ABI response to Occupational Health: Working Better

October 2023

The UK insurance and long-term savings market and the ABI

The Association of British Insurers is the voice of the UK's world-leading insurance and long-term savings industry. A productive and inclusive sector, our industry supports towns and cities across Britain in building back a balanced and innovative economy, employing over 300,000 individuals in high-skilled, lifelong careers, two-thirds of which are outside of London.

The UK insurance and long-term savings industry manages investments of over £1.9 trillion, contributes over £16bn in taxes to the Government and supports communities across the UK by enabling trade, risk-taking, investment and innovation. We are also a global success story, the largest in Europe and the fourth largest in the world.

The ABI represents over 200 member companies, including most household names and specialist providers, giving peace of mind to customers across the UK. Please note we would be happy, and stand ready, to provide further information if this would be helpful to the DWP.

Executive summary

We welcome the Government's focus on workplace health and supporting workers, particularly disabled people and those with long-term health conditions to stay and succeed in employment.

It is crucial Government includes insurance in its drive to increase demand for workplace health support. We are concerned that the current consultation is focused too narrowly on the provision of certain core occupational health (OH) services, rather than including wider health and wellbeing provision being delivered through insurance. This would be an enormous missed opportunity. OH provides an important service for employers, but it is only one part of the workplace health market. Increasing demand for OH in isolation will not deliver on the Government's objectives to improve productivity and prevent ill-health related job loss. Indeed, there is a material risk that it would distort the wider workplace health market with numerous detrimental effects leading to worse health outcomes for the workforce.

Narrow measures will limit employer choice, pushing demand away from other models of OH provision and wider products and services that may best suit their needs. For example, health insurance is a simple and effective way to put in place a broad package of health and wellbeing support for employees. It is easy to set up and provides a flexible funding mechanism for employers to deliver the mix of services that their employees need and is an effective solution for employers of all sizes. Some health insurance policies known as 'Cash Plans' also help employers cover the cost of everyday healthcare such as GPs, dentistry or physiotherapy via a small monthly premium. These offer an affordable whole workforce health solution, well suited for SMEs.

OH is not always the appropriate solution to produce a good outcome. Traditional core OH services usually provide a medical assessment of a person's fitness for work followed by recommendations to employers about possible

adjustments. However, generally the services stop there without implementing, monitoring or funding their recommendations. Taking a broader approach is more effective. Our analysis of over 16,000 vocational rehabilitation cases found that 9 in 10 (86%) people who use vocational rehabilitation services provided by their income protection insurance were successfully supported to stay in work or return to work following an absence due to illness or injury. 42% of those absent were supported back to work in under 4 weeks and 81% in under 6 months.

Additionally, health insurance delivers immediate impact – in a typical year, in a company of 1,000 people, a health insurer will treat around 236 people for ill health. By giving employees fast, easy and confidential access to treatment for a wide range of conditions, health insurance plays an important role in getting people into high-quality treatment quickly. By making access to care confidential, health insurance makes it more likely that people will seek early treatment, particularly for mental health conditions. This reduces the risk of escalation into more serious conditions that then cause people to have to give up work.

International examples demonstrate the benefit of using policy and taxation measures to utilise the whole work and health landscape and how the interaction between different kinds of health services, including OH and insurance, promote positive work outcomes.

The wider workplace health market is essential for maintaining adequate supply to meet demand for OH and workplace health services. Solutions must use the capacity that is already available across the market, for example the services provided by vocational rehabilitation practitioners, rather than create demand that cannot be matched by OH capacity alone. Insurance utilises OH where appropriate amongst other means of assessment, and often focuses on quick access to early intervention, ongoing case management, and wider evidence-based health and return-to-work services. This approach balances supply and demand by seamlessly allocating employees to the most appropriate support for their needs.

But most importantly, insurance already plays a crucial role in workplace health and retaining the workforce. It is a highly effective route to OH, plus additional effective prevention and vocational rehabilitation services for millions of workers. Our data shows that in 2021, over 1.6 million people used the services available to them through insurance, using them 5.5 million times (3.5 times per person on average). This includes those working for SMEs who hold 90% of in-force Group Income Protection (GIP) policies. Currently only a small proportion of businesses in the UK have Group Income Protection (GIP) policies, however 90% of these policies are owned by SMEs. This demonstrates that SMEs value GIP, and it suggests that including insurance in policy and tax measures to drive demand, as well as reducing barriers to uptake, will lead to wider coverage primarily amongst SMEs.

We therefore believe that the Government's plans to develop a simple and clear definition for the baseline for quality OH provision and the proposed national health at work standard should include insurance. We agree that a tiered approach would mean that expectations for different employer demographics are proportionate and incentivise employers to go beyond the baseline.

As to driving change, we believe that reforming statutory sick pay (SSP) would be a much more effective solution than auto-enrolment. Auto-enrolment has worked extremely well to reverse the decline in worker pension participation. But it does not translate well to the government's OH aims because, unlike automatically enrolling employees in a pension contract, employees cannot "passively" use OH. Instead, we recommend reforming SSP. International evidence shows that increasing the level of employer-provided sick pay incentivises employers to invest in sickness management including prevention and rehabilitation.[1] This in turn reduces sick pay costs for

[1] https://www.jstor.org/stable/24292127

employers, benefits costs for the State, and economic inactivity.

