Insuring a return

A role for health and protection insurance in helping the long-term sick get back to work

Scott Corfe
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SMF Social Market Foundation

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Kindly supported by

ABI

FIRST PUBLISHED BY

The Social Market Foundation, February 2021
11 Tufton Street, London SW1P 3QB

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ACKNOWLEDGEMENTS

This report would not have been possible without the sponsorship of the ABI and the generous cooperation of ABI members. We are also grateful to Opinium and Indiefield for provision of primary research. Further, we owe considerable thanks to a number of stakeholders whose engagement helped ensure the authors were appraised of a wide range of perspectives on the issues of workplace sickness, long-term absence, presenteeism, the relevant public policy environment and the state of the health and protection insurance sector. These include: the British Chambers of Commerce (BCC), The Federation of Small Businesses (FSB) and FSB Insurance, GRiD, the Work Foundation, Equipsme, the Department for Work and Pensions, HM Treasury, The Association of Medical Insurers and Intermediaries, the Association of Financial Mutuals (AFM), the Institution of Occupational Safety and Health (IOSH), and the Chartered Institute of Personnel and Development (CIPD).

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Before joining the SMF, he was Head of Macroeconomics and a Director at the economics consultancy Cebr, where he led much of the consultancy's thought leadership and public policy research. Scott's expert insights are frequently sought after in publications including the Financial Times, the Guardian, the Times and the Daily Telegraph. Scott has appeared on BBC News, Sky News, Radio 4 and a range of other broadcast media.

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EXECUTIVE SUMMARY

About this report

This report was commissioned by the ABI and carried out by the Social Market Foundation, which retains editorial independence. The scope of the research is to examine the role that insurance products can play in improving the health of the UK workforce – both among employees and the self-employed. The most comprehensive assessment of workplace absence costs from government suggested that, in 2015, the economic costs of sickness absence and worklessness could be as large as £130 billion a year, and the associated costs to the Exchequer as large as £55 billion a year. Tackling this should, therefore, be a key area of interest to policymakers.

The research includes an examination of the role played by products such as income protection and private medical insurance in:

- Reducing absence rates
- Facilitating swifter return to work following illness or injury
- Reducing rates of presenteeism
- Generating fiscal benefits to government through reduced welfare spending, healthcare savings and higher tax revenues through supporting return to work

The report draws on a wide range of evidence – existing studies, online surveys of employers and employees, in-depth interviews with businesses and insurance industry data. The SMF commissioned two online surveys from Opinium – a survey of HR-decision makers in businesses, and a separate survey of individuals that had suffered a long-term absence of more than four weeks (50% of the sample with insurance benefits and 50% without such benefits). In addition, the SMF undertook 35 in-depth over-the-phone interviews with businesses.

The key findings of the research are described below.

The current functioning of the insurance market

- **Survey research and in-depth interviews show that the key motivation for businesses providing health or protection insurance is its role as an incentive and signalling tool – most crucially as a means of recruiting and retaining staff.** Employers often agreed that insurance provided a signal to staff that they are 'valued' and some employers consider it a moral duty to provide such 'benefits'.
- **Among employers, workplace health is generally seen as a "second-order" benefit of products such as private medical insurance and income protection insurance, being less-commonly cited as a motivation for purchase than recruitment and retention.** In the depth interviews undertaken in the research, business owners often had to be prompted before mentioning and discussing the potential linkages between insurance, staff absence and health in the workplace.
- **Despite health being a second order benefit of insurance among businesses, a significant majority of *individuals* that had suffered a long-term absence from work (of more than four weeks) reported benefits from having access to insurance, highlighting the health benefits that such products can bring:**

  - Private medical insurance (PMI) was described as 'indispensable' or 'helpful' by 82% of respondents who had it at the time of their absence inducing illness or injury.
  - 78% reported that their income protection (IP) coverage was 'indispensable' or 'helpful' to their recovery.
  - 76% said that their health plan was either 'indispensable' or 'helpful' to their recovery.
  - Two-thirds of those who had critical illness cover at the time of their illness found that it was 'indispensable' or 'helpful' in their recovery.
  - For those who found PMI 'helpful' or 'indispensable', the most frequently reported benefit was the swift access to care it provided. This was closely followed by the 'peace of mind' that the PMI coverage gave to the recipient.
  - For those who found IP 'helpful' or 'indispensable', the most frequently reported benefit was the 'peace of mind' that having it provided to the recipient. The second most frequently reported reason was because it eased financial difficulties associated with their absence from work.

- **Despite the offer of insurance benefits (provided by employers) not being driven primarily by health-risk-management motives, the insurance companies consider large numbers of claims each year and pay out substantial sums of money annually to those who are ill or injured.** For example, in 2019 the industry paid out on more than 98.3% of claims received against protection policies, with around £5.7 billion paid out by the industry altogether on protection policies that same year.[1] This was £470 million more than in 2018.

- **Among businesses, cost and not deeming insurance products to be relevant were the two most widely-cited reasons for not offering insurance benefits to staff.** The disparity between businesses often not viewing insurance as a "health product", and employees reporting products as being beneficial in aiding return to work following absence, suggests that businesses might not fully understand the full range of services offered by insurers. This includes a wide range of services aimed at reducing absence rates and presenteeism within a business, such as:
  - Assessments (ergonomic, functional, etc.)
  - Early intervention mental health support
  - Line manager workshops
  - Employee resilience training
  - Personal support following bereavement
  - Referrals to local care services
  - Online workshops
  - Mental health first aid (MHFA) courses
  - 'Cancer in the Workplace Training' for line managers and HR
  - Online GP services reducing the need for employees to see their own GP
  - Second Medical Opinion services providing clinical certainty for employees and their families with correct diagnosis and treatment being given and better clinical outcomes and return to work times
  - Employee Assistance Programmes providing health and wellbeing support as well as counselling support

- **The research highlights a seemingly substantial "knowledge gap" for insurance, with individuals often underreporting being covered by products such as income protection.** This suggests that individuals might have access to insurance benefits, including the ability to access preventative services, financial support and private medical care, yet not realise this. Others might believe they are covered by insurance which they do not have.

Fiscal benefits

- **Economic modelling presented in this report suggests that increased use of insurance products such as income protection and private medical insurance could deliver significant benefits to the exchequer**. These include:

    - Benefits to the exchequer of up to £600 million a year through reduced sickness absence.
    - Initial benefits to the exchequer of up to £800 million a year through lower incidence of individuals leaving the workforce following absence. These benefits also accumulate over time, as the total number of people supported to remain in the workforce adds up.
    - Exchequer benefits of £300 million a year through reduced rates of presenteeism.

Considerations for the health and protection insurance industry

- **The insurance industry needs to do more to clarify to individuals and businesses (and the latter in particular) the nature and purpose of their products and their potential benefits.** This research suggests there are substantial understanding gap between what the industry devises and promotes its products for and the motivations behind many employer reasons for purchasing them.
- **The insurance industry should identify ways it can improve its current stock of data, to better illuminate potential health and wider societal benefits of health and protection insurance products.** More detailed information on the possible causality between insurance services provided and health/return-to-work outcomes, would help to build a more compelling case for the role of insurance in tackling illness, injury and presenteeism in the workplace. Specific examples of useful data include measures of the relative quality of private healthcare treatment versus NHS treatment (for example in terms of speed of returning to good health and operation success rates). Data demonstrating the role that prevention services – such as annual health "MOTs" for staff – can play in reducing sickness rates and presenteeism would also be valuable in helping to convey to businesses the role that insurance can play in improving health.
- **If the industry is to sustain itself and in-time expand further into more challenging markets like the small business market, it will need to consider more product innovation.** To do so, it will need to tackle the issues of (at least perceived) cost, trust and transparency, perceptions of complexity, fears over "small print" and non-pay-out on claims that pervade parts of the consumer and small business populations. The industry also needs to adapt to expectations of greater product choice, including the trend for more tailored products and services that suit individual circumstances.

Considerations for policymakers

- **As in Australia, higher earners in the UK could be 'nudged' into taking out PMI or other insurance (e.g. IP) to enable tax money to be spent meeting the health needs of those on lower incomes.** In Australia, those above a certain income threshold without private insurance face higher income tax rates, and most people who buy private insurance are eligible for rebates. A stated intention of this policy is "to encourage individuals to take out private hospital cover, and where possible, to use the private system to reduce the demand on the public Medicare system." The Coronavirus crisis has raised a number of questions about "capacity" in the public health system; encouraging higher earners to use private healthcare to "reduce pressure on the NHS" might be an appropriate avenue for exploration. There may also be useful lessons from Australia as to how higher levels of take-up of "protection insurances" such as IP can reduce the disability benefits costs borne by the taxpayer, while providing those off sick with more financial security.
- **Reforming Statutory Sick Pay requirements could be a powerful way of improving workplace health.** The Netherlands has substantially improved return-to-work rates and labour market participation through re-configuring their sick pay system, which has incentivised businesses to take a more pro-active approach towards supporting ill and injured workers. This includes through taking out insurance to ensure that substantial sick pay requirements under the Netherlands system can be met. Sick pay structures could be reformed in the UK along similar lines. The Coronavirus crisis has increased debate about the low level of Statutory Sick Pay in the UK, suggesting that there might be significant public and political will to increase it. As in the Netherlands, an increase in Statutory Sick Pay should increase incentives on employers to improve workplace health and reduce absence rates. Employees would benefit from greater financial stability in the event of sickness, and insurance can help businesses manage the costs associated with higher rates of Statutory Sick Pay.
- **A reform of long-term absence and disability is needed with perhaps even the extension of sick pay.** The auto-enrolment principle could be extended to sick-pay, resulting in a co-funded (employer and employee) or sole funded (employer) insurance coverage, with the aim of creating incentives for both employers and employees about what happens to them when they are sick, how much they would get and who from. Additional benefits could be greater health focus for employers and employees and a reduction in the State disability bill if organisations adopted a kitemarked income protection solution.
- **A simplification of tax and legislative barriers could support wider uptake of insurance products with potential health benefits.** Options include an annual allowance for benefits-in-kind taxation so that, up to a financial threshold, receiving benefits-in-kind (e.g. through health insurance) is not penalised. It should also be ensured that the welfare system does not penalise use of insurance, as is the case at present. Currently about one in five recipients of Universal Credit may find their individual income protection policy to be of no value in the event of absence from work due to illness or injury, because of the way income protection payments interact with the Universal Credit system. For employers there are challenges around P11d and how their support services impact on associated legislation and tax.

CHAPTER 1 - INTRODUCTION

Health and work have risen up the Government's policy agenda in recent years. 2019 saw the Department for Work and Pensions (DWP) launch a consultation on the different ways in which government and employers can take action to reduce ill health-related job losses.[2] The consultation, "Health is Everyone's Business", ran from July 2019 to October 2019. The consultation included the publication of DWP documents exploring the costs and consequences of sickness and injury at work[3], as well as the role of different policy proposals in improving health outcomes in the labour market. [4] Policy options explored include reforms to the role that could be played by occupational health, the insurance sector and the legal framework (including Statutory Sick Pay requirements).

The government intends to use the evidence and views gathered during the consultation to develop proposals and understand the impact of policy changes on both employers and employees. The evidence base from the consultation will also help to determine what approach offers the best value for money and is affordable in the context of the next Spending Review.[5]

It is noteworthy that the DWP consultation has focused heavily on the role of occupational health in reducing absence from work and job losses, including through direct subsidies or voucher schemes to reduce the cost for Small and Medium-Sized Enterprises (SMEs). DWP's policy proposals document included an entire chapter devoted to occupational health reform. In contrast, the role of insurance-based solutions, such as through private medical insurance and income protection insurance, was only mentioned marginally – in references to their role played in other markets such as the Netherlands.

Yet there is, in essence, a role that could be played by insurance-based solutions in delivering health improvements as well as fiscal benefits to the government. Prevention services often included in insurance-based solutions, such as access to counselling, physiotherapy and health checks, can reduce presenteeism and sickness/injury rates. Insurance can also provide more rapid return to work following illness or injury, through swifter access to treatment. Potential fiscal gains for government from insurance-based solutions include reduced National Health Service costs (through use of private treatment, preventative services and swifter return to work), reduced welfare spending (through more rapid return to work), as well as increased tax revenues (through more rapid return to work as well as taxation on group income protection payments). The potential benefits of insurance-based solutions mean that, in our view, they are worthy of greater discussion in the government debate around policy options for improving health among the workforce – both among employees and the self-employed. The Coronavirus crisis has increased focus on the inadequacies of the UK's social safety nets – in terms of supporting public health and the finances of those that are unable to work due to illness – meaning there is now likely to be much stronger appetite for significant policy reforms with respect to workplace health and social security.

The focus of this report is to shed more light on the role of insurance in improving health at work. To do this, we draw on a wide range of evidence – existing studies, new online surveys of employers and employees, in-depth interviews with businesses and insurance industry data. We commissioned two online surveys from Opinium – a survey of HR-decision makers in businesses, and a separate survey of individuals that had suffered a long-term absence of more than four weeks (50% of the sample with insurance benefits and 50% without such benefits). In addition,

the SMF undertook 35 in-depth over-the-phone interviews with businesses. Full details of survey and interview methodology can be found in the appendix of this document.

In the report, we explore uses and perceptions of insurance in the context of health, and also explore the decision-making process of businesses in deciding whether or not to purchase insurance. The primary focus of the research is on private medical insurance and income protection insurance, though in places we also touch on other types of insurance with conceivable health benefits. This includes cash plans, life insurance and critical illness cover.

In addition to direct health benefits through access to, for example, swifter healthcare and preventative services, we also explore the financial benefits of insurance. The UK's low level of Statutory Sick Pay potentially places a substantial financial burden on households in the event of absence from work – something that the Coronavirus crisis has brought into focus. Insurance products such as income protection can provide stronger financial support during absence. This can in turn support health, especially mental health, through providing peace of mind and reducing stress associated with absence and illness.

It is likely that the spread of COVID-19 to the UK, in 2020, will reinforce the salience of workforce health and wellbeing related issues because the impact of COVID-19 is likely to have considerable and long-lasting consequences for individuals, families, communities and employers. The most direct impact will be on those who suffer from a severe bout of COVID-19 who may need to be absent from work for a long period and the aftermath of experiencing a more than mild COVID episode. Further, some who catch COVID-19 will endure "long COVID"[6]. While little understood, some of the effects of it are proving to be significant for some people. Such sufferers may require months, if not years, of ongoing healthcare support and may find it more difficult to return to the life they had prior to their having COVID-19.[7] Beyond the health problems directly attributable to COVID-19, additional health and wellbeing issues could arise out of the changes to working patterns and other effects resulting from the policy response to COVID-19. This includes the reported increase in mental health problems,[8] [9] as well as the plethora of health conditions that went undiagnosed and therefore are yet to be treated because of the rapid reorientation of the NHS towards dealing with COVID-19 patients.[10] Those who had already got a diagnosis but were awaiting treatment or were part-way through treatment which got delayed for similar reasons may also suffer detrimental consequences as a result, perhaps lasting years.[11] Consequently, the future is likely to be replete with a number of health and wellbeing uncertainties emanating from the COVID crisis, leading to unknown health and economic costs for individuals, families, communities and businesses.

This report primarily concerns itself with providing more data and insights on the linkages between insurance and workplace health outcomes, rather the setting out specific policy options for government. As such, we see this as a hopefully useful contribution to the policy debate on work and health, and the role that insurance can play in improving it. Our report concludes with a discussion of policy areas which we believe are worthy of further consideration and debate, in light of the evidence presented in this report.

The structure of this report is as follows:

- **Chapter 2** - provides an overview of the latest trends in sickness, injury and absence.
- **Chapter 3** - examines uptake of insurance products in the UK workforce.
- **Chapter 4** - explores the decision-making process underpinning usage and non-usage of insurance. It also explores perceptions of insurance both from the perspective of businesses and employees.
- **Chapter 5** - explores the potential fiscal benefits of insurance-based solutions for improving workforce health outcomes.
- **Chapter 6** - contrasts the policy landscape in the UK with elsewhere, in the context of insurance.
- **Chapter 7** - sets out areas for consideration, for policymakers and the insurance industry, in light of the findings in this report.

CHAPTER 2 - WORKPLACE SICKNESS, PRESENTEEISM AND ABSENCE

Sickness, injury and absence in the workplace, among employees and the self-employed, impose substantial costs on society. Businesses are impacted by disruption due to staff absence, costs associated with sick pay and also costs associated with measures such as hiring temporary staff in the event of absence. Employees are impacted by lost income through absence, as well as the possibility of being unable to return to work following a severe injury or illness. In addition, Government and therefore taxpayers also bear costs, such as those related to healthcare and welfare payments. Further, the events of 2020 show that, in some extraordinary circumstances, the public health response to a particular health threat can add extra costs on-top of an already substantial problem.

The most comprehensive assessment of these costs from Government suggested that, in 2015, the economic costs of sickness absence and worklessness could be as large as £130 billion a year, and the associated costs to the Exchequer as large as £55 billion a year.[12] Further, the government reported that around 300,000 people a year fall out of work and into the welfare system because of health-related issues.[13]

The impact of COVID-19 and its consequences is likely to increase such costs further.[14] There are a number of ways in which "COVID costs" are likely to feed through into greater levels of societal detriment, including lost productivity, additional claims on the NHS's resources, more sick pay payments and higher welfare claims. For example, those who are ill with COVID-19 and therefore absent from work, especially those who experience "long COVID"[15], will require healthcare services and sick pay and some may have to claim welfare benefits. Many may not be able to continue to their previous jobs or resume full-time work[16] resulting in potentially significant productivity losses for both individual firms and, in-aggregate, across the economy. In addition, there are likely to be a range of detrimental in-direct impacts. These will accrue as a result of the legacy of the lockdowns, the changes to working and social patterns that have developed[17] as a result of the public health measures (aimed at controlling the spread of the virus) taken by the authorities and the backlog of delayed treatments and undiagnosed (and therefore untreated) conditions that has built up over 2020.[18] The extra demands on the NHS, the additional sick pay that will need to be paid out, the greater numbers of welfare claims and the lost productivity (due to absence from the workplace or people no longer able to do the jobs they were previously doing or work the hours they were able to before the COVID disruption) will generate considerable costs.

Recent years have also seen growing concern about the impact of "presenteeism" on the UK economy. Presenteeism occurs when ongoing physical or mental conditions prevent employees from being fully productive at work. Although they are not absent from work, their reduced productivity still poses economic costs. A study by Vitality, in partnership with RAND Europe, the University of Cambridge and Mercer, found that British businesses lost the equivalent of £92bn as a result of ill-health related absence and presenteeism in 2019.[19]

The Stevenson Farmer report of late 2017, *Thriving at Work*, estimated the cost of presenteeism caused by poor mental health to employers is £17bn to £26bn per year, far more significant than the estimated £8bn cost of absenteeism.[20] Meanwhile, a Money and Mental Health Policy Institute survey estimated 2.3 million employees in the UK are experiencing mental health problems that affect the amount of paid work they could do.[21]

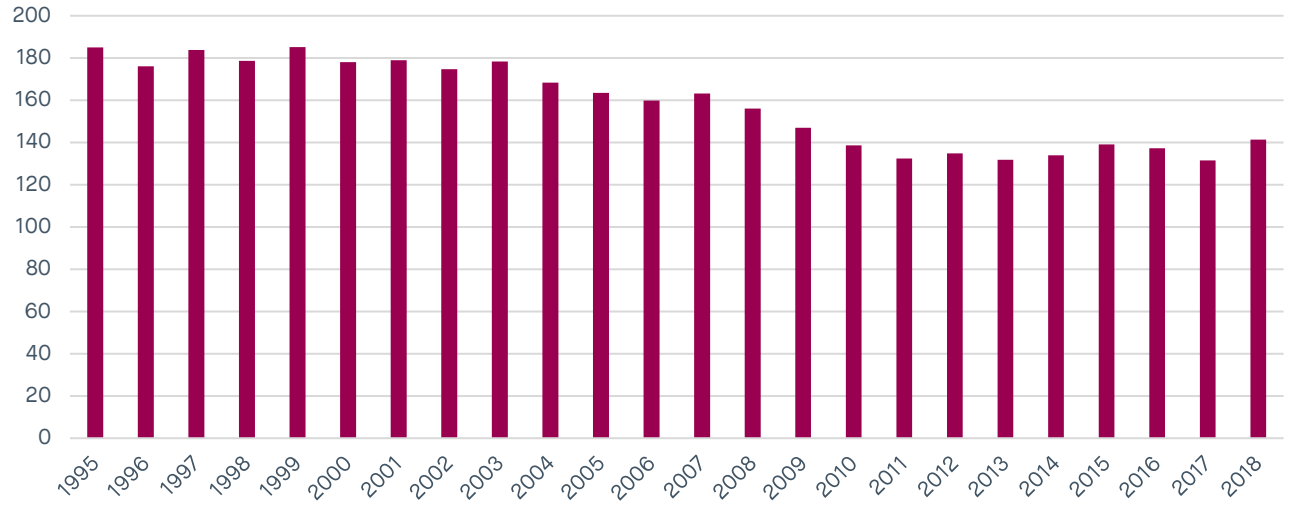
The Department of Health provides a broader view of all impacts of mental ill health, which it describes as the single largest cause of disability in the UK. Costs in England alone are estimated at £105bn each year, which includes the direct costs of services, lost productivity at work and reduced quality of life, as well as the costs of reduced educational outcomes and employment and increased crime, plus the wider impact on quality of life.[22]

Given the scale of these costs, it is important to understand recent trends and drivers of absence from work in the UK – particularly long-term absence, defined as four weeks or more off work. It is also important to understand the drivers of presenteeism in the UK – insofar as this is possible with the available data (presenteeism is inherently more difficult to measure than absence). That is the focus of this chapter, which sets the scene for the subsequent assessment of the role of insurance-based solutions in improving health outcomes.

Trends in sickness and absence in the workforce

According to the Office for National Statistics, an estimated 141.4 million working days were lost in the UK in 2018, equivalent to 4.4 days per worker. While down on two decades ago – 178.6 million days were lost in 1998 – this is still a substantial figure, with associated economic costs.

Figure 1: Number of days lost through sickness absence, UK, 1995 to 2018, millions



Source: ONS

Furthermore, some organisations such as the IPPR think tank have noted that the decline in absence might be driven by negative developments as well as positive ones. Positive developments include improving workforce health due to, for example, reduced rates of tobacco use. Another positive development could be workplaces becoming safer. On the negative side, the IPPR has noted that job insecurity might be making employees less willing to take time off due to sickness for fear of negative repercussions. Employers might also be increasingly using absence as a key indicator of staff performance, reducing willingness to take time off.[23]

Another consideration is the fact that employees may feel less comfortable taking time off for some health problems than for others. A survey commissioned by Canada Life found that about a fifth of respondents would be more likely to go into work if mentally ill than physically ill[24].

Reluctance to take time off work might be leading to a situation where reduced rates of sickness absence are not telling a complete picture of workplace heath; absence might be being replaced with higher rates of presenteeism at work. CIPD's Health and Wellbeing at Work Survey found that 86% of over 1,000 respondents to the 2018 survey said they had observed presenteeism in their organisation of work over the last 12 months, compared with 72% in 2016 and just 26% in 2010[25]. The long-term consequences of the shift to large numbers of employees working from home during 2020 further complicates this picture.[26] It raises a question as to how permanent the change in working patterns ends up being and, consequently, what impact this might have on phenomena like presenteeism. Whether, for example, presenteeism (albeit remote presenteeism) will grow as delineations between work-life and home-life become more blurred or, conversely, whether it improves the situation. Certainly, the prospect of permanently altered working patterns for many, raises a number of questions for employers about how to manage employees in such circumstances including health, well-being and absence risks.[27]

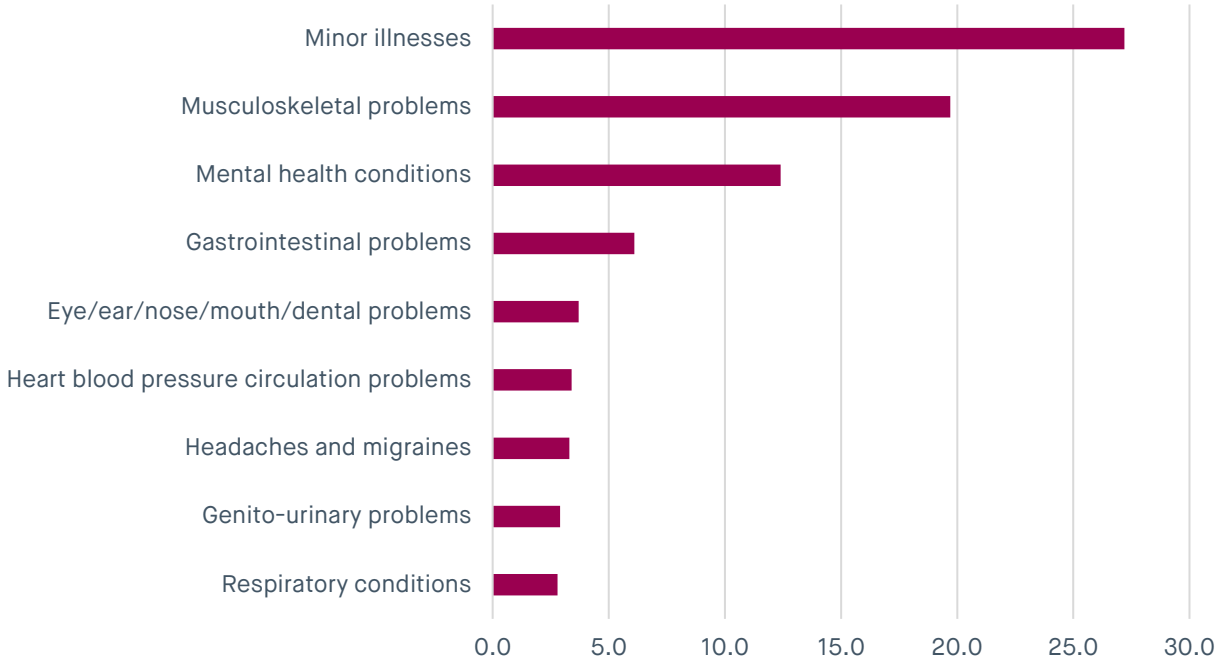
Segmentation of absence rates

As well as trends over time, it is also important for policymakers to consider the distributional impact of sickness, injury and absence, which we outline below.

