



NorthWest
Public Health
Observatory

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synthesis

bringing together policy, evidence and intelligence

KEY messages:

- Work leads to a more healthy life both physically and mentally, and being out of work is related to a reduced health status. However, working can also lead to injuries and ill health sometimes with resultant inability to continue working and its consequent health problems for workers and productivity issues for employers. Worker absence has major financial implications for all businesses but particularly for small businesses with few employees
- The workplace is an ideal setting for maximizing opportunities for health benefits, such as choice of healthy foods, provision of exercise facilities or links with health service programmes. It is likely that many local initiatives are taking place in workplaces but there are no adequate systems in place to monitor and evaluate these or to spread good practice
- The current trend of an ageing population means that there are increasing numbers of older people in the workforce and decreasing numbers of younger people. To help alleviate the economic burden due to rising dependency ratios, Government have suggested increasing the pensionable age from 65 to 68 years, bringing state pension in line with increasing life expectancy
- On top of this, the substantial amount of Government policy on health and work is heavily underpinned by multi-agency working. However, success requires committed multi-agency investment in workplace health from a wide range of Government Departments and Agencies including from Health Services
- This report highlights some areas where intelligence relating working life to health has already been developed. This is adequate to understand that the North West has much to gain from investing in workplace health and to identify that much more needs to be implemented, monitored and evaluated. Information, such as: patterns of workplace initiatives for health promotion or health services; location of premises that pose considerable risks to employees working in the community; working days lost to parents with sick children etc, will all help complete a more comprehensive picture of workplace health in the North West region. The NWPPO is committed to supporting the collation of this additional intelligence across all agencies working on this agenda

1 Introduction

For most adults work is central to a healthy life, providing not only financial rewards but also contributing to physical and psychological well-being. Worklessness results in the loss of income and also leads to the loss of the many other health-related aspects of life, such as daily routine, social contact and self-esteem.

In the UK, the number of people in employment has reached the highest level since records began; 28.57 million (74.9% of working age people)¹. For those who are in employment, work is a major part of everyday life, with the average employee spending 34.6 hours of their week in work². Although employment rates are high, large numbers of people are still out of work, with an estimated 1.41 million unemployed in the UK (approximately 5% of the working age population)¹. Work can have both positive and negative effects on health and it is the responsibility of employers and employees alike to work together to reduce the impact of the negative effects and promote a safe and healthy working environment.

The Relationship Between Work and Health

The broader relationship between work and health may be understood in terms of three mechanisms³:

- Work that provides fulfillment or job satisfaction, and particularly allows individuals discretion and control over their working lives, appears to confer considerable health benefit when measured in terms of overall mortality
- Conversely, types of jobs that are lacking in self-direction and control appear to confer far fewer health benefits and the rates of mortality and morbidity among these workers appear to be consistently higher
- The absence of work (unemployment) produces considerable negative health effects

High demand/low control (job strain) has been associated with a 38% increased risk of coronary heart disease. Similarly stressful psychosocial work environments are associated with a range of indicators of reduced health and physical disease⁴. Adverse effects of stressful psychosocial work environments on health should be interpreted in the context that (after the first year of life) midlife is the period when social inequalities in health manifest themselves most strongly⁵. Psychological well-being, social participation and physical health are negatively affected by unemployment⁶. However, again the impact may vary with career stage, where later in a career there are increased mental and physical health problems associated with unemployment. There are also considerable negative health outcomes of unemployment in the early years of potential employment that can have an impact over the remainder of the life course⁷.

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KEY facts & figures:

- *The North West population currently constitutes just over 4 million working age people (aged 16 to 64) with 516,200 (12.3%) in 2005 claiming benefits associated with an inability to work (IB, JSA and SDA)¹*
- *The region had 382,100 people claiming Incapacity Benefit (IB) and 101,500 claiming Job Seekers Allowance (JSA) in May 2005. The IB claimant rate at 9,102 per 100,000 remains much higher than the English average (6,108 per 100,000) whereas the JSA rate at 2,418 per 100,000 has declined close to the English average (2,288 per 100,000)*
- *In the North West (as with all of England), claimants of IB and severe disability allowance are predominantly diagnosed with mental and behavioural disorders (40%) and diseases of the musculoskeletal system (19%)*
- *People living in the most deprived fifth of areas in the North West have the highest standardised claimant ratio for IB and severe disablement allowance - nearly double that of the average for the region and six times higher than for people living in the most affluent areas*
- *Records for injuries and ill health in the workplace show that the North West had 4001 major injuries to workers and 26 fatal injuries in 2004/2005 - the highest and second highest numbers, respectively, across all regions*
- *In the North West, major injuries to employees increased by 15% since 2001/2002 and major injuries to the self-employed increased by 42%. These compare to increases of 8% and 34% respectively in Great Britain. The number of fatal injuries decreased by only 4% in the North West compared to a 12% decrease in Great Britain between 2001/2002 and 2004/05*
- *Absence from work is consistently higher among manual than non-manual workers; 11.2 days compared with 7.9 days absence in North West employees in 2003. However, national trends show that days lost to absence from work are gradually falling*
- *Short-term illnesses, such as cold and flu, cause most absence of both manual and non-manual employees. Recurring illness, such as back pain, asthma and repetitive strain injury, are the second highest cause of absence in manual workers but stress is the second highest cause in non-manual workers*
- *The cost of sickness absence to the UK economy is £12.2bn a year. Workers in the North West are the most likely to take sick leave; with an average of 10 days per employee per year*
- *By 2041, the working age population in the North West is projected to include a greater number of older people (1,166,005 aged 50-64 years - 31.5% of the total working age population) than today with an equivalent decrease in the proportion of younger people (1,036,675 aged 15-29 - 28.0%; and 1,496,249 aged 30-49 - 40.5%). At the same time, over 1.5 million people in the region will be over retirement age; 408,000 (27%) more than in 2001*

Two of England's major public health white papers have identified the relationships between work and health and how the workplace is an important location through which to improve health and reduce inequalities. 'Saving Lives: Our Healthier Nation'⁸ highlighted the complex relationship between individuals, work and health, stating that it is the health and well-being of people living in the most run-down communities, which have suffered most. The financial benefit to businesses of reducing illness is also recognised:

“ Cutting the cost of sickness at work will help to decrease burdens on business. ”

The white paper, 'Choosing Health: Making Healthier Choices Easier,'⁹ has an overall theme to improve the choices individuals are able to make allowing them to have more 'fully engaged' health, i.e. a balanced diet, regular exercise, sensible drinking, safer sex, no smoking and fewer working days lost. It expands on previous policy related to work and health:

“ The environment we work in influences our health choices and can be a force in improving health both for individuals and the communities they are part of. Work offers self-esteem, companionship, structure and status as well as income. ”

The more recent Department of Work and Pensions (DWP) paper 'Health, Work and Well-being - Caring for our Future'²⁰ is a strategy pulling together all the different strands of work across government and sets out what action is being taken to deliver real change for the health and well-being of working age people. It will play a significant role in ensuring delivery of the workplace health commitments outlined in 'Choosing Health', and places real responsibility not just in the hands of Government, but also with employers, individuals, the healthcare profession and stakeholders.