Finally, we support the government's ambition to provide information and advice on workplace health and disability provisions. We recommend that employers are obliged to remind employees of the workplace benefits available to them on an annual basis, rather than just on day one. We also recommend a dedicated page on the DWP Mid-Life MOT website reminding workers to check what health-related benefits are available to them through their employer and encourages them to use them.[2]

Question 1: What would you consider to be a robust and reliable source of evidence to establish a simple and clear baseline for quality OH provision?

- **Evidence based outcomes from an expert advisory group**
- **The government guidance to support employee health outcomes in the workplace, including specifying a clear and simple baseline for minimum levels of OH support**
- **Anything else? Give reasons for your views.**

A baseline for quality OH provision

We welcome the government's ambition to establish a baseline for quality OH provision. To achieve the best outcomes possible for individuals, businesses and the economy, it is vitally important that the whole market is used effectively. The baseline should work across different models of OH provision and it must not preclude insurance and other models of provision. Precluding insurance and other options in the market will have a negative distorting effect by funneling employer choice away from solutions that may be best suited to them. We agree that the government should commission an Expert Advisory Group to develop a reliable source of evidence to establish a simple and clear baseline for quality OH provision. This group should include representatives from the wider OH and workplace health ecosystem. Insurance is an effective model for the procurement and provision of OH services, particularly for SMEs, and the insurance industry should be represented in the Expert Advisory Group.

Guidance

We welcome the government's ambition to develop better information and advice on workplace health and disability provisions. Insurance and vocational rehabilitation should be explained and included in the examples of best practice. This will benefit employers, employees, and the economy by enabling greater choice and increasing capacity.

In response to question 2, we set out our recommendations to remind employees of their workplace benefits annually, and to add a dedicated page on the DWP Mid-Life MOT website reminding workers to check what health-related benefits are available to them through their employer and encouraging them to use them.

Measuring OH coverage

Insurance as a model for OH provision should be factored into estimates for coverage of OH in the UK. This will provide a more accurate picture of OH coverage and progress towards the government's targets.

Question 2: What best practice examples have you seen where workplaces are used to better support employee health outcomes that could be used instead to bolster greater take-up of OH provision? What kind of model would you prefer for

[2] https://jobhelp.campaign.gov.uk/midlifemot/home-page/

sharing this good practice, particularly to support SMEs?

Drivers of demand to bolster take up of OH and return-to-work services

Driving demand for products and services that improve workforce health outcomes, particularly amongst SMEs, is key to reducing rising health-related economic inactivity. Yet evidence from the Institute of Employment Studies found SMEs are not driven to seek OH services unless there is a live issue.[3] Supporting this, a recent survey by the Federation of Small Businesses found that 44% of small businesses that do not provide OH services said it is because they do not have an existing health issue amongst staff.[4] Insurance can help to address the lack of take-up of OH amongst SMEs as demonstrated by 90% of Group Income Protection policies belonging to SMEs. Currently, around one-third of GIP policies cover businesses with fewer than 10 workers.

In addition, research by the Social Market Foundation found that staff retention was a key motivator for 45% of businesses that provide health insurance or are seriously considering offering it in the next 12 months, and recruitment was a key motivator for 30% of these businesses.[5] Earlier this year we commissioned Public First to survey a representative sample of over 2,000 members of the public about their views on insurance. Over half of the respondents said that health insurance and income protection are significant factors when they're deciding where to work, demonstrating that these products have broader appeal for employers.

A recent report by CIPD and Simplyhealth shows that sickness absence rates remain the most common metric used by organisations to evaluate the impact of their wellbeing activity/spend, followed by staff retention levels.[6]

Using best practice for education

We support the use of best practice models both to drive take-up and to educate employers about how to use OH and wider return-to-work services to ensure the best possible outcomes for employees. It is important that best practice helps employers navigate OH and any additional health and return-to-work services they already have in place. This will encourage individuals to make use of services that address health issues early.

Normally, traditional OH services provide a medical assessment of a person's fitness for work, which is followed by recommendations to employers about workplace adjustments. However, generally the services stop there without implementing, monitoring or funding their recommendations. Evidence shows that taking a broader approach and focusing on early intervention is effective. Insurance utilises OH where appropriate amongst other means of assessment, but often focuses on quick access to early intervention and case management. Our analysis of over 16,000 vocational rehabilitation cases found that 9 in 10 (86%) people who use vocational rehabilitation services that are provided by their insurance were successfully supported to stay in work or return to work following an absence due to illness or injury. 42% of those absent were supported back to work in under 4 weeks and 81% in under 6 months.

