ABI response to joint HMT-HMRC consultation on tax incentives for occupational health

October 2023

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

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

Executive summary

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

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

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

OH is not always the appropriate solution to produce a good outcome. Traditional core OH services usually provide a medical assessment of a person's fitness for work followed by recommendations to employers about possible adjustments. However, generally the services stop there without implementing, monitoring or funding their recommendations. Taking a broader approach is more effective. Our analysis of over 16,000 vocational rehabilitation cases found that 9 in 10 (86%) people who use vocational rehabilitation services provided by their income protection insurance were successfully supported to stay in work or return to work following an absence due to illness or injury. 42% of those absent were supported back to work in under 4 weeks and 81% in under 6 months.

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

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

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

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

We therefore believe that a narrow approach that misses insurance and focuses only on incentives will be a significant missed opportunity to reduce ill-health-related job loss and improve productivity. To achieve the aims of this consultation, it is essential that taxation measures meet three criteria.

1) Reduce costs for employers – to create employer behaviour change.
2) Use tax incentives to target services where there is evidence that they are effective for keeping people in work – to ensure that increased demand leads to better health outcomes.
3) Promote an effective market – to maintain choice in the market, effective services, and capacity to meet demand.

If tax measures fail to meet any of these criteria, they will be at best ineffective and very likely counterproductive. That is why we strongly urge the Treasury to address tax incentives and reduce tax barriers in response to this consultation.

Insurance is an important model for the provision of OH services but faces excessive tax barriers. The total tax burden on health insurance currently adds between 50-72% to premiums before tax, between employers and employees. At the same time, the double taxation of group income protection inhibits take up through salary sacrifice. These regressive taxes work in opposition to government aims by creating a barrier to health support at a time when record numbers are unable to work for health reasons and the NHS is under unprecedented pressure.

We urge the Treasury to include insurance in the scope of tax incentives as a route to OH provision. While we have a strong preference for the blanket inclusion of insurance in benefit in kind (BiK) tax exemptions, we set out other alternatives for how it could work. We would welcome a discussion with the Treasury about these options.

We support the consideration of alternative tax incentives and welcome further discussions about how they could be used to promote an effective workplace health market that utilises health insurance and income protection. We recognise the merit of a super-deduction as an effective way to reduce costs for employers and drive demand. However, if the scope was too narrowly focused on traditional OH the incentive would significantly distort the market, leading to worse outcomes for the health of the workforce.

Question 1: Why do employers provide OH services to their employees? For example, it could be to increase workplace participation, increase workplace performance, or for the health and wellbeing of the employee.

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

We know that long term worklessness is bad for physical and mental health, and there is evidence to suggest that work is good for health.[1] A survey commissioned by DWP shows that employers acknowledge the link between work and employee health and wellbeing and that it is their responsibility to encourage employees to be healthy.[2] However, evidence shows that this alone does not always lead to demand. Therefore, to successfully bolster greater take-up, tax and policy measures must leverage a range of drivers of demand to appeal to businesses with differing needs.

The same DWP survey also shows that organisation size has a direct bearing on employer health and wellbeing provision. Many smaller employers reported insufficient demand to justify investing in formal or preventative schemes.

As part of research commissioned by the ABI, the Social Market Foundation surveyed HR decision-makers to understand what drives demand for health and protection insurance.[3] They found that:

- Health and protection insurance is offered by some as a tool for retaining staff in a business and attracting talent.

[1] https://cardinal-management.co.uk/wp-content/uploads/2016/04/Burton-Waddell-is-work-good-for-you.pdf
[2] https://www.gov.uk/government/publications/sickness-absence-and-health-in-the-workplace-understanding-employer-behaviour-and-practice/sickness-absence-and-health-in-the-workplace-understanding-employer-behaviour-and-practice-summary
[3] https://www.smf.co.uk/wp-content/uploads/2021/05/SMF-Insuring-a-return-May-2021.pdf

- "A duty of care to staff" and the organisation's reputation were cited by many respondents as motivations.
- Workforce health risk management factors (e.g. supporting sick or injured members of staff, helping them return to work more quickly or at all) were raised as a motivating factor by around one-in-five businesses that provide health insurance and about 17% of businesses that provide income protection. One in five respondents who offered PMI reported that they did so because of its potential role in preventing ill-health. For those that offered IP, prevention was cited as a motivating factor for 12%.

Insurance is a route to OH and wider health and return-to-work-services. We urge the Treasury to consider insurance when designing tax measures to increase demand. The broader appeal as a tool for staff retention and recruitment will help to increase take-up amongst businesses.

Question 2: What OH treatments are most commonly provided to employees? Have you observed any changes to this since the COVID-19 pandemic?

OH and the role of insurance

Traditional OH services usually provide a medical assessment of a person's fitness for work followed by recommendations to employers about possible adjustments and support they may require. OH services generally stop there and do not implement, follow up on, monitor, or fund their recommendations without re-referral from the businesses at extra expense. This additional cost is often a barrier to the employer obtaining more support.

Insurance policies purchased by employers, such as health insurance and group income protection, offer access to occupational health services. They also go beyond what OH usually provides, providing vocational rehabilitation, early intervention, and health services targeted at key reasons for sickness absence. Life and Critical illness insurance policies, often offered through the workplace, also provide mental health support and GP services.