Distribution of absences by reasons for absence

Excluding days lost through minor illnesses such as colds, the most common reasons for staff absence were musculoskeletal problems (19.7% of all days lost in 2018) and mental health conditions (12.4% of days lost in 2018). Excluding days lost to minor illnesses, musculoskeletal problems and mental health conditions accounted for 44% of days lost in the UK in 2018. As such, policies which focus on these conditions could go a long way towards reducing overall absence rates.

Figure 2: Percentage of days lost through sickness absence, by reason, UK, 2018



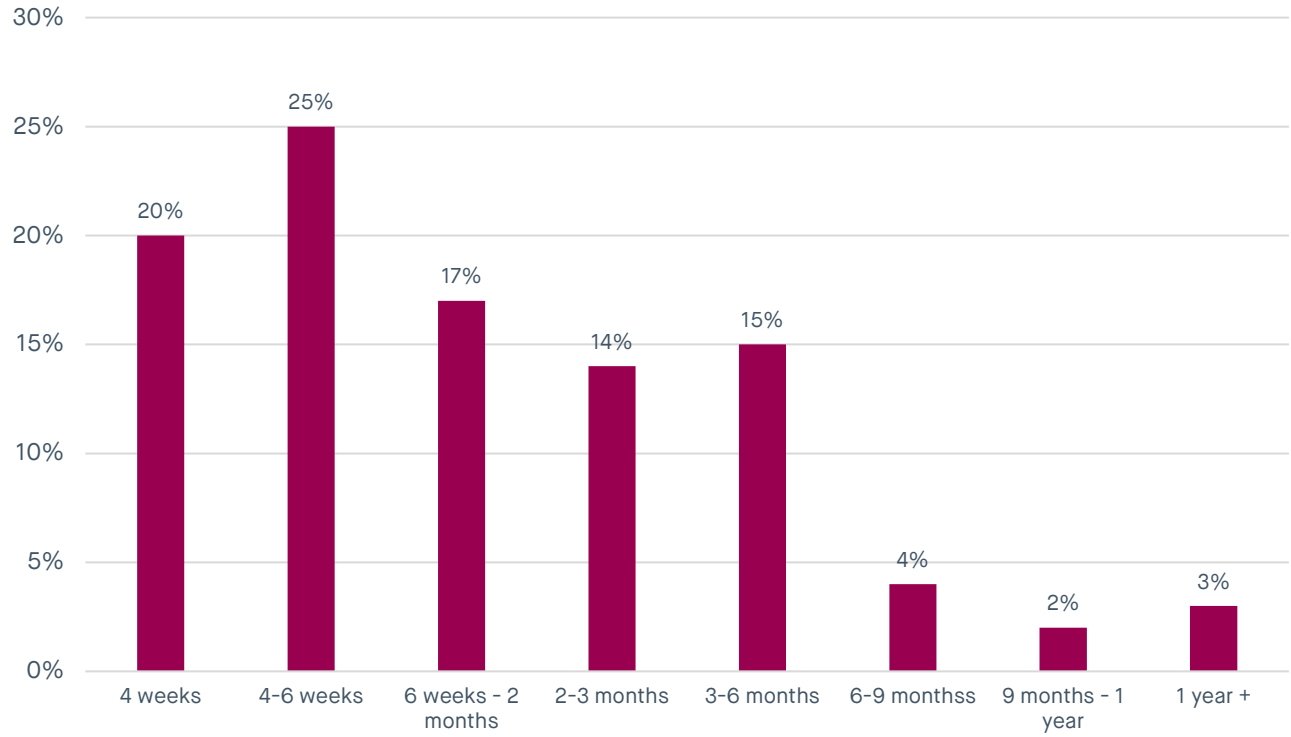
Source: ONS

Duration of absence

While most absence in the UK is short-term in nature, analysis by the Department for Work & Pensions and Department of Health & Social care shows 1 in 25 people in work having a spell of long-term sickness absence (LTSA) over a 12 month period (1.4 million working-age people having a total of 1.8 million spells of LTSA). This is defined as four weeks or more of absence. Over 100,000 people leave work following a spell of LTSA each year. The longer a LTSA persists the greater the likelihood an individual does not return to work following their absence.[28] If LTSA leads to unemployment, this can have sustained negative implications for individuals as well as government (in terms of associated welfare costs). Given the link between absence duration and likelihood of returning to work, policy should focus on ensuring absence is as short in duration as possible. This includes through swift access to appropriate healthcare.

About half (45%) of LTSA is less than six weeks in duration, while about one in ten (9%) of spells of LTSA are greater than six months long.

Figure 3: Distribution of the duration of LTSA spells

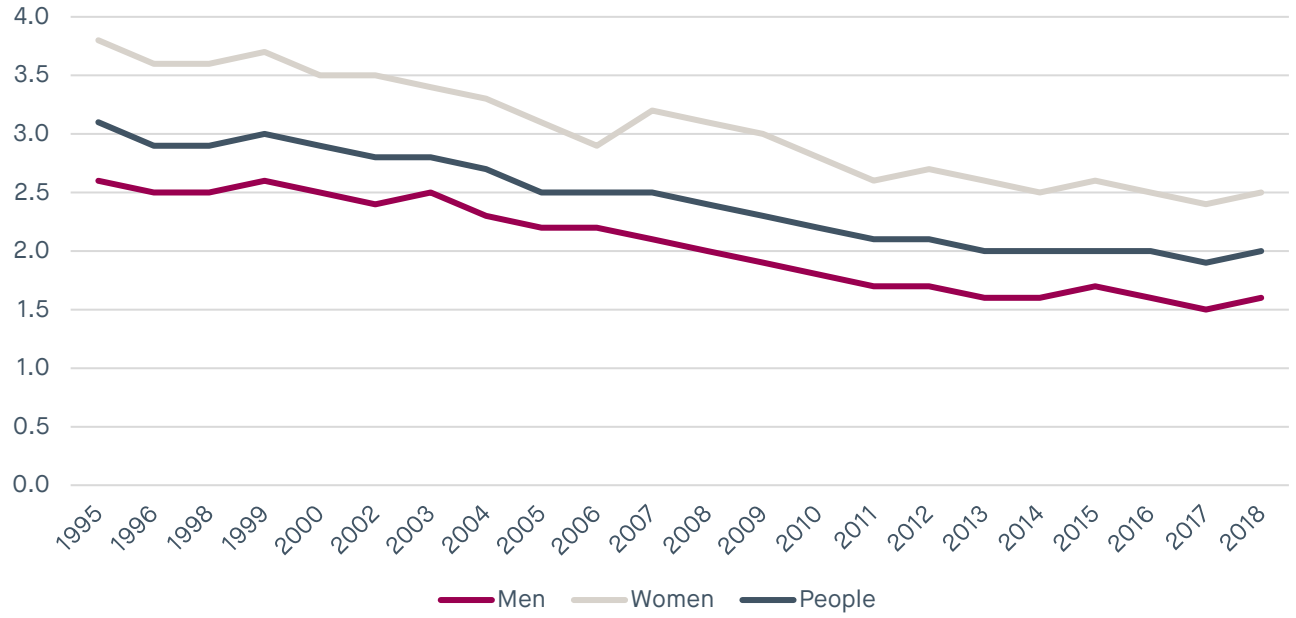


Source: DWP and DHSC analysis

Gender, age and regional distribution of absence

ONS data show that absence rates have been consistently higher for women than for men since 1995, though absence rates have declined for both sexes over this time period. Women lost 2.5% of their working hours in 2018 as a result of sickness or injury, while men lost 1.6% of their working hours. Higher absence rates among women suggest that, on an individual level, they may face greater personal costs associated with absence – for example in the form of lost earnings.

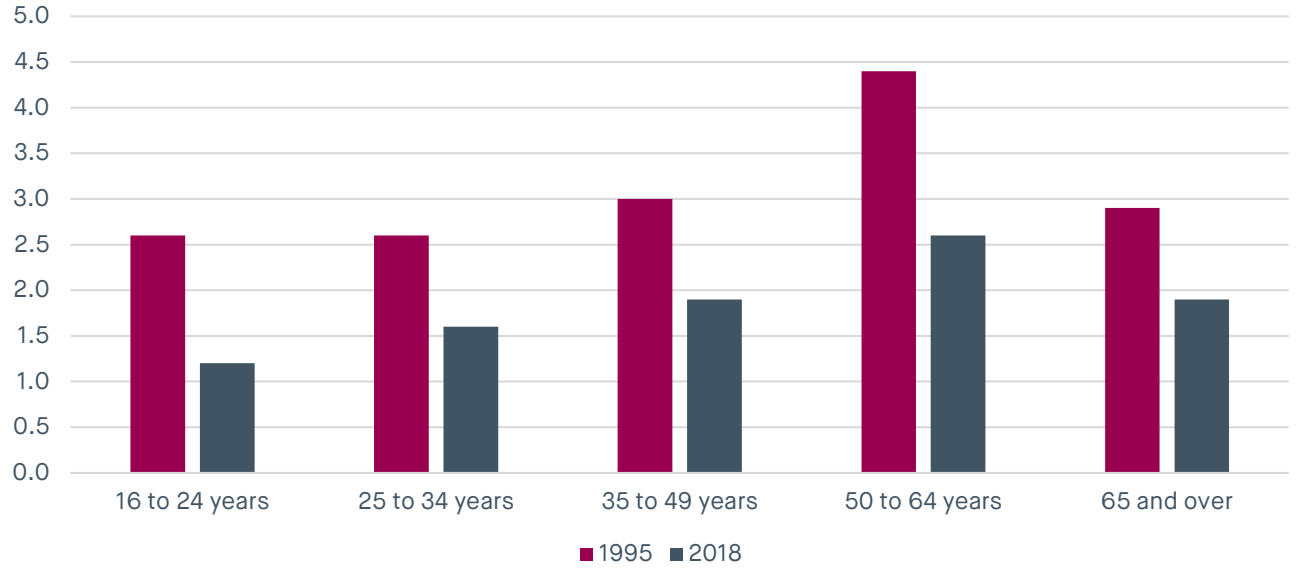
Figure 4: Sickness absence rate, %, by sex, UK, 1995 to 2018



Source: ONS. The sickness absence rate is defined as the proportion of total hours lost as a result of sickness or injury to total hours worked

In terms of the age breakdown of absences, absence rates are highest among those aged 50-64. Absence rates across all age groups have declined significantly between 1995 and 2018. Absence rates are higher among those in older age groups, reflecting the fact that they are more likely to develop health problems. With the UK population ageing, demographic trends could place upward pressure on absence rates, though this might be partly or fully offset by health improvements which reduce the proportion of older individuals suffering significant health problems.

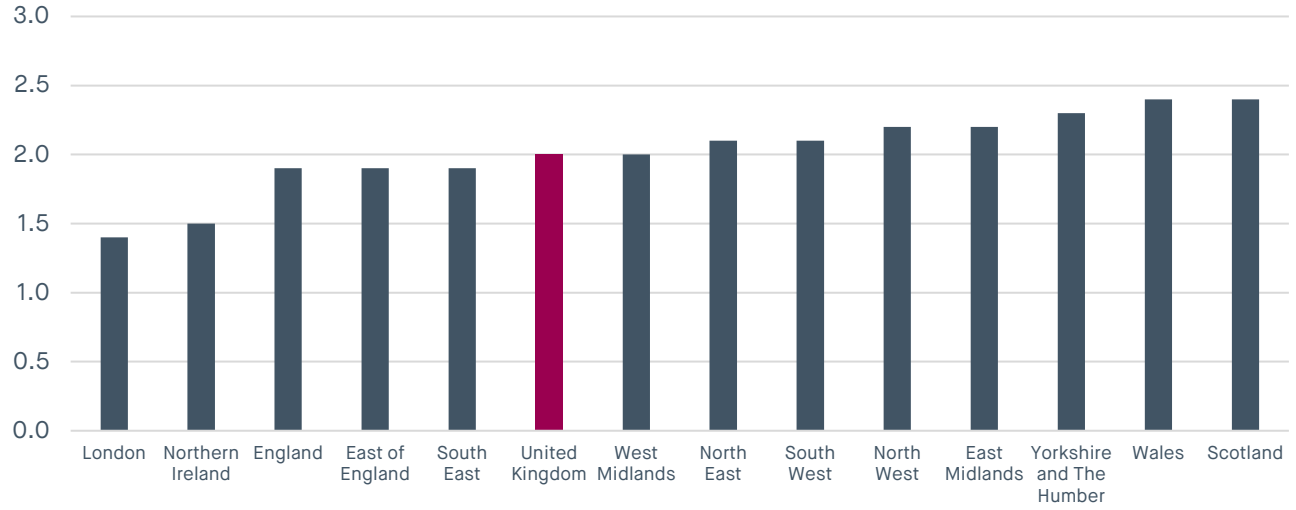
Figure 5: Sickness absence rate, %, by age group, UK, 1995 and 2018



Source: ONS. The sickness absence rate is defined as the proportion of total hours lost as a result of sickness or injury to total hours worked

Absence rates differ across regions of the UK. In 2018 they were lowest in London (1.4%), and highest in Wales and Scotland (both 2.4%). The ONS has noted that these figures can be largely explained by the differing age profiles and occupations for workers in different parts of the UK. [29]

Figure 6: Sickness absence rate, %, by region, UK, 2018

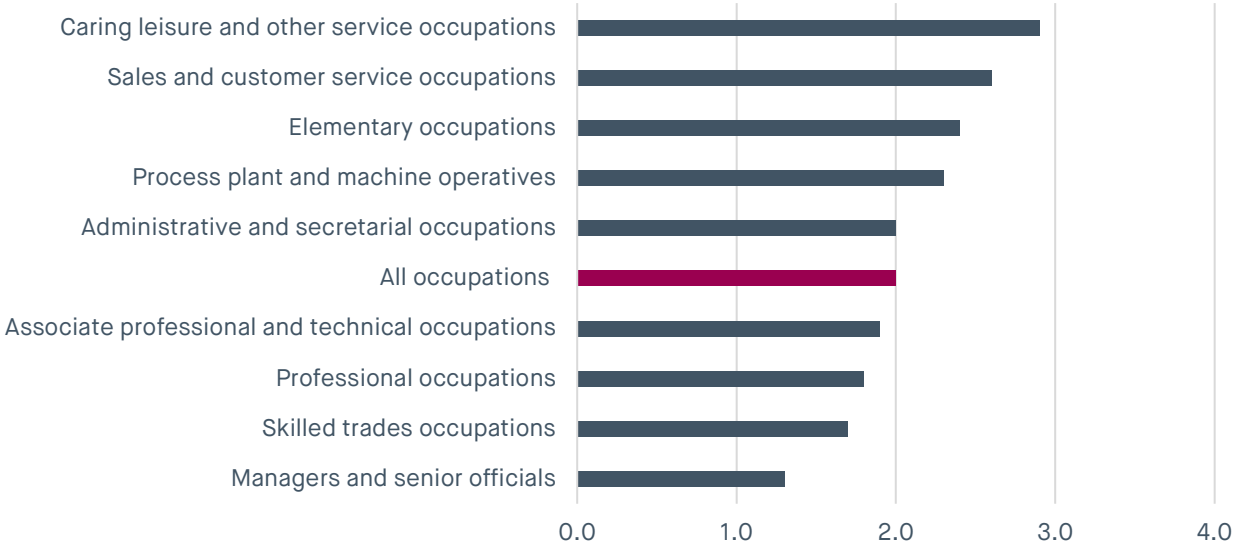


Source: ONS. The sickness absence rate is defined as the proportion of total hours lost as a result of sickness or injury to total hours worked

Occupational variations in absence

Notably, absence rates tend to be higher in lower-paid than higher-paid occupations in the UK. Workers in caring, leisure and other service occupations had the highest sickness absence rate in 2018, at 2.9%. This is followed by those in sales and customer services occupations (2.6%) and elementary occupations (2.4%). In contrast, those working in managerial and senior roles had a sickness absence rate of just 1.3%.

Figure 7: Sickness absence rate, %, by occupation, UK, 2018



Source: ONS. The sickness absence rate is defined as the proportion of total hours lost as a result of sickness or injury to total hours worked

This suggests that absence has a particularly negative financial impact on those on lower incomes, relative to individuals' wealth and earnings. Lost earnings due to absence might be particularly problematic for lower income households due to a lack of savings providing a financial buffer until an individual can return to work.

Likelihood of becoming absent

The ONS has undertaken statistical regression analysis to understand how characteristics such as sex, region and occupation, in isolation, affect absence rates. The analysis attempts to control for overlap in characteristics affecting absence rate. For example, we know that Londoners are younger on average than those elsewhere in the UK – as such it is unclear, just from looking at absence rates, whether London's lower rate of absence is just a reflection of the age distribution of the population, or whether other factors might be at play. Similarly, we know that men and women tend to work in different industries and occupations; are differences in absence rates by sex just a reflection of this, or does sex alone have some bearing on absence? Regression analysis attempts to "unpick" these drivers of absence.

The ONS estimated that, from January 2018 to December 2018, the likelihood of reporting sickness absence (when controlling for different factors that may influence sickness) for different groups were:

- By sex, 39% higher for women relative to men
- By age, 41% lower for workers aged 16 to 24 years, 24% lower for workers aged 25 to 34 years and 21% lower for workers aged 35 to 49 years, all relative to those aged 50 years to State Pension age
- By sector, 8% higher for workers in the public sector relative to workers in the private sector
- By size of organisation, 40% higher for workers in organisations with 500 or more employees relative to workers in organisations with fewer than 25 employees
- By occupation group, 12% lower for managers and senior officials relative to those working in professional roles, but 52% higher for workers in the caring, leisure and other service occupations sector.

Can insurance play a role in improving the health of the workforce?

This chapter has shown that a substantial number of working days are lost in the UK due to illness and injury, with associated costs for individuals, businesses and government. Furthermore, costs to individuals are not borne evenly. Higher absence rates for those in lower skill occupations suggest that lower income households may be especially impacted by absence, for example.

This chapter noted that absence rates have declined significantly over the past 20 years. However, we also noted that declining absence might mask a significant issue with presenteeism in the workplace. The productivity costs of presenteeism also need to be a consideration for government and businesses.

Insurance-based policy solutions can address some of the issues identified in this chapter. Prevention and treatment services offered via insurance can tackle key reasons for staff absence, including the two largest non-minor reasons – mental health and musculoskeletal

problems. Prevention services can also play a role in reducing presenteeism. Increasing access to income protection and private medical insurance among those on lower incomes could conceivably reduce differentials in absence rates and provide a greater financial buffer in the event of long-term absence. As we discuss later in this report, mandatory sick pay in the UK is very low compared with similar economies – and there is scope for insurance to play a much bigger role in bridging this gap and create a sickness pay system which better ties sick pay to an individuals' earnings.

Box 1: Range of health and prevention-related services provided through health and protection insurance policies

- Pre- and post-claim return to work support provided by vocational rehabilitation consultants
- Assessments (ergonomic, functional, etc.)
- Early intervention mental health support
- Line manager workshops
- Employee resilience training
- Personal support following bereavement
- Referrals to local care services
- Support on mental, physical, financial and emotional/socialisation health.
- Online workshops
- Mental health first aid (MHFA) courses
- 'Cancer in the Workplace Training' for line managers and HR
- Online GP services reducing the need for employees to see their own GP.
- Second Medical Opinion services providing clinical certainty for employees and their families with correct diagnosis and treatment being given and better clinical outcomes and return to work times.
- Employee Assistance Programmes providing health and wellbeing support as well as counselling support.

Source: ABI

Insurance could reduce absence and presenteeism rates, and provide financial and other support, through the following channels:

- Swifter access to healthcare, through using private services rather than the NHS.
- Financial support for individuals in the event of long-term absence (e.g. from income protection insurance and critical illness cover).
- Access to "prevention" services as part of the insurance package – reducing the chance of an absence occurring in the first place.
- Access to rehabilitation support and services as part of the insurance package. This can include "day one" access to specialists in occupational therapy, counselling and physiotherapy.

An associated reduction in absence due to use of insurance could result in fiscal benefits for government: greater tax revenues through swifter and more likely return to work, reduced public healthcare costs through use of private health services, and reduced welfare spending. Curbing presenteeism and improving workforce productivity should also bolster government tax revenues from multiple sources including income tax national insurance and corporation tax.

An Important way in which insurance-related benefits reduce absence rates is through the introduction of another party – the insurer – with incentives to reduce absence and speed up return to work. As insurers face greater costs if claims are made – for example to access private treatment or income protection payments – they are incentivised to prevent claims occurring. This can be achieved through prevention and rehabilitation services, which reduce absences and minimise their extent if they occur. Creating these incentives is particularly important in the UK context, given the relatively weak incentives placed on employers to reduce absence due to low mandatory sick pay.

Later in this report, we explore attitudes towards insurance among businesses and individuals in the UK that have experienced a long-term absence. This includes an examination of the extent to which workplace health-related reasons are a key driver of purchasing products such as income protection and private medical insurance. Insights from insurer data, surveys and depth interview are used to test the hypotheses described above.

CHAPTER 3 - UPTAKE OF INSURANCE BENEFITS

This chapter provides an overview of current coverage, in the UK, of health and protection insurance products. To illustrate the "state of coverage", this chapter relies upon several primary sources, each of which provide parts of the overall picture and, together, offer a outline of insurance coverage across the UK. Those open sources include:

- The reinsurer Swiss Re's annual publication of data on the group and individual markets for health and protection insurance.[30]
- The Workplace Wellbeing and Protection Report by Corporate Advisor Intelligence.
- The FCA's Financial Lives survey 2017, which provides a detailed snapshot of engagement with, use and ownership of financial products in the UK.[31]
- The ABI's annual "UK Insurance and long-term savings: key facts" document.

Income Protection (IP)

This section looks at the scale of IP coverage across the UK and how that coverage is distributed across a number of dimensions, including:

- The proportion of the UK population with IP policy coverage, and the number of people, in particular, covered by GIP policies.
- The proportion of those who are protected by a policy that have coverage because of their employer.
- Which age groups predominate among those who are covered by IP.
- A breakdown, into household income cohorts, of those with IP coverage.

The FCA's Financial Lives survey suggests that, overall, 4% of the UK population are covered by an IP policy of some kind, as highlighted in Table 1 below.

Table 1: IP policy coverage

	Proportion of UK population that have coverage	Proportion of those with coverage that are employed	Proportion of those with coverage who are self-employed
Income protection	4%	84%	13%

Source: FCA

Table 1 also shows that among those with IP coverage, more than eight in ten are employed and just over one in ten are self-employed.

Table 2 below shows that two-thirds of those who are covered by IP obtain access to their policy through their employer.

Table 2: Proportion of IP policies that are part of an employee benefits package

Source of the benefits provision	Proportion of those with IP coverage
Employee benefit package	66%
Not part of an employee benefit package	29%
Mixed (some coverage as part of a benefits package, others not)	3%
Don't know	2%

Source: FCA

Data from the Workplace Protection and Wellbeing Report (reproduced in Table 3) show that, in 2019, more than two and half million employees in the UK were covered by GIP policies. The same report also highlighted that the number of employers in the UK offering GIP to staff is over seventeen and a half thousand.

Table 3: GIP coverage

GIP	Total number
Employees covered	2,614,526
Employers providing coverage	17,652

Source: Corporate Advisor Intelligence

The ONS estimates that there are around 2.4 million businesses in the UK with employees, along with 3.5 million sole traders and over 400,000 partnerships. This suggests that approximately 0.7% of businesses in the UK (with a directly employed workforce) provide access to GIP to their staff.