'Choosing Health' identifies the workplace as a setting that can have a positive impact on achieving healthy choices by:

- *Improving health and reducing health inequalities by reducing barriers to work*
- *Improving working conditions to reduce the causes of work-related ill health*
- *Promoting the working environment as a source of better health*

This synthesis report will address these three aspects in turn, presenting evidence, policy and intelligence, nationally and for the North West where available. We have also included a section in this report that covers the working age population and its relationship with the health of the population.

2 Improving Health and Reducing Inequalities Through Employment

Evidence of Worklessness Effects on Health

In England and Wales (like many other countries) there is a positive association between mortality and unemployment for all age groups, with suicide increasing within a year of job loss, and cardiovascular mortality accelerating after two or three years and continuing for the next 10-15 years¹⁰. In 2005, an evidential review highlighted the relationships between measures of morbidity and unemployment¹¹. This and other population studies show that:

- Standardised mortality ratios are higher for men who have been out of work¹²
- There is an estimated 20% excess risk of death for both men actively seeking work and their wives, with the possibility that this may be higher still in areas of higher unemployment⁶
- While poverty can be thought of as one of the potential mediating factors for increased mortality, unemployed people also adapt to their new status so that further deterioration (in terms of health and social status) does not occur beyond 12-18 months⁶
- There appears to be some association between unemployment and mortality due to health conditions such as cardiovascular disease, but this relationship is less clear for other conditions such as stroke¹¹
- Studies illustrate that during the anticipation and termination phase of factory closure, illness and health service use increase, the rate of hospital admissions doubles and conditions such as cardiovascular disease and high blood pressure increase^{12,13}

In particular, there is a strong association between unemployment and increased measures of psychological and psychiatric morbidity. General Health Questionnaire (GHQ) and generic measures of mental health show¹¹:

- A positive association between unemployment and prevalence of common mental disorders¹⁴
- Stabilisation of unemployed people's mental health levels once they have undergone a period of adjustment to their new circumstances¹⁵
- The impact of job insecurity and job loss on mental health appears to vary according to age, social support, duration of unemployment and level of unemployment within an area¹³
- While the relationship between unemployment and mental health may well be mediated through a number of factors such as education and income, the evidence to support this in a UK context is not yet available¹⁴

Suicide has been positively associated with unemployment rates in several European countries including Britain, with the British rate of suicide for unemployed men being 1.6 times that of employed reference populations¹⁰. Confounders to this relationship have been identified and include levels of social support, geography, gender, age and type of employment. Upon re-employment, there appears to be a reversal of these effects¹¹.

Sickness Leading to Unemployment

Incapacity Benefit (IB) was introduced in April 1995, when it replaced Invalidity Benefit (IVB) and Sickness Benefit (SB). Every year, substantial numbers of benefit claimants experience periods of both unemployment and sickness, or disability, and move from Jobseeker's Allowance (JSA) to IB.

An article produced for the DWP¹⁶ examined the characteristics and labour market position of benefit claimants who experience both ill health or disability and unemployment. It found that such people are disadvantaged in the labour market because:

- Physical or mental health conditions that are enduring and/or variable can be the most difficult to combine with work
- Claimants with health problems or disabilities often found employers intolerant of these and ignorant of their implications
- Many of those who came to JSA from IB said that their ability to work continued to be affected by their health or disability
- Claimants reported that their health problems and disabilities could restrict the environments they could work in and the hours they could work
- Claimants who were suffering from mental health problems often found it difficult to talk about this publicly. They felt that they faced discrimination among employers, an opinion that was supported by staff
- Research with employers has found that they are less willing to take on people with mental health problems than with physical disabilities¹⁷

Many of the characteristics that encompass issues relating to both capability and employability can be barriers to work. Claimants who experience several of these are often the hardest to help. They may well want to work but are limited in the number of hours they can work or the nature of jobs to which they have access, which may be the most poorly paid opportunities¹⁶.

A large-scale survey of people leaving IB found that two-thirds of respondents had been disallowed the benefit but the remaining third had left voluntarily. Compared to those remaining on benefit, both voluntary and disallowed leavers were much younger, and more likely to be women¹⁸. The most common medical conditions that formed the basis for a spell on IB were musculoskeletal, specifically problems affecting the back and neck. Overwhelmingly, respondents reported some continuing health problems at the point of leaving benefit, even amongst those who left voluntarily. The majority reported experiencing continuing disadvantage in the labour market, which they linked to their condition.

The main destinations show there are two widely divergent paths after leaving IB:

- There is a strong bias towards work and independent income for voluntary leavers and some disallowed non-appellants
- There is a contrasting bias away from work and towards benefit dependent incomes for the disallowed leavers and appellants

continued overleaf ►►►

Policy Related to Health and Employment

'Saving Lives: Our Healthier Nation'⁸

'Saving Lives' identified a link between unemployment and mental illness and stated that it is possible to reduce the risk of various mental illnesses, such as depression, by strengthening support systems. For example, unemployed people are less likely to suffer depression and to have better success finding work if they are given social support and help in developing job-seeking skills. The paper also highlights ways in which individuals, local partnerships and national government can 'beat mental illness', including bettering individuals' lives through employment opportunities, encouraging the development of healthy schools and workplaces, and improving employment opportunities through 'welfare to work' programmes.

'Pathways to Work: Helping People into Employment'¹⁹

The green paper titled 'Pathways to Work' sets out a strategy for enabling people with health conditions to move into work and so become and remain independent. 'Pathways to Work' pilots were set-up, and have been successful in helping new IB claimants return to the workplace, and the model is now being rolled out nationally. However, it must be noted that longer-term claimants are not currently a priority and that many areas will not receive this initiative for some time to come.

'Choosing Health: Making Healthier Choices Easier'⁹

A priority area in 'Choosing Health,' the white paper, suggests as much encouragement and assistance as possible should be put into ensuring an individual remains in employment after sickness. Job modifications, phased returns and temporary redeployment are all proposed options.

Workplace health is included within two of the six major priorities areas:

- Tackling inequalities
- Improving mental health and well-being

'Delivering Choosing Health' identifies implementation mechanisms and responsibilities. For tackling inequalities, four DWP Public Service Agreement (PSA) targets are noted as relevant; three connected with reducing worklessness and the fourth with improving health and safety outcomes. Looking at mental health and well-being the workplace features strongly as a setting to both improve health, through encouraging employers to adopt policies and practices to promote better mental health at work, and reduce the ill-health effects of work, by tackling stress and supporting staff suffering from distress.