Health and income protection insurance give employees fast and easy access to treatment for a wide range of conditions. This immediately minimises time off work, and by treating conditions earlier it also reduces the risk of escalation into more serious conditions that then cause people to fall out of work for prolonged periods of time.

Income protection

Income Protection insurance is designed to mitigate the risks of workers leaving the workforce due to illness, injury or disability. When an individual does fall out of work, their policy provides a proportion of their pre-disability income (typically up to 75%) through their employer. Importantly, as this helps to sustain income, it increases spending power as well as National Insurance and tax receipts.

To support individuals to stay in work, policies offer access to vocational rehabilitation based on case management. This helps employers and employees by preventing an issue from worsening and leading to absence, or by helping the employee return work even if they've had an extended period of absence.

Vocational Rehabilitation is underpinned by a biopsychosocial approach rather than the medical model that traditional OH assessments are based on. This means it looks at cases from all angles (i.e., health, personal and workplace factors) to reach the best workplace outcome, rather than simply considering medical information. There is strong evidence that this approach linked to the workplace can be both effective and cost effective for improving occupational outcomes.[4]

Health service utilisation for health insurance

In 2021, 1.47 million people accessed the services available to them through health insurance, up by more than a third (36%) since 2019. These customers accessed their health services 5.2 million times.

- 140,000 people accessed health services for mental health 600,000 times in total. Insurers' often offer talking therapies, CBT and counselling, but sometimes customers also speak to their remote GP for mental health support.
- Almost half a million (490,000) people received support for musculoskeletal (MSK) conditions 2 million times in total.
- 50,000 people accessed services for cardiovascular support 120,000 times in total.
- 60,000 people used health services for cancer 400,000 times. 6.7 times per person on average.
- 30,000 people used health services for neurological conditions 60,000 times, twice per person on average.

The number of people who accessed virtual GPs through insurance increased more than fivefold (440%) between 2019 and 2021.

Question 3: What OH treatments are most effective for improving workplace participation, or effective at achieving other objectives (e.g. performance or health outcomes)?

While traditional OH commonly provides medical assessments and makes recommendations to employers, it is less common that this is followed up with direct support based on the recommendations. This can happen however if there is a re-referral from the business, but this is an extra expense that acts as a barrier.

One of the key benefits of insurance is that it is a model for the provision of numerous health and return-to-work services alongside OH. The additional services provided through insurance offer direct support for employees, described in more detail below, and often employ a case management approach.

Therefore, to support better outcomes for workers, businesses and the economy the government must include insurance and vocational rehabilitation in its plans to improve workplace health. Only incentivising one route to OH will skew the wider workplace health market to the detriment of employer choice, effective support, worker retention and return-to-work outcomes.

Health service utilisation through insurance

In 2021, over 1.6 million people used the health services available to them through insurance. These customers used the services 5.5 million times in 2021.

[4] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/209474/hwwb-vocational-rehabilitation.pdf

Health insurance

For many employers, health insurance is a simple and effective way to put in place a broad package of health and wellbeing support for their people. It is easy to set up and provides a flexible funding mechanism for employers to deliver the right services to suit their employees. It delivers immediate impact – in a typical year, in a company of 1,000 people, a health insurer will treat around 236 people for ill health. This minimises time off work, and by treating conditions earlier it also reduces the risk of escalation into more serious conditions that then cause people to fall out of work for prolonged periods of time.

For over 50s, cancer and MSK are the main drivers of claims. This age group have also made increasing use of mental health support.

Employers are also becoming increasingly aware of the impact of menopause on workforce participation. Bupa found that almost 1 million women have exited the workforce because of the menopause. Those who take a long-term absence from work to manage menopause symptoms take an average of 32 weeks of leave, resulting in damage to individuals' careers and a huge loss of productivity to a business.[5] Health insurance provides businesses with targeted support for women's health. Health insurers both support access to appropriate services and support employers to embed more flexible working so that their workforce can manage symptoms and stay-in-work.

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

Income protection

Income Protection (IP) insurance is designed to mitigate the risks of workers leaving the workforce due to illness, injury or disability. To do so, it provides evidence-based health services via the workplace, including CBT, counselling and vocational rehabilitation. Waddell, Burton and Kendall conclude in their extensive literature review that there is a strong scientific evidence base for many aspects of vocational rehabilitation.[6] Early symptoms are typically treated with less resource-intensive support and high-intensity support is provided for worse symptoms. This type of early intervention often prevents the need for more substantial interventions down the line and is generally viewed as the optimal way to allocate resources.

Workforce participation outcomes from vocational rehabilitation accessed through insurance

ABI analysis of around 16,000 vocational rehabilitation cases found that nearly 9 in 10 (86%) people remained in the workforce following access to rehabilitation services through insurance.[7] This remains the case for older workers. Approximately 8 in 10 50+ year olds who used vocational rehabilitation services

[5] https://committees.parliament.uk/writtenevidence/39244/html/
[6] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/209474/hwwb-vocational-rehabilitation.pdf
[7] https://www.abi.org.uk/globalassets/files/publications/public/health/abi-closing-the-evidence-gap---how-insurance-supports-good-health-and-productivity.pdf

provided by insurers for MSK (84%), mental health (82%), cardiovascular conditions (80%), and cancer (75%) were either supported to stay in work or return to work after an absence.