The IP market has grown, as data from Swiss Re, shows. In its latest "market updates" for both individual IP policy coverage and GIP, it found that:

- GIP coverage grew by 6% between 2018 and 2019 and the number of "in-force" policies increased by 1.9% over the same period.[32]
- Individual policy sales grew by 20.9% between 2018 and 2019.[33]

Table 4 shows how IP policy coverage breaks down across age cohorts. Coverage is concentrated among those in the 35 to 54 age brackets, which together account for more than 60% of policies.

Table 4: Age breakdown of those wit income protection coverage[1]

Age cohorts	Proportion of those with IP coverage
18-24	7%
25-35	18%
35-44	32%
45-54	31%
55-64	12%
65-74	1%

Source: FCA

Table 5 illustrates that those who have IP coverage are to be most often found (45%) in the £30k to £70k per annum household income ranges.

Table 5: Household income breakdown of those with income protection coverage[2]

Household income brackets	Proportion of those with IP coverage
<£15k	2%
£15k - £30k	8%
£30k-£50k	22%
£50k-£70k	22%
£70k-£100k	17%
£100k-£250k	13%
£250k+	1%
Don't know	14%

Source: FCA

Private Medical Insurance (PMI)

This section presents an overview of the scale of PMI coverage across the UK and how it is distributed across a number of different dimensions, which Include:

- The proportion of the UK population with a PMI policy and the number of people in the UK covered by PMI provided through their employers.
- Which age groups in the population predominate among those who are covered by PMI.
- The distribution of those with PMI coverage across household income cohorts.

The FCA's Financial Lives survey suggests that, overall, 12% of the UK population are covered by a PMI policy, as highlighted in Table 6 below.

[1] Please note that all data presented is rounded. Consequently, in some cases the totals may not sum to precisely 100%.
[2] Please note that all data presented is rounded. Consequently, in some cases the totals may not sum to precisely 100%.

Table 6: PMI policy coverage

	Proportion of UK population that have coverage	Proportion of those with coverage that are employed	Proportion of those with coverage that are self-employed
PMI	12%	73%	8%

Source: FCA

Table 6 also shows that most policies cover employed people. Less than 10% of those with coverage are self-employed.

Table 7 indicates that over two-thirds of PMI coverage is through an employer-provided "benefits package".

Table 7: Proportion of PMI policies that are part of an employee benefits package

Source of the benefit provision	Proportion of those with PMI coverage
Employee benefit package	67%
Not part of an employee benefit package	30%
Mixed (some coverage as part of a benefits package, others not)	2%
Don't know	1%

Source: FCA

Table 8 reveals that the 67% with PMI courtesy of their employer, equates to more than 2.3 million people with coverage.

Table 8: Group PMI coverage

PMI	Total number
Employees covered	2,303,362
Employers providing coverage	127,200

Source: Corporate Advisor Intelligence

Using ONS estimates of the number of businesses in the UK with employees, indicates that around 5% of businesses in the UK (with employees) offer access to PMI coverage to (at least some) members of their workforce.

Table 9 suggests that those with PMI are predominantly found among the 35 to 44 and 45 to 54 age groups. These two age groups account for half of the total number of PMI policy beneficiaries.

Table 9: Age breakdown of those with PMI [3]

Age cohorts	Proportion of those with PMI
18-24	4%
25-35	15%
35-44	25%
45-54	25%
55-64	16%
65-74	11%
75+	5%

Source: FCA

Table 10 demonstrates that there Is a similar distribution of PMI policy holders across four household income cohorts. Nealy 70% of those with coverage live in households with annual income between £30k and £250k.

Table 10: Household income breakdown of those with PMI [4]

Household income brackets	Proportion of those with PMI
<£15k	2%
£15k - £30k	8%
£30k-£50k	17%
£50k-£70k	17%
£70k-£100k	18%
£100k-£250k	17%
£250k+	3%
Don't know	17%

Source: FCA

Critical Illness Cover (CIC)

This section presents an overview of the scale of CIC coverage in the UK and how it is distributed across different population cohorts, which include:

- The percentage of the populace that have CIC coverage and the number of people in the UK who access CIC through their employer.
- The age groups within which those with CIC coverage are most often found.
- The distribution of those with CIC across different household income cohorts.

Table 11 shows that around one in ten of the population have CIC coverage, according to the FCA's Financial Lives 2017 survey data.

[3] Please note that all data presented is rounded. Consequently, in some cases the totals may not sum to precisely 100%.
[4] Please note that all data presented is rounded. Consequently, in some cases the totals may not sum to precisely 100%.

Table 11: CIC policy coverage

	Proportion of UK population that have coverage	Proportion of those with coverage that are employed	Proportion of those with coverage that are self-employed
Critical illness cover	10%	82%	11%

Source: FCA

FCA data further suggests that CIC coverage is mainly found among those who are employed, with eight out of ten of those with access to CIC being an employee and only one in ten self-employed.

According to FCA data, which is displayed In Table 12, only two in ten obtain their CIC coverage through their employer. The overwhelming majority who have it, access it in different ways.

Table 12: Proportion of CIC policies that are part of an employee benefits package

Source of the benefit provision	Proportion of those with PMI coverage
Employee benefit package	21%
Not part of an employee benefit package	70%
Mixed (some coverage as part of a benefits package, others not)	6%
Don't know	3%

Source: FCA

Table 13 shows that over half a million employees are covered by CIC In the UK and access to CIC Is offered by more than 4,000 employers provide policy access.

Table 13: CIC coverage

CIC	Total number
Employees covered	594,200
Employers providing coverage	4,368

Source: Corporate Advisor Intelligence

CIC coverage is predominately found among those in the 35 to 54 age range. Of those with CIC policy coverage,, the 35 to 44 and 45 to 55 age cohorts account for almost two-thirds of those that have it.

Table 14: Age breakdown of those with CIC[5]

Age cohorts	Proportion of those with CIC
18-24	3%
25-35	22%
35-44	32%
45-54	31%
55-64	10%
65-74	2%

Source: FCA

The plurality of those with CIC can be found in households with annual income between £30k and £70k. Around 46% of those with CIC coverage live in households with income levels within that range.

Table 15: Household income breakdown of those with CIC[6]

Household income brackets	Proportion of those with CIC
<£15k	2%
£15k - £30k	12%
£30k-£50k	22%
£50k-£70k	24%
£70k-£100k	15%
£100k-£250k	11%
£250k+	2%
Don't know	14%

Source: FCA

Health Cash Plans (HCP)

This section presents an overview of the scale of HCP coverage across the UK and how it is distributed across different sections of the population, including.

- The proportion of the UK population with a HCP in place.
- The percentage of those with HCPs covered through their employer.
- The age groups that predominate among those with HCP.
- The distribution of those covered by HCPs across different household income cohorts.

The FCA's Financial Lives survey suggests that, overall, 6% of the UK population are covered by a HCP policy of some kind. The FCA data is reproduced in Table 16.

[5] Please note that all data presented is rounded. Consequently, in some cases the totals may not sum to precisely 100%.
[6] Please note that all data presented is rounded. Consequently, in some cases the totals may not sum to precisely 100%.

Table 16: HCP coverage

	Proportion of UK population that have coverage	Proportion of those with coverage that are employed	Proportion of those with coverage that are self-employed
Health Cash Plan	6%	64%	11%

Source: FCA

FCA data further suggests that HCP coverage is mainly found among those who are employed. Just over six in ten of those with HCP's are employed. While just over one in ten of those with a HCP, are self-employed. Among those with HCP, around four in ten acquire their coverage through their employer, while over half of those covered obtain coverage in other ways, as highlighted in Table 17.

Table 17: Proportion of HCP policies that are part of an employee benefits package

Nature of coverage	Proportion of those with HCP coverage
Employee benefit package	42%
Not part of an employee benefit package	54%
Mixed (some coverage as part of a benefits package, others not)	3%
Don't know	1%

Source: FCA

Table 18 illustrates that over a million and a half employees are covered by HCP's in the UK. Further, HCPs are provided by nearly 20,000 employers across the country.

Table 18: Number of employees covered by HCP and employers offering it

HCP	Total number
Employees covered	1,588,257
Employers offering HCP	19,549

Source: Corporate Advisor Intelligence

There are around 2.4 million businesses in the UK with employees. Data presented in Table 18 suggest that 0.8% of businesses (who employ someone) in the UK offer access to HCPs.

Table 19 reveals that HCP coverage is most often found among those in the 45 to 64 age range. People in the 45 to 54 and 55 to 64 age cohorts account for 45% of those with HCP.

Table 19: Age breakdown of those with HCP coverage[7]

Age cohorts	Proportion with HCP
18-24	4%
25-35	10%
35-44	18%
45-54	24%
55-64	21%
65-74	15%
75+	8%

Source: FCA

Table 20 presents a breakdown the distribution of HCP coverage by different household income cohorts. It shows that the largest single group of people with HCP are to be found in the £30k to £50k a year household Income range. Nearly a quarter of those with HCP coverage come from households with annual earnings in that range. An equal proportion of HCP holders (18%) are found in the £15k to £30k and £50k to £70k annual household income cohorts.

Table 20: Age breakdown of those with HCP coverage[8]

Household income brackets	Proportion with HCP
<£15k	6%
£15k - £30k	18%
£30k-£50k	24%
£50k-£70k	18%
£70k-£100k	9%
£100k-£250k	7%
£250k+	1%
Don't know	16%

Source: FCA

Life Insurance (LI)

This section explores the available data on the scope of LI coverage across the UK and the distribution of coverage among different parts of the population. It presents data on:

- The proportion of the UK population with LI. policy coverage
- The proportion of those with LI that receive it due to their employment status.
- Information on the age distribution of those with LI coverage.
- How those covered by LI are spread across household Income brackets.

The FCA's Financial Lives survey suggests that, overall, 28% of the UK population are covered by a life insurance policy, as highlighted in Table 21 below.

[7] Please note that all data presented is rounded. Consequently, in some cases the totals may not sum to precisely 100%.
[8] Please note that all data presented is rounded. Consequently, in some cases the totals may not sum to precisely 100%.

Table 21: LI policy coverage

	Proportion of UK population that have coverage	Proportion of those with coverage that are employed	Proportion of those with coverage that are self-employed
Life insurance	28%	68%	5%

Source: FCA

FCA data further shows that LI coverage is mainly found among those who are employed. Just under seven in ten of those with LI are employees, while only one in twenty are self-employed.

Among those with LI, 14% acquire their coverage through their employer, as shown in Table 22. The overwhelming majority of people with LI acquired their policy in alternative ways.

Table 22: Proportion of LI policies that are part of an employee benefits package

Nature of coverage	Proportion of those with LI coverage
Employee benefit package	14%
Not part of an employee benefit package	71%
Mixed (some coverage as part of a benefits package, others not)	10%
Don't know	5%

Source: FCA

Table 23 shows that over 55,000 businesses offer LI to their employees. This suggest that 2.3% of UK businesses that have employees, offer access to LI to members of their workforce.

Table 23: Group life Insurance coverage

Group LI	Total number
Employees covered	9,933,870
Employers offering LI	55,806

Source: Corporate Advisor Intelligence

As Table 24 illustrates, coverage predominates among those in the 35 to 54 age range. Those with LI In the 35 to 54 age group account for more than half of those with LI.

Table 24: Age breakdown of those with life insurance[9]

Age cohorts	Proportion with income protection coverage
18-24	2%
25-35	16%
35-44	24%
45-54	28%
55-64	16%
65-74	9%
74+	6%

Source: FCA

[9] Please note that all data presented is rounded. Consequently, in some cases the totals may not sum to precisely 100%.

Table 25 shows that most of those with LI can be found in the £30k to £50k household Income cohort, with nearly a quarter of those with HCP coverage falling into households with those levels of Income.

Table 25: Age breakdown of those with life insurance[10]

Household income brackets	Proportion with Life insurance
<£15k	7%
£15k - £30k	15%
£30k-£50k	22%
£50k-£70k	18%
£70k-£100k	12%
£100k-£250k	8%
£250k+	1%
Don't know	17%

Source: FCA

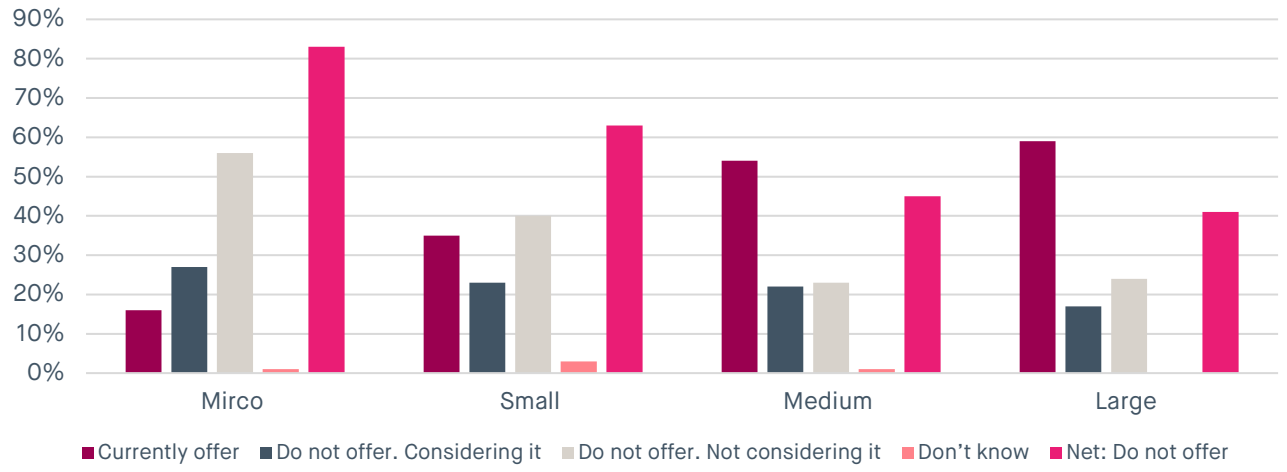
Insurance benefits by business size

The results from the survey of HR Decision Makers carried out to help inform this report, suggest that the likelihood of an employer offering insurance benefits is positively associated with the size of the business.[34] As Figure 8 and Figure 9 show, for PMI and IP, the proportion of businesses in a given size category offering coverage is higher in the larger business-size categories.

PMI and business size

Figure 8 shows, within each business size category, what proportion of firms offer PMI to at least one member of staff. What proportion do not offer PMI and what percentage are "seriously considering" providing access to such benefits to at least one member of their workforce, in the next 12 months.

Figure 8: Proportion of firms in each business size category offering PMI



Source: Opinium survey of HR Decision Makers within businesses

[10] Please note that all data presented is rounded. Consequently, in some cases the totals may not sum to precisely 100%.

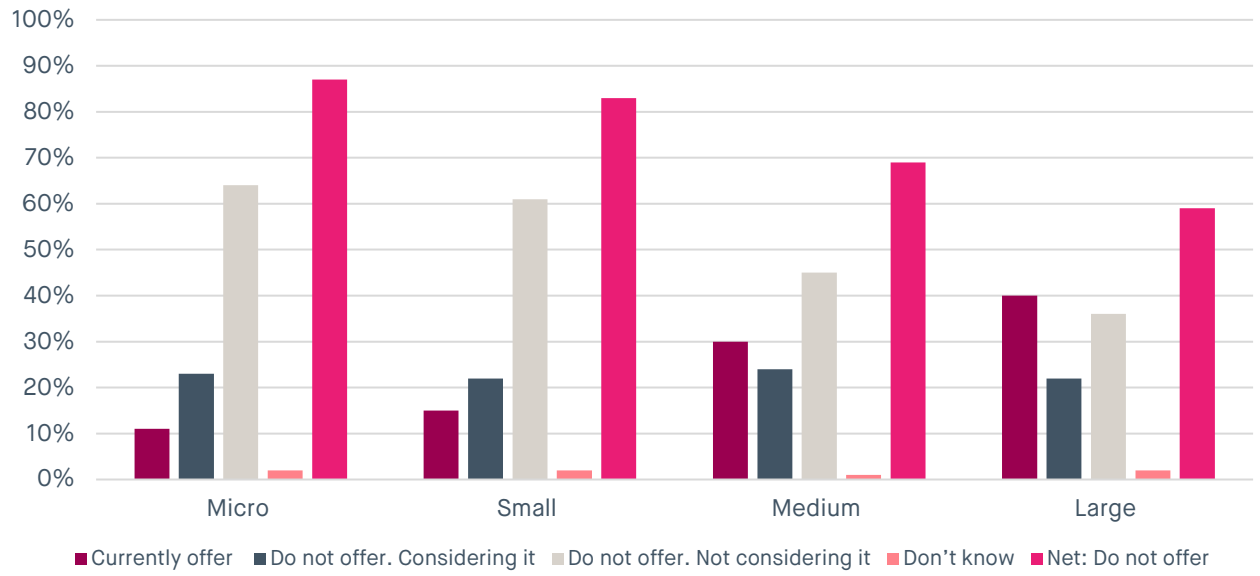
The proportion of larger businesses that "currently offer" PMI is much higher as a proportion of the total number of larger businesses (59%) than it is among micro and smaller businesses (16% and 35% respectively).

Further, the proportion of medium-sized and large business respondents ruling out offering PMI is much smaller than the proportion of micro and small businesses ruling it out i.e. saying that they “do not offer PMI and are not considering doing so”. Although it should be noted that more micro and small firms stated that they were actively considering offering PMI to at least one member of their workforce in the next 12 months. This was greater than the proportion of medium-sized and larger enterprises saying the same.

IP and business size

Figure 9 shows the proportion of businesses, within each business size category, that “currently offer” access to IP insurance to at least one member of staff. It also highlights the proportion of firms, within each size category, that “currently do not offer IP but are seriously considering doing so in the next 12 months”. Figure 9 also demonstrates the proportion of enterprises in each size category that “currently do not offer IP and are not considering doing so” i.e. those least likely to consider taking up the opportunity to provide IP to some or all of their staff.

Figure 9: Proportion of firms in each business size category offering IP



Source: Opinium of HR Decision Makers within businesses

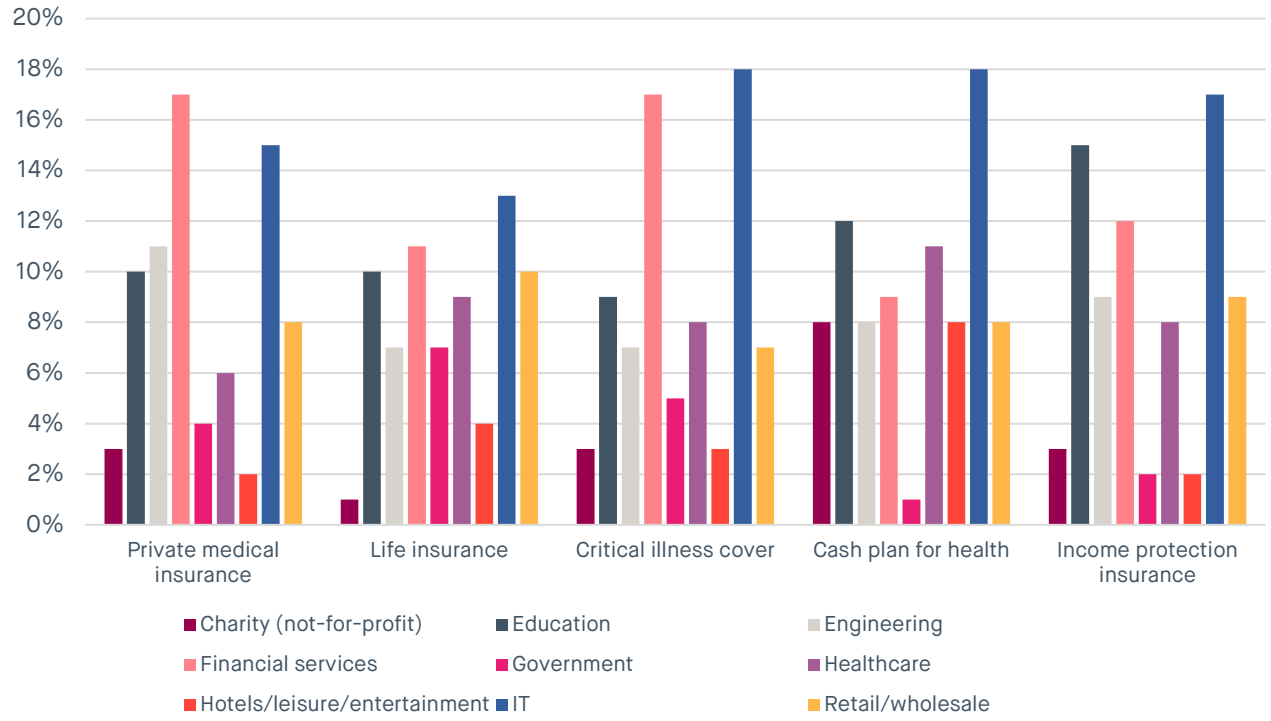
As Figure 9 shows, the overall trends are similar to those observed about PMI in Figure 8. The proportion of larger businesses that "currently offer" IP Is much greater (40%) than the proportion of micro and smaller businesses (11% and 15% respectively) that do. Further, the proportion stating that their business does “not offer and are not considering” providing IP is higher in the micro and small businesses categories than in the medium-sized and large business size categories. While 64% of micro-businesses say this and 61% of small businesses, a much lower 45% of medium-sized forms and a lower-still 36% of larger businesses took the same position. Somewhat differently to the PMI data, the proportion of respondents in each size category saying that they were actively considering providing IP coverage to at least one member of the

workforce, was broadly equal. For example, 23% and 22% of HR Decision Makers in micro and small-businesses answered that their firm "does not offer" IP "but is considering it", while 24% and 22% of HR Decision Makers in medium-sized and larger enterprises said the same.

Sectoral coverage of insurance benefits

Figure 10 illustrates the sectoral distribution of those who were surveyed for this report and had taken a prolonged period of time off work (i.e. were long-term sick) due to an injury or illness and were covered by at least one type of health or protection insurance product at the time. The chart shows that among the individuals who participated in the survey, those with one of the forms of health or protection coverage were often found in professional services such as finance, IT and education.

Figure 10: Occupational distribution of those with health or protection insurance 'benefits'



Source: Opinium survey of individuals who had suffered long-term illness/ injury in the last five years and had insurance "benefits" in-place at the time

There are some notable variations between sectors, however. For example, HCPs are more prevalent among those in healthcare than PMI. More respondents who worked in the charity sector reported being covered by HCPs at the time of their illness or injury than in any other sector. PMI was more prevalent among those working in engineering than any of the other kinds of health or protection coverage. Among those who had LI, Government employees were more often found compared to other categories of insurance or protection coverage.

CHAPTER 4 - WHY DO PEOPLE AND BUSINESSES USE INSURANCE PRODUCTS?

This chapter presents the findings from both survey and qualitative data collection exercises which help explain why employers provide access to health or protection insurances. It explores why many employers, particularly smaller businesses, do not provide health or protection "benefits" for their staff. It also examines evidence about how effective different types of health and protection insurance can be in helping individuals who are ill or injured and consequently had to take time off work because of their illness or injury.

This balance of evidence discussed in this chapter suggests health risk management is not a primary motivating factor for the provision of access to health or protection "benefits" for smaller businesses. The picture is more mixed for larger enterprises. The main reasons why businesses, and smaller firms in particular, provide health and protection insurance to their staff is as incentives and use such "benefits" as signalling mechanisms, and are also motived by a desire to "do the right thing". Whereas larger businesses use them more strategically, with such insurance products utilised as part of strategies to manage health risks among their workforce and the potential impacts of ill-health and injury on the business.

Engaging with the market

Understanding the motivating factors behind the take-up of health or protection insurances and the kinds of factors which act as barriers to businesses in particular, offering coverage to their workforces, will help illuminate the drivers of demand for such products and the likely scope for expansion of the market.

Businesses are responsible for a significant proportion of the health and protection products that are currently purchased. Further, as Figures 8 and 9 shows, there is a proportion of the business community actively looking to purchase PMI and IP products. Consequently, it is important to understand what motivates a firm to, or constrains a firm from, offering such provision to members of their workforce. It is also helpful to policymakers who might be considering a greater role for insurance in social policy, to better understand where there might be scope for reducing some of the barriers that businesses face and consequently, potentially, opening up avenues to more extensive coverage.