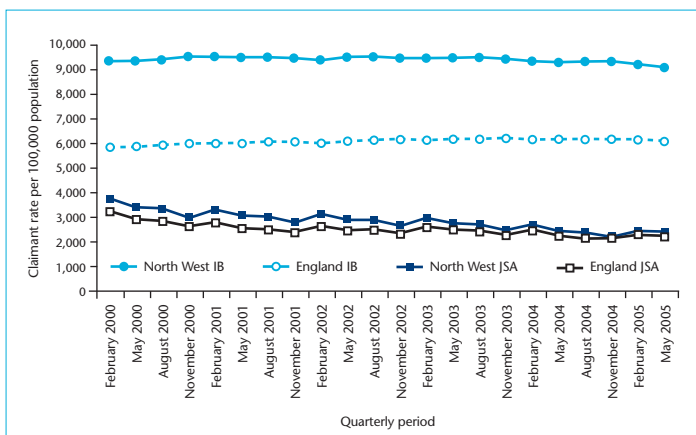
Intelligence Related to Health and Employment

The main data available relating to worklessness patterns are numbers of claimants of benefits associated with an inability to work⁴. Between February 2000 and May 2005 in the North West there has been a small decline in the numbers of working age claimants for JSA, from 155,400 to 101,500, and for IB, from 383,700 to 382,100. The claimant rate per 100,000 population indicates that for the North West IB rates are consistently far higher at around 9,000 per 100,000 than the England average of around 6000 per 100,000 and show no signs of convergence (Figure 1).

By contrast, claimant rates for JSA have shown a modest decline in the North West, from 3,781 per 100,000 in 2000 to 2,418 per 100,000 in May 2005, and have almost converged with the England average (Figure 1).

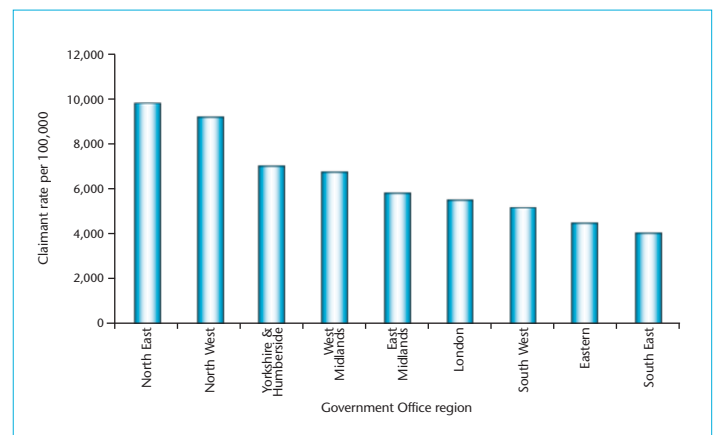
For the latest annual data (August 2004 to May 2005), the North West has the second highest rate of IB claims across English regions; an average of 9,241 claimants per 100,000 population, which is over double the lowest rate found in the South East; 3,995 claimants per 100,000 population. There is a fairly strong North - South divide in working age claimant rates for Incapacity Benefit (Figure 2).

Figure 1: Working age benefit claimant rate in the North West and England between February 2000 and May 2005



Source: DWP Benefit claimants - Working age client group (5% sample) www.dwp.gov.uk

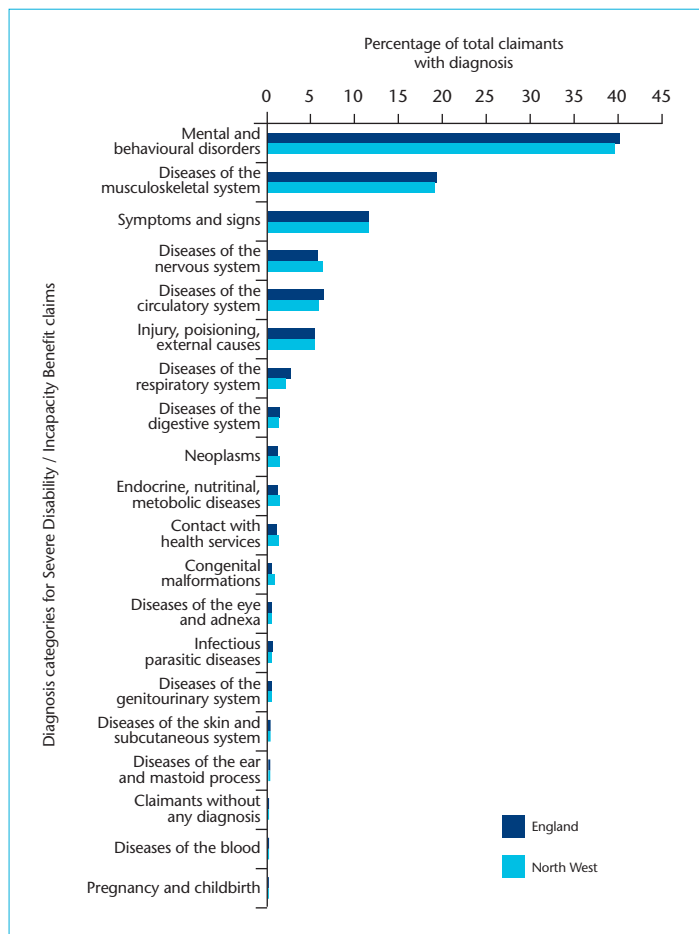
Figure 2: Average working age claimant rate of Incapacity Benefit by Government Office region in England between quarters August 2004 and May 2005



Source: DWP Benefit claimants - Working age client group (5% sample) www.dwp.gov.uk

Reasons for claiming IB or SDA in both the North West and England as a whole can be identified by a range of diagnostic categoriesⁱⁱ (Figure 2). There is little difference in the picture in the North West compared with England, both show that mental and behavioural disorders (40%), diseases of the musculoskeletal system (19%) and the non-specific symptoms and signs (12%) account for the largest proportion of all incapacity or severe disability claimants.

Figure 3: Percentage claimants of Incapacity Benefit / Severe Disability Allowance by major diagnosis in the North West and England at May 2005



Source: DWP Benefit claimants - Incapacity benefit / severe disablement allowance www.nomisweb.co.uk

Newly available local area data on levels of benefit uptake helps to identify geographic localities within the North West where lower income levels and poorer general health may result in health inequalities²¹. Based on a national average of 100, North West local authorities (Table 1) show higher claimant ratiosⁱⁱⁱ across deprived urban areas, and lower ratios in more affluent rural areas:

■ The highest average standardised Attendance Allowance^{iv} ratios are Barrow in Furness (157), Knowsley (153) and Liverpool (142); the lowest are Macclesfield (92), Congleton (95) and Crewe and Nantwich (96)

■ The highest average standardised Disability Living Allowance^v ratios are Knowsley (234), Liverpool (211) and Barrow-in-Furness (190); the lowest are Eden (64), Macclesfield (68) and South Lakeland (69)

■ The highest average standardised Incapacity and Severe Disablement Allowance ratios are Liverpool (223), Knowsley (209) and Manchester (206); the lowest are Eden (60), Macclesfield (64) and South Lakeland (67)