Our data also enables us to look at stay-in work and return-to-work rates by condition.

Nearly 1 in 10 people who accessed vocational rehabilitation required support for cancer. 4 in 5 were supported to stay in or return to work. When someone suffers from a long-term condition such as cancer, there can be a cliff edge following treatment. Vocational rehabilitation maintains the link between the individual and their employer and provides return-to-work support following treatment.

- Macmillan reported that over 700,000 working age people are living with cancer across the UK, and over 100,000 are diagnosed every year.[8] Through their vocational rehabilitation pilot for individuals living with cancer, they found significant improvements in employment status and health-related quality of life.
- A 2021 survey by the Institute for Employment Studies suggests that in the general population a quarter of people living with cancer do not return to work at all.[9]

Nearly 1 in 4 (24%) people in our sample who accessed vocational rehabilitation for a mental health condition did not need to take any time off work and 2 in 3 (64%) were supported to return to work following absence. Over 2 in 5 (42%) returned to work in under 4 weeks and more than 4 in 5 (81%) returned to work in under 6 months.

Research by the Royal College of Psychiatry suggests that nearly 1 in 4 wait more than 12 weeks to start NHS mental health treatment and nearly half say that waiting times worsen their mental health.[10] Vocational rehabilitation can reduce pressure on these services as nearly 1 in 4 (24%) people who accessed vocational rehabilitation for a mental health condition did not need to take any time off work and 2 in 3 (64%) were supported to return to work following absence. In addition, nearly half (45%) of our sample referred to vocational rehabilitation support for a mental health condition were referred in under 4 weeks, and 9 in 10 before two months. Following referral, 9 in 10 (90%) received support in under 4 weeks. This reduces the likelihood of these conditions worsening owing to delays in accessing treatment.

Nearly 1 in 5 (19%) people who accessed vocational rehabilitation for an MSK condition did not become absent from work, and more than 2 in 3 (67%) were supported back to work after absence. Over one third (35%) returned to work in under 4 weeks and more than 3 in 4 (77%) returned to work in under +6 months.

Disability

[8] https://www.macmillan.org.uk/documents/getinvolved/campaigns/workingthroughcancer/making-the-shift-specialist-work-support-for-people-with-cancer.pdf
[9] https://workingwithcancer.co.uk/content/files/Cancer-Employment-Survey-Results-Summary-1.pdf
[10] https://www.rcpsych.ac.uk/news-and-features/latest-news/detail/2022/10/10/hidden-waits-force-more-than-three-quarters-of-mental-health-patients-to-seek-help-from-emergency-services#:~:text=Waits%20can%20be%20longer%20than,including%20divorce%20and%20family%20breakdown.

The Federation of Small Businesses (FSB) found that 25% of small business owners are disabled or have a health condition and 51% of small employers have employed a disabled person or someone with a health condition in the last 3 years.[11]

Health insurance and income protection provided through the workplace play an important role in supporting disabled people at work. The consistency of support through case management is particularly effective for supporting and reintegrating disabled people into the workforce.[12]

Group Income Protection policies set out the criteria for membership such as six months' continuous service and employees who meet that criteria will be covered regardless of whether they have a disability or long-term health condition. Group insurance, provided through the workplace, is particularly beneficial to individuals with disabilities who can otherwise find it difficult to purchase cover individually.

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

Question 4: How much do employers typically spend on OH services? Does the existence of the £500 cap on recommended medical treatment influence the amount that employers are likely to spend on OH services?

The impact of BiK exemptions on business spend

The £500 cap on medical treatment likely has a negligible influence on the amount employers spend on OH services. This is because BiK exemptions target employees who would otherwise pay income tax on the whole value of a benefit in kind.

To target businesses most effectively, tax incentives should reduce costs to businesses. To ensure that they increase productivity and reduce ill-health related job loss, tax incentives must include the wider workplace health ecosystem in scope and strengthen rather than skew the market.

There is a risk that incentivising lower spending on one-off treatments could create a 'race to the bottom' leading to wider provision of cheaper and less effective services. An employer may spend below the cap to keep costs down for employees when higher-value services would be more effective. It is important to ensure that employer choice is preserved and decisions on spend are weighed up against the effectiveness of the benefit so that they reflect value for money.

Question 5: To what extent does the tax treatment of OH services affect the decisions employers make on whether to provide OH services and what to provide as a part of them? For example, would an employer be more likely to offer a treatment that is exempt than one that is not, and to what extent is that decision influenced by the tax treatment?

To be successful, it is essential that taxation measures meet three criteria:

1) Reduce costs to employers – to create employer behaviour change.

[11] https://www.fsb.org.uk/resource-report/business-without-barriers.html
[12] https://labourmarketresearch.springeropen.com/articles/10.1186/s12651-021-00299-9

2) Target evidence-based services that are effective for keeping people in work – to ensure that increased demand leads to better outcomes.
3) Promote an effective market – to maintain choice in the market, effective services, and capacity to meet demand.