Many smaller employers use OH and return-to-work products and services less often than larger companies and are therefore less adept at using them effectively. With less experience, smaller employers or their

[3] https://www.employment-studies.co.uk/system/files/resources/files/hse_whc_ef.pdf
[4] https://www.fsb.org.uk/resource-report/business-without-barriers.html
[5] https://www.smf.co.uk/wp-content/uploads/2021/05/SMF-Insuring-a-return-May-2021.pdf
[6] https://www.cipd.org/globalassets/media/knowledge/knowledge-hub/reports/2023-pdfs/8436-health-and-wellbeing-report-2023.pdf

employees often notify the insurer later about a health issue. Our data demonstrates this and how it can impact on work outcomes.

Insurer vocational rehabilitation teams were notified within 4 weeks for 39% of cases for large companies, compared to 14% of cases for SMEs. Those employed by large companies experience better work outcomes, suggesting correlation between early notification and good outcomes.

- For cardiovascular conditions 13% of large corporate employees stayed in work, compared to only 3% of SME employees. Non-return to work outcomes were recorded at 15% with large companies, compared to 29% for SMEs.
- For MSK conditions, 22% of large corporate employees stayed in work, compared to only 10% of SME employees. Non-return to work outcomes were recorded at 14% for large companies, compared to 23% for SMEs.

Creating more touch points, work and health conversations, and better culture

To meet the government's aims it is crucial to create better workplace culture and engagement with OH, health and return-to-work services. One simple way to do this is by creating more touchpoints for workers to be aware of what services are available to them. This will help to create conversations about health in the workplace and drive up engagement with prevention and health services.

The statutory obligations relating to the 'Written Statements of Employment Particulars' (Day One Statement) should be extended so that employers must remind employees about their benefit entitlements on an annual basis, including any health or return-to-work services. As it stands, employers are only required to outline employee benefits once, on an employee's first day. In addition, when employee benefits change, employers should be required to issue a clear notification to employees that sets out the changes and what they mean.

Health-related gaps in the Mid-Life MOT should be addressed to better enable individual responsibility. We propose a dedicated page on the DWP Mid-Life MOT website reminding workers to check what health-related benefits are available to them through their employer and encouraging them to use them.

Understanding of SME demographics

The term SME is being used as a catch-all for a wide range of businesses with differing levels of motivation and ability to provide health and wellbeing services. To gain a better understanding of the barriers and drivers of demand for OH, the government should survey employers categorised by different demographics such as more detailed sector breakdowns, turnover, region and number of employees. This would also enable the government to better understand how different drivers such as recruitment and retention could be leveraged to support better workplace health provision.

Question 4: Are there particular benefits these measures could bring for people with protected characteristics? In what ways could this be achieved?

The ABI and its members share the view that employers have a hugely important role in creating supportive workplaces that recruit and retain people with health issues relating to protected characteristics. Ensuring that people can access targeted support ranging from help managing a long-term health condition to gender and age-related health issues stands to significantly benefit businesses and the economy while creating equity by helping people reach their full potential. That's why any measures that the government considers for expanding access to OH must include wider health and return-work-services, and insurance as a model for the

procurement and provision of these services.

Women's health

There are many issues that cause people to silently fall out of the workforce because they don't get the right health support. Bupa found that almost 1 million women have exited the workforce because of the menopause. Those who take a long-term absence from work to manage menopause symptoms take an average of 32 weeks of leave, resulting in damage to individuals' careers and a huge loss of productivity to a business.[7] Health insurance provides businesses with targeted support for woman's health, including support for menopause as well as periods and endometriosis. Health insurers both support access to appropriate services and support employers to embed more flexible working so that their workforce can manage symptoms and stay-in-work.

This reinforces the point that the government must consider insurance as a part of a joined-up approach to workplace health. Not doing so will be a significant missed opportunity to improve outcomes for individuals with health issues related to protected characteristics.

Disability and long term-illness in the workplace

The Federation of Small Businesses (FSB) found that 25% of small business owners are disabled or have a health condition and 51% of small employers have employed a disabled person or someone with a health condition in the last 3 years.[8]

Health insurance and income protection provided through the workplace play an important role in supporting disabled people at work. The consistency of support through case management is particularly effective for supporting and reintegrating disabled people into the workforce.[9]
Group Income Protection policies set out the criteria for membership such as six months' continuous service and employees who meet that criteria will be covered regardless of whether they have a disability or long-term health condition. Group insurance, provided through the workplace, is particularly beneficial to individuals with disabilities who can otherwise find it difficult to purchase cover individually.

Many of these policies cover a business's entire workforce irrespective of seniority. For example, supermarkets with group income protection cover from the top level down to the shop floor.

Question 6:

a. What should such a national health at work standard for employers, embedding a baseline for quality OH provision, include, especially given the requirement to accommodate different employer needs?

Insurance plays an important role in workplace health and retaining the workforce. It is an effective route to OH, prevention, and rehabilitation services for millions of workers. Our data shows that in 2021, over 1.6 million people used the health services available to them through insurance. This encompasses OH as well as wider services that support prevention, early care, diagnosis, treatment, recovery and support. These customers used the services available to them through insurance 5.5 million times – that's 3.5 times per person on average.
We urge the government to include insurance in the national health at work standard, both as a model for OH services and for wider health and return-to-work services. There are two broad reasons for this. Firstly, including insurance will support better outcomes for workers, businesses and the economy. Secondly, not including insurance will skew the wider workplace health ecosystem to the detriment of employer choice,

[7] https://committees.parliament.uk/writtenevidence/39244/html/
[8] https://www.fsb.org.uk/resource-report/business-without-barriers.html
[9] https://labourmarketresearch.springeropen.com/articles/10.1186/s12651-021-00299-9

effective support, worker retention and return-to-work outcomes.