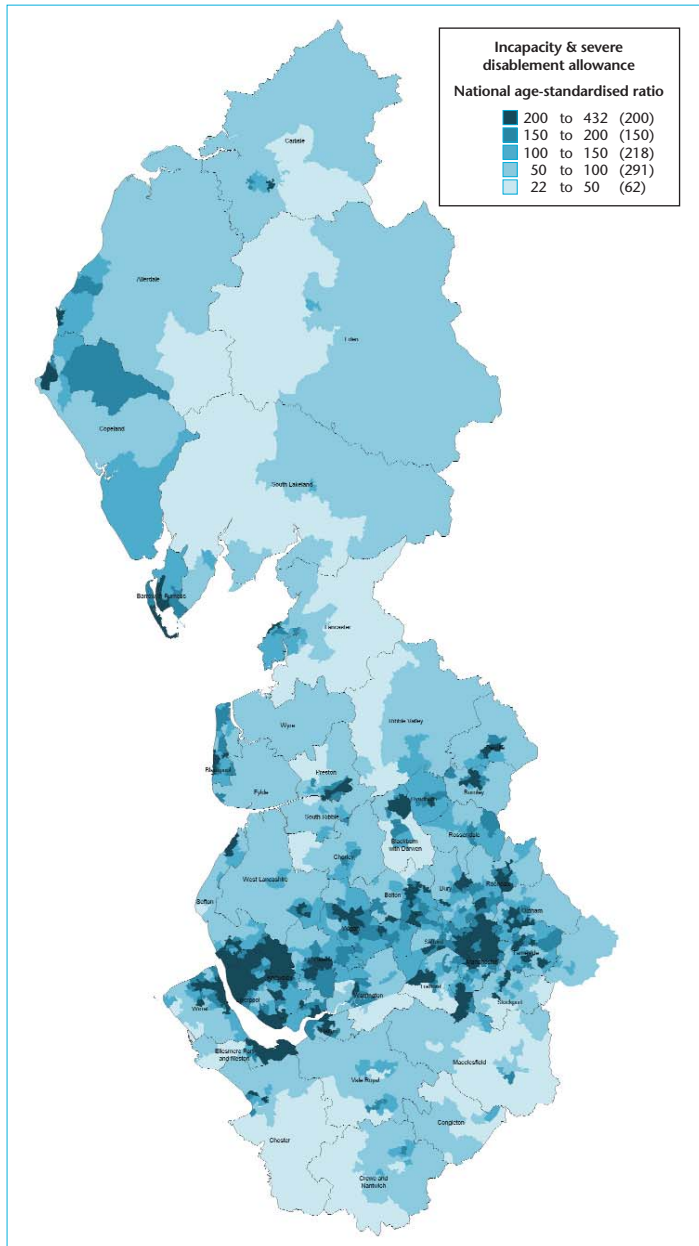
At smaller geographies (Census Middle Super Output Areas: MSOA) the variation in claimant rates across the North West localities illustrates more finely the higher claimant rates in the more deprived urban areas around Liverpool, St Helens and Knowsley, through Wigan and to Manchester; with lower rates in more affluent rural areas of the North West (Figure 4). Combining these small area data shows that claimant rates are six times higher in the most deprived quintile of areas compared with the most affluent quintile of areas within the region (standardised ratiosⁱⁱⁱ of 252 compared to 44 respectively)(Figure 5).

Table 1: Standardised claimant ratio of benefits in North West Local Authorities at August 2004²¹

Local Authority	Attendance allowance claimant rate	Disability living allowance claimant rate	Incapacity benefit & severe disablement allowance claimant rate
Allerdale	125.05	113.87	109.93
Barrow-in-Furness	157.31	189.95	186.41
Blackburn with Darwen	130.60	156.03	165.84
Blackpool	121.45	166.70	171.15
Bolton	121.24	135.09	139.35
Burnley	129.49	139.84	176.31
Bury	111.28	119.85	123.58
Carlisle	117.84	109.47	112.24
Chester	103.07	92.83	90.59
Chorley	111.65	105.37	91.51
Congleton	94.51	74.98	68.44
Copeland	116.95	123.53	124.06
Crewe and Nantwich	95.52	83.30	89.91
Eden	98.65	64.19	59.86
Ellesmere Port & Neston	113.21	121.39	102.78
Fylde	101.60	100.05	95.84
Halton	135.59	185.57	163.09
Hyndburn	134.02	149.69	155.09
Knowsley	152.57	234.24	209.46
Lancaster	108.69	110.87	116.24
Liverpool	141.95	210.90	222.74
Macclesfield	91.80	68.84	63.95
Manchester	117.14	151.55	206.19
Oldham	117.31	129.58	140.64
Pendle	108.11	110.43	137.38
Preston	110.73	119.36	133.58
Ribble Valley	100.97	76.15	74.65
Rochdale	113.93	142.80	159.81
Rossendale	119.84	130.07	126.16
Salford	127.30	160.62	173.25
Sefton	125.41	145.74	138.51
South Lakeland	111.21	68.95	67.46
South Ribble	110.71	102.69	85.43
St Helens	141.04	170.09	161.28
Stockport	103.68	93.13	89.18
Tameside	121.96	136.54	152.00
Trafford	110.72	95.23	92.30
Vale Royal	104.35	104.68	91.79
Warrington	110.59	116.00	103.70
West Lancashire	117.77	137.57	119.30
Wigan	135.92	155.90	162.21
Wirral	122.27	162.65	149.56
Wyre	101.49	116.03	97.57

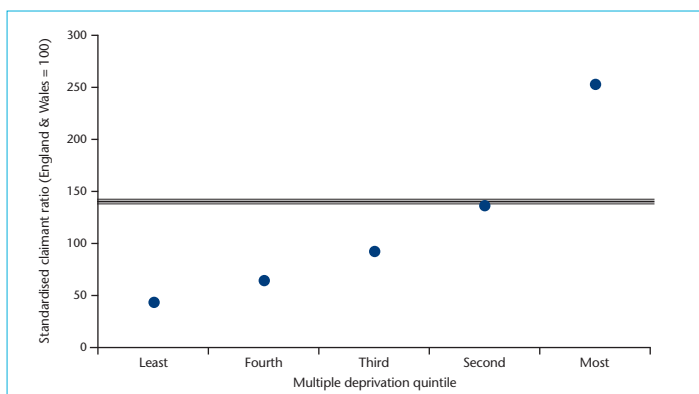
Source: NWPHO - www.nwpho.org.uk/inequalities

Figure 4: Standardised claimant ratio of Incapacity Benefit/Severe Disablement Allowance in the North West region at August 2004²¹



Source: NWPHO - www.nwpho.org.uk/inequalities

Figure 5: Standardised claimant ratio for Incapacity Benefit / Severe Disablement Allowance by deprivation quintile in the North West at August 2004²¹



Source: NWPHO - www.nwpho.org.uk/inequalities

3 Improving Working Conditions to Reduce the Causes of Work Related Ill-Health

Evidence of Improving Work Conditions

Occupational health deals with the effect that work has on your health and ensuring that you are fit to do your job. Occupational health and safety regulation is the responsibility of the Health and Safety Commission (HSC) whilst the Health and Safety Executive (HSE) and local government are the enforcing authorities who work in support of the Commission. National guidance considers occupational health to be more than simply the relationship between work, health and disease but rather encompassing the following²:

- Mortality and morbidity that is directly attributed to specific hazards and risks in the workplace
- Positive and negative effects on health of the levels and types of self-direction and control in the workplace, which are not necessarily disease specific or attributable to hazards, but which nonetheless affect health
- Consequences of the absence of work

There are many types of occupational illnesses, including musculoskeletal disorders (including back problems and repetitive strain injury), asthma, deafness/hearing loss and mental ill-health. The most common of these are musculoskeletal disorders and mental ill-health²². It is estimated that one fifth of the working population (around 5 million workers) of Great Britain suffer from work related stress²³.