Failure to meet any of these criteria, will be at best ineffective and very likely counterproductive. That is why we strongly urge HMT to address both tax incentives and tax barriers in response to this consultation.

Insurance, which faces excessive tax barriers, is an important model for the provision of OH services. A narrow approach that misses insurance and focuses only on incentives will be a significant missed opportunity to reduce ill-health-related job loss and improve productivity.

Tax incentives

While it is important to drive up employee service utilisation, as highlighted above, tax treatment targeted at employees, rather than employers, is likely to have a negligible impact on business demand.

If uptake is driven by the employee, then incentives should target the employee to create employee demand. Conversely, if demand is driven by the employer, then the incentives should target the employer.

There may be some services ultimately paid for by the employer, but where demand is driven by the employee, and incentives like BiK exemptions may be more effective. There also may a case for incentives that target employees to reduce the likelihood of opt-outs.

Tax barriers 1 – Insurance Premium Tax (IPT) stands in the way of good outcomes

To reduce costs for employers and promote an effective work and health market, the Treasury must review the taxation of health insurance to reduce barriers to uptake.

The total tax burden on health insurance currently adds between 50-72% to premiums before tax, between employers and employees. This works in opposition to government aims by creating a barrier to health support at a time when the NHS is under unprecedented pressure and record numbers are unable to work for health reasons.

Insurance Premium Tax (IPT) demonstrates how regressive taxation can distort a market and work in opposition to the government's objectives. Since 2015, insurance premium tax (IPT) has doubled from 6% to 12%. This has impacted families and businesses who take out health insurance by driving up the price of their cover, and it creates a barrier to purchasing cover, pushing more people into the NHS. Evidence shows that the decision to introduce Insurance Premium Tax in 1994, at a rate of 2.5%, coupled with the 1996 decision to remove tax relief on premiums for the over-60s, triggered an almost continuous decline in the consumer market in the years since. It also stilted the workplace health insurance market, leading to declines over the last 15 years while funnelling growth into alternatives such as Health Trusts and individual self-pay.[13] The outcome of this is additional pressure and costs placed on the NHS.

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

Tax barriers 2 - the wider tax burden on health insurance

IPT in conjunction with Class 1a NIC and BiK tax work against the government's goal to support businesses to play a greater role in promoting a healthy workforce.

ABI data shows that in 2021 the average premium per subscriber for corporate health insurance was £1,048. For a £1,000 premium before tax, the total taxes paid amount to £498.56 for a 20% income tax rate, and £722.56 for 40%. These percentages are calculated after insurance premium tax (12%) is added to the premium.

- Employers pay the premium plus 12% IPT, and then Class 1a National Insurance Contributions (NIC) at 13.8% of the total. This would amount to £1,274.56 on a £1,000 premium.
- Employees do not pay the premium, but do pay benefit in kind tax, at 20%-40% of the premium plus IPT. That is £224 to £448 for a £1,000 premium. The cost to employees would be reduced if insurance was included in the scope of the BiK exemption.

This acts as a barrier to the benefits of insurance and is obstructive to government aims to improve workforce participation. We argue that insurance offers a model for employers to provide OH, vocational rehabilitation and health services, including those in scope of the BiK exemption, to their employees and should be included in scope of BiK exemptions.

Tax barrier 3 – the double taxation of group income protection (GIP)

Under HMRC's current interpretation of the rules, group income protection is double taxed if an employee enters into an OpRA salary sacrifice arrangement. That means that where the employee enters a salary sacrifice arrangement to secure additional cover, the foregone salary is taxable as a benefit in kind, and the corresponding proceeds are also taxable, leading to double taxation.

The ABI does not agree with this current position.

Consider the £500 BiK exemption cap in light of rising inflation

The government should consider whether the value of the exemption cap set at £500 remains appropriate given increasing medical costs as a result of rising inflation.

Question 6: Small and Medium Enterprises are significantly less likely to offer OH services. Why is this? Are there other characteristics of employers that tend them towards offering less or more OH services?

Drivers of demand for SMEs

Driving demand for products and services that improve workforce health outcomes, particularly amongst SMEs, is key to reducing rising health-related economic inactivity. Yet evidence from the Institute of Employment Studies found SMEs are not driven to seek OH services unless there is a live issue.[14] Supporting this, a recent survey by the Federation of Small Businesses found that 44% of small businesses that do not

[14] https://www.employment-studies.co.uk/system/files/resources/files/hse_whc_ef.pdf

provide OH services said it is because they do not have an existing health issue amongst staff.[15]

In addition, research by the Social Market Foundation found that staff retention was a key motivator for 45% of businesses that provide medical insurance or are seriously considering offering it in the next 12 months, and recruitment was a key motivator for 30% of businesses. Earlier this year we also commissioned Public First to survey a representative sample of over 2,000 members of the public about their views on insurance. Over half of the respondents said that private medical insurance and income protection are significant factors when they're deciding where to work, demonstrating that these products have broader appeal for employers.[16]

Insurance can help to address the lack of take-up of OH amongst SMEs. It serves as an effective pathway to OH for SMEs and provides necessary return-to-work support beyond OH.