The reasons businesses provide health and protection insurance coverage

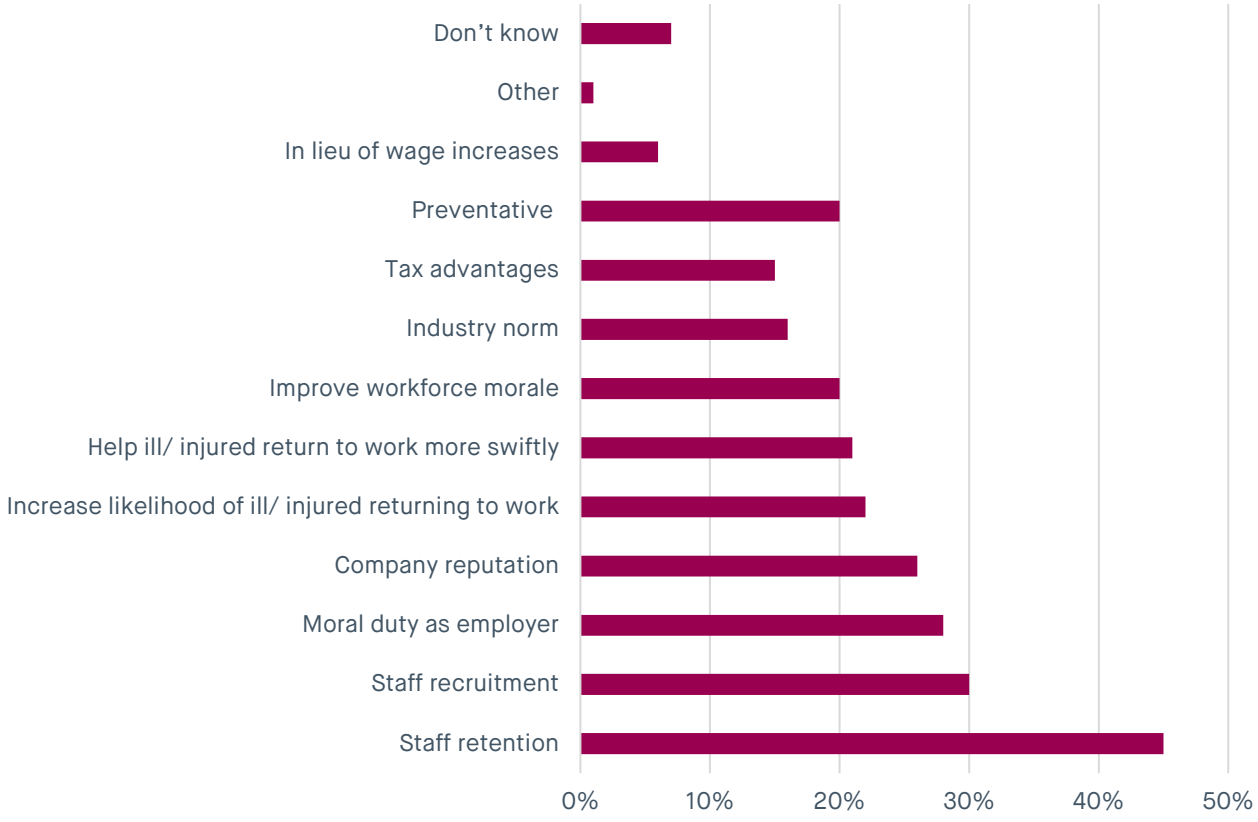
To help build-up a picture of the dynamics of the demand-side of the market (or potential market) for health and protection insurance, a survey of HR Decision Makers was conducted for this report.[35] The survey found that:

- Health and protection insurance is offered by some as a tool for retaining staff in the business and for attracting recruits.
- "A duty of care to staff" and the organisation's reputation were cited by many respondents as motivations too. Both "moral duty" and "company reputation" motivations can be seen as having, at least, an indirect link to issues of retention and recruitment, i.e. it seems reasonable to believe that a caring employer with a good reputation will have staff retention and recruitment benefits.
- Workforce health risk-management factors (e.g. supporting sick or injured members of staff, helping them return to work more quickly or, indeed, at all) were raised as a

motivating factor by around one-in-five businesses providing PMI, and 17 per cent of those providing IP. Similar proportions reported such reasons behind the motivation to provide CIC and CHPs to staff. One in five respondents that offered PMI reported they did so because of its potential "preventative" role (another key part of health risk management). Among those providing IP, "prevention" was cited by 12 per cent of respondents as being a motivating factor.

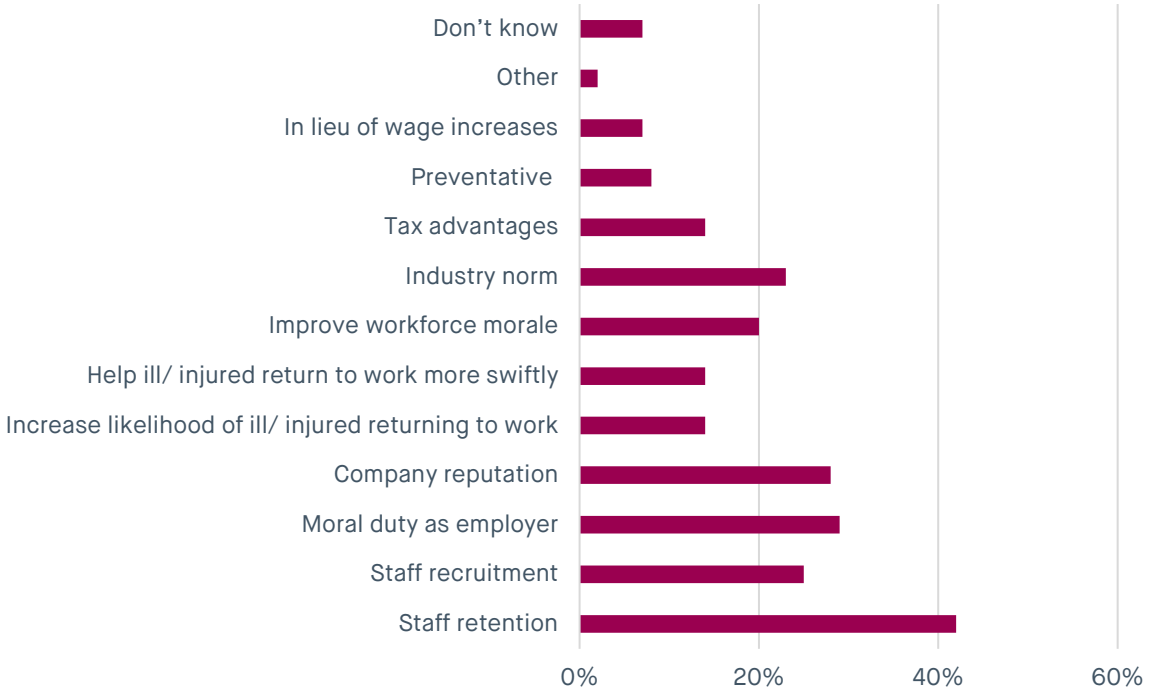
Figures 11 to 15 below show the full range of reasons why employers offer access to PMI, LI, HCP, CIC and IP, to (at least some of) their staff.

Figure 11: Reasons for providing (or considering offering) PMI



Source: Opinium survey of HR Decision Makers within businesses

Figure 12: Reasons for providing (or considering offering) LI

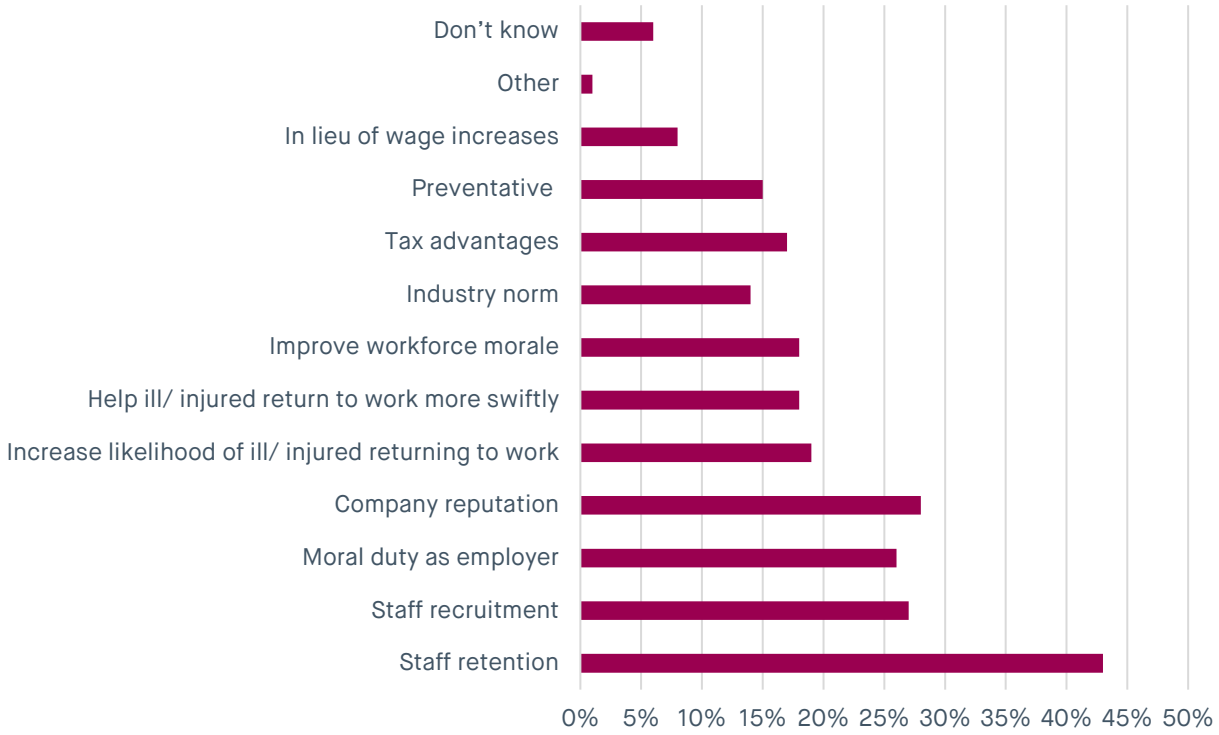


Source: Opinium survey of HR Decision Makers within businesses

Figure 13: Reasons for providing (or considering offering) HCP

Source: Opinium survey of HR Decision Makers within businesses

Figure 14: Reasons for providing (or considering offering) CIC



Source: Opinium survey of HR Decision Makers in businesses

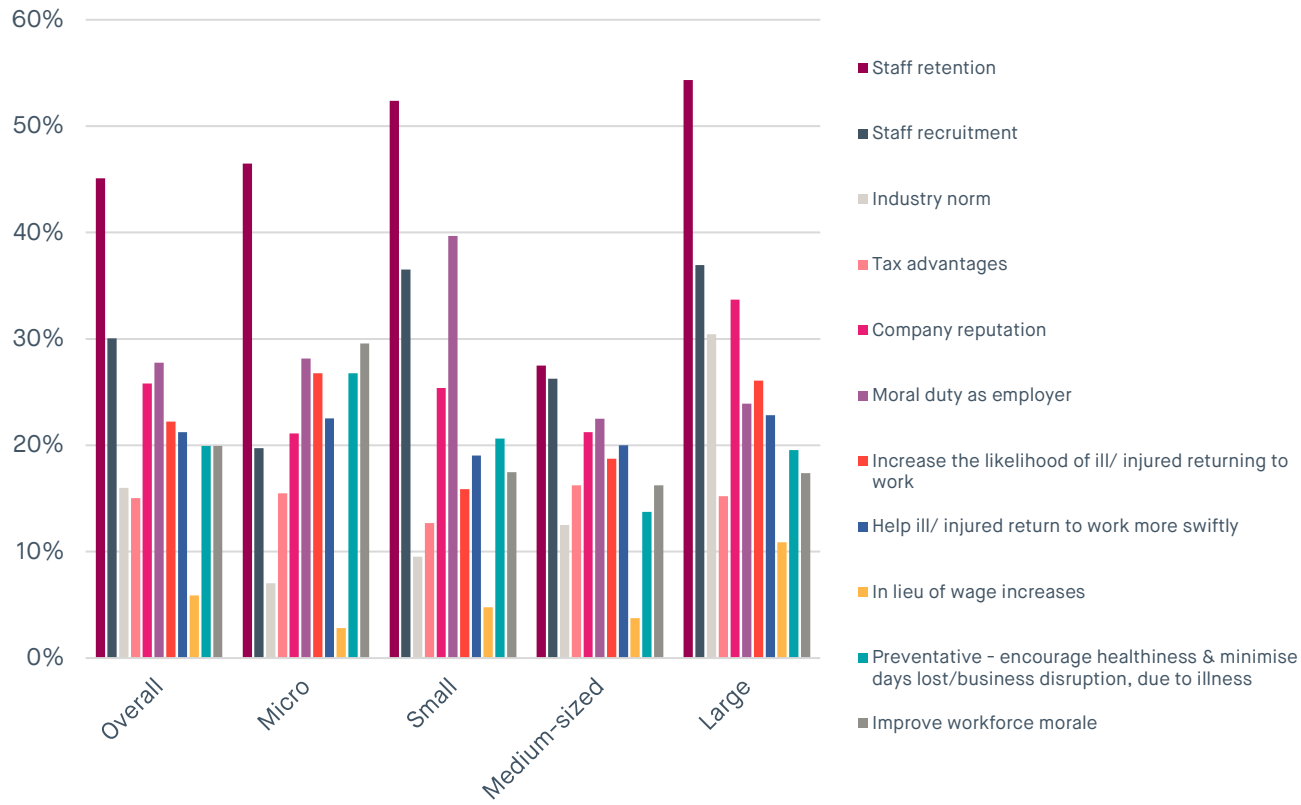
Figure 15: Reasons for providing (or considering offering) IP

Source: Opinium survey of HR Decision Makers within businesses

The reasons for providing health and protection insurance coverage: business size

A breakdown of the HR Decision maker survey responses about why they provide or were "considering" offering PMI "in the next 12 months" (Figure 16) by business size shows that "staff retention" is the dominant motivation across all enterprise size categories.

Figure 16: Reasons that businesses in different size categories provide (or considering offering) PMI



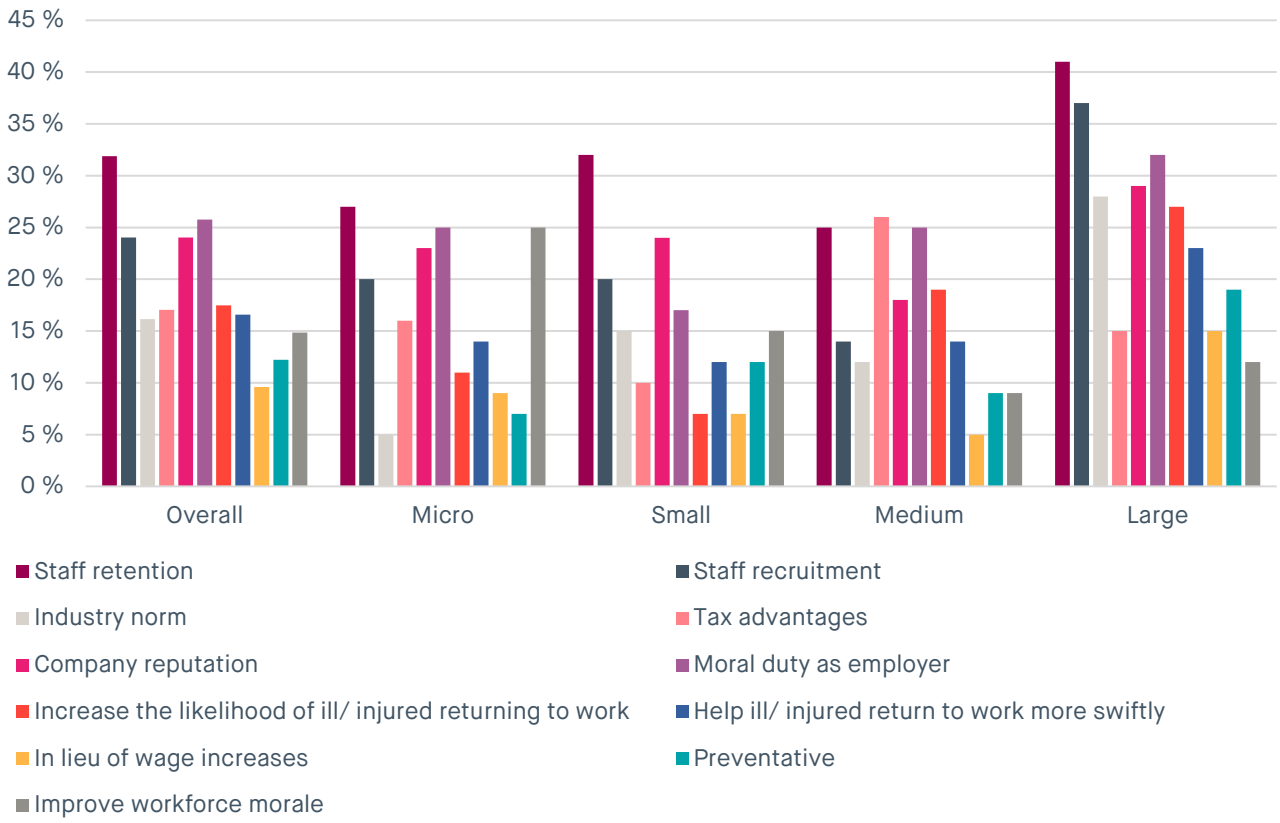
Source: Opinium survey of HR Decision Makers within businesses

While "retention" is the preeminent reason and "recruitment" the second most frequently cited motivation in three of the four size categories, the data presented In Figure 16 reveals some notable differences between businesses of different sizes, for example:

- Medium-sized businesses were much less likely to cite "retention" as a motivation (28%) for offering PMI, compared to businesses in the other three categories. 46% of micro-businesses cited "retention", 52% of smaller businesses and 54% of larger respondents.
- Among larger businesses, providing PMI because it is an 'industry norm' was a much more common answer than among businesses in other size cohorts. 30 per cent of larger businesses listed this reason, compared to 7% of micro-businesses, 10 per cent of small and 13% of medium-sized firms.
- Providing PMI for the purposes of "increasing the likelihood of ill/ injured returning to work at all" or to "help ill/ injured return to work more swiftly" were cited as motivating factors for offering access to PMI, by HR Decision Makers in larger businesses, more frequently than by HR Decision Makers in businesses of other sizes.

Figure 17 shows that "staff retention" was the most frequently cited reason as to why, overall, businesses provided or were "seriously considering offering, in the next 12 months", IP coverage to at least some members of their workforce. This was replicated in every size category except among respondents in medium-sized businesses.

Figure 17: Reasons that businesses in different size categories, provide (or are considering offering) IP



Source: Opinium survey of HR Decision Makers within businesses

The data presented In Figure 17 reveals some notable variation in the reasons why businesses in different size groups provide access to IP coverage, for example:

- Among larger businesses who offer IP, staff "retention" (41%) and "recruitment" (37%) were the most often cited factors. Further the proportion of respondents giving these answers was substantially larger than in the other size categories e.g. among small businesses the proportions were 32% and 20% respectively.
- Providing IP because doing so is an "industry norm" was more often reported by larger businesses (28%) as a reason for providing IP than by respondents in businesses in the other size categories. This difference mirrors the differences in motivations for offering PMI, where larger businesses were also much more likely to mention "industry norm" as a factor.
- Micro-businesses cited "workforce morale" as a reason for providing IP (25%) more frequently than businesses of other sizes (small - 15%, medium-sized 9% and larger businesses 12%).
- Larger businesses were much more likely to say that IP was offered to "manage workforce health risks". For example, 27% of larger businesses said that a reason why they provided

IP was to "increase the chances of a member of the workforce returning to work after illness/ injury". In contrast, only 7% of respondents in small businesses and 11% in micro-businesses offered access to IP because it might to "increase the chances of a member of the workforce returning to work after illness/ injury". Further, while 23% of HR Decision Makers in larger businesses stated that IP was provided, in-part, with the aim of "helping the ill or injured members of the workforce return to work more swiftly than they otherwise would have been able to", only 12% of small and 14% of micro-businesses said a reason for providing IP coverage to at least some members of their staff was because it might "help ill or injured members of the workforce return to work more swiftly than they otherwise would have done".

The reasons for providing health and protection insurance coverage: qualitative evidence

The qualitative evidence collected as part of the research for this report broadly reinforces the evidence from the surveys, i.e. that health and protection insurance products are often used as both a signalling mechanism and an incentive tool by many employers. The qualitative data (collected from 35 In-depth Interviews with 35 HR Decision Makers, in predominantly small and medium-sized organisations) provided greater detail about the employer perspective on workplace health and wellbeing issues and perceptions and experiences of health and protection insurance policies.

Box 2: reasons why organisations offer health and protection "benefits"

Data from in-depth interviews with 35 HR Decision Makers found that the most common reasons why firms offered health and protection insurance benefits to staff, were recruitment and retention. In addition, motivations like keeping up with "industry norms" and "doing the right things for staff" were also prominent. This cluster of reasons can be categorised as "incentive" and "signalling" measures taken by employers, as they compete to hold onto or attract the right people to their business.

- One of the in-depth interviews conducted was with a senior manager at a medium-sized maritime logistics business. He described a key motivation for his firm offering PMI as matching what is '*...commonly offered elsewhere*'. It is an "industry norm" and it would be disadvantageous for the business not to offer what competitors, that are also trying to recruit and retain staff, are offering.
- Another example of the centrality of insurance "benefits" to attracting and retaining staff was provided in an interview with the Managing Director of a healthcare company, which specialised in severe trauma rehabilitation services. He stated that, for his business, '*Benefits are important tools for attracting and retaining staff ...especially in the health sector*' where, he noted, his business competes for labour against very big organisations both private and public such as the NHS, which provides staff with "market-leading" pensions.
- A third example came from an interview with the Managing Director of an events and entertainment logistics company, which had been trading for about a decade. The firm not only organises events, but also provides entertainers and sources and hires props for films. He was clear when asked why his company provided both PMI and IP. It was because '*...other employers in the industry offer it, improving staff retention and making it easier to hire talent and making staff feel valued*'.
- In firms at the smaller end of the size spectrum, provision of health and protection benefits – if provided – is often done so to senior staff members only. In such circumstances the same kinds of reasons motivate the provision of insurance coverage "benefits". As the HR Director of a small boutique professional services firm noted, when describing why they paid for senior staff to have coverage, it was "*...to show we care about wellbeing*" and that "*...the company values loyalty*". Notably, after prompting by the interviewer, the HR Director acknowledged that there are health risk management benefits to providing such coverage, too. The participant stated that being covered by PMI or IP for example, could provide a degree of "*...peace of mind*" for both the individual and the firm, if someone important to the business was ever seriously ill. Consequently, they agreed that that insurance could be "*...a way of reducing costs associated with illness, injury or absence*".

Barriers to providing health and protection benefits

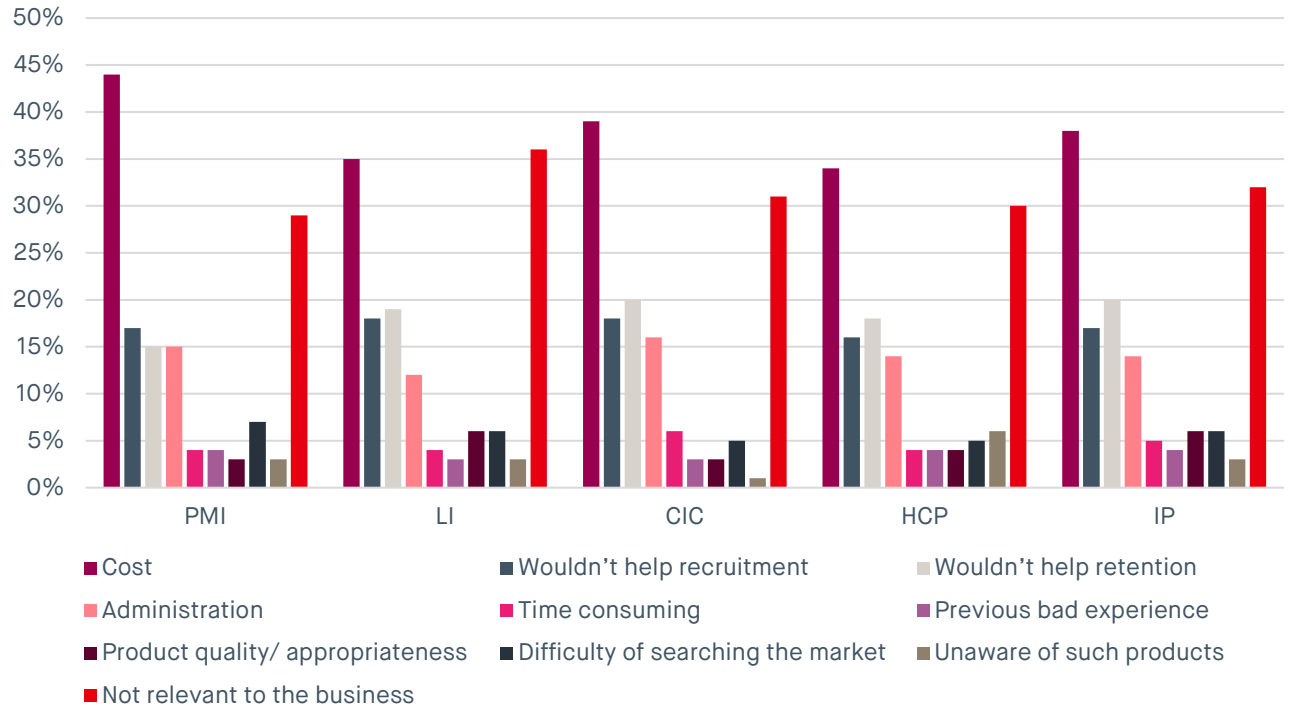
Many people who have health or protection insurance coverage have that coverage because their employer provides it. However, as the data in Tables 1, 6, 11, 16 and 21 illustrate, large proportions of the UK population are not covered by any of the insurance products this report is concerned with. This raises the question as to what barriers stand in the way of more employers offering such "benefits" to at least some of their staff? This section presents the evidence

collected from a survey of 500 HR Decision Makers in businesses of all sizes and 35 in-depth interviews, also with HR Decision Makers, but primarily in smaller organisations. By helping identify some of the most significant barriers to take-up, it offers to policymakers, for example, who consider there should be more of a role for private insurance to support the health and wellbeing of the UK workforce and help save the taxpayer money and boost the economy, to better understand how coverage through employers in particular, could be expanded.