The Costs

There are an estimated 3.5 million businesses in the UK, the majority of which (over 90%) are small with less than ten employees. Despite this, almost half of the workforce are employed by large organisations. Work related ill-health causes suffering not only for the employee but also has major financial implications for the employer's business as well as the staff left to cover the work of their colleagues. In addition to the direct cost of paying for sickness absenteeism, there are additional costs to businesses in the form of overtime payments, lost production, missed deadlines and the cost of recruiting and retraining staff²³.

The costs to small businesses in particular can be extremely high, for example, the loss of a single employee through ill-health may result in failure to complete orders to deadlines, causing damaging delays and potential customer loss. Investing in health and safety and occupational health at work can therefore reduce levels of sickness and accidents as well as improving performance and productivity.

Policy Related to Improving Health at Work

The current definition of workplace health has been refined significantly over the past six years with the publication of numerous documents. The common theme within these is the recognition that successful intervention in the workplace is only achievable through multi-agency working. The significance of the setting in terms of tackling the determinants of ill-health and overall how this can positively affect the wealth creators has started to mould a common vision for the health and economic agenda makers.

'Securing Health Together'²⁴

'Securing Health Together', published in 2000, as a cross-government ten year occupational health strategy, was the result of the recognition that despite huge successes in reducing accidents, work-related ill-health remained a significant problem. It identified the need for partnership working at all levels to impact on its aims of:

- Reducing ill-health both in workers and the public caused, or made worse, by work
- Helping people who have been ill, whether caused by work or not, to return to work
- Improve work opportunities for people currently not in employment due to ill-health or disability
- Using the work environment to help people maintain or improve their health

These aims were instrumental in bringing together workplace agendas and were responsible for formulating many of the current priorities nationally and regionally. Added to this was a set of aspirational targets for stakeholders to achieve.

'A Strategy for Workplace Health and Safety in Great Britain to 2010 and Beyond'²⁵

This strategy developed from the 'Revitalising Health and Safety (2000)'²⁶ statement of June 2000. It commits to understanding the value and contribution of partner organisations and sees that amongst all HSE/HSC challenges, occupational health demands a more strategic and partnership-based approach. It recognises that leverage on health issues requires new methodologies involving those traditionally employed to look at the enforcement of existing regulations.

HSE/HSC also commit to strengthening their role in getting people back to work through a much greater emphasis on rehabilitation. They cite the importance of using their links with the DWP for this purpose, and working with other stakeholders (e.g. trade unions, employers, insurers and health professionals) to engender change. The provision of accessible advice and support is noted as key in preventing ill-health, promoting rehabilitation and getting people back to work more quickly.

'Choosing Health: Making Healthier Choices Easier'⁹

'Choosing Health' sets out the action, which employers, employees, government and other agencies can take to improve work and health issues. It recognises that bad jobs can injure or make people ill or damage the economy and includes: a focus on the effective management of health and safety; measures to tackle stress at work through applying appropriate human resource practices and policies to improve job quality; and the improvement and expansion of occupational health support.

'Delivering Choosing Health (2004)' identifies that at a regional level, overall responsibility for delivering the white paper lies with the Director of Public Health and with respect to the workplace health agenda, it is recognised that Government Offices, Regional Assemblies and Regional Development Agencies all play an important role in shaping the wider economic determinants of health. Workplace health is also included within two of the six major priority areas and, for each area potential 'big wins' are noted and relevant national PSA targets are listed.

Policy Related to Improving Health at Work

'Health, Work and Well-Being – Caring for Our Future'²⁰

The scope of workplace health has been condensed into a single strategy aimed at people of working age and gives an ambitious national vision building on 'Choosing Health'. The strategy aims to achieve a society where:

- The health and well-being of people of working age is given the attention it deserves
- Work is recognised by all as important and beneficial, and institutional barriers to starting, returning to, or remaining in work are removed
- Healthcare services in the NHS and the independent sector meet the needs of people of working age so they can remain in, or ease their return to work
- Health is not adversely affected by work, and good quality advice and support is available to, and accessible by all
- Work offers opportunities to promote individual health and well-being, and access to and retention of work promotes and improves the overall health of the population
- People with health conditions and disabilities are able to optimise work opportunities and
- People make the right lifestyle choices from an early age and throughout their working lives

The strategy has three key themes:

- Engage stakeholders both nationally and locally through:-
 - A National Stakeholder Network
 - Developing a Charter for Health, Work and Well-being incorporating a detailed action plan
- Improve working lives through:-
 - Healthier workplaces
 - Improved occupational support
 - The public sector leading by example
- Healthcare for working age people through:-
 - Engaging healthcare professionals to recognise the importance of work for their patients' well-being
 - Work focused treatment
 - Better access and provision of interventions for the management and control of common mental health problems
 - Exploring new methods and models to bridge the gap in return to work support
 - Publishing evidence on vocational rehabilitation and supporting the Framework for Vocational Rehabilitation

Intelligence Related to Work-Related Ill-Health

The HSE disseminate annual statistics illustrating occupational safety and ill-health collated from a number of sources²¹. Figure 6 is an illustration of the most recent HSE publication including provisional 2004/2005 data that shows²⁷:

- In 2004/05, there were 26 fatal injuries to workers in the North West, 3,848 reported major injuries and 15,611 over 3 day injuries to employees. There were 13 fatal and 1,429 non-fatal injuries to members of the public. The rate per 100,000 employees was 129.0 for fatal and major injuries, and 521.0 for over 3 day injuries, compared with Great Britain averages of 116.6 and 461.2 respectively. However, differences between regional injuries can be explained by the regional differences in composition of employment, for example by industries and occupations
- Over the period 2001/02 to 2004/05, the number of fatal injuries to workers in the North West decreased by 4% compared to a decrease of 12% for Great Britain. Major injuries to employees increased by 15% and major injuries to the self-employed increased by 42% in the North West. These compare to increases of 8% and 34% respectively in Great Britain

■ In 2004/05 an estimated 2.0 million people in Great Britain suffered from ill health that they thought was work-related, 576,000 of these were new cases in the last 12 months²⁸. In the North West the work-related illness prevalence rate of 5,000 per 100,000 people ever employed was similar to those for England (4,600 per 100,000 people) and Great Britain (4,700 per 100,000 people).