Currently only a small proportion of businesses in the UK have Group Income Protection (GIP) policies, however 90% of these policies are owned by SMEs and around one-third cover businesses with fewer than 10 workers. This demonstrates that SMEs value GIP, and it suggests that including insurance in policy and tax measures to drive demand, as well as reducing barriers to uptake, will lead to wider coverage primarily amongst SMEs.

Understanding of SME demographics

The term 'SME' is a catchall for a wide range of businesses with differing levels of motivation and ability to provide health and wellbeing services. To gain a better understanding of the barriers and drivers of demand for OH, the government should survey employers categorised by different demographics such as more detailed sector breakdowns, turnover, region and number of employees.

Question 7: How would any of the proposed additional treatments listed above enable you to support increased OH provision and improve workforce participation? Do you have any other comments on these proposals? If so, please comment on each in turn.

We are supportive of the Treasury's aim to create behavioural change through the taxation system. It is important to encourage employers to provide workers with quality OH, health, and return-to-work services, and employees to utilise these services.

We strongly urge the Treasury to include insurance as a route to the provision of current and proposed treatments listed in the consultation paper. Not doing so is a significant missed opportunity and poses material risk to the wider work and health market. It will push businesses away from insurance which is well suited to SMEs and businesses without an HR function who can 'plug it in' with immediate effect.

While we have a strong preference for the blanket inclusion of insurance in BiK exemptions, we set out another alternative for how it could work below. We welcome a discussion with the Treasury about these options.

[15] https://www.fsb.org.uk/resource-report/business-without-barriers.html

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

Above we set out three key criteria for the success of government measures to have a genuine impact on productivity and reducing ill-health-related job loss. Failure to meet any of these criteria will be at best ineffective and very likely counterproductive. These are (1) reducing costs to employers, (2) targeting evidence-based services that are effective for keeping people in work, and (3) promoting an effective market.

Here, we largely focus on promoting an effective market and the need to avoid a narrow scope.

The risk of distorting the market

OH is one part of a broader workplace health ecosystem and works best alongside other products such as insurance and services such as vocational rehabilitation. The government must promote an effective market, preserve employer choice, allow cases to be matched to appropriate services, while ensuring sufficient capacity across the market to meet demand.

We propose that the Treasury should include Health Insurance policies in scope of the BiK exemption. Health Insurance is an important model for the provision of OH, health, and wider return-to-work services that spread demand to the most appropriate services, leading to better outcomes and reducing the strain on supply in one area, i.e., OH.

Failing to include insurance and isolating one small part of the wider ecosystem will have a negative impact on the market and ultimately lead to worse outcomes for individuals, employers and the workforce.

1. *Limited employer choice*

Employer choice must be preserved to ensure that the market reflects individual employer needs. Insurance is well suited to many businesses including small businesses. Skewing employer choice away from insurance towards a traditional OH model that may be less suitable would create a worse market for businesses and have a negative impact on the workforce.

2. *Pushing demand towards inappropriate services*

There is a risk of over-medicalising issues in the workplace – this means pushing demand towards medical services and treatments that may work against good outcomes. As set out below, evidence suggests that the medical model approach can be counter-productive for many common health conditions. Skewing the market towards the medical model therefore carries the risk of working against the aim of this consultation to improve productivity and reduce ill-health related job loss.

Insurance provides support based on the medical model where appropriate, but also offers services such as vocational rehabilitation based on the biopsychosocial model. There is strong evidence that a biopsychosocial approach linked to the workplace can be effective and cost effective for improving occupational outcomes.[17]

[17] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/209474/hwwb-vocational-rehabilitation.pdf

- The medical model of OH focuses on defining functional limitations and restrictions.[18] This comes from the traditional risk assessment approach to health and safety.[19]
- This approach can have a detrimental effect for resolving common health problems with a high prevalence in the general population - for example, mild/moderate mental health problems or musculoskeletal conditions. These issues have complex risk factors, often lack 'injury' or 'disease', and causation is ambiguous.
- There is also evidence suggesting that individuals' responses to illness are likely to be influenced by a wider combination of social and circumstantial factors.[20] Vocational rehabilitation provided through insurance utilises a combination of therapeutic and also social interventions that address the clinical problem and issues in the individual's physical and social environment.[21]

3. Insufficient supply to meet demand

A distorted workplace health market also carries material risk for the OH market. There is insufficient supply to meet the current level of demand in the OH market. Funnelling further demand towards OH in isolation will exacerbate longstanding issues with OH supply.

Even if the level of OH supply does improve, tax measures would still create worse outcomes for customers to the extent that the demand is diverted towards just one part of the wider ecosystem. As already described, this will push people away from the kind of early-intervention and evidence-based biopsychosocial services offered through health insurance and income protection.

How to include insurance

We see three main approaches to including health insurance in the scope of a BiK tax exemption.