Better outcomes for workers, businesses and the economy

Health insurance is an effective solution for employers of all sizes as it is simple to buy and administer, and it doesn't rely on having HR infrastructure. By giving employees fast, easy and confidential access to treatment for a wide range of conditions, health insurance plays an important role in getting people into high-quality treatment quickly. This minimises time off work and treating conditions earlier also reduces the risk that they will escalate into more serious conditions which cause people to have to give up work. By making access to care confidential, health insurance makes it more likely that people will seek early treatment for things like mental health conditions. This in turn stops issues from escalating.

Earlier this year we published an analysis of 16,000 people who had accessed healthcare services provided through employer-provided insurance. Mental health was the most prevalent reason people accessed the healthcare services available to them. This was the same across all age groups. Overall, 33% of people who accessed mental health services were supported to stay in work and 56% were supported to return to work – the vast majority in under four weeks.

Income protection is designed to mitigate the risks of people leaving the workforce due to illness, injury or disability. As well as prevention and early intervention services, customers are also offered vocational rehabilitation to help them remain in work. Early symptoms are typically treated with less resource-intensive support and high-intensity support is provided for worse symptoms. This type of early intervention often prevents the need for more substantial interventions down the line and is generally viewed as the optimal way to allocate resources.[10]

Another important aspect of income protection is the financial support it provides if someone has time off work and suffers a loss of earnings due to injury or illness. Most products pay claimants a monthly income after a pre-agreed waiting period, which means that people can continue to pay their bills, rent or mortgage until they recover. This added benefit of financial security is important to employees' and employers' financial and mental well-being and reduces the need for reliance on State benefits.

Some health insurance policies known as 'Cash Plans' also help employers cover the cost of everyday healthcare such as GPs, dentistry or physiotherapy via a small monthly premium. These offer an affordable whole workforce health solution, well suited for SMEs. Yet, research by Simplyhealth and CIPD shows that only 25% of companies currently offer all of their employees a cash plan.[11]

The risk of distorting the market

OH is one part of a broader workplace health market and works best alongside other products and services such as early intervention and vocational rehabilitation. To ensure sufficient supply capacity to meet the government's ambitions, and to avoid distorting the market and limiting employer choice, it is fundamental that a national health at work standard includes health insurance and income protection policies.

Failing to include insurance as a model for OH delivery and wider health and return-to-work services will have a negative impact on the market and ultimately lead to worse outcomes for individuals, employers and the

[10] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/209474/hwwb-vocational-rehabilitation.pdf
[11] https://www.cipd.org/globalassets/media/knowledge/knowledge-hub/reports/2023-pdfs/8436-health-and-wellbeing-report-2023.pdf

workforce. We have included the negative consequences of failing to do so below.

- Employer choice must be preserved to ensure that the market reflects individual employer needs. Insurance is well suited to many businesses including small businesses. Skewing employer choice away from insurance towards a traditional OH model that may be less suitable would create a worse market for businesses and have a negative impact on the workforce.
- Failing to include wider health and return-to-work services in the health at work standard risks over medicalising issues in the workplace. As set out below, evidence suggests that the medical model approach can be counter-productive for many common health conditions. Skewing the market towards the medical model therefore carries the risk of working against the aim of this consultation to improve productivity and reduce ill-health related job loss. Insurance provides support based on the medical model where appropriate, but also offers services such as vocational rehabilitation based on the biopsychosocial model.[12] There is strong evidence that a biopsychosocial approach linked to the workplace can be effective and cost effective for improving occupational outcomes (ibid).
    - The medical model of OH focuses on defining functional limitations and restrictions.[13] This comes from the traditional risk assessment approach to health and safety.[14]
    - This approach is not appropriate and can have a detrimental effect for resolving common health problems with a high prevalence in the general population - for example, mild/moderate mental health problems or musculoskeletal conditions. These issues have complex risk factors, often lack 'injury' or 'disease', and causation is ambiguous (ibid).
    - There is also evidence suggesting that individuals' responses to illness are likely to be influenced by a wider combination of social and circumstantial factors.[15] Vocational rehabilitation provided through insurance utilises a combination of therapeutic and also social interventions that address the clinical problem and issues in the individual's physical and social environment.[16]

Question 7: For an accreditation scheme, should the levels or tiers be based on business size and turnover? What other factors should we consider for the tiers? What incentives should be included in the higher tiers?

