.

Dimensions of the issue

- **The scale of sickness absence:** The 2006 CBI/Axa survey *Absence Minded* estimates the annual cost of sickness absence at over £13 billion. Days lost had dropped from 168 million in 2004 to 164 million in 2005, but the overall cost of absence had risen.
- **The ageing of the workforce:** With an increase of a million in the number of over-50s and decline of a million people in their 20s, the adaptability of the workplace for workers in their 50s, 60s and 70s is important.
- **The numbers on incapacity benefit (IB):** Reversal of the 15 year growth, from 0.4 million to 2.7 million, is an essential driver of new policies. Amongst the age 50 to State Pension Age population, there are seven people on IB for each unemployed person.
- **Equal opportunities for disabled people:** The employment rate for different broad categories of disabled people is very varied. In summary, the *Labour Force Survey* (Spring

2005) shows that employment rates are:

- 65% for those with respiratory conditions;
- 60% with cardio-vascular conditions;
- 50% with musculo-skeletal conditions;
- 25% with learning difficulties;
- 20% with mental health problems.

This is one of the greatest challenges for employment programmes and targets.

- **Early retirement due to ill health:** Despite a rise in the employment rate of people over 50 in recent years, ill health is much the most commonly cited cause of early retirement.
- **Government's 80% employment rate goal:** Achieving the Government's goal depends on adding a million more people over age 50 to the workforce and moving another million off incapacity benefit into work.

Strategy

In its 2005 strategy document, the Government said its aim was access to occupational health advice and support for all employees; to help people manage minor health problems in work by ensuring they get swift treatment; to help people avoid work-related health problems; and to provide support to people out of work to manage their health conditions and return to work.

It laid out steps for the development and implementation of the strategy. These included the setting up of a national stakeholder council, the publication of a charter for health, work and well-being, a stakeholder summit and the appointment of a National Director for Health and Work.

The Government work is led by Lord Hunt, Minister at the Department for Work and Pensions with responsibility for health and safety at work, and by Rosie Winterton, Minister for Health Services at the Department of Health. They co-chair the national stakeholder council.

At its first meeting, the stakeholder council drew up the charter - to create an environment that promotes the health and well-being of all those in work and all those who wish to work. For copies of the strategy and the charter, see the website at: www.health-and-work.gov.uk

The stakeholder summit in early May 2006 canvassed views on how best to take the strategy forward. As no regulations back the charter, Government see its initiative as one that seeks to persuade and encourage.

Evolution of policy

The key milestones of the last few years are:

2000

- Launch of the Health and Safety Commission strategy to reduce work-related ill health. Targets, to be achieved by 2010, were set for the first time. They included cutting deaths and major injury accidents by 10%; reducing the rate of occupational ill health by 20% and associated working days lost by 30%. By 2005-06 evidence showed that the rate of fatal and major injury was not on track to meet the ten-year target, whilst the rate of occupational ill-health was on track and the number of working days lost probably on track.

2001

- NHS Plus established to offer occupational health (OH) services to small and medium sized employers (SMEs) in England and to improve the provision of OH services for the NHS workforce. More than 50% of NHS OH units offer clinical services. NHS Plus also provides OH advice for employers on its website.

2003

- First Pathways to Work pilots launched. Pathways offers return to work support for new incapacity benefit claimants. The schemes have subsequently been rolled out in phases to Jobcentre Plus districts with high levels of claimants. By December 2006 they covered 40% of all new and repeat claimants and by April 2008 they will be available nationally to new IB claimants.

2004

- Ministerial taskforce established to tackle sickness absence in the public sector, which represents a fifth of the workforce. Its *One Year On* report, issued in 2005, showed

sickness absence in local and central Government had fallen. But, according to the CBI/Axa survey, public sector sickness absence is still 30% higher than in the private sector.

- Report by the Social Exclusion Unit on a project examining ways of reducing social exclusion among adults of working age with mental health conditions.
- Framework for vocational rehabilitation published by the Department for Work and Pensions to provide a new common approach to vocational rehabilitation. It recognised the need for more evidence on effective rehabilitation interventions and factors affecting entry into and return to work. A research group has been set up to prioritise evidence gaps and improve the knowledge base.
- A White Paper on public health, *Choosing Health*, included a section on work and health. This focused on reducing barriers to work; improving work conditions to reduce work-related ill health; and raising awareness of the work environment as a potential source of better health.
- *Management Standards for Work-related Stress* launched by the Health & Safety Executive (HSE) to raise awareness of the issue and to encourage employers to work towards reducing stress in the workplace. Available for use in organisations free of charge. In 2005 ACAS worked with HSE to reduce work-related stress in a pilot scheme involving 80 organisations in health, education, local and central government and financial services.

2005

- *Health, work and well-being – Caring for our future* strategy document published. The Government's aims and steps for development and implementation of the strategy are summarised in the Strategy section above.
- Investors in People and the Department of Health collaborate to develop a business improvement tool addressing the health and well-being of employees. It is now in its second pilot phase.
- Office of Disability Issues created to provide cross-government focus on disability issues and to improve opportunities for disabled people in areas such as education and employment.