1) Blanket inclusion – an employee does not pay income tax for health insurance policies on the value of the premium paid annually, up to the BiK exemption cap (currently £500). We favour this approach as it would have the largest impact on employer demand, which is a key aim of this consultation.
2) Conditional inclusion 1 – depending on whether an individual accesses one of the BiK exempt services. Income tax would not be paid on the value of the premium paid annually up to the BiK exemption cap (currently £500). This approach would target employee uptake of services.
3) Conditional inclusion 2 – depending on whether an individual accesses one of the BiK exempt services, up to the value of that service. This would likely be the most challenging and less effective than the previous options.

Question 8: For each of the categories of treatments that are currently available, is the existing definition appropriate and does it support OH provision or does it create issues?

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

Under the current rules for the exemption for a 'recommended medical treatment', to qualify for the exemption, the employee must have been either assessed as unfit for work due to injury or ill health for at least 28 consecutive days by a health care professional or absent from work due to injury or ill health for at least 28 consecutive days. Intervention after 28 days since onset reduces the chance of a positive work outcome compared to the provision of support much earlier.

ABI data shows that 42% of our sample – individuals accessing vocational rehabilitation through insurance – who became absent were then supported back to work in under 28 days with early intervention through insurance.[22]

Health insurance and income protection specialise in early intervention to treat conditions before they worsen, minimising the risk of long absences and in many cases preventing absence altogether.

This is particularly important at a time when the prevalence of mental health conditions is rising and waiting lists are increasing, taking younger workers out of the workforce. The importance of early intervention with mental health conditions is well evidenced. Three quarters of adults with mental health conditions experience their first symptoms by the age of 24. Early intervention and quick treatment are crucial to prevent persistent and ongoing issues for younger people with mental health conditions.[23] Our data shows that one-third of 16-24 year olds who accessed vocational rehabilitation through insurance for a mental health condition did not need to take leave from work. A further 56% were supported to return to work after absence.[24]

Question 9: Are there are other costs that should be in scope, and how would they help achieve our goal of improved OH provision and greater labour market participation?

Accommodate affordable health support to target key demographics

Consideration could be given to increasing the benefit in kind trivial benefits value from £50, for example to £200 – or alternatively introducing a broader 'health support' threshold to ensure that this increase in value is targeted at the right kind of services.

A higher threshold would allow plans such as the health cash plan to be provided by employers to all staff. A cash plan can be an effective and cost-efficient way to provide smaller companies with an attractive benefits package to obtain and retain staff.

Cash plans are health insurance policies that help employers cover the cost of everyday healthcare such as GPs, dentistry or physio via a small monthly fee (from less than £10). Their affordability means that they can be used to target employee demographics with higher absence and job dissatisfaction. Yet, research by

[22] https://www.abi.org.uk/globalassets/files/publications/public/health/abi-closing-the-evidence-gap---how-insurance-supports-good-health-and-productivity.pdf
[23] https://www.centreformentalhealth.org.uk/sites/default/files/2018-09/CentreforMentalHealth_MissedOpportunities_16-25years.pdf
[24] https://www.abi.org.uk/globalassets/files/publications/public/health/abi-closing-the-evidence-gap---how-insurance-supports-good-health-and-productivity.pdf

Simplyhealth and CIPD shows that only 25% of companies currently offer all of their employees a cash plan.[25]

Question 11: Do you see a case for any of the above costs being in scope of additional tax relief under the BiK exemption? If so, please discuss why, and how this would help achieve the government's objective of increasing employer provision of OH services and labour market participation.

Insurance must be included in tax measures from this consultation. Regarding the scope of BiK exemptions, we believe a blanket inclusion of health insurance is the best option. This is because it would have the largest impact on employer demand and greater coverage – for example by reducing the likelihood of employee opt-outs.

- Blanket inclusion of health insurance would mean that an employee does not pay income tax on these policies for the value of the annual premium up to the BiK exemption cap (currently £500).

Blanket inclusion of health insurance in scope – financial impact

ABI data shows that in 2021 the average premium per subscriber for corporate health insurance was £1,048. For a £1,000 premium before tax, the total taxes paid amount to £498.56 with a 20% income tax rate, and £722.56 for 40%.

A £500 benefit in kind tax exemption would reduce the total tax on a £1,000 per year health insurance by between £112 - £224 per person depending on income tax rate. This would reduce spend on OH services through insurance. In addition to quality OH services, workers would get access to preventative services, GPs and treatment. Importantly they would also have streamlined access to any support recommended by OH.

How poor tax treatment of insurance leads to negative societal trends

Consistent rises in IPT for health insurance have shrunk the individual consumer market over time while distorting and inhibiting the employer paid market. Corresponding to increases in IPT, LaingBuisson analysis estimated a 15%-25% year on year rise in the number of uninsured people self-paying using savings or credit.[26] Hip and knee replacements are commonly self-funded and can cost between £10-15k. This is a significant cost for the average patient that could be avoided through a health insurance policy. With more people turning to self-pay, the government must consider the tax treatment of health insurance with a view to reducing cost barriers resulting from tax.

Question 12: Are there alternative tax incentives that you think would be more effective in incentivising employers to invest in OH services for employees? If so, please explain why.