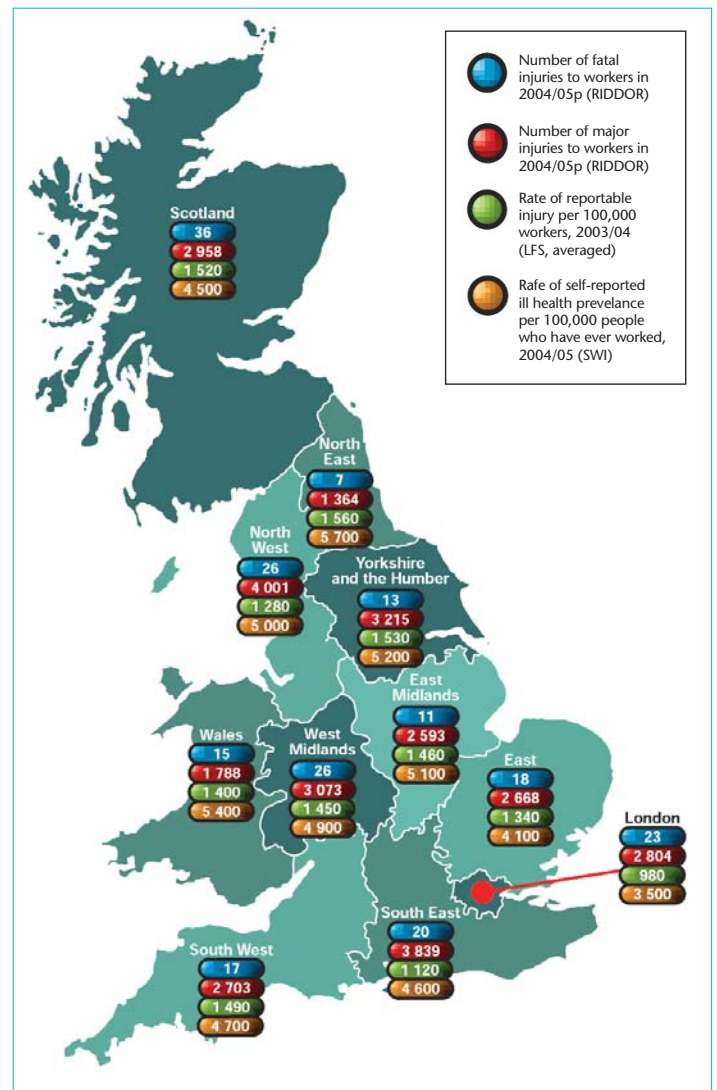
■ Across Great Britain musculoskeletal disorders (bone, joint or muscle problems) are by far the most commonly self-reported work-related illness, with an estimated 1,108,000 people ever employed affected. Stress, depression or anxiety was the second most commonly reported illness, affecting an estimated 557,000 people ever employed, followed by breathing or lung problems (183,000) and hearing problems (81,000)²⁸ (Figure 7). These are very similar to the conditions that are diagnosed in people claiming benefits associated with inability to work (Figure 3).

Sickness Absence Statistics

The Confederation of British Industry 2005 document 'Who cares wins' gives the most recent absence and turnover statistics for 2004 in Great Britain, and reports that the average absence was 6.8 days per employee, equivalent to 3.0% of working time, an estimated total of 168 million working days lost for the year. Regionally the North West has the second highest absence rate of all the regions, at 7.9 days, behind the South West²⁹. 'Room for improvement'³⁰ published a year earlier, gives absence and turnover statistics for 2003 and breaks this data down further showing average absence rates by region for manual and non-manual employees (Figure 8). The highest absence level in 2003 was found in the North West (10.1 days per employee or 4.4% of total working time) and so is markedly higher than the 2004 rate. The lowest absence level was found in Scotland with an average of 5.6 days, and the gap between the best and worst performing region was 5.5 days on average per employee.

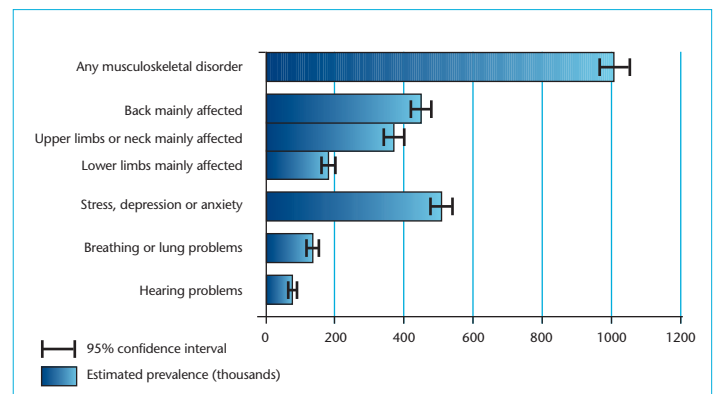
In the North West in 2003, the absence rate in manual workers was 11.2 days compared to 7.9 days in non-manual workers. This is possibly due to an increased likelihood of accidents or work-related ill-health, greater acceptance of absenteeism or lower levels of commitment than among professional and managerial staff. Short-term illnesses, such as cold and flu were ranked as the most significant cause of absence for both manual and non-manual employees. For manual workers recurring illness such as back pain, asthma and repetitive strain injury, was the second most significant cause of illness, followed by serious long-term illness. For non-manual employees, stress was the second most significant cause.

Figure 6: Injuries and ill health in Great Britain by country and region²⁸



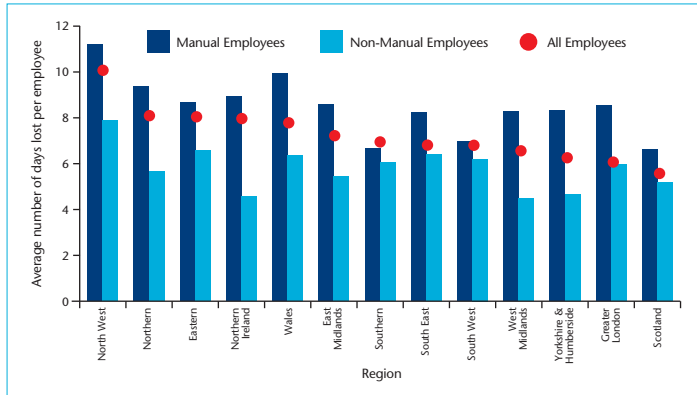
Source: Health and Safety Commission. (2005) Health and safety statistics 2004/2005

Figure 7: Estimated prevalence of self-reported work-related illness in Great Britain, by type of complaint, 2004/05²⁸



Source: Health and Safety Commission. (2005) Health and safety statistics 2004/2005

Figure 8: Absence levels in the United Kingdom by region manual, non-manual and all employees 2003



Source: Confederation of British Industry. (2004) Room For Improvement – CBI Absence and Labour Turnover Survey 2004

Two surveys concur that workers in the North West are most likely to take sick leave^(31,32), with 12% having taken more than three weeks off in the last 12 months. The average for the region was 4.4% equating to 10 days per employee per year.