Accreditation

A national health at work standard must achieve two core aims: (1) drive positive behaviour change fairly amongst businesses, and (2) promote an effective workplace health market. Either one without the other would fail to meet the government's objective of improving productivity and preventing ill-health related job loss. Therefore:

- It must not preclude any models of service delivery. If a business has an insurance policy that includes the services set out in the standards, then the business is compliant.
- We agree that the standard should be tiered by type of business. It should be differentially weighted to reflect the expectations on different businesses, which cannot be universal. The classification of businesses could include a range of demographics such as sector, turnover, number of employees and region.
- We also agree that it should be tiered by provision, for example ranging from 'minimum' to 'excellent' as set out in the consultation. This would incentivise good behaviour and prevent a 'race to the bottom'

[12] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/209474/hwwb-vocational-rehabilitation.pdf
[13] https://www.tandfonline.com/doi/abs/10.1080/09638280410001672517
[14] HSE review of the risk prevention approach to occupational health: applying models to 21st century occupational health needs: health models information pack (HSL/2005/57). Health & Safety Executive/Health & Safety Laboratory
[15] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/181060/health-at-work.pdf
[16] https://koha.kingsfund.org.uk/cgi-bin/koha/opac-detail.pl?biblionumber=18999

in the workplace health market. However, it's vital that products and services beyond OH are included. For example, access to vocational rehabilitation, virtual GP appointments, and employee assistance programmes (EAPs).

- This would also help to alleviate some of the market distorting impacts highlighted above. One basic way this could work is by having a gradient of accreditation levels. Level 1 could include adherence to the baseline for OH, as well as simple and cost-effective solutions like EAPs and access to virtual GPs. Level 2 accreditation could include further health and return to work services, including access to early intervention, mental health counselling, and vocational rehabilitation.

Question 9: How should such an accreditation scheme be monitored and assessed? What assessment or evidence should employers need to provide each level?

To adhere to the health at work standard, an employer's insurance policy should cover all employees. This will encourage businesses to provide equitable access to a range of OH, health, and return-to-work services.

We are already seeing more employers offering health and income protection insurance to their entire workforce. In the income protection market, we're also seeing a shift to more affordable policies that provide financial cover for long term sickness absence of 2-5 years, rather than until retirement. While more affordable, these policies with a shorter claim duration still provide workers with access to OH and return-to-work services (including vocational rehabilitation) and significant financial protection when an individual can't work due to illness or injury.

Question 10: What Government support services would be most valuable for employers seeking to improve their support for health and disability in the workplace, including as they work by towards a baselined quality OH provision as set out in a national health at work standard for employers, embedding a baseline for quality OH provision? Give reasons for your views.

Many of the proposals outlined in the consultation could have merit and warrant further investigation. However, the government must address existing barriers to insurance take up to help employers of all sizes support employees with disabilities and long-term health conditions. We would welcome the DWP's support for this.

Existing barriers – taxation

For many employers, health insurance is a simple and effective way to put in place a broad package of health and wellbeing support for their employees. It is easy to set up and provides a flexible funding mechanism for employers to deliver the mix of services that their employees need. It delivers immediate impact – in a typical year, in a company of 1,000 people, a health insurer will treat around 236 people for ill health.

Despite the valuable role health insurance plays towards government objectives, there are numerous barriers that inhibit uptake. Insurance Premium Tax (IPT) offers an important lesson on one way that taxation can distort a market against the government's objectives. Since 2015, IPT has doubled from 6% to 12%. This affects families and businesses who take out health insurance by driving up the price of cover. Importantly it also prevents others from purchasing cover, putting additional pressure on the NHS and working against the government's goal to support businesses to play a greater role in promoting a healthy workforce.

Consistent rises in IPT for health insurance have shrunk the individual consumer market, and distorted and inhibited the employer paid market.[17] During this time, LaingBuisson analysis estimated a 15%-25% year on

[17] Tax and the UK health insurance market, Bupa 2020

year rise in the number of uninsured people self-paying using savings or credit.[18] Hip replacements can cost between £10-15k – this is a significant cost for the average patient.

Existing barriers – benefits system

Individual income protection (IIP) plays an important role in bolstering the health of the workforce. IIP customers are made up of employed workers who do not have an occupational scheme and self-employed workers. Reducing the barriers to IIP created by its treatment in UC calculations would be a particularly good outcome for the self-employed who have less access to OH and return-to-work services and do not get statutory sick pay.

Currently, IIP is treated as unearned income and therefore every £1 paid by an IIP policy reduces someone's UC entitlement by £1. Immediately you may think this is helpful from a benefit spending perspective as IIP income reduces State spending on UC payments by a greater amount than GIP income. However, we believe this is a short-term view and that we need to think about what happens if people don't take out IIP even though they could be financially better off in the long run and have greater financial certainty in the future, and crucially have access to all of the healthcare services and returned phase to work as flexibility in claim payments. Therefore, we recommend that income obtained through an IIP claim should be subject to the taper rate when calculating UC entitlement.

There is rightly a disregard for IIP income if it is used to make regular mortgage payments. However, New Policy Institute analysis found that people in receipt of IIP were more likely to be renters than homeowners, and this same disregard is not in place for income used to pay regular rental payment.[19] The disregard should be extended to renters to ensure that benefits are equitable for different demographics.

Reducing the barriers to IIP, without creating new ones, would help to ensure self-employed people don't lose out compared with their employed counterparts, both in terms of overall income replacement rate and their access to insurer-provided healthcare services.