We support the use of tax incentives to drive up demand for workplace health services. As we have outlined above, to effectively change employer behaviour tax measures should target employers directly. One way to

[25] https://www.cipd.org/globalassets/media/knowledge/knowledge-hub/reports/2023-pdfs/8436-health-and-wellbeing-report-2023.pdf
[26] https://www.laingbuisson.com/shop/private-healthcare-self-pay-uk-market-report-5ed/

do this, that we encourage the Treasury to seriously consider, is reducing the tax barriers to the uptake of insurance. Another way is developing incentives that reduce the cost of providing these products and services for businesses.

Tax incentives that target employers directly

A super-deduction is an effective way to reduce costs for businesses and therefore would be an effective way to change employer behaviour and drive demand. Therefore, if the scope is too narrow, i.e., on traditional OH in isolation, this incentive carries a significant risk of distorting the market against the aim of improving productivity and reducing ill-health-related job loss.

That's why it's essential health insurance and income protection are considered as part of any alternative tax incentives. Both products provide an effective route to OH alongside wider health and return-to-work services. If the Treasury further explores a super deduction or alternative tax measures that target employers directly, we strongly urge you to seek input from the ABI with a view to including insurance.

Risks to consider – super deduction

While a super deduction brings clear benefits for businesses and workers, it is also important to consider risks to the exchequer. For example, the risk of rewarding investment that may have happened anyway. That's why we support a separate consultation on a super deduction to give due consideration to this – however this consultation must include insurance in scope for reasons set out above.

Ultimately, the primary driver for encouraging businesses to provide services and products to promote the health of their workforce is the cost to the business. This is weighed up against how useful the service will be, both as an attractive employee benefit and a useful resource for keeping employees healthy and productive so that employers get a good ROI.

Including both health insurance and income protection insurance

In addition to health insurance, the government must consider Group Income Protection insurance (GIP). GIP is designed to mitigate the risks of workers leaving the workforce due to illness, injury or disability. To do so, it provides evidence-based health services via the workplace. Evidence also shows that work outcomes are improved if clinical healthcare is linked to the workplace.

Replacement income is paid by the insurer, but through the employer, maintaining an important link to employment. Payments are treated as earned income subject to tax and National Insurance in the normal way.

Nearly two- thirds of policies have a claim payment period which can last up to last until the age of retirement and, sometimes, beyond to age 70 (64% in 2022). and one -fifth have a maximum benefit duration last up to 5 years (20%).[27] Policies often include cover for pension contributions to ensure financial resilience beyond the age of retirement.

[27] Swiss Re, Group Watch 2023

Question 13: Are there particular tax incentives that would be better suited to helping small and/or medium sized businesses invest in OH services?

We agree that there is merit in designing tax incentives targeted at SMEs as demand tends to be lower amongst these businesses. An effective tax incentive would preserve employer choice in the wider workplace health market by avoiding a narrow scope.

Provision of OH services through insurance is well suited to SMEs

The insurance model of proving OH benefits is simple to administer and use for SMEs and we strongly recommend that the Treasury considers both health insurance and income protection in the scope of any tax incentives.

Health insurance is simple for companies to buy and administer, and doesn't rely on having an HR infrastructure and so significantly simplifies the process for SMEs. In addition to OH services including assessments, employees gain fast, easy, and confidential access to treatment for a broad range of conditions early on – this minimises time off work and reduces the risk that conditions will escalate into more serious conditions.

Group Income Protection (GIP) is provided by employers of all sizes to their employees and helps them to manage sickness absence by supporting prevention and swift return to work following illness or injury. The suitability of these policies for SMEs is demonstrated by the fact that 90% of Group Income Protection policies belonging to SMEs. Currently, around one-third of GIP policies cover businesses with fewer than 10 workers.[28]

US Small Business Health Care Tax Credit

There are international examples of tax incentives for health insurance. The US implemented a small business tax credit to address low take up of health insurance amongst SMEs. While this was solving a different problem, i.e., healthcare coverage across the US, it was an issue relating to SME coverage and therefore shares important traits.

The US small business health care tax credit is worth up to 50% of the cost of employees' premiums for two taxable years. A small employer is eligible for the credit if (a) it has fewer than 25 full-time equivalent employees, (b) the average annual wages of its employees are less than $50,000 dollars and (c) it pays a uniform percentage for all employees that is equal to at least 50% of the premium cost of employee only insurance coverage.

The driver for the Small Business Tax Credit was to incentivise and support small business provide health insurance by offsetting the cost. Until 2018, not providing health insurance would result in businesses facing tax penalties due to the Affordable Care Act (ACA).

[28] Swiss Re, Group Watch 2023

Based on 2016 data, there was a 50 percent increase in the number of small-business employees (firms with 99 or fewer employees) enrolled in Medicaid between 2013 and 2016.[29]
The tax credit faced some criticism in 2016 due lack of awareness among businesses.[30] This demonstrates the importance of supporting tax measures with clear and well-advertised education and guidance.

The importance of education and guidance

Smaller employers use OH and return-to-work products and services less often than larger companies and are therefore less adept at using them effectively. With less experience using the products, they often notify the insurer later about a health issue. Our data demonstrates this and how it can impact on work outcomes.

Our data shows that large companies notify insurers quicker than SMEs about a health problem – insurer vocational rehabilitation teams were notified within 4 weeks for 39% of cases for large companies, compared to 14% of cases for SMEs.[31] Those employed by large companies experience better work outcomes, suggesting correlation between early notification and good outcomes.