In 2004 the average direct cost of absence was £495 per employee, if this was projected across the whole workforce; the cost to the UK economy in 2004 would be £12.2bn. Indirect costs were also estimated which averaged at an additional £667 per employee, equivalent to a further £16.4bn costs to the economy. Costs for businesses (1-49 employees) are lower, at £310 per employee compared with £527 in those employing over 5,000 staff. This is explained by higher levels of absence in larger businesses and their increased likelihood of providing cover for absent staff. In the smallest organisations, absence cost is 1.5% of payroll compared to 3.3% in the largest organisations.

4 Promoting the Workplace as a Source of Better Health

Evidence of Workplace Health Promotion

The workplace provides an ideal environment to implement the lifestyle elements of health promotion as identified in 'Choosing Health'. Board level commitment has, for example the potential to influence the choice of food offered within the workplace, whilst the social networks built up at work can provide support for initiatives such as smoking cessation. A comprehensive approach to health promotion in the workplace is one in which both individual and organisational influences on health are targeted simultaneously³³.

Workplace health promotion can be described as:

“...the combined efforts of employers, employees and society to improve the health and well-being of people at work. This can be achieved through a combination of: improving the work organisation and the working environment, promoting active participation and encouraging personal development.”³⁴

A Cochrane review³⁵ appraised a number of studies of workplace interventions aimed at helping individuals to stop smoking; these were: group therapy, individual counselling, distribution of self-help materials and nicotine replacement therapy as well as methods aimed at the workforce as a whole, for example tobacco bans. The results for initiatives aimed at individuals were consistent with those in other settings; the workforce initiatives were less clear. Tobacco bans decreased consumption during the day, there did not appear to be an increase in quit rates when social and environmental support was added to these and there was a lack of evidence that comprehensive programmes reduced the prevalence of smoking. Competitions and incentives increased attempts to stop smoking, though there was less evidence that they increased rates of actual quitting.

Health-promoting programmes can have a positive impact on the workforce³⁶. Heart conditions and other risk factors were lessened by participation in an occupational activity programme. Often, the introduction of an activity programme was connected to a reduction in the number of smokers. Furthermore, health promotion measures led to between 12% and 36% reduction in sickness absence, with a saving of 34% in absenteeism costs. Therefore every pound spent on promoting health in the workplace could lead to a £2.50 saving for businesses.

Surveys in the UK have revealed that the main barriers to running health promotion activities are the limited size of the workplace concerned (55%), people being too busy (11%), people thinking that they were unnecessary (9%) and not worth doing (9%). However, around 60% of those surveyed considered that such activity was important, suggesting that they would respond to efforts to facilitate health promotion activity³⁷.

The British Heart Foundation (BHF) has recently instigated a number of pilot research projects, which are part of a wider programme called 'Well@Work', to trial methods of healthy interventions aimed at improving the health of employees at a variety of workplaces. Funded by Active England (Sport England and Big Lottery Fund's joint awards) and the Department of Health, it is a £1.5m, two-year programme to test ways of getting England's workplaces healthier. The aim is to establish which changes made in and around the workplace positively influence employees' lifestyles and improve their health and safety and which do not³⁸. The evaluation is being conducted by the University of Loughborough. Wigan Leisure and Culture Trust is the lead within the North West and is working with Ashton, Leigh and Wigan Primary Care Trust and Healthworks Ltd.

There are now a number of initiatives aimed at mainstreaming workplace health promotion; increasingly the business case for having a healthy workforce is persuading employers to allocate suitable resources. The Faculty of Public Health (FPH) and the Faculty of Occupational Health Medicine (FOHM) have recently produced a guide for occupational safety and health professionals and employers to assist them in creating a healthy workplace³⁹. This guide highlights eight areas where employers and employees can take steps to create a workplace that is supportive of, and conducive to good health for those who work there. Many of the areas highlighted for action are relatively straightforward but have the potential to make a substantial impact on the health and productivity of the workforce. Guidance is also available to employers to assist them to promote healthy eating at work, simple measures such as the provision of suitable facilities for food storage and preparation to more sophisticated suggestions, for example providing information about the nutritional content of canteen food⁴⁰.

Policy Related to Workplace Health Improvement

Employers have a legal duty to protect the health and safety of their employees. The Health and Safety at Work Act (HSWA) 1974⁴¹ lays down duties and a series of regulations that must be met in order to comply with the law. Comprehensive codes of practice are available to employers to assist them with compliance. Full details regarding statutory obligations can be accessed through the HSE website (www.hse.gov.uk). Trade Unions play a vital role not only in identifying problems but also initiating high profile campaigns for their members and training safety representatives.

The HSWA is over thirty years old and a flurry of European Directives issued in the 1990s has resulted in some modernisation of the law. However the resulting Statutory Instruments are generally specific and other than the Management of Health and Safety at Work Regulations 1999 are not overarching.

The DWP, the Department of Health (DH) and the HSE have collaborated to produce 'Health, Work and Well-being – Caring for our future'²⁰. This makes a commitment to appoint a national director of occupational health whose remit is to:

- *Oversee implementation of the Health, Work and Well-being Strategy*
- *Raise awareness of work and its relationship with health and well-being*
- *Help develop specific outcome measures designed to monitor the strategy's progress and success*
- *Lead a national debate on occupational health and well-being*

This strategy places health at the heart of work and includes initiatives aimed at integrating health promotion into the workplace will be led by public sector employers (the NHS in particular are moving forward with this), non-governmental organisations (such as Groundwork) and large businesses.

Intelligence Related to Workplace Health Improvement

Improving the health of the workforce and keeping people in work has the potential to reduce health inequalities as employment is a significant health determinant. A healthy workforce is good for business as sickness absence is reduced. It is likely that many individual initiatives are taking place in workplaces throughout the North West but there does not appear to be a single system to record this.

With the move away from occupational safety towards health at work, it is imperative that evaluation takes place in order to identify which schemes are the most successful. Failure to do this will result in wasted resources in the workplace and a consequential reduction in employer support.

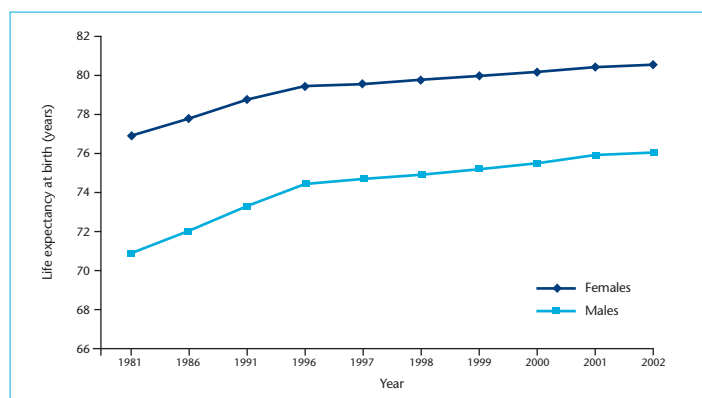
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Wider Aspects of Health and Work – Working Age Population

Improvements in Life Expectancy

Cited in the bible, historically, three score years and ten was the life expectancy of 'mankind'⁴³, a figure from which recommendations regarding the pensionable age have traditionally been set. Today, however, there has been a shift in population such that a considerable improvement in life expectancy has been observed (Figure 9). Survival rates in the United Kingdom have increased by 30% in the last eight years¹, resulting in a larger population of older individuals. Current figures show that there are 20 million people in the UK aged 50+ years, a figure that has increased from 13.8 million in 1951 and is predicted to rise to 27.2 million by 2031⁴⁴. These changes may be attributed to the improving general health of the population achieved through better health care, housing and social structure, as well as falling birth rates⁴⁵, and will inevitably impact upon the workforce composition and aspects such as savings and investment rates⁴⁶.