Question 11: Should access to a Government-funded support package be conditional on accrediting to the proposed national health at work standard for employers, embedding a baseline for quality OH provision? Give reasons for your views.

The ABI agrees that access to a government-funded support package should be conditional on accreditation to the proposed national health at work standard for employers. However, it's crucial that the health at work standard reflects and enhances the entire workplace ecosystem. A siloed focus on one small part of the market will be a missed opportunity and do more harm than good.

Question 12: Drawing on examples from international comparators, what could be effective in driving employer demand to enable a shift towards higher rates of access?

Employers play a fundamental role in helping disabled people and those with long-term health conditions to stay at and return to work. Different countries use legal and voluntary means to encourage employers to fulfill this role using various levers.

Based on international examples, we believe that a combination of legal measures and tax incentives are required to have a meaningful impact on employer behaviour. However, as we have already written, for this impact to be positive the government policy must not skew the market towards just one part of the market. This is a significant

[18] https://www.laingbuisson.com/shop/private-healthcare-self-pay-uk-market-report-5ed/
[19] https://www.abi.org.uk/globalassets/files/subject/public/protection/npi-for-abi-final-report.pdf

risk that must not be ignored.

International examples, whether socialist-leaning or liberal, demonstrate the necessity of a robust package of support that utilises the whole workplace health ecosystem (inc. vocational rehabilitation), reinforced by incentives for businesses linked to an adequate safety net for workers.

International example 1 – Poland

As shown in the consultation paper, Poland is one example of a country with 100% OH coverage.[20] However, it is important to recognise that in Poland OH is just one part of a much more comprehensive workplace health ecosystem with great emphasis placed on vocational rehabilitation and a strong sick pay safety net.

In addition to OH, all workers in Poland are covered by compulsory sickness insurance. Self-employed workers may apply for voluntary insurance. Insured workers in Poland that are unable to work are entitled to:

- Sick leave salary
- Sickness benefit
- Rehabilitation benefit

Sick leave salary is financed by the employer and payable for the first 33 days of incapacity and is worth 80-100% of salary. After that, sickness benefit worth between 70-100% of salary is paid by the Social Insurance Institution (ZUS) for up to 182 days.

Rehabilitation benefit is 90% of salary for up to 12 months and is granted to an insured person who has exhausted the right to receive sickness benefit but is still unable to work, and further medical treatment or rehabilitative care could support their ability to work. This benefit is targeted at people who may otherwise fall out of the workforce and demonstrates the importance of vocational rehabilitation. Having appropriate support in place to target this level of severity is essential for tackling economic inactivity amongst the working-age population.

Poland – support for disabled people and those with long term health conditions

Below are some examples of specific measures in place in Poland to help disabled people and those with long-term health conditions to stay in work or get back to work after absence. We support exploration of these measures to help support workers with disabilities.

- Additional paid time off – employees with a moderate or severe degree of disability have the right to additional time off work once a year for a period not exceeding 21 working days. This leave can be used by the employee for various purposes, such as participating in vocational rehabilitation, undergoing specialist medical examinations, receiving treatments, or repairing orthopedic equipment.
- If an employer hires a person with a moderate or severe disability, they are obliged to adapt the workplace accordingly. However, their definition of an adapted workplace is arguably too broad and imprecise.

International example 2 – The Netherlands

In the Netherlands, employers are legally required to obtain OH support and take up is estimated at 80%. However, the Netherlands recognises that OH alone is not sufficient and so it also operates a system of compulsory private health insurance, including compulsory basic cover and optional additional cover. To ensure that insurance can play an effective role in supporting workforce participation, the Netherlands maintains an

[20] https://www.gov.uk/government/consultations/occupational-health-working-better/occupational-health-working-better#chapter-three-developing-the-work-and-health-workforce-capacity-including-the-expert-oh-workforce-to-build-a-sustainable-model-to-meet-future-demand

accommodating taxation environment for insurance, as opposed to the punitive system in the UK. While the general rate of insurance premium tax in the Netherlands is 21%, there are exemptions for life insurance, accident, invalidity and occupational disability insurance, health and medical expense insurance, unemployment insurance, and absenteeism insurance.[21] This has resulted in most of the population (84%) purchasing supplementary voluntary insurance which covers a range of services that are not covered by the statutory insurance. This includes dental care, alternative medicine, physiotherapy, glasses and lenses, and contraceptives.

To achieve similar levels of success as the Netherlands, the government must consider the whole work and health landscape and how the interaction between different kinds of health services, including OH and insurance, promote positive work outcomes.

There are also higher rates of statutory sick pay in the Netherlands. Sick pay is a lever that is proven to effectively incentivise employers to invest in prevention and rehabilitation support for workers.[22] This in turn reduces sick pay costs for employers, benefits costs to the state, and economic inactivity.

Any solution to the challenge of workplace health must use the capacity that is already available across the market rather than create demand where there is insufficient capacity. Reforming statutory sick pay would do this by retaining choice in the market and spreading demand appropriately.