2006

- *Our Health, our care, our say* White Paper published by Department of Health. It includes plans for the roll-out and evaluation of NHS life checks for people at critical ages to enable them to assess their own risk of ill health.
- Green Paper *A new deal for welfare: Empowering people to work* issued by the Department for Work and Pensions outlining proposals for welfare reform.
- Employment Adviser in GP Surgeries project established in five Pathways areas to run for two years, testing voluntary referral to employment-focused advice and support.
- Workplace Health Connect launched by Health & Safety Executive. A free advisory service for individuals and small businesses in England and Wales on health, safety and return to work issues (www.workplacehealthconnect.co.uk). A similar service, Safe and Healthy Working, was launched by the Scottish Executive in 2003 (www.sahw.co.uk).
- Dame Carol Black appointed the first ever National Director for Health and Work to spearhead initiatives that improve health in the workplace and that support people with disabilities and health conditions to enter, return to and continue in work.
- A new £10 million capital fund for NHS Plus announced. The funding will be used to support pilot sites of good practice in occupational health care which could then be rolled out to other companies to learn from.
- The Disability Discrimination Act is extended to include a disability equality duty. The duty requires public authorities to build disability equality into everything they do.

Commonest work-related health conditions

Mental health problems such as anxiety, stress and depression have overtaken musculo-skeletal disorders as the commonest self-reported, work-related illnesses. But the 2005/2006 *Labour Force Survey* figures indicate that the rise in incidence of mental health problems has levelled off and is now falling. The incidence of musculo-skeletal disorders is also declining.

Out of a total estimated 30.5 million working days lost in 2005-06 due to work-related ill health and injury, 10.5 million (35%) were due to anxiety,

stress or depression and 9.5 million (31%) were due to musculo-skeletal conditions.

The reasons for the rise in self-reported stress and less severe mental disorders over recent years are complex. Work pressure, long hours, poor working conditions, 'bad' jobs with lack of personal control, and job insecurity have contributed to the increase in mental health problems at work, but they do not tell the whole story.

Occupational psychiatrists point out that the causes of stress are often multi-factorial, resulting from a combination of pressures, some of which may be personal, familial or financial. There is also a trend for people to 'medicalise' their psychological problems. They may present with symptoms for which there are no underlying pathological causes but that result in sickness absence. With less stigma attached to mental health disorders these days than previously, people have become more willing to discuss them with doctors rather than disguise them as physical conditions.

Nevertheless, people disclosing mental health conditions still face employment barriers. In a 2006 CIPD/KPMG survey of more than 1,000 UK employers, nearly one in five admitted they would not consider employing incapacity benefit claimants with a history of mental ill health.

The age profile for incapacity benefit claimants with mental health conditions is different for men and women: for men claims peak in the 30-45 age band and then decline; for women they rise steadily through to age 60.

Recent research on work and health

Is Work Good for your Health and Well-Being? by Gordon Waddell of Cardiff University and A Kim Burton of Huddersfield University, published by DWP in September 2006, is an important document (TSO ISBN 0-11-703694-3). For the first time there is an authoritative statement about the relationship between work, unemployment and health. It is based on comprehensive study of the available evidence rather than original research. TAEN has been seeking this for some time.

It is also a carefully worded document because this is sensitive territory. Circumstances that are good one week may shift marginally the next week to be negative. What is benign for one person may be destructive for another. Perceptions and attitudes, not hard facts, are hugely important.

With all those provisos, it is striking how positive is the message about the value of work and the negative impact of unemployment: *“Work is generally good for physical and mental health and well-being of healthy people, many disabled people and people with common health problems”* (p36). *Sick and disabled people should wherever possible remain or re-enter work as soon as possible because it is therapeutic, promotes recovery, participation, quality of life and reduces poverty.”* But ‘good’ jobs are better still - defined by safety, fairness, job security, personal fulfilment and job satisfaction, good communications, personal autonomy and supportive environment.

The authors say that it is difficult to disentangle evidence about ageing because early retirement may be a result of health problems, involuntary job loss or voluntary exit from the workforce, each of which may have different financial, social and health effects; but they conclude: *“There is no evidence that continuing working is generally harmful to the health of older workers and it may be beneficial. Decisions about retirement age can properly be made on social, economic and other non-health grounds”* (p32). There is a strong association between worklessness and poor health.

These conclusions apply equally to people with cardio-respiratory, musculo-skeletal and common mental health problems, the three most common categories of ill health. They therefore apply equally to manual and physical activities as non-manual work. They apply to all ages. However, they also feature a major ‘social gradient’ which is of course related to the eight-year life expectancy differential across society.

Older women, work and health

Older Women, Work and Health: reviewing the evidence was published by TAEN and Help the Aged in November 2006. The report highlighted the paucity of studies exploring the links between the work and the health of older women, despite their increasing participation in the labour market. The majority of studies focus on the male workforce and on the mid-age group of workers (25-49 year-olds).

The factors affecting the health and well-being of older working women include levels of income, occupational status and concentration in certain professions and types of work, pension arrangements (or lack of them) and domestic and caring responsibilities. Women are more likely

than their male co-workers to report work-related stress and are more likely to have musculo-skeletal problems.

The authors, Lesley Doyal and Sarah Payne of the School for Policy Studies at the University of Bristol conclude that greater commitment to age and gender equality is needed in occupational health research, in the organisation of work, in health interventions in the workplace and in the framing of wider social policy if the needs of older working women are to be met. Copies of this report are available from TAEN and from the website www.taen.org.uk/resources/health

More work is needed on the impact of the menopause in the workplace as there are some 2.6 million women in their 50s in work. A research report, *Women Police Officers: Ageing, Work & Health*, commissioned by the British Association of Women in Policing explores the experience of ageing at work with particular reference to the menopause. See www.bawp.org for more detail.

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