Obstacles to take-up identified by employers

Among those who are reluctant to offer access to health or protection benefits a number of specific obstacles to doing so were cited by respondents. Figure 18 below illustrates the main obstacles to taking up PMI, LI, CIC, HCP or IP.

Figure 18: Barriers to offering health or protection insurance 'benefits' faced by businesses



Source: Opinium survey of HR Decision makers within businesses

As the chart above illustrates, there are two predominant reasons why employers are not offering or not considering offering one or more of the five types of insurance they were surveyed about. These are "cost" and a perceived "lack of relevance" to the respondent's business:

- "Cost" was the barrier most frequently cited across all types of insurance (except LI where "lack of relevance" was the answer most often given). Across all five types of insurance more than a third raised "cost" as a key challenge to providing some coverage to their workforce. However, "cost" was most salient in relation to PMI, where 44 per cent of those "not offering PMI" and "not considering doing so in the near future", said that (perceived) cost was an obstacle to offering it.

- The second most frequently given reason, across all types of insurance (except LI), for not offering access to health or protection benefits by the organisations surveyed for this report was a "lack of relevance". 29% of respondents said PMI was not relevant to them. 31% of those who said they didn't and had no intention of offering CIC. 30% rejected HCP and 32% said they had no interest in offering IP because It was not relevant of their business.

Barriers to PMI take-up

The survey evidence shows that the most significant barrier to providing PMI across the various business size categories in consistent. "Cost" is a key barrier no matter the size of the business. The proportion of respondents saying that PMI was "not relevant to their business", was considerably higher among micro businesses (37 per cent) than those in other categories. Across the other size cohorts, the proportion of firms reporting its "irrelevance" were relatively similar. 20% of small businesses said It was "not relevant" to their business, a quarter of medium-sized business respondents said the same and just over a fifth of larger firms.

The second tier of reasons why employers failed to offer access to PMI coverage to at least one member of their workforce, included:

- Doubts that it would help "recruitment" or "retention" (both important motivators to offering PMI, as noted earlier in this report).
- The "administration costs" (i.e. the "opportunity costs" of the administration associated with searching the insurance market, the purchasing process and maintaining and renewing policies).

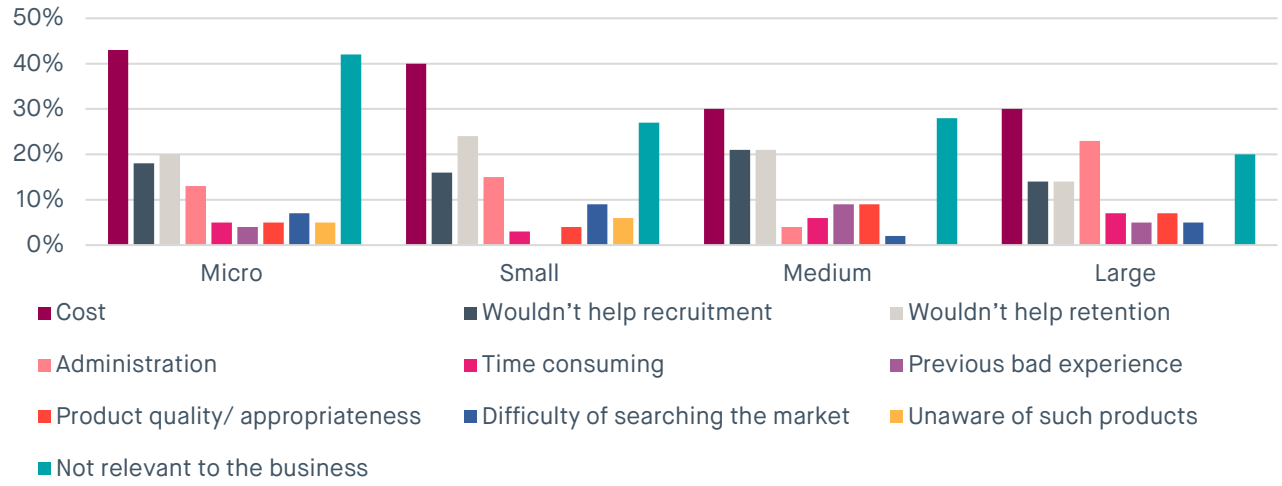
Figure 19: Reasons that businesses in different size categories do not offer a PMI "benefit"

Source: Opinium survey of HR Decision Makers within businesses

Barriers to IP take-up

In the survey of HR Decision Makers, the most frequently identified barriers to taking-up and offering access to an IP policy to (at least some) people in a business are broadly the same as those that inhibit PMI take-up i.e. "cost" (or at least perceived cost) and a "lack of relevance".

Figure 20: Reasons that businesses in different size categories do not offer IP 'benefits'



Source: Opinium survey of HR Decision Makers within businesses

- 43% and 40% of HR Decision Makers in micro and small businesses that "do not offer access to IP" (to any member of their workforce) said that the "cost" of IP policies was a barrier to take-up. The proportion of medium-sized and larger businesses that said "cost" acted as a barrier was 30%.
- Among micro-businesses that currently do not provide access to IP, 42% reported said the reason was because the "benefit" was "not relevant" to their business. A significantly higher proportion of micro-businesses gave this as a reason compared to respondents in other size categories, for example, 27% of smaller firms reported IP not being "relevant" as a barrier for not offering it, 28% of medium-sized businesses and one-in-five larger enterprises.
- The second tier set of barriers to take-up identified by respondents include disbelief that providing IP would help with "recruitment" and "retention". Although there are some notable variations between size categories. 21% of HR Decision Makers in medium-sized firms not offering IP did not consider that providing it would help with "recruitment". A lower proportion of larger firms (14%) made the same point. While 24% of smaller firms rejected the idea that IP might help with staff "retention", 14% of larger firms not offering it agreed that its ineffectiveness at helping "retain" staff was a reason why they failed to make IP available to at least some of their workforce.

Barriers to providing health and protection insurance coverage: qualitative evidence

The qualitative research data collected (as part of the research for this report) from 35 HR Decision Makers in primarily smaller businesses reinforces many of the findings from the survey about what acts as barriers to the take-up of health and protection insurance. The in-depth interview data helps provide additional detail as to why businesses make the decisions that they do. In boxes 3 to 7, summaries of some of the qualitative data collected from the in-depth interviews about why some businesses do not take up the opportunity to provide (to at least some, if not all of) their workforce with either health or protection insurance "benefits".

Box 3: a confluence of factors (cost, complexity, inappropriate products) creating barriers to take-up

A number of factors that act as barriers to the take-up of health and protection insurance were cited, again and again, in the in-depth interviews. Cost was important. So too were issues of complexity and transparency and consequently perceptions about the suitability of insurance products, especially for the smallest firms. Sometimes price was the clinching reason. However, for participants, more often than not, it was a combination of such factors that deterred them from taking-up health or protection insurance coverage through their firm.

An interviewee running a 10 year old small business in the property sector with less than 30 employees – and who had looked into the insurance market with the intention of providing health or protection insurance "benefits" to her workers – was deterred in the end by the cost, noting that the products she investigated were '*…too expensive*' for her business.

Another interviewee, the owner-manager of a small landscape gardening business, similarly noted that she had looked-into offering insurance "benefits" to her staff. She found that '*…these are not straightforward products*'. The complexity made it unclear as to whether '*I will get what I want when I need it?*'. In the end, the opaqueness, stemming from the product complexity were key factors in her not proceeding to purchase a policy.

The owner-manager of a young (less than four years old) financial services firm was clear in his depth-interview that cost was a '*…key barrier*', with '*Income Protection too costly for a small firm*'. As other participants in the in-depth interviews also highlighted, cost was an important but not the only factor that created barriers to his firm providing health and protection insurance "benefits" for his workforce. Complexity and their consequent appropriateness for smaller firms were also important factors. He considered PMI to be '*…a minefield…too complex for a small business. It is better fitted to larger employers*'.

An owner of a landscape gardening micro business – who acknowledged the potential for health issues to develop among her staff as a result of the physically demanding work that her employees undertake - made clear that, having looked into "employee benefits" (such as insurance) in the past, she had concluded their cost was too great for her business to afford. The cost issue was not an isolated obstacle. While prominent for the interviewee, it operated in conjunction with other factors, such as her previous negative experiences of trying to navigate the market for health and protection Insurance. These other factors included:

- A perception that '…insurance companies only care about large corporates'. Adding that she would '…like to get group protection for her business. But as a small business she can only get individual cover'.
- A perception of the market that it could not "…cater to the circumstances of her very small business".
- The use of "jargon", which made the task of searching the market and identifying potential product offers very "challenging".

Box 4: sickness and absence not a significant risk for the organisation

A recurring reason, which emerged from the in-depth interviews, for a lack of interest among some smaller and medium-sized businesses in health or protection insurance products, was the low priority they gave to issues of sickness and health issues, as significant risks to the success of their business, compared to other risks they considered to be more important. That is not to say those who took this view failed to see that health issues could not be disruptive to their organisation. However, there were more pressing risks which, for many participants, posed much greater threats to their success than illness and absence. Consequently, when such challenges arose the dominant approach to dealing with them was to take a "flexible" approach and adapt workloads and business practices and manage customer relationships, in order to cope with the problems.

One respondent managing personnel issues in an education-focused enterprise described two recent absences in one particularly important team that had been very disruptive to the business. One colleague was off for several months due to an operation that resulted in post-operation complications. The business coped by '*...re-jigging duties among remaining staff*'. The other colleague was absent for several months due to a recurring back problem. Similarly, existing work was re-distributed around existing staff. The business had decided that coping with the "shock" of an absence by being "flexible" and adapting was the most appropriate approach and enabled them to "weather the storm".

Another example from the in-depth interviews came from the owner-manager of a small mining and engineering consultancy. In her remarks recounting her firm's experience of long-term absence due to illness, she highlighted how a member of her small team being off sick for three months had been deleterious to the business: '*...consultancy is client relationship-focused. When the key point of contact with important clients is not available for a long period of time, re-organising those relationships and adding to the burden of other colleagues is disruptive*'. Nevertheless, the business adapted and was ultimately able to '*...come out the other side*'.

In some circumstances, as highlighted by several interview participants, the "coping" strategy does not just rely upon re-distributing work among other colleagues or managing customer expectations but can also involve the temporary employment of additional staff, to cover for a period. For example, the Managing Director of a card and wrapping paper designer and manufacturer interviewed for this research, had to bring in temporary staff, when one member of workforce was off ill for a considerable period, due to a foot injury.

Some of the firms who took the "flexible" approach to managing the risk of sickness and absence from the workplace helped their staff through their time-off with generous sick-pay from current revenues or reserves. It was suggested by those that chose such a route that his was an important way of fulfilling an employers' obligations to their staff. The owner-manager of the same mining engineering consultancy described her approach and rationale for taking such an approach: '*...I'm happy to pay sick-pay. I was able to pay out of the business's reserves. It is a risk and any prudent business has reserves to cover such eventualities*.

In contrast, others found through hard experience that cutting back their sick pay, after previously being quite "generous" with their sick pay policy, was a better way of managing illness and absence risks among their workforces. The HR Director for a medium-sized professional services firm interviewed as part of the research, said that absence had been an issue for the business, describing it as '*...quite common*'. He laid out how his company's strategy had changed and they'd found that the one that minimised illness and workplace absence the best was to limit '*...paid sick leave to just five days per year*'. He noted that this had reduced "*...absence issues substantially*".

Box 5: limited interest among the workforce

A number of those interviewed noted that they had not taken forward providing health or protection insurance to their workforce because there was no appetite among their staff for such "benefits", when the issue had been broached with them. This seemed to be particularly true among those firms who had a large number of younger employees.

In an interview with the person responsible for personnel issues in a small plastics manufacturing business, the lack of interest among younger workers was an important factor in their decision not to offer any health or protection insurance "benefits" to their workers. She stated that 'Younger workers are not interested in health benefits…they're healthy and they'd rather have more salary'.

Another participant in the qualitative research, with a predominantly young workforce, argued that there was little point in offering insurance "benefits" because '…with an average age of 30…they are not interested as they are not in the family planning stage of life, for the most part…they are mainly interested in salary rather than insurance perks'. In this latter example, it was noted by the interview participants that without the younger members being part of any scheme, the costs of offering health or protection insurance to the older (and consequently more "vulnerable" and "expensive") members of the workforce made providing such "benefits" prohibitively expensive.

Box 6: adaptations to the workplace and working patterns

It was commonly noted by interviewees that the businesses they spoke on behalf of, had made attempts to reduce the risks associated with workplace health problems through making "reasonable" and "cost effective" adjustments to the work environment and the patterns of working of . Especially of staff had been ill or injured and had to continue working or has returned to work.

More often than not, the qualitative evidence collected from the 35 in-depth interviews, suggested that such measures are ad-hoc and evolve over time in-light of experience. This pattern was particularly evident in among smaller and medium-sized firms in the interview sample. This pattern was confirmed by a representative of the small business community also interviewed for this project, who noted, smaller enterprises find it easier to make '*...common-sense adjustments for individual employees as and when problems arise*'. He added that this was, in-part, because of the non-hierarchical and flexible structure of smaller firms, which meant they could be "agile" in their decision-making.

The qualitative research uncovered a number of examples, two which are briefly summarised below as typical of the kinds of descriptions and explanations given by many of the interview participants:

- The Managing Director of a small online and telephone concierge business was interviewed as part of the in-depth qualitative research for this report. He said that he had implemented a number of "injury risk" mitigating measures. He had come to realise he needed to do this because of the nature of some of the tasks his employees were required to do. He actively took steps to learn from "*...other businesses and research about the importance of measures to mitigate injury risks*'. For example, some of the marketing activity his business undertook required staff to stand for long periods of time, often in cold places like railways stations. Further, delivering the services the business provided required similarly long periods of sitting down and working with IT – both activities well-known for causing long-term musculoskeletal problems. He described how '*I learnt*. Consequently he said he "*...work hard to ensure there are opportunities for sitting for those who have to stand for long periods*...[and there are]...*screen protectors and other support such as foot stools for those sitting for long periods*'.
- The Human Resources Manager in a small plastics manufacturer interviewed for this report highlighted how her firm provided subsidised healthy food in their canteen to encourage staff to be "*...a bit healthier*". She also highlighted how the firm had spent a lot of money ensuring that all office furniture is ergonomically 'correct' and that risks associated with other equipment in the business are mitigated with appropriate measures, all to help insure common injury risks such as Repetitive Strain Injury (RSI) are minimised. Staff are also subtly encouraged to be healthier.

Physical adaptations and alterations to working practices were not the only changes interviewees reported their organisations making to help reduce health and injury risks and improve the wellbeing of their workforces. In some of the interviews, flexible work opportunities were common. In particular, working from home, flexible start and finish times, an extra day of holiday for birthdays and the option to "purchase" extra leave were mentioned a steps that had been taken, with the objective of easing stress, enabling a better work-life balance for those who wanted it.

Smaller businesses and insurance

The circumstances in which micro-firms in particular, but smaller businesses more generally, operate within are very different to that of enterprises further up the size scale. They are resource constrained in multiple ways. They are financially constrained.[36] They also face considerable knowledge and time constraints, too. Therefore, micro and small businesses tend to have limited 'bandwidth' for dealing with challenges beyond their core business operations i.e. keeping revenues coming-in and meeting legal obligations (e.g. paying wages and complying with taxes and regulatory obligations). Therefore, for smaller businesses it is often necessary to ruthlessly prioritise the allocation of their limited resources, whether that be financial, time or knowledge.

Understanding the constraints on smaller firms is key to recognising how issues of price, complexity, opaqueness, the administrative burden, the comparative unimportance of prioritising health management risks, preferences for ad-hoc flexible solutions (or partial solutions) and the numerous other the barriers to taking-up health or protection insurance coverage (identified in Figures 18, 19 and 20 and Boxes 3 to 6) are substantial barriers to smaller firms taking up health and protection insurance.

To explore this further, drawing on stakeholder Interviews with representatives of the small business community and experts in small business insurance, Box 7 below outlines some of the management realities, difficult trade-offs (including financial ones) and other challenges that owner-managers of smaller businesses face when making any decision, including ones about insurance.

Box 7: The difficulties of being a small business owner and insurance

An in-depth interview with an expert on small business insurance revealed the unique position of smaller firms towards insurance and the many challenges that unique position is the result of. The interviewee highlighted some of the specific legal, financial and other difficulties they face, when considering or dealing with insurance issues:

'*Small businesses take a very different view of insurance to larger businesses. Employing people is a key threshold for smaller firms. At that point they start to look for external advice on how to manage risks around key issues that arise as a result of taking an employee on and the business expansion that employing someone is a result of. In the first instance they are concerned with legally required insurance obligations such as Employer Liability (EL) and any relevant sectoral requirements such as professional negligence obligations…Beyond minimum legal obligations, they then take a risk-based view of what other insurances they may need…the order of importance of different classes of insurance to smaller businesses is broadly along the following lines: Public liability insurance and product liability insurance. Goods and equipment insurance…Only with these more important risks taken care of will medical or income protection insurances be considered by smaller firms. They are 'nice-to-have', not essential…*'.

The small business insurance expert interviewee explained that a typical small firm might spend at the most (and frequently less) £1,000 on insurance, annually. Therefore, if that budget is taken up with priority insurances as described above, it would be difficult to get a small firm to spend more resources on additional insurances. Further, he added, that for a small business, all expenditure on products like insurance is contingent on sufficient revenues being generated:

'*…the purchase of something such as insurance is directly linked to selling something/ providing a service to someone/ getting an invoice paid by a customer. In contrast, in larger firms there are substantial savings and large quantities of money around, which disassociate economic activities from each other*'.

A number of additional insights about why smaller firms often do not engage with the health and protection insurance market were provided by the various small business representatives interviewed in-depth for this report. Specifically, they noted that:

- Small firms will inevitably use health and protection insurance products less frequently, compounding the price and associated "value-for-money" problem for them. This is, in-part, because employees in smaller firms are typically less likely to be long-term sick or injured than those in larger organisations.
- There is a perception among some that the NHS provides a lot of services such as Occupational Health that it, in fact, does not. If an owner-manager believes the NHS already provides a service, they're unlikely to be willing to pay "twice" for it, which, buying insurance that included Occupational Health service coverage would be perceived as doing.

The same interviewees also highlighted how, often, it is not long-term illness or injury among their staff, that is the biggest problem for smaller businesses, but regular intermittent absence i.e. a member of the workforce that is off sick of injured for a few days or weeks at a time, perhaps in some cases two-or three-months, but who returns and then is off sick again for a period. This, it was suggested, can be more difficult to deal with and consequently more disruptive to the business as it makes investing in adaptations e.g. bringing in a temporary replacement, more difficult to plan.

Supporting health, recovery and return to work

While all employers may not offer access to health and protection insurance "benefits" primarily due to their potential role in "health-risk management", the insurance companies do consider large numbers of claims each year and pay out substantial sums of money annually to those who are ill or injured. The table below shows the data for 2018 (published in 2019) on pay outs on protection insurance policies.

Table 26: Claims and pay-outs for different types of health and protection insurance

Products	Number of claims paid	Percentage of new claims paid	Total value paid (000s)*	Average value of claims paid
Critical Illness	17,995	91.6%	£ 1,215,957	£ 67,573.28
Term Life	39,638	97.4%	£ 3,073,382	£ 77,535.28
Total Permanent Disability	474	71.7%	£ 32,345	£ 68,174.01
Whole of Life	229,197	99.99%	£ 794,106	£ 3,464.73
Income Protection	16,591	87.2%	£ 669,397	£ 17,728.80
All Protection Products	**303,896**	**98.3%**	**£ 5,785,187**	**£46,895.22**

Source: GRiD, ABI and SMF calculations

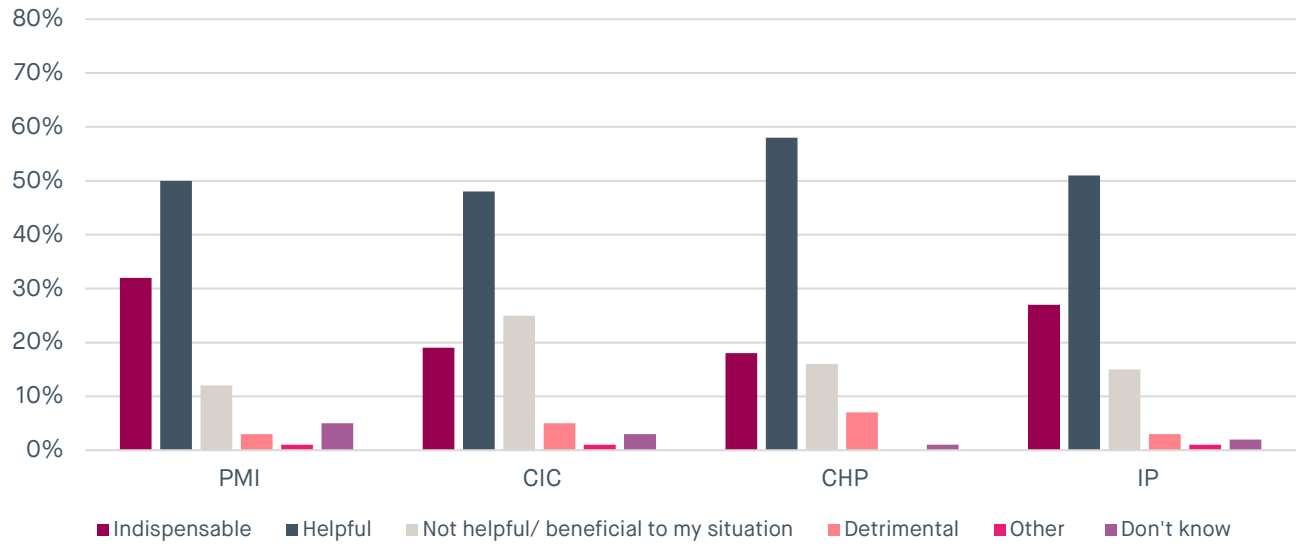
Further, data published by GRiD (Group Risk Development) earlier this year, about GIP policy usage, found that in 2019:[37]

- There were 74,707 "interactions" between those covered by GIP and the support services available through GIP policies.
- The GIP sector paid-out benefits to 15,773 people in 2019.
- The main causes of the claims against GIP policies in 2019 were cancer (27%) and mental illness (22%).
- Nearly three and a half thousand people (34% of all claims submitted) were "helped back to work" before they reached the point of making the claim.

The value of health and protection insurance coverage to those who are ill or injured

Respondents to the survey of individuals who had taken time off work due to illness or injury - in the preceding five years –and had access to PMI, CIC, IP and HCP's at the time of their illness or injury, were asked to report on the extent to which the policy they were covered by was helpful to them at the time.. The responses were, overall, positive about what their policy coverage helped them with. Figure 21 shows that for each product, a majority of respondents rated their coverage "indispensable" or "helpful" to their recovery.