Reforms to statutory sick pay in the UK could significantly help the government to achieve its aims. We recommend:

1) Increasing the rate of SSP. Currently, workers on SSP receive as little as £1.10 an hour in the first week and less than £3 an hour thereafter. This means one in three workers on sick pay are living in poverty.[23]
2) Allowing for phased returns to work to support disabled people and those with long-term health conditions to get back into the workforce at the right pace.
3) Reducing the lower earnings limit so that people can claim SSP regardless of earnings level.
4) Reforms should be accompanied by support for SMEs to invest in evidence-based return-to-work services, including through the insurance model of service provision.

The Netherlands example demonstrates the benefit of addressing the barriers to take up of insurance products that provide OH and broader health and rehabilitation support. The taxation and the benefits system can and should be used to encourage responsible behavior by employers and workers alike.

Question 14: What lessons could be learned from self-reporting models and Automatic-Enrolment that could be applied to increase access to OH amongst employers? Please include which elements of these examples could be delivered for OH.

Self-reporting

We are supportive of proposals for larger businesses to self-report on an annual basis. However, to reduce the burden on business and avoid risks of skewing the market explained above, reporting measures and the conditionality of access to government support must not reduce employer choice in the wider workplace health market.

The explicit aim of the measures consulted on here is to increase productivity and reduce ill-health related job loss. As demonstrated with international examples above, countries of interest rely on a broad and balanced system of OH and wider support, and a particular emphasis on safety nets such as sick pay and vocational

[21] https://business.gov.nl/regulation/insurance-premium-tax/#art:exemptions-from-insurance-premium-tax
[22] https://www.jstor.org/stable/24292127
[23] https://www.centreforprogressivechange.org/blog/reporteconomicbenefitsssp

rehabilitation.

While we agree that the availability of Government support for larger organisations should be conditional on an employer providing work and health support above a threshold, that threshold must include OH and broader return-to-work services such as vocational rehabilitation. Insurance must also be included as a model for the delivery of these services. We urge the government to consult the ABI further in the development of self-reporting criteria.

Auto-enrolment

If the government's primary aim is to mandate for all employers to provide a baseline level of OH for all employees, then it does not need automatic enrolment as a mechanism. If the government does mandate employer-provided OH provision, it should make sure OH is not narrowly defined as this would limit employer choice, pushing demand away from other models of OH provision and wider products and services that may best suit their needs.

If the government's aim is to encourage all employers to offer OH to their employees, again, we do not think that automatic enrolment aligns with this approach. We recommend a more effective lever for individuals and businesses is to reform SSP, remove existing tax barriers and improve existing incentives.

If the purpose of auto-enrolment is to minimise opt-out rates by employees, then in our view the government will still need to address tax barriers first. Everyone will hopefully reach an age where they need their pension, but not everyone will experience ill health or injury and need OH support. This disparity alone could drive up employee opt-out rates for auto-enrolled OH services. If there is a cost for the employee or they are taxed this would further increase opt-out rates. Employees receive a tax incentive to save into their pension whereas employees pay tax for insurance.

Finally, one of the key drivers of auto-enrolment's success has been inertia, but policymakers and industry are now working hard to engage people with their pension. The key to the success of this intervention is that people use the health services available to them early, to prevent conditions worsening.

Taxation in AE

Tax relief is a useful mechanism for encouraging employees to save into a pension. GIP is a good example of poor taxation inhibiting demand for a product that provides benefits for employees and businesses. Under the current HMRC interpretation, GIP contributions by scheme members, funded by salary sacrifice under optional remuneration arrangements (OpRA), are subject to double taxation. Foregone salary is taxable as a benefit in kind and the corresponding proceeds (i.e., amount claimed on the policy) are also taxable, leading to double taxation.

The risk of opt outs and low engagement

Auto-enrolment demonstrates that leveraging inertia is an effective way to drive up participation amongst individuals. However, there are several risks that may drive opt-outs for auto-enrolled OH.

Many individuals, particularly those with mental health conditions or issues relating to protected characteristics, may be reluctant to disclose sensitive information to their employer. This could drive opt-outs among the population that require support the most. By providing confidential care in addition to OH, insurance increases the chances that people seek support through employer-provided services.

Another opt-out risk is that everyone needs a pension while not everyone will experience ill health or injury and need OH support. This disparity could drive up employee opt-out rates for auto-enrolled OH services, depending on whether there was a cost for the employee.

A further lesson from pensions is that the inertia that drives up participation can cause poor engagement. In research conducted for the ABI, over half of the 4,000 working-age adults interviewed did not think they had a pension.[24] Low utilisation of health services provided by employers is an existing challenge that could lead to AE falling short of its potential for workplace health. To help to drive up engagement and create a culture of supportive workplaces, employers should be required to inform workers about their benefits including health services yearly, not just on the first day of work, as is the case with the annual pension statement.[25] This should happen irrespective of auto-enrolment.

Insurance provides numerous benefits to incentivise utilisation:

- Many health insurers offer incentives and rewards to all of their customers such as reduced gym membership fees. They also use interactive apps and reward people for being active, which also promotes good health. Adopting such an approach could help to reduce opt-out rates as well as benefiting their health.
- Protection products offer financial benefits in addition to health and return-to-work services. Income protection also offers generous income replacement if the employee is unable to work due to illness or injury.