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

SME demographics

The term SME covers a large heterogeneous group of businesses with differing appetite and ability to provide OH and return-to-work services. Ability to spend on these services differs between businesses largely due to margins and volumes of employees.

To gain a better understanding of the barriers and drivers of demand for OH, the government should survey employers categorised by different demographics such as more detailed sector breakdowns, turnover, region and number of employees. This would also enable the government to better understand how different drivers such as recruitment and retention could be leveraged to support better workplace health provision.

Question 14: To what extent would tax incentives be more effective in increasing employer investment in OH, compared to legal measures to provide OH, which could vary by the size of the business?

Based on international examples, we support a combination of legal measures and tax incentives to increase employer spend on keeping their workers healthy and productive. To be successful, both kinds of intervention must target employers, reduce costs, drive demand towards effective evidence-based services,

[29] https://www.commonwealthfund.org/publications/issue-briefs/2018/oct/affordable-care-act-impact-small-business#:~:text=More%20than%205.7%20million%20small,%2C%20or%20small%2Dbusiness%20employees.
[30] https://www.govinfo.gov/content/pkg/CHRG-114hhrg99544/html/CHRG-114hhrg99544.htm
[31] https://www.abi.org.uk/globalassets/files/publications/public/health/abi-closing-the-evidence-gap---how-insurance-supports-good-health-and-productivity.pdf

and promote an effective market where supply can meet demand and employers can choose products and services that suit their needs.

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

International example 1 – The Netherlands

In the Netherlands, employers are legally required to obtain OH support and take up is estimated at 80%. However, the Netherlands recognises that OH alone is not sufficient and so it also operates a system of compulsory private health insurance, including compulsory basic cover and optional additional cover.

To ensure that insurance can play an effective role in supporting workforce participation, the Netherlands maintains an accommodating taxation environment for insurance, as opposed to the punitive system in the UK. While the general rate of insurance premium tax in the Netherlands is 21%, there are exemptions for life insurance, accident, invalidity and occupational disability insurance, health and medical expense insurance, unemployment insurance, and absenteeism insurance.

This has resulted in most of the population (84%) purchasing supplementary voluntary insurance which covers a range of services that are not covered by the statutory insurance. This includes dental care, alternative medicine, physiotherapy, glasses and lenses, and contraceptives.

There are also higher rates of statutory sick pay to incentivise employers to invest in prevention and rehabilitation. Sick leave is proven to effectively incentivise employers to invest in prevention and rehabilitation support for workers. This in turn reduces sick pay costs for employer, benefits costs to the state, and economic inactivity.

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

International example 2 – Poland

Poland is one example of a country with 100% OH coverage.[32] However, in Poland OH is just one part of a much more comprehensive workplace health ecosystem with great emphasis placed on vocational rehabilitation and a strong sick pay safety net.

The healthcare system in Poland is based on universal health insurance. A mandatory health insurance contribution, amounting to 9% of earned income, is collected by the Social Insurance Institution (ZUS) and directed to the National Health Fund (NFZ). NFZ finances healthcare services provided to the insured and reimburses the cost of medicines.

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

The Occupational Medicine Service Act in Poland obliges the employer to enter into an agreement with a selected medical facility for the provision of preventive care to their employees.
In addition to OH, all workers in Poland are covered by compulsory sickness insurance. Self-employed workers may apply for voluntary insurance. Insured workers in Poland that are unable to work are entitled to:

- Sick leave salary
- Sickness benefit
- Rehabilitation benefit

Sick leave salary is financed by the employer and payable for the first 33 days of incapacity and is worth 80-100% of salary. After that, sickness benefit worth between 70-100% of salary is paid for up to 182 days by the Social Insurance Institution (ZUS). Rehabilitation benefit is 90% of salary for up to 12 months after that, and is granted to an insured person who has exhausted the right to receive sickness benefit but is still unable to work, and further medical treatment or rehabilitative care could support their ability to work. This benefit is targeted at people who may otherwise fall out of the workforce and demonstrates the importance of vocational rehabilitation. Having appropriate support in place to target this level of severity is essential for tackling economic inactivity amongst the working-age population.

Question 17: Do you have any comments on the government's assessment that tax incentives would positively impact the health of employees and lead to both fewer employees leaving the workforce and encouraging those currently employed to return to the workforce?

Successfully promoting the health of the workforce and reducing the number of people falling out of work will require tax incentives meeting three criteria.

1) Reduce costs to employers – to create employer behaviour change.
2) Target evidence-based services that are effective for keeping people in work – to ensure that increased demand leads to better outcomes.
3) Promote an effective market – to maintain choice in the market, effective services, and capacity to meet demand.

Driving demand towards one segment of the wider workplace health ecosystem is unlikely to meet the second criteria and will certainly fall short of the third. Failure to meet any of these criteria, will be at best ineffective and very likely counterproductive.

Focusing on barriers as well as incentives

While we agree that there is merit to introducing tax incentives that are in line with the criteria set out above, the government must also look at existing tax barriers that work against the aims of this consultation. We have included examples of tax barriers to health insurance in answer to question 5.