Figure 21: Usefulness of the insurance in helping with recovery from illness/ injury



Source: Opinium survey of individuals who had suffered long-term illness/ injury in the last five years and had insurance "benefits" in-place at the time

The data presented in Figure 21 highlights a high proportion of respondents for each product category, stating that their coverage played a useful role in their recovery and return to work:

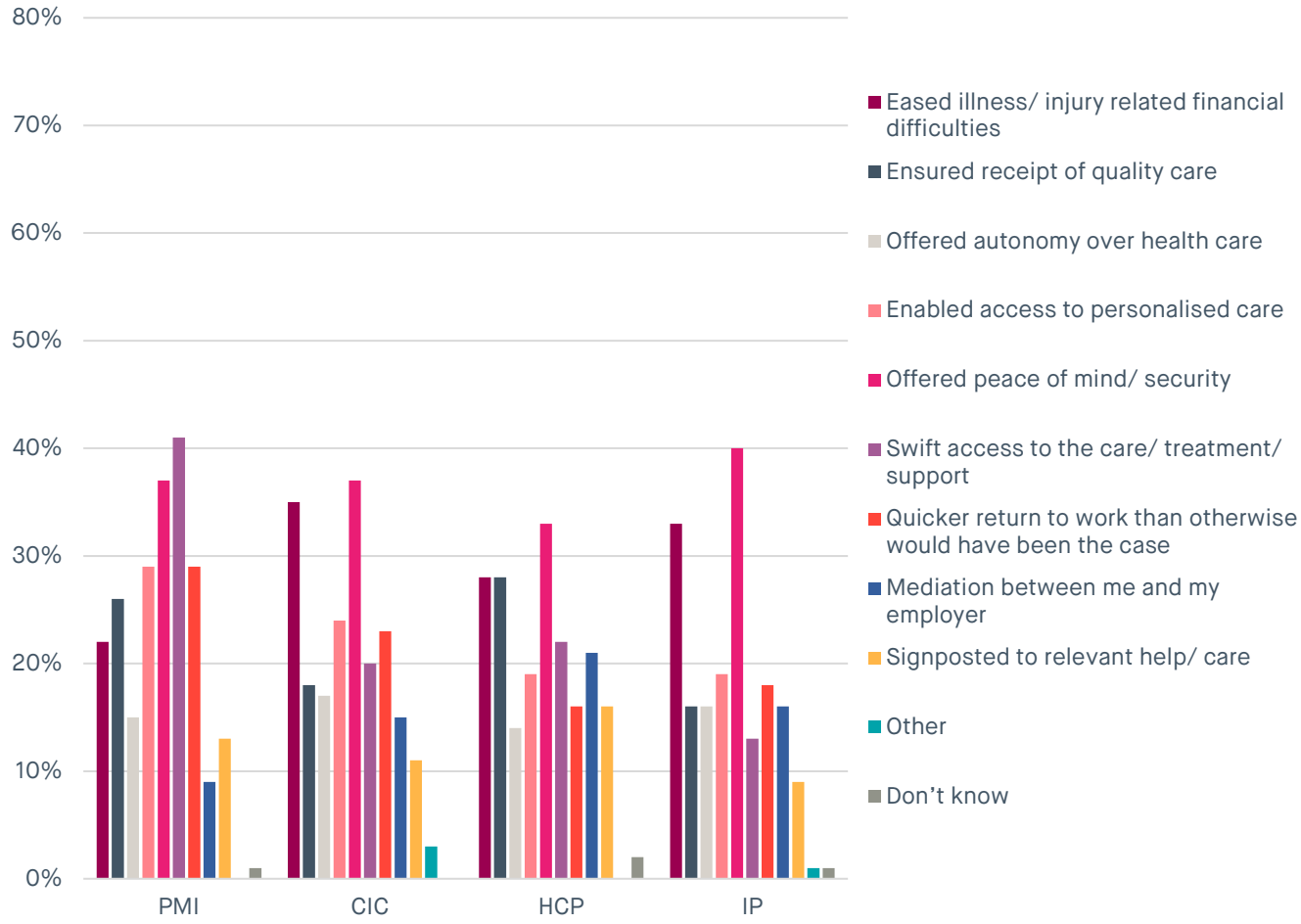
- PMI was described as "indispensable" or "helpful" by 82% of respondents who had coverage at the time of their illness or injury induced absence from their workplace.
- 78% reported that their IP coverage was "indispensable" or "helpful" to their recovery.
- 76% said that their HCP was either "indispensable" or "helpful" to their recovery.
- Two-thirds of those who had CIC at the time of their illness found that it was "indispensable" or "helpful" in their recovery.

While, as is clear in earlier chapters of this report, employers may not have originally primarily provided health or protection insurance coverage to better manage the health risks of their staff, and lessen any knock-on effects on their business, but Figure 21 suggest that for many people who are ill or injured, have to take time off work and do have coverage, such products can and have played such a role.

The ways in which health and protection insurance coverage can be useful

Among those who considered one or more insurance product types to be either "indispensable" or "helpful", the data presented in Figure 22 suggest that the ways the product was or products were "indispensable" or "helpful" varied somewhat, was dependent on the nature of the product they were covered by.

Figure 22: Way(s) in which health or protection insurance cover was helpful at the time of illness/injury



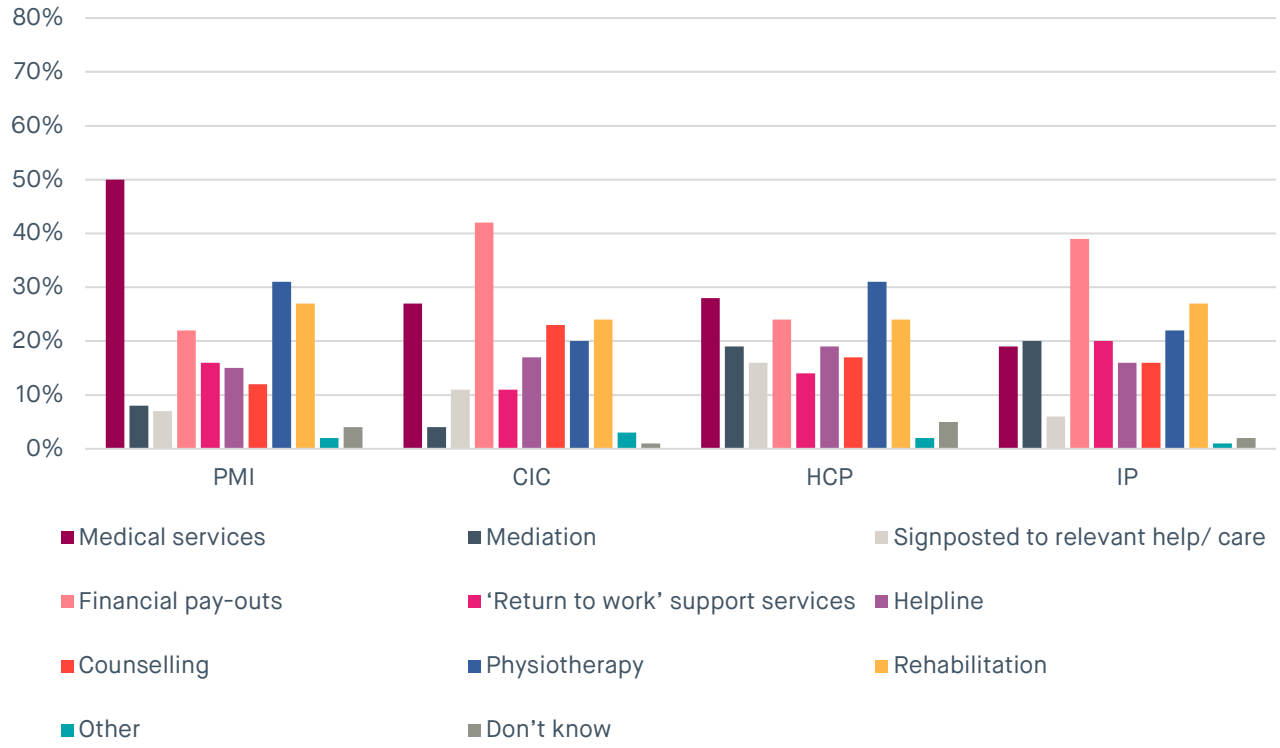
Source: Opinium survey of individuals who had suffered long-term illness/ injury in the last five years and had insurance "benefits" in-place at the time

- For those who found PMI "helpful" or "indispensable", the most frequently reported benefit was the "swift access to care" that PMI enabled (41%). This was closely followed by the "peace of mind" that the coverage gave to the user (37%). Just under a third of those with PMI and who found it "helpful" or "indispensable" reported that the coverage was beneficial because it resulted in "access to personalised care". Close behind that were 29% who reported that having PMI coverage "facilitated a quicker return to work than might otherwise have been the case".
- For those who found IP "helpful" or "indispensable", the most frequently reported benefit was the "peace of mind" that having the coverage provided to the user (40%). The second most frequently reported reason why those with IP felt that it was either "helpful" or "indispensable" to their recovery was because it "eased financial difficulties" associated with their absence from work (33%).

The services provided by health and protection insurance that aided recovery from illness or injury

Figure 23 illustrates the kinds of services that the respondent had access to, through their insurance, at the time of their illness or injury, that proved directly relevant and helpful to them and consequently facilitated their return to work.

Figure 23: Aspects of the health or protection coverage helpful in dealing with illness/ injury



Source: Opinium survey of individuals who had suffered long-term illness/ injury in the last five years and had insurance "benefits" in-place at the time

Among those who utilised PMI and described the service is "indispensable" or "helpful", Figure 23 shows that it was the "medical services" aspect of PMI coverage, for example, that was most frequently cited as particularly helpful to their recovery and return to work (50%). The "physiotherapy" (31%) treatment, accessible through the policy, was the second most popular reason.

Among those respondents covered by an IP policy, and who reported that they found it "indispensable" or "helpful", the financial pay outs were the most helpful aspect of the policy to their recovery and return to work (39%). This was followed by the rehabilitation services that respondents were able to access as a result of having IP coverage (27%). Other aspects of IP policies such as "mediation" and "return to work support services" were reported by around a fifth of relevant respondents as being helpful to their recovery and return to work.

Use of health and protection insurance for health risk management: qualitative evidence

Some employers who provide health and protection "benefits" to their staff recognise that there can be health risk management benefits as a result of having such insurance coverage in-place and, further, this kind of benefit is a key motivator for taking up policy coverage. Examples from the 35 in-depth interviews of health or protection insurance being utilised as a tool for health risks management within a business are described in Boxes 8 and 9.

Box 8: recognising the health risk management benefits of health and protection insurance

Among the number of the HR Decision Makers interviewed in-depth for this report around half were speaking on behalf of firms that did offer some kind of health or protection cover to at least one (but often more) member of the workforce. Many acknowledged the potential benefits of health and protection insurance, particularly if prompted to think about whether such insurance could deliver or had delivered benefits to their business.

For example, one Managing Director of a medium-sized computer hardware manufacturer benefited from providing health insurance, CIC and IP to his workforce, noting that '*...20 to 30 people working for the company have been long-term sick over the years...the government provides poor support...hence a need to offer insurance benefits to staff*'. He highlighted that some of the preventative elements of the PMI his staff had coverage from were proving particularly useful, positively impacting long-term health risk factors, such as weight, among his staff. He stated that '*...Fitbits, annual staff MOT, gym access...were slowly having an effect on the behaviour of some staff...less boozing and more exercising*'.

However, despite the health gains and reduction in the risk of sickness disrupting his business, at least in-part, as a result of the insurances packages he was providing to staff, the original motivation for him, to put an extensive package of PMI, CIC and IP in-place was not explicitly to manage the health risks of his workforce and in turn the risks to his business. Rather, it was a combination of a personal experience of poor healthcare in the past and a belief in "helping people", and based upon those motivations he decided that a health and protection package was the best way to do so The interviewee stated that '*my business is not about me hoarding money. I want to help people who have helped me*'.

Box 9: larger businesses use health and protection benefits strategically, which explicitly includes a role in managing health risks

There was a noticeable contrast, in the in-depth interviews undertaken to inform this report, between the perspective provided by larger businesses about the motivations for and the usefulness of health and protection "benefits" and those offered by those speaking on behalf of smaller firms. Among the former, the provision of such products was planned and strategic and the reasoning for such an approach more explicitly embraced the idea that “benefits”, like health and protection insurance, were important tools for managing health-related risks that could impact the business as well as having benefits like “recruitment2 and “retention” and “doing the right thing” for staff.

The findings that larger enterprises are more “strategic” in their use of employee “benefits” often with the aim of helping manage the health risks of their employees, is consistent with the survey data described in this report e.g. the survey of HR Decision Makers found that the proportion of larger businesses surveyed citing "workforce health-risk management" as a motivating factor behind offering access to health and protection “benefits” was noticeably higher, than it was among businesses in other size categories.

The reasons given by those interviewed for this report and representing the largest businesses, for their ability to be more strategic about workforce “benefits” included the greater in-house capacity and expertise that they have which enables them to identify, organise and manage the provision of such "benefits" effectively, the purchasing power leverage that larger enterprises have at their disposal allows them to get the best prices and the most bespoke deals from providers and the growing priority given to health and well-being at the board level of larger firms means that obtaining competitive packages to provide to the workforce is a high priority. In combination, it was noted, these factors reinforce each other and result in the ability to provide high quality comprehensive workforce support packages.

It was notable that, the representatives of the largest firms that took part in the in-depth interviews, all described how health and well-being policies in their companies were comprehensive, planned on a multi-year basis and embodied in a “workforce strategy” of some kind. In contrast to how most of the smaller firms, that were spoken to in-depth and that provided “benefits”, operated.

One research participant, in-charge of the corporate “benefits” at a multinational business services firm, highlighted how the extensive package of coverage provided through the firm he worked for (and which he managed) was the result of three key motivations, all emanating from the top of the organisation:

- A ‘…duty of care to staff’.
- Supporting the productivity of the workforce by ensuring they’re looked after because in the professional services business ‘…staff are the key asset’.
- The provision of health and wellbeing “benefits” allows the business ‘…a degree of control over health and absence’. He argued that ‘…PMI is a key tool to speed up care and recovery…a compliment to IP, which is there to help if the problem is more long-term’.

In another in-depth interview, the Head of Workplace Benefits for a multinational pharmaceutical company highlighted similar reasoning for the extensive “benefits” package that they provided to their staff. Stating that their offer is ‘…part of a wider strategy to be seen and behave like a modern employer…providing all the care and other benefits a responsible modern employer should do…having such measures in place is the right thing to do’.

A confluence of motivations for providing extensive “benefit” packages is evident among larger employers. However, health risk management is clearly prominent among them. Alongside side motivations found among employers of all sizes who provide some health or protection “benefits” to members of their workforce, namely, the idea of providing such support being a manifestation of an employers’ “duty of care” and of ”doing the right thing”.

Summary

This chapter has utilised the evidence from two tailored surveys, 35 in-depth interviews with predominantly smaller and medium-sized businesses and meetings with numerous key stakeholders from industry, government, research organisations and representative groups to provide an extensive picture of what motivates employers in particular, to provide health and r protection insurance "benefits" to (at least some of) their staff. Equally importantly, it has also identified a range of barriers that prevent businesses from offering such coverage. Key points highlighted in this chapter include:

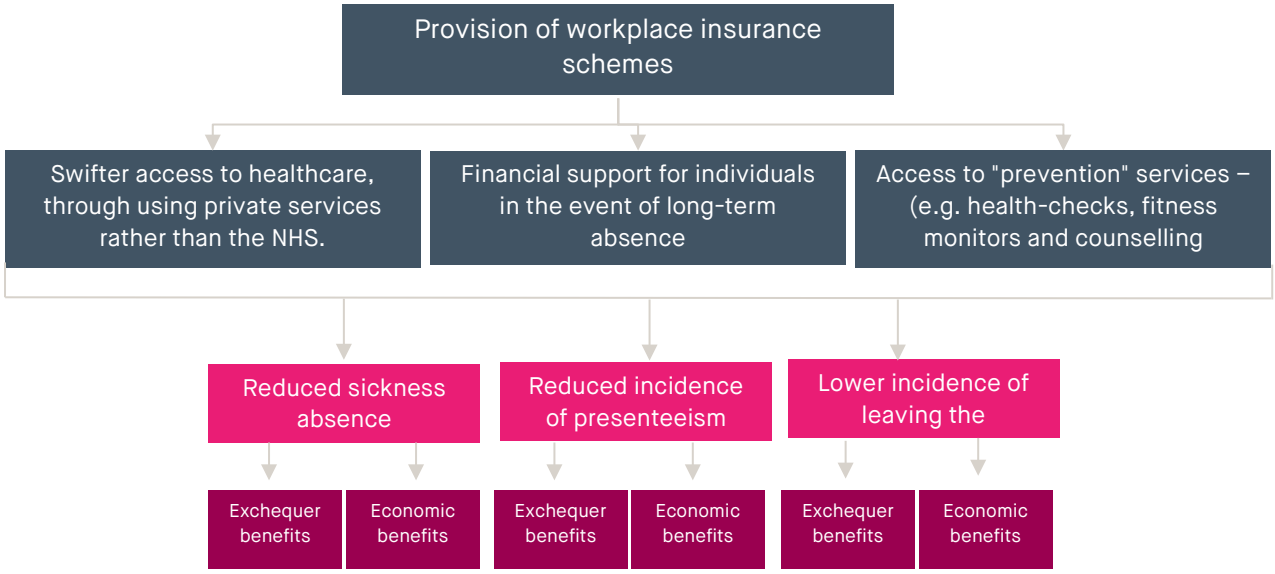
- A key motivation for businesses that provide health or protection insurance is its role as an incentive and signalling tool - most importantly to existing staff, to whom it is offered as a method of "retaining" them, supplementing income and possibly other "benefits" and signalling how "valued" staff are by their employer. It is also used by many businesses as a "recruitment" inducement by some employers. Simultaneously, offering health or protection coverage shows potential recruits that the employer looking to hire additional staff is "caring" and "value" their staff.
- Workforce health risk management is a second order motivating factor behind "retention" and factors like "industry norms" for most employers. However, it tends to be more prominent among larger businesses as a reason for providing health and protection coverage to (at least some) staff.
- Among the barriers to take-up identified in the research, "cost" was frequently raised, while a sizeable proportion of businesses took the view that such products are "irrelevant" to them. This tended to be provided more often as a response by HR Decision Makers in smaller firms. There are other barriers at work too. It is clear from the qualitative research findings that the financial "cost" is not a barrier that exists in isolation. but often inter-sects with other concerns such as "complexity" and opaqueness of terms and conditions which is linked to a fear that insurers may not pay-out when needed and a sense that such products are not sufficiently tailored to the circumstances of smaller businesses.
- The small business community is a particularly challenging market for any insurance in general and therefore is likely to be so for health and protection insurance products. Small firms (and micro-business in particular) operate under significant financial and other constraints. The consequences of such constraints are that risks are strictly prioritised. This means that health or protection insurance will always vie with other issues for a limited "pot of resources". In such a context, complexities, opaqueness around products and negative perceptions of the insurance industry or previous experiences of insurance products and a preference for a flexible "coping" strategy among many small and medium-sized businesses towards staff illness and injury, will play a role in helping an owner-manager or management team to decide how to use their limited resources among competing uses.

CHAPTER 5 - MODELLING THE FISCAL BENEFITS OF INSURANCE-BASED SOLUTIONS

We have highlighted the potential for insurance-based policy solutions to be part of a strategy to reduce sickness absence, the incidence of employees leaving the workforce altogether and presenteeism. The benefits of this to the individual are clear; not just through avoiding the potential reductions in incomes from both short and long-term absence, but also through reducing the risks of leaving the workforce and struggling to re-enter work once on out-of-work benefits.[38]

As well as these benefits to the individual, there are also potentially significant benefits to the economy and the Exchequer. The most comprehensive assessment of these costs from Government suggested that, in 2015, the economic costs of sickness absence and worklessness could be as large as £130 billion a year, and the associated costs to the Exchequer as large as £55 billion a year. These costs would be considerably higher when also considering the costs of presenteeism, which is estimated to be a more significant cost that absenteeism.[39] Figure 40 highlights the potential routes through which these benefits might be felt.

Figure 24: The potential for workplace insurance schemes to provide economic and Exchequer benefits



Exchequer benefits can include: increased tax revenues, reduced benefit spending and reduced spending on public services like the NHS.

Economic benefits can include: productivity and output benefits and reduced costs to businesses.

To understand the scale of the economic and Exchequer benefits that insurance-based policy solutions could provide, this section summarises the outputs from new modelling on the potential economic and Exchequer benefits. Each of the three main areas are covered below, with the methodology based on that used by the Department for Work and Pensions in their health and disability Green Paper.[40] Results below are based on a central case of output losses from absence that lies between the DWP's high and low cases.

Reduced sickness absence

There were more than 140 million working days lost to sickness absence in the UK in 2018. This amounts to nearly 550,000 full-time equivalent (FTE) positions across the economy. The exact impact of insurance-based policy solutions on sickness absence is hard to quantify from existing research. However, one recent report estimated that those accessing early intervention and rehabilitation services experienced 16.6% shorter absence periods than those who do not access them.[41] Whilst uncertain, due to a limited evidence base, the combined impacts of other types of support may be greater still.

To account for this uncertainty, we have modelled the Exchequer and economic benefits of reducing sickness absence by between 5% and 10% (roughly corresponding to between 30% and 60% of employees being covered by the schemes, and a 15% impact on periods sickness absence). Overall, the results suggest:

- Benefits to the economy of up to £2.6billion a year; and
- Exchequer benefits of up to £600 million a year.

Lower incidence of leaving the workforce

Around 160,000 people leave work and move onto disability and sickness benefits each year.[42] The exact impact of insurance-based policy solutions on the likelihood of employees leaving the workforce permanently is uncertain. Existing literature, and evidence collected from a sample of insurers for the purposes of this research suggest that return-to-work rates of some policies are as high as 90% for those who claim. Other estimates are lower, suggesting figures closer to 50%. As such, we have adopted a cautious approach to assumption for this modelling. We have modelled the Exchequer and economic benefits of reducing the incidence of employees leaving the workforce to sickness and disability benefits by between 15% and 30% (roughly corresponding to between 30% and 60% of employees being covered by the schemes and a return to work likelihood of 50%). Overall, the results suggest:

- Initial benefits to the economy of up to £2.4billion a year; and
- Initial Exchequer benefits of up to £800 million a year.

These benefits also accumulate over time, as the total number of people supported to remain in the workforce adds up. This suggests that after five years:

- Benefits to the economy in the fifth year are up to £11billion; and
- Exchequer benefits in the fifth year of up to £4 billion.

Reduced incidence of presenteeism

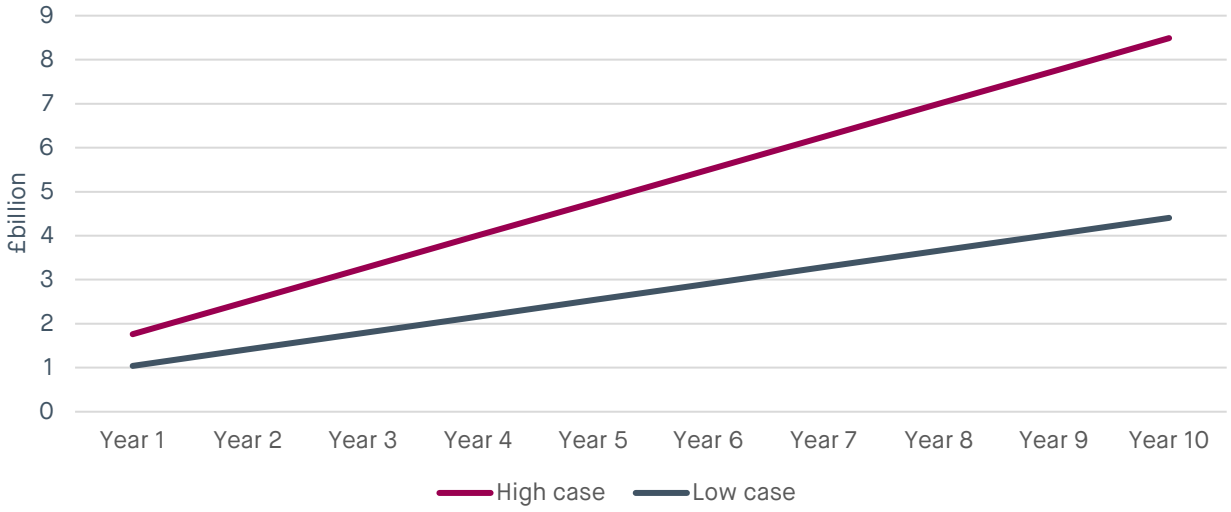
Existing evidence suggests that the scale of presenteeism in the UK workforce is significant. For example, combining research on the average number of productive days lost to presenteeism for different industries,[43] with the number of employees in these industries, suggests that nearly 750million productive days are lost to presenteeism in the UK economy each year.[44] It is clear that reducing this by even a small proportion would lead to significant economic and Exchequer benefits, however there is little evidence on the potential impacts of insurance-based policy solutions on presenteeism. As such, we use an extremely cautious figure of a 1% reduction, to provide an indication of the scale of benefits. This suggests:

- Benefits to the economy of £1.4billion a year; and
- Exchequer benefits of £300million a year.

Combined benefits to Exchequer and the economy

Figure 25 and Figure 26 below demonstrate the total potential Exchequer and economy benefits, based on the modelling and assumptions used above.