Maintaining a competitive market

The pensions market is competitive, which maintains consumer choice and the availability of high-quality products. The government must make sure not to reduce competitiveness and choice in the workplace health market by excluding insurance and vocational rehabilitation.

As with the roll out of AE, it would be important to mitigate increased admin for smaller employers, and we suggest developing simple guidance or a standard template to support their access to appropriate services.

Clarity, confidence and risk assessment

Before proceeding there would need to be clarity about exactly what employers would need to purchase, and how exactly an auto-enrolment solution would target the problem the government is trying to solve. As part of this, the government should also conduct a risk assessment on the impact on the wider market, to help mitigate a race to the bottom in terms of what providers offer.

Whatever approach the government takes, an important learning from auto-enrolment is that it must avoid low-paid workers (typically women and ethnic minorities) being excluded by the eligibility criteria.

Question 17: How can we promote OH as an attractive career to encourage a wider range of professionals to join and/or remain in the profession?

According to a recent survey, 82% of OH providers saw a rise in demand for rehabilitation and 70% of occupational therapists feel unable to provide this in their area. This is partly attributable to additional costs for services

[24] https://www.abi.org.uk/globalassets/files/publications/public/lts/2022/britain-things-pensions-dashboard-report-jan-2022.pdf
[25] https://www.abi.org.uk/products-and-issues/topics-and-issues/workplace-wellbeing/how-to-use-day-one-statements-to-boost-wellbeing/

beyond the traditional OH assessment being placed back on the employer where there is limited budget. Unlike vocational rehabilitation, traditional OH providers make recommendations that the employer is responsible for implementing.

Traditional OH is often used by employers to challenge an employee's absence as part of performance management. While this can appeal to employers, we believe that it is important to support employees through their return-to-work journey. Health and income protection insurers are well suited to this supportive role. For example, it is in the best interests of GIP insurers and the businesses they support to produce a return-to-work outcome and reduce the impact of a claim. Similarly, for health insurers, earlier and more cost-effective services are preferable to escalating conditions which are much more costly.

Question 19: What actions or mechanisms (including technology) can be used to ensure that the multidisciplinary OH workforce will be utilized by service providers in an effective way to respond to an increase in demand for quality expert and low intensity work and health support (OH)?

The insurance model of service procurement and provision is a good example of a mechanism for bringing together support based on different models of illness and disability. The insurance model provides support based on both the medical model and biopsychosocial, and crucially provides an effective means to intervene early and prevent worsening issues. That's why insurance as a route to OH and return-to-work services should be encouraged through the measures consulted on here.

The government is right to be concerned about an increase in demand for OH, given current issues with capacity. That's why it's important that government's measures look to use the capacity that is already provided by the wider market rather than seeking to increase the supply to one part of that market.

This makes sense from a capacity perspective, but also because of the effectiveness of support provided beyond OH, such as vocational rehabilitation, based on the biopsychosocial model. As we have written above, not including wider health and return-to-work carries the risk of skewing the market towards the medical model and working against the aims of this consultation.

Question 22: What further action can the Government take to support multidisciplinary teams to deliver work and health conversations in other settings (for example NHS or community settings), to improve health outcomes address health disparities?

The independent healthcare sector plays a significant role in the UK's healthcare system. For example, almost 1.2 million NHS patients received acute treatment in the independent sector and almost 42% of NHS community service providers are from the independent sector. The sector also invests in training. In 2021, 1800 apprenticeships were delivered by the Independent Healthcare Provider Network and more than 4,000 NHS junior doctors have undertaken their training in independent hospital facilities since 2000.[26]

Our survey of over 2,000 people earlier this year found that overall, respondents think that greater involvement of the independent sector in the UK's healthcare system will help. 7 out of 10 respondents agree that "A person paying privately for treatment is one less person the NHS has to worry about". 2 out of 3 support greater involvement of independent providers to increase NHS capacity and over half think greater independent sector involvement would speed up NHS services. In addition, around half of respondents would consider using independent healthcare themselves and believe those who can afford it should be encouraged to take out these

[26] https://www.ihpn.org.uk/wp-content/uploads/2018/03/IHPN-infographic-2021-22.pdf

products.[27]

When we asked about insurance, 50% or more of respondents said that those who can afford to take out health and protection products should be encouraged to do so. Respondents were particularly positive about being able to access independent healthcare services as a workplace benefit, with approximately half of respondents saying that private medical insurance and income protection are significant factors when they're deciding where to work, and therefore employers should be incentivised to offer these products to their workforce as they provide people with peace of mind and help to reduce NHS wait times.

Insurers invest a significant amount of resources and research into preventing ill-health. They help people to proactively manage lifestyle factors through behavioural nudges, incentives and prompt access to diagnostics and treatment. These prevent health conditions from happening and worsening, improving people's quality of life and reducing the need for more complex and costly treatment. By supporting and incentivising employers and individuals to make healthier choices, insurance complements and supplements public services.

27 https://www.abi.org.uk/globalassets/files/publications/public/health/abi_report_a_sustainable_healthcare_system_for_all_june-2023.pdf