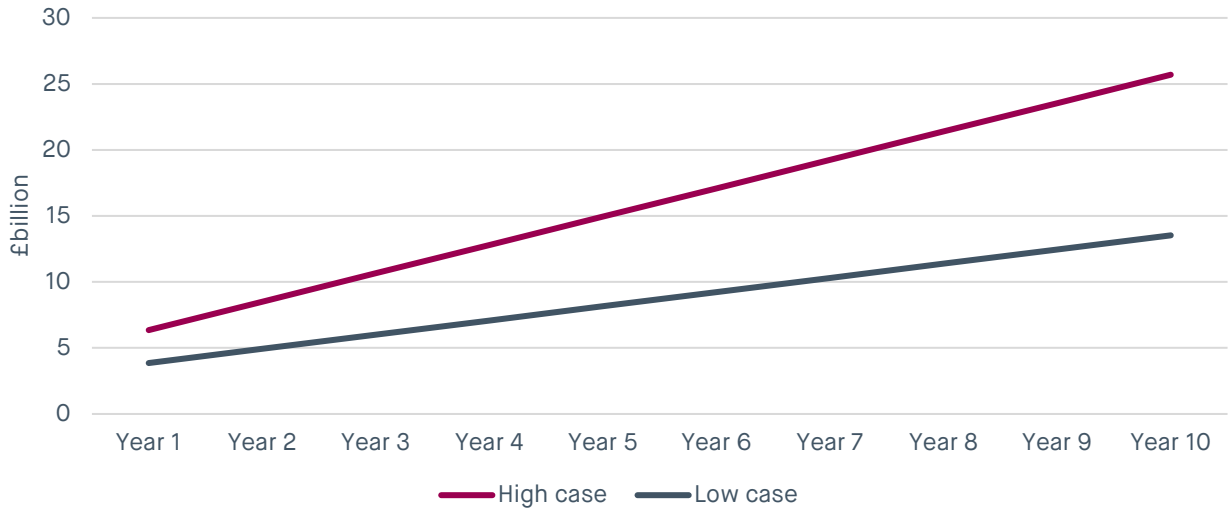
Figure 25: Potential Exchequer benefits



Source: SMF modelling

Notes: High case assumes sickness absence reduced by 10%, reduction of those leaving the workforce to disability benefits of 30% and a reduction in presenteeism of 1%. Low case assumes sickness absence reduced by 5%, reduction of those leaving the workforce to disability benefits of 15% and a reduction in presenteeism of 1%.

Figure 26: Potential economy benefits



Source: SMF modelling

Notes: High case assumes sickness absence reduced by 10%, reduction of those leaving the workforce to disability benefits of 30% and a reduction in presenteeism of 1%. Low case assumes sickness absence reduced by 5%, reduction of those leaving the workforce to disability benefits of 15% and a reduction in presenteeism of 1%.

CHAPTER 6 - THE INSURANCE POLICY LANDSCAPE IN THE UK AND ELSEWHERE

Countries have approached occupational insurance in different ways. Variations in public healthcare and welfare provision (such as out-of-work benefits) have a bearing on uptake of private medical, income protection and other types of insurance. This chapter looks at the policy landscape in the UK, followed by a brief overview of health insurance and income protection in five countries: Belgium, Germany, the Netherlands, Australia and the United States.

The UK policy landscape

Health insurance and healthcare

The UK operates a system of universal public healthcare. As such services provided by private medical insurance policies are arguably at least partly 'duplicative' of what is already provided by the NHS, resulting in low uptake.[45] Having said that, access to private healthcare might offer swifter treatment, access to more effective healthcare and more choice.[46] It has been argued, on the other hand, that in some instances NHS care might by more effective, particularly in the case of serious illnesses such as cancer, heart disease or stroke, where an individual will receive priority NHS treatment.[47]

Desk research reveals little in the way of robust, comparative studies of the UK's private and public healthcare systems, making it difficult to assess the extent to which greater use of one type of healthcare system in the UK would lead to better health outcomes. A fair summary of the (limited) evidence base appears to be that some healthcare is better in quality in the private sector, whereas others are of similar quality or better in the public sector. The objective of policy should be to steer individuals towards private healthcare it is of high quality and of good value – though there is a significant quantification task yet to be done here.

Most PMI policies currently taken out in the UK are group policies, where individual employees pay no, or some, contribution towards the premium. As a 'benefit in kind', the premiums are taxable at the employee's marginal income tax rate, and the employer will pay National Insurance contributions. As we note later in this chapter, health insurance is taxed at a relatively high rate in the UK, in terms of Insurance Premium Tax, which might be a driver of relatively low uptake.

Whether provided by the public or private sector, it is clear that the UK healthcare system lags behind peers on key metrics – highlighting the need for improvement. In 2017, the Commonwealth Fund published a ranking of health care systems in 11 countries.[48] The rankings measured indicators for performance across the following domains: care process, access to care, administrative efficiency, equity and care outcomes. The UK ranked 1st overall, although it came 10th for health outcomes. This was largely due to falling far behind the other countries in two specific measures: the five-year relative survival rates for breast cancer and colon cancer. The fact that the UK lags behind its peers on detecting and treating cancer is a known phenomenon in health literature.[49]

Income protection insurance and welfare

In the UK, employers must pay Statutory Sick Pay (SSP) to employees for a maximum of 28 weeks. This is currently set at £95.85 per week, which equates to just under a fifth of regular average weekly earnings.[50] Some employers may offer more than this through occupational sick pay schemes. After this period, employees still unable to work can apply for government support.

By international standards, the SSP rate in the UK is low and the duration of support is long. While the UK offers a flat rate, in many other countries sick pay is related to earnings. Typically, sick pay is provided at the full wage rate or a high percentage of the wage rate but for a much shorter duration – generally less than 10 weeks – followed by sickness benefits funded by statutory insurance or general taxation. This is the case in Sweden and Germany, where employers have duties to rehabilitate sick employees. An exception is the Netherlands where the duration is longer: employers are required to provide 70% of wages for 2 years if necessary.[51]

The low rate of SSP in the UK, and its lack of relation to an individuals' earnings, means that the system risks leaving individuals facing significant financial hardship in the event of workplace absence due to illness or injury. Despite this, as discussed earlier, uptake of income protection insurance and critical illness cover is relatively low in the UK, suggesting few individuals have actively sought to mitigate this risk through private sector solutions. As discussed, the reasons for this are likely to be numerous and include the cost of insurance products, the features of available products (such as deferment periods being deemed too long) and perceived complexity of products.

COVID-19 and the policy response to it has obscured a lot of other policy, not least in the area of welfare reform. Nevertheless, some changes to the benefits system set-in-place before COVID "hit" the UK, are seemingly still likely to go ahead. For example, Employment and Support Allowance (ESA) is currently the main benefit for those out of work due to ill health. ESA, alongside other benefits, is due to be replaced by the Universal Credit. Claimants for ESA must undergo a Work Capability Assessment, which entails a questionnaire and medical assessment. This is used to decide whether or not the applicant has limited capability for work.

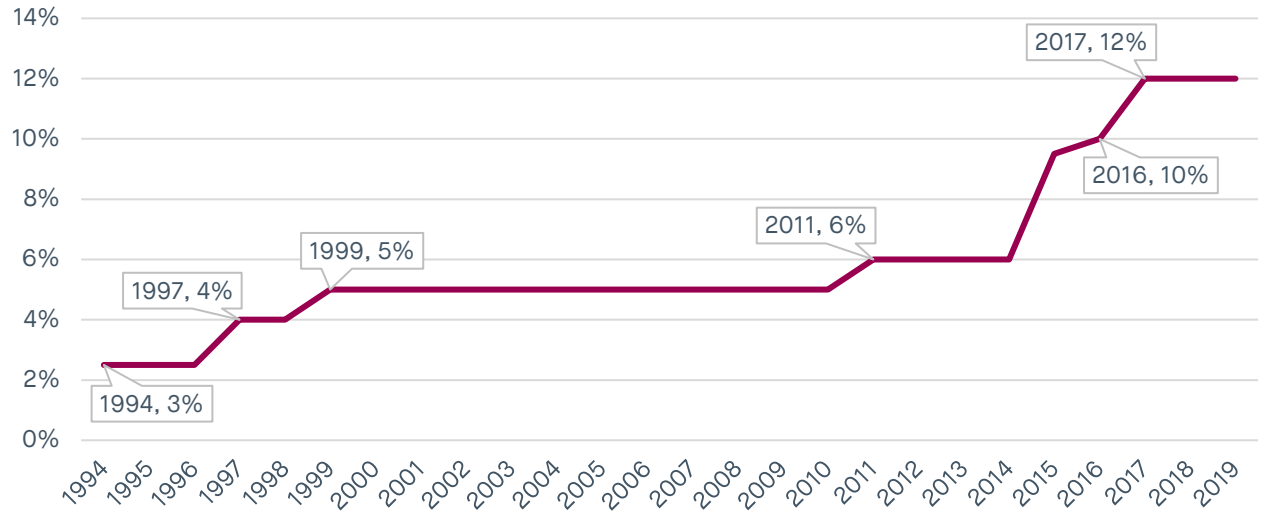
A 2019 report by the New Policy Institute for the ABI revealed that current and potential policyholders of income protection policies may stand to lose from the rollout of Universal Credit. As income protection counts as 'unearned income', the value Universal Credit recipients would be eligible for would fall, such that one in five may find their income protection policy to be of no value in the event of absence from work due to illness of injury.[52] The interaction between income protection insurance and the benefits system should be a consideration of policymakers, to remove disincentives to taking up insurance.

Insurance Premium Tax

Insurance Premium Tax is a tax on insurers for providing most types of insurance, including some of those covered in this report. Private medical insurance is liable for IPT. Health cash plans are liable for IPT. Life insurance is exempt. Critical illness cover is exempt. Income protection policies that count as long-term insurance (i.e. permanent health insurance) are exempt.

Due to European Union regulations on value-added tax, most insurance is exempt from VAT.[53] In 1994 the UK government introduced the Insurance Premium Tax as a way of taxing insurance transactions, later developing two rates. Long term insurance continues to be exempt from tax, but others are subject to the lower rate, currently at 12%. This rate has risen over the past decade.

Figure 27: Standard rate of Insurance Premium Tax



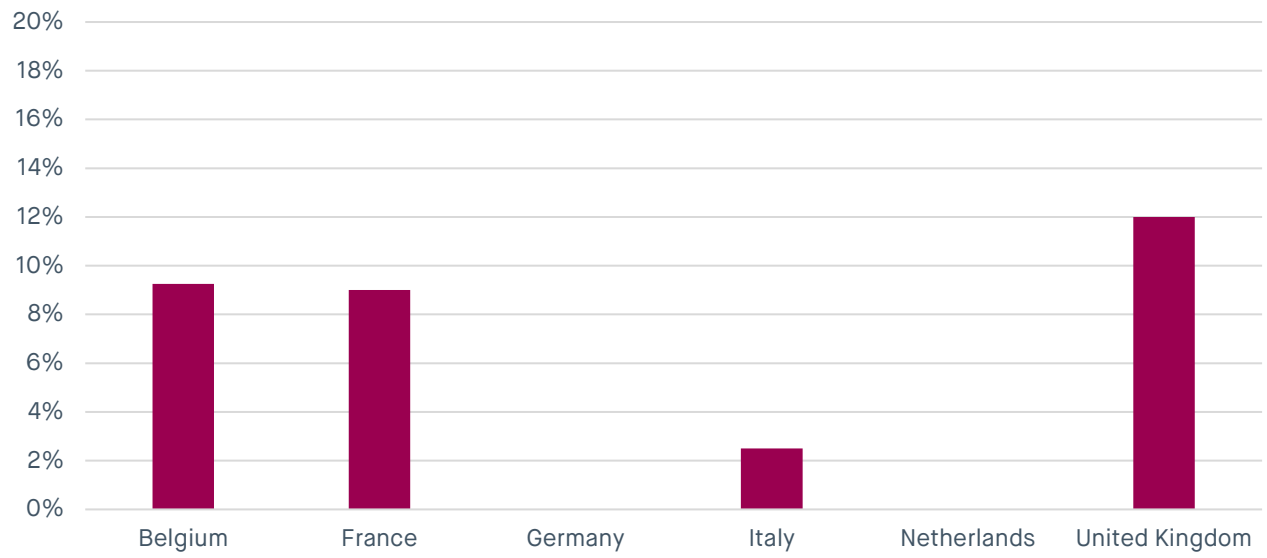
Source: House of Commons Library research briefing [54]

The rise in rates means it is likely insurance companies raise prices for policyholders, be they individuals or businesses in the case of group cover.

The next chart displays the equivalent of the IPT (for health) in other countries. Like the UK, many European countries have chosen to enact a substitute for VAT to raise revenue from the insurance industry in different bands. Life insurance tends to be exempted. Private health insurance policies are liable for a lower rate in some countries (as in the UK), or exempt entirely (as in Germany). The UK has one of the highest rates of IPT for health products in Europe.

With previous analysis presented in this report showing cost being a major disincentive to taking up insurance, the prevailing rate of IPT could affect uptake of insurance products. If policymakers wish to encourage use of (at least some types of) insurance, for example due to some of the fiscal benefits identified in the previous chapter, IPT reform might be an appropriate avenue to explore.

Figure 28: Insurance tax for health products in selected European countries



Sources: WHO[55], ABI[56], Euromod[57], Insurance Europe[58], Netherlands government[59]

Examples from other countries

Belgium

Belgium operates a system of compulsory public health insurance. Public health insurance is linked to social security contributions. Employees must register at a local social security office and sign up to one of five health insurance funds (this can be done by the employer). Social security contributions from both the employer and employee contribute to public healthcare funding.[60]

The system is based on refunds: at the point of use the employee incurs costs, but most of it is refunded by the insurer. Private insurance is also available and can allow for wider coverage, as well as full refunds for healthcare.

Belgium was not covered in the Commonwealth Fund report mentioned earlier. In a profile of EU health systems conducted by the OECD in 2019, Belgium was noted for large disparities in health status by income. Those in the top income quintile were 50% more likely to report being in good health than those in the bottom quintile – one of the largest disparities in western Europe. The gap in unmet medical needs between the top and bottom quintile is the largest in western Europe.[61]

When it comes to the outcomes of the health care system, Belgium was in the top third of EU countries for treatable causes of mortality, performing better than the UK. Five year net survival rates are equal to or better than the UK for four different cancers.[62]

In the case of ill health, employers pay sick pay for a month, the amount being dependent on the type of work the employee did: manual labour ('blue-collar' work) and intellectual work ('white-collar' work). This distinction in labour rights dates back over a century.[63]

Blue-collar employees receive 100% of their normal wage for the first seven days of absence, then this proportion declines for the rest of the month. White-collar employees receive 100% of their normal wage for the first 30 days. Those on short-term contracts receive entitlements in a schedule resembling that of blue-collar workers. [64]

For all employees, the statutory obligation of the employer ends after 30 days and those still absent are entitled to payments from their health insurance funds for up to a year, set at 60% of wages up to a ceiling subject to a medical check. After one year, employees are eligible for invalidity benefit, capped at 65% of previous earnings.

Netherlands

The Netherlands operates a system of compulsory private health insurance. There are two components: compulsory basic cover and optional additional cover.

With basic cover, employees are covered for certain 'basic services' as specified by government. It is funded by a monthly premium and a one-off annual payment. The monthly premium is part-paid by the employee, part-paid by the employer. The annual payment is paid by the employee, and only if services have been used. There are subsidies available to low income earners. [65]

Insurers must offer the same package to everyone for the same price: the 'community rating'. As premiums cannot be adjusted for different risk profiles, insurers are compensated by a central health-based risk-adjustment system.

Additional cover provides for services not included in basic cover, such as dental and physiotherapeutic care. This is the main focus of competition between insurers as they seek to offer more tailored policies. Additional cover is popular, with some 84% of the population purchasing a policy. [66]

The current system has been in place since 2006. Prior to this, the Netherlands had both private and public insurers for health care. Reasons for reforming the system included a desire for greater efficiency by introducing market forces and for a reduction in waiting times. [67] One study soon after the reforms took effect concluded there was a more competitive market with greater consumer mobility; individuals became more likely to compare prices and options under the new system than the previous system. [68]

In the Commonwealth Fund's ranking of 11 countries, the Netherlands came in 3rd place overall. Its worst domain was administrative efficiency, for which it came 9th. Measures for this domain included surveys of doctors reporting time spent on administrative issues related to insurance, getting patients medication/treatments due to coverage restrictions and issues related to reporting data to other agencies. More doctors reported time spent on these activities as a 'major problem' compared to other countries.

On outcomes, the Netherlands came 6th, ahead of the UK, mostly due to better survival rates for breast and colon cancer.

In cases of ill health and income support, the Netherlands has one of the most generous policies in Europe. The employer pays the employee 70% of earnings for up to two years. This payment has a minimum for the first year (the minimum wage) and a maximum (set by the government). The sickness absence process is managed by the employer, employee and independent government agencies. One of these agencies provides a doctor, who will assist the return to work

for the employee.[69] A reintegration plan for the employee is drawn up and enacted by employer, employee and doctor.

Failure to cooperate can lead to a rescission of payments to the employee. If after the two-year period the employer's activities to assist the return to work were insufficient, they can be asked to continue payments for a further year.[70]

The idea behind Dutch policies is to transfer risk from the state to the employer as well as encourage employers to take a greater role in assisting return to work.[71]

The employer is no longer obligated to continue payments after two years. At this point, the employee is eligible to apply for government benefits. The sums paid out by government depend on the degree of incapacity for work assessed by a doctor and a labour expert.[72] The benefit has no fixed end date but ceases upon reaching the pension age, for example, among other thresholds.[73]

A study investigating the privatization of sick pay and the impact on employer incentives found three key lessons to be learned from the Netherlands. [74]

The first is that government has a role to play with regards to informing and engaging with employers in cases of sickness absence. Employers need to be made aware of the financial risks they face. The Dutch system also shows how even if rules are legislated, these need to be complemented with active engagement and alerting employers as to their statutory duties.

Another lesson is that despite some concerns, transferring risk to the employer does not necessarily imply worse labour market outcomes for those with disabilities. Whilst there may some screening of workers, employers also show greater commitment to those already employed.

Third, the Netherlands shows that private employer incentives can be successfully implemented in the context of an economy with government benefits for those absent due to sickness. Employers take greater initiative with regards to prevention and reintegration with result of fewer employees moving from receiving pay-outs from the employer to pay-outs from the state.

One impact of the Netherlands model – with employers bearing much of the risk of staff sickness and absence – is that it has stimulated an insurance market and investment in income protection policies. This has been noted by the Department for Work and Pensions in the UK in its assessment of policy options for improving workplace health[75]. As such, the Netherlands model highlights the potentially strong linkages between welfare, sickness pay policy and the insurance sector.

Empirical evidence on the impact of privatised and generous statutory sick pay, such as in the Netherlands, is limited. Cross-country comparisons are often not particularly informative, given the wide range of other factors driving differences in labour market outcomes. However, an examination of the impact of reforms *within* a country over time can provide insights. In addition to the Netherlands, Norway and Austria serve as useful 'natural experiments'

In Norway, employers were exempted from short-term sick pay for pregnancy-related absences since 2002. Comparing the change of this type of absence after 2002 with the change of other types of absence for which employers remained liable for sick pay, the removal of employer incentives increased the number of short-term absence spells[76]. This suggests that employers

are indeed able to lower the risk of sickness spells, when presented with greater costs associated with absence.

In Austria where, since 2000, employers have not been exempted for sick pay for blue-collar workers. This removal caused sickness incidence to drop by approximately 8% and sickness absences were almost 11% shorter in duration[77].

Turning back to the reforms in the Netherlands, the overall evidence suggests that, amongst some other reforms, these changes have contributed substantially to the sharp decline in disability insurance inflow in the Netherlands, amounting to about 60%[78].

Evidence from the Netherlands shows that smaller firms, in particular, have opted for private insurance of sick pay following the reforms. Despite concerns that using insurance might undermine incentives for employers to improve workplace health, reductions in absenteeism due to the extension of sick pay have also been realized for the group of employers who opted for private insurance[79]. Anecdotal evidence suggests that private insurers applied some form of incentives—such as co-payments or experience rating—or obligations to curb sick pay[80].

While a Netherlands-type approach to workplace health could yield benefits, policy design is important. We noted earlier the role of independent government agencies in managing the sickness absence process in the Netherlands. The UK's past forays into this space have not always been successful; the government's "Fit for Work" occupational health scheme was scrapped due to low referral rates[81].

Germany

Germany operates a system of compulsory multi-payer health insurance. Both public and private insurers co-exist.

All German residents must register for health insurance. Employees are automatically enrolled into one of over a hundred sickness funds. This entitles them to health care under the Statutory Health Insurance plan, which provides a standardized level of comprehensive care. Sickness funds cannot refuse members.

Health care is funded by employees, employers and the government. Premiums paid by employees are income dependent and matched by employers. The sickness funds send premiums they collect to a central fund, which then redistributes the money in accordance with the different risk profiles the funds have taken.[82]

Those above a certain income threshold are permitted to opt-out of SHI if they obtain a private health insurance policy. However, they must pay a tax. Around 11% of the population have private health insurance.[83]

Private health insurers offer a greater choice of doctors and hospitals than that available under SHI, and private rooms. The greater allure of private care seems to be in shorter waiting times, and the ability to offer young high-earners smaller premiums compared to those due under SHI. Depending on the product there may be further coverage that is not provided under SHI, such as comprehensive dental care.

As premiums are risk-rated (i.e. dependent on age, pre-existing medical history), policyholders face higher premiums the older they get, so many of those eligible opt to stick with SHI. Further,

the difficulty with switching back to the public scheme later may act as a disincentive to pursue private cover.

In the Commonwealth Fund ranking of 11 countries, Germany came 8th overall. The UK outperformed Germany across all domains except access and outcomes. On access, Germany scored much better on measures related to timeliness. For instance, 19% of UK patients reported having to wait at least two months to see a specialist. In Germany the figure was 3%. Germany came 2nd in the access domain, against the UK's 3rd.

On outcomes, Germany came 8th against the UK's 10th, again mostly due to better survival rates for cancer.

Premiums for SHI also fund other benefits, including sickness pay (private insurance may also fund this). In cases of sickness absence employers must pay normal wages for 6 weeks. Following this period, the employee is entitled to a benefit from their sickness fund of 70% of their normal wage up to 78 weeks, subject to a cap.[84]

There is an additional sickness benefit available to parents to take care of sick children for up to 10 days.[85]

Sick pay in Germany as a proportion of GDP is second only to the Netherlands in Europe, mostly covered by employers. It has also increased the most in Germany, from 1.1% in 2003 to 1.7% in 2013.[86]

Australia

Australia operates a hybrid system of compulsory public health insurance and optional private health insurance.

The government provides public health care through Medicare. This entails 'free' treatment for everyone, but it is funded by the Medicare Levy, which is effectively an extra income tax, as well as general taxation.[87] However, there are some exceptions to what is covered so even those paying the levy may have to pay for care unless covered by private insurance.

Purchase of policies with private health insurance companies, or 'health funds', are optional. What is covered by a private policy differs by product. Some may offer hospital cover (treatment as a private patient), some will offer non-Medicare services, and others will offer a combination.

Private health insurers operate a 'community rating' system, which means that everyone pays the same premium for their health insurance and health funds are prevented from discriminating against members based on health status, age or claims history[88].

There are a number of financial incentives in place to increase or reduce the cost of premiums so as to incentivise private insurance coverage. Younger people are eligible for discounts.[89] With the Lifetime Health Cover, those above the age of 31 who do not have private insurance must pay higher premiums (a rate which increases every year).[90] Those above a certain income threshold without private insurance face higher income tax rates[91], and most people who buy private insurance are eligible for rebates.[92] A stated intention of this policy is "to encourage individuals to take out private hospital cover, and where possible, to use the private system to reduce the demand on the public Medicare system."[93]

As of September 2019, 44% of Australians hold private (hospital) cover. This figure has been broadly stable since 2000, when the Lifetime Health Cover was first introduced.[94]

Employees in Australia must hold accounts in industry superannuation funds, or 'supers', formed by employers. These form the basis of the pension system, but also provide other benefits. By default, life insurance, or 'death cover', is included, often with total and permanent disability (TPD) cover. An analysis by KPMG highlighted that more than three quarters of Superannuation Funds provide LI alongside the core pension offer.[95] Further, the same paper suggested that 68% of Superannuation Funds offered TPD and 28% provided IP policy coverage too.[96] As the data indicate, the majority of life insurance policies are held via "supers". Due to larger markets (which generates financial scale economies and lowers risks), the premiums are often lower than those outside of supers. At the same time, on the downside, this means policies are untailored to the individual.[97]

Critical illness cover, or 'trauma insurance', is often taken out with life insurance. There is no standardisation of policies, but the industry has in recent years looked to form standards in policies (as is the case with the ABI's standards for critical illness cover in the UK).

The same KPMG report as that referenced above, suggested that between 2013 and 2016, more than 48,000 claims for TPD were paid out, and more than 100,000 Australians accessed their IP policy for financial support.[98] Typically, these "*...default group insurance in superannuation provides higher...benefits compared to government safety net social security benefits*"[99], which suggests that those in receipt of such pay-outs will be financially better off than if they only had the state to fall back on. The average pay-out under IP policy coverage, for example, is around A$20,000.[100] Under TPD, it is A$103,000. In total, across all LI, TPD and IP coverage associated with Superannuation Funds, more than A$13 billion was paid out to claimants between 2013 and 2016.[101] Pay-outs from IP policies alone have been estimated as being likely to save the Australian Disability Support Pension (DSP) scheme between A$3 billion and A$4.2 billion over ten years.[102]

In the Commonwealth Fund's rankings of 11 countries, Australia came in 2nd place overall. Its worst domain was equity, for which it came 7th. The equity domain measures the difference in care process and access between high income individuals and low-income individuals. Australia's score in this domain was mainly brought down by indicators for timeliness. For instance, while 37% of those with above average incomes responded it was 'somewhat or very difficult to access after-hours care', the corresponding figure for those on below average incomes was 51%. The UK had the best equity domain ranking.

In contrast, Australia came 1st for outcomes, where the UK came 10th. Australia scored well across all outcome indicators, though was particularly boosted by a leading score for colon cancer survival rates.

Australia also came 1st for administrative efficiency, where the UK came 3rd. Australia scoring highly across all efficiency indicators. Notably there were far fewer doctors who had reported time spent reporting data to other agencies as a major problem compared to any other country in the ranking.

Sick leave in Australia also encompasses carer's leave i.e. time spent caring for a family member. Employees are entitled to 10 days of 'personal leave' per year of employment. A cumulative entitlement, any unused days get carried over to the next year. Employers pay the normal wage for such time taken off, and may ask for 'reasonable' evidence of sickness (or sickness of family

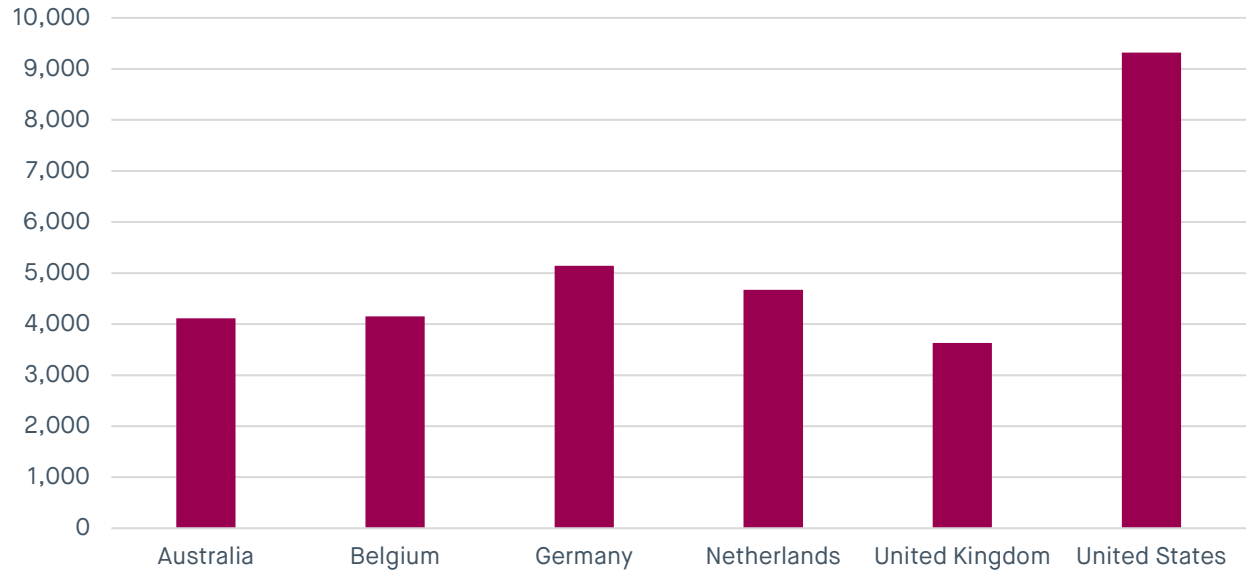
member), for instance a medical certificate.[103] Outside of sick leave, if an employee takes more than 3 months off due to illness, they are no longer protected from dismissal.[104]

After sick leave, an employee can apply for Sickness Allowance from the government. This payment is subject to a means test, an asset test and varies with personal circumstances (with or without partner, children). The highest sum a single person with dependent children is eligible for is currently AU$302.35 per week, which equates to around 19% of median weekly earnings, only slightly higher than SSP in the UK.[105]

United States

Unusually for an advanced developed economy, the US does not have a system of comprehensive health care for all citizens. It nevertheless has the highest per capita health care spending in the world.

Figure 29: Per capita health expenditure 2018 for selected countries (in 2010 US$)



Source: OECD Health Statistics 2019106. These figures are adjusted for inflation and purchasing power parity.

Health care in America resembles a blend of models used in other countries. Some sections of the population receive free health care; many receive insurance through their employer; others are left to pay out of pocket.

Public health insurance covers certain sections of the population. Medicare and Medicaid provide health care for the elderly, people with chronic illness and low-income earners. In conjunction with the State Children's Health Insurance Program, nearly half of all healthcare expenditure is paid for by the government.[107]

Most coverage outside of these agencies is provided for employees by employers. Employers also pay most of the monthly premiums. Changes in legislation expanded coverage from 2013, providing incentives for employers to provide insurance and standardizing essential benefits.[108]

The 'individual mandate' required individuals to hold some cover, which contributed to rising coverage – until this requirement was repealed with effect from 2019. In combination with other

policies under the current administration, private insurance coverage has declined. Around 10% of non-elderly adults are uninsured, with 'costs' cited as the most common reason for lack of purchase.[109]

American healthcare has been subject to much criticism. The consequences of the system include job lock[110] (limited mobility of workers for fear of losing coverage) and inequity[111] (as low-income individuals benefit less than high-income individuals).

In the Commonwealth Fund ranking of 11 countries, the US came last. It appeared at, or near, the bottom of every domain except care process, for which it came 5th – which is still worse than the Netherlands (4th), Australia (2nd) and the UK (1st).

Another area where the US is anomalous among major economies is the area of sickness policy. In cases of ill health, federal law mandates an employee's entitlement to unpaid sick leave which itself is only applicable to at least medium-sized employers. Even then, most employees who are eligible cannot afford to take unpaid time off.[112]

There is no federal law mandating paid sick leave. A minority of states have chosen to implement laws mandating paid leave, resulting in different policies across the country. Roughly two-thirds of employers voluntarily provide paid sick leave, though this tends to benefit employees at the upper end of the earnings distribution more than those at the lower end. [113] Workers in industries such as hospitality must decide between taking time to recover but losing pay, and earning money but risk health deterioration. In industries such as food and restaurants, this is not only a moral issue but a public health one.[114]

Efforts to introduce paid sick leave at the federal level have stalled in Congress. The latest effort, the proposed Healthy Families Act, would require employers to provide up to 7 days of paid sick leave.[115]

CHAPTER 7 - AREAS FOR POLICY EXPLORATION

In the preceding chapters, a number of issues have been explored which have implications for the health and protection insurance industry and for public policy makers, too.

This report has identified and explored a number of barriers to wider take-up of health and protection insurance, that exist. It has examined the direct evidence their role as tools for reducing the impact of illness, injury and absence from the workforce on businesses and the taxpayer.

It has also looked at aspects of the social policy framework in a number of countries, aiming to identify where private insurance (of various kinds) plays a positive role in supporting health and wellbeing of workers and encourages participation in the labour market, and whether there might be any lessons for the UK.

This final chapter will outline the findings from the surveys of HR Decision Makers and of individuals who had suffered from illness or injury that led to them taking time-off work in the preceding 5 years, about the changes to products and the policy environment that might encourage greater take-up and consequently the amount of health and protection insurance coverage across the economy.

It them outlines a number of propositions for the insurance industry and policymakers, based upon the cumulative evidence presented in this report, which are aimed at stimulating further discussion by both groups about:

- Whether and how the health and protection insurance market might work better.
- Whether and how health and protection insurance might play a more significant role in in enhancing the health and wellbeing of the population, reducing the amount of illness and injury induced workplace absence in the UK, improving return to work rates and minimising presenteeism among the national workforce and, ultimately, saving the taxpayer money (e.g. in benefits payments) and the economy lost productivity.

The market for health and protection insurance

The preponderance of evidence in this report suggests that the market for health and protection insurance is not working as well as it might. For example, FCA data shows that only LI has extensive product penetration into the UK population, with more than a quarter of people covered by a policy, according to the FCA's Financial Lives survey. PMI is the second most frequently purchased product, with just over one in ten people in the UK having coverage. The remaining three types of product (IP, CIC and HCP) all have penetration levels below 10% of the population. Consequently, the ability of health and protection insurance products to contribute to creating a healthier population in general, and workforce in particular, is currently limited by the low levels of coverage.

The evidence in this report suggest that there is a notable divergence between the motivations of employers for offering access to a health or protection Insurance products and that of the industry for offering them. A mis-alignment between the aim and understanding of business on the one hand and the insurance industry on the other about how and why health or protection insurance can generate value for a business, suggest a market that is not operating optimally.

Further, while overall the market for protection products is expanding, a number of barriers to take-up persist for many potential customers. These no doubt slow and could perhaps ultimately limit the expansion of the market. Whether such barriers are due to perception, or rather mis-perception, or reality, their presence suggests there is further for the industry to go, if it wants to substantially grow product penetration levels among UK employers and therefore health and protection coverage across the UK's workforce.

Specific measures which might encourage greater take-up of health and protection insurance

As part of the two surveys (one with HR Decision Makers and those individuals who had needed to take time off from work due to illness or injury) conducted to inform this report, respondents were asked for their views about the kinds of industry changes and policy measures that would be likely to increase their interest in "taking-up" health or protection insurance for the first time or "enhancing" their existing health or protection insurance coverage. Figures 30 and 31 below show the results.

Figure 30: Measures that would incentivise employers currently not offering insurance 'benefits' to do so

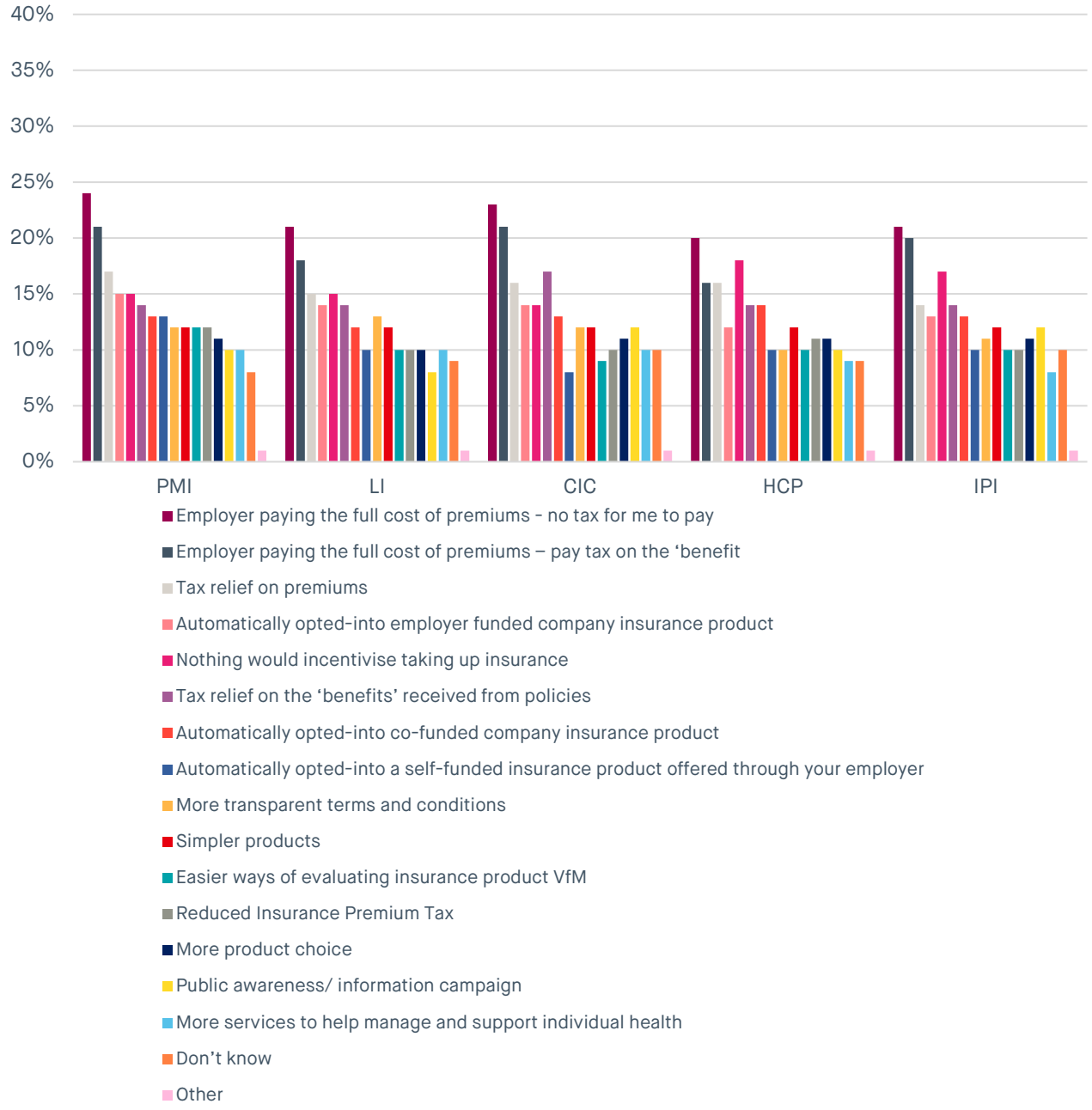
Source: Opinium survey of HR Decision Makers within businesses

Across all five types of insurance product, a similarly high proportion of respondents – representing businesses that do not currently offer an insurance product nor are considering doing so in the near future - said that there was "nothing that could be done" to entice them to do so. In the case of PMI 47% ruled out any incentive inducing their business to offer anyone in their firm medical insurance. For LI the proportion was 50%, for CIC 47%, HCP 46% and IP 45%.

Among those firms who do not rule out providing access to health or protection insurance coverage, tax incentives stood out as the most popular measure that could induce them to offer

health or protection coverage, across all five types of insurance. This is an answer consistent with the prominence of “cost” as one of the most salient barriers to take-up.

Figure 31: Measures that would incentivise those individuals without health or protection insurance to take it up or those with coverage to enhance it



Source: Opinium survey of individuals who had suffered long-term illness/ injury in the last five years (both those who did not have an insurance “benefit” at the time and those that did)

The data suggest that there are a number of measures which might encourage those individuals who don’t have health or protection insurance coverage to get it, or those that already have some coverage to enhance their current policy. The measures garnering the most support among individuals are employer-subsidised packages. This is true for each type of insurance respondents were asked about:

- The option of "employer paid for" health or protection insurance and an exemption from taxation on the "benefits-in-kind" were the most popular measures of the two variants of

employer-subsidised coverage. One option that Is currently floating around policy-making circles Is for a *de minimis* exemption from tax of "benefits-In-kind" up to a threshold.
- 24% said they would be incentivised to take-up or upgrade their PMI, 21% said they would be likely to get or enhance their LI, while 23%, 20% and 21% reported that they would sign-up for or improve their CIC, HCP or IP coverage.

The survey evidence indicates that some measures, if well designed and implemented, could generate increased take-up of (and thus coverage) all five types of health and protection insurance. However, it is also clear that there is not one single option that could be seen as a likely "game changer" e.g. stands out from other options too such an extent that it could result in a "step change" in take-up (and coverage) rates. Further, it should be noted that employer involvement was popular. Therefore, employers would clearly need to be persuaded of the benefits of provision or enhanced provision for their workforce. How specifically this might be achieved Is, of course, something for the Industry to contemplate.

Possible implications for the insurance industry

Box 10 outlines five propositions, based upon the evidence outlined in this report, which are intended to provoke consideration by the insurance industry, about:

- How the “understanding” gap that exists between the industry and business users in particular, might be lessened.
- The extent to which some of the barriers that continue to inhibit take-up of health and protection insurance products, especially among smaller businesses, can be reduced.

Box 10: five propositions for insurance industry change

Proposition one: the insurance industry needs to do more to clarify to businesses, in particular, the nature and purpose of their products and their potential benefits. Equally, employers could, no doubt, do more to make employees aware of their access to insurance benefits, in a way that is transparent. Employees should be regularly reminded of their eligibility and coverage.

Proposition two: the insurance industry should identify ways it can improve its current stock of data e.g. collecting more detailed information on outcomes and the possible causality between services provided and the outcomes for those who utilise them and (where appropriate) employers. Specific examples of useful data include measures of the relative quality of private healthcare treatment versus NHS treatment (which, for example, might include comparable metrics on the relative speed of returning to good health and operation success rates). As discussed in the previous chapter, comprehensive data on this is lacking at present. Data demonstrating the role that prevention services – such as annual health "MOTs" for staff – can play in reducing sickness rates and presenteeism would also be valuable in helping to convey to businesses the role that insurance can play in improving health.

Proposition three: if the industry is to sustain itself and in-time expand further into more challenging markets like the small business market, it will need to consider more product innovation. To do so, it will need to tackle the issues of trust and transparency (Including fears over "small print" and non-pay-out on claims) and perceptions of complexity that pervade parts of the consumer and small business population and adapt to changing expectations of greater choice - including the trend for more tailored products and services. Tackling cost barriers and making efforts to reduce uncertainty and concerns about increasing year-on-year premiums could also go a long way in encouraging individual and business interest.

Proposition four: Insurers need to be realistic about the potential for small business customers. An expert in small business insurance made some pertinent observations in an interview for this research, which should be taken on board. He suggested the following:

- The category of small business that is likely to be the most receptive to messaging about insurance are those above the micro-business threshold i.e. those in the 10 to 50 employee range. Business under that size are unlikely to be interested or capable of affording much of what is available.
- Most insurers are big companies focussing on a "big offer" to larger businesses. In order to increase interest in and take-up of insurance by more SME, products needs to be clear and simple.
- Small firms need to be able to see the benefits of insurance products. This is best done through utilising "real stories" that "speak" to small business owner-managers.

Proposition five: the modelling exercise in chapter 5 suggests that increased health and protection insurance coverage could deliver benefits for individuals, employers, taxpayers and the economy, through helping reduce the length of absence from the workplace due to sickness. It may also have an impact on the levels of presenteeism and, perhaps, the total number of people that have to take time off of work due to illness, too.

Further, increased uptake of appropriately designed IP insurance policies, for example, could help address some of the financial problems that people experience when ill and reliant on the UK's relatively low rate of Statutory Sick Pay – reducing the financial "cliff edge" that many individuals face if they find themselves unable to work.

Public policy implications

The modelling in Chapter 5 suggests that there could be gains to taxpayers and the economy from greater coverage of the workforce by health and protection insurance. International evidence also indicates that social policy "systems" that explicitly or indirectly rely upon private insurance can bring net benefits for the taxpayer and economy, if the incentive structures are appropriate. However, if the UK was to decide to move down this path, a shift in the approach to welfare provision In the UK will need to be carefully considered and designed as it would be a significant change to the current model of welfare provision in the UK. Box 12 sets out some broad propositions for policymakers contemplating sick pay, workforce illness, workplace absence and return-to-work policy reform.

Box 11: proposition for public policy reform

Proposition six: following the Australian example, higher earners could be "nudged" into taking out PMI or other insurances to enable taxation to be spent meeting the health needs of individuals further down the income scale. Possible lessons from other countries have, perhaps, been given added salience by the COVID-19 crisis, which has raised a number of questions about "capacity" in the public health system; encouraging higher earners to use private healthcare could "reduce pressure on the NHS".

Further, Australian pension schemes frequently "bundle in" additional "protection insurance" products such as LI and IP alongside the standard pension package. This has seemingly led to large numbers of Australians being covered by LI and IP among other services. It has been estimated that this "additional coverage" could save Australian taxpayers billions of Australian dollars over 10 years. The Australian experience suggests that packaging such products with other more widely utilised long-term savings vehicles can, on the face of it, lead to higher take up and fiscal benefits for the taxpayer and more money for those that are sick and injured while they are ill. Therefore, the Australian experience of both health and protection insurance might offer lessons for the UK that are worth exploring.

Proposition seven: the Netherlands has substantially improved return-to-work rates and labour market participation through re-configuring their sick pay system, which has incentivised businesses to take a more pro-active approach towards supporting ill and injured workers. Sick pay structures could be reformed in the UK along similar lines. The Coronavirus crisis has increased debate about the low level of Statutory Sick Pay in the UK, suggesting that there might be an opportunity to explore the idea of increasing it. As in the Netherlands, an increase in Statutory Sick Pay should give employers a better incentive to improve workplace health and reduce absence rates. Employees would benefit from greater financial stability in the event of sickness. Crucially, appropriate insurance products could help businesses manage the costs associated with higher rates of Statutory Sick Pay regime.

Proposition eight: the auto-enrolment principle could be extended to sick-pay, resulting in a co-funded (employer and employee) insurance coverage. Such an approach helps create an Incentive for both parties to be pro-active about health, illness, absence and return-to-work. The success of auto-enrolment in the pensions space shows that the auto-enrolment aspect is technically feasible and that such an approach does increase up-take of the "benefit" that people are auto-enrolled in. Such an approach embodies the idea of "nudging" people into changes In the norms in consumer and business behaviour (e.g. creating the norm that one should be saving into a pension and that one should have provisions in place to cope with the financial consequences of long-term absence from work). However, how a co-funded system of sick-pay would Interact with the tax and benefits system would need to be rigorously worked through, If the auto-enrolment approach Is to seriously contemplated.

Proposition nine: a less ambitious approach to reform, but one consistent with some of the findings outlined in Figure 31, would be to Implement a package of tweaks to the current system, which would reduce the cost of taking out health or protection policy coverage and minimise other potential difficulties that having private coverage can come up against. Options include an annual allowance for "benefits-in-kind" taxation so that, up to a financial threshold, receiving "benefits-in-kind" (e.g. through health insurance) is not penalised. Further, the welfare system should not penalise the use of insurance, as is the case at present. Currently about one in five recipients of Universal Credit may find their individual income protection policy to be of no value in the event of them being absent from work due to illness or injury, because of the way IP payments interact with the Universal Credit system. For employers there are challenges around P11d's and how their support services impact on associated legislation and tax.

APPENDIX – ABOUT THE SURVEYS

Two Opinium online surveys were commissioned as part of this research.

1. Survey of HR Decision Makers

503 HR decision makers within businesses were surveyed from the 14th to the 21st of November 2019. The table below shows the segmentation of survey respondents by business size.

	Number of survey respondents
Mirco (1-9)	166
Small (10-49)	110
Medium (50-249)	105
Large (250 +)	121

2. Survey of individuals that had suffered a long-term absence (more than four weeks) from the workplace due to injury or illness.

1,000 individuals, evenly split between those with and without insurance, were surveyed from the 14th to the 21st of November 2019. The table below shows the segmentation of survey respondents by gender, age, employment status and region of the UK.

		Number of survey respondents
Gender	Male	573
	Female	426
	Other	1
Age	18-34	236
	35-54	487
	55+	277
Region	Scotland	74
	Northern Ireland	23
	North East	50
	North West	113
	Yorkshire and Humberside	83
	East Midlands	75
	West Midlands	75
	Wales	45
	East of England	67
	London	139
	South East	160
	South West	94
Employment at time of illness/injury	Employed in a micro-business (between 1 and 9 employees)	88
	Employed in a small business (between 10 and 49 employees)	152
	Employed in a medium-sized business (between 50 and 249 employees).	205
	Employed in a large business (more than 250 employees).	347
	Employed in the Public Sector	153
	Self-employed.	49

3. In-depth interviews

35 semi-structured in-depth interviews with HR Decision Makers in a range of (predominantly small) organisations, half of which offered (either or both) health and protection insurance to at last one member of the workforce and half that did not. The table below shows the size and sector breakdown of the organisations, on behalf of which, those interviewed were speaking.

	1 to 49 employees	50 to 249 employees	500 plus employees
Charity	1	-	-
Construction	1	1	
Business, financial and professional services	6	3	1
Education and personal and household services	2	3	-
Healthcare and Pharmaceuticals	-	1	1
ICT	1	2	1
Leisure, entertainment, hospitality, and tourism	3	-	-
Manufacturing and engineering	2	1	-
PR and marketing	1	-	-
Property	2	-	-
Retail	1	-	-
Transport and logistics	-	1	-
Total	**20**	**12**	**3**

ENDNOTES

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[34] For the purposes of this report, businesses are split into the following size categories: Micro – fewer than 10 employees; Small – 10-49 employees: Medium – 50-249 employees: Large – 250 or more employees

[35] Business of all sizes (with employees) were surveyed. Micro-business (1-9 employees), small businesses (10–49 employees), medium-sized businesses (51–249 employees) and larger businesses (250+ employees).

[36] The median profit for small and medium sized enterprises in 2019, was around £8,000. Although this figure disguises variation, it nevertheless provides useful indication of the kinds of financial constraints SMEs are operating within, when deciding on where to prioritise expenditure in the future. Source: Statista, "Median profit made by small and medium enterprises (SME) in the United Kingdom (UK) in 2019, by enterprise size". (2019). Accessible at: https://www.statista.com/statistics/291299/average-profit-of-smes-in-the-uk-by-enterprise-size/ Accessed: 20/02/20.

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