Figure 9: Life expectancy at birth for the United Kingdom between 1981 and 2002



Source: Office for National Statistics - Expectation of life (in years) at birth and selected age. www.statistics.gov.uk

Implications of an Ageing Workforce

Nearly 50% of the 1.2 million people claiming IB in February 2005 were aged between 50 and 64 years and only one in ten of these expected to work again. Influences on health and life expectancy include deprivation, level of education, employment⁴⁷, social class⁴⁸ and place of residence^{21,48,49}. These, and others (lifestyle factors such as diet, exercise, smoking and the use of drugs) have the potential to impact negatively upon life expectancy and produce differences in people being able to finance their old age. Improvements may be achieved in the workplace through improved health and safety practices, and by older people taking a reduced share in manual occupations⁴⁶.

The report 'An ageing population – Implications for the North West' published by Lancaster University in 2000 stated that an increasingly ageing population will have varying impacts upon different communities in terms of health, economic, social and physical issues and accessibility to services⁴⁵. The report projected a decline in the North West population between 1996 and 2001 with an increasing proportion of people aged 50+ years, suggesting that an increasing ageing population would in turn, lead to a decrease in the proportion of people in work of working age (18-64 years). This has also been discussed in reports produced by the Actuarial Profession to the House of Lord Select Committee on Economic Affairs⁵⁰, and the United Nations Economic and Social Council⁵¹, which have highlighted concerns that increasing numbers of elderly people will lead to a greater number of dependants when compared to the number of people who are working.

Policy Related to Extending the Pensionable Age

A recent report by the Pensions Commission⁵² has suggested a rise in the pensionable age from 65 to 68 years. This is with a view to bringing the state pension in line with life expectancy and to counteract public expenditure on the ageing population, thus decreasing the economic burden on the government⁵³. Recent figures show that expenditure has risen in this area from £250 to £500 billion in the last ten years⁵⁴, and the aim is to reduce this cost as well as producing a cost-neutral to net savings to businesses of £155 million per year.

The standard age of retirement across the developed world is 65 years with variation between the ages of 60 and 67 years. Countries such as Canada, Italy, the US and New Zealand have raised their retirement ages. In New Zealand, this has been met with positive effects of an increase in the work force and the number of people aged 55 to 64 years at work⁵⁵. In the UK however many pensioners live in poverty, and both age and gender based inequalities in living and working conditions need to be addressed. Increases in the pensionable age must consider those people from lower socio-economic groups who have lower life expectancies, in order that they are not disadvantaged in this area⁵².

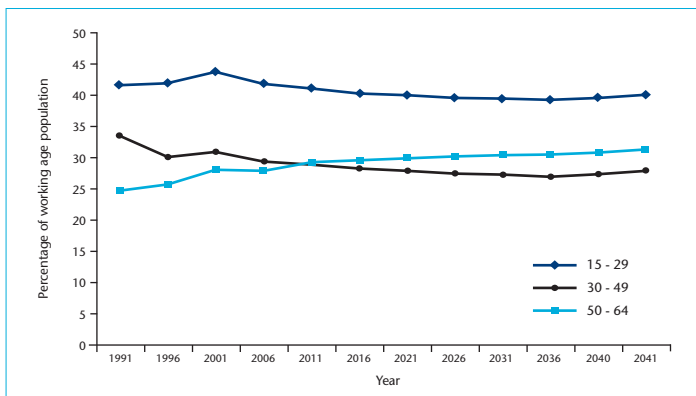
When looking at why people choose to retire early, it has been suggested that growth in occupational schemes, improvements in pre-retirement saving levels, increases in social security benefits and pension and early retirement schemes^{46,55,56} may be responsible. It has been highlighted, however, that one third of the UK's retired population aged 50 to 69 years also felt that they were forced into retirement (www.statistics.gov.uk/focuson/olderpeople). Aims to reduce incentives to retirement, deter people from taking early retirement and facilitate later working may be achieved through education and training, age discrimination legislation, financial incentives for employers and employees, and a concentrated focus on occupational health⁵².

Intelligence Related to a Changing Composition of the UK Workforce

There has been an increase in the mean age of the UK workforce from 37.5 years to 39 years between 1991 and 2001⁴⁶. The average age of people in the workforce may be further accelerated by increasing numbers of older workers choosing to delay retirement in addition to the changing needs of the labour market.

In the UK, by 2010 the proportion of working age people between the ages of 50 and 64 years will be greater than at any time since 1975, with a predicted rise from 5% to 32%. At the same time, the proportion of working age people aged 30 to 49 years falls from 2005⁴⁶. In the North West (Figure 10), the predicted pattern is similar, such that the proportion of people aged 15 to 29 years and 30 to 49 years, will decline markedly between now and 2040. By contrast, people aged between 50 and 64 years are predicted to increase between now and 2016, after which there will be a gradual decrease until 2040. By 2040, over 1.5 million people in the North West will be over retirement age. This is 408,000 (27%) more people than in 2001.

Figure 10: Proportions of working age population in the North West by age group



Source: Lancaster University (2000) *An ageing population - Impacts for the North West*. www.nwpho.org.uk/documents

Further details regarding Local Authority, age, gender and ethnicity specific information may be found at: www.nwpho.org.uk/ethnic/ethnicchooser.asp

6 Conclusion & Recommendations

Existing evidence points to employment being an important factor for both a physically and a mentally healthy life. Those unable to work for whatever reason tend not to achieve optimum health status. Nationally, the last few years has seen a downward trend in the proportion of working age people who are claiming benefits associated with inability to work. However, the North West Region currently has the second highest rate of Incapacity Benefit (IB) claims in England and is around 50% higher than the English average and shows little sign of convergence. Claimant rates for Job Seekers Allowance (JSA) are also higher than the English average, however this has improved in recent years and the gap has reduced dramatically. While work can provide the means to a healthier life it can also lead to injuries resulting in an inability to continue working. The number of people in work as well as the average number of hours being worked is increasing, which could increase the likelihood of work related injuries and also have a negative affect on general health. Recent Government policy has recognised the issue on a national basis and initiatives have been put in place to address these areas. However, the North West has a relatively poor record in relation to workplace injuries. In 2004/05 it had the largest number of major injuries to workers of any part of Great Britain and also had the second highest number of fatal injuries.

There has been a substantial amount of policy written on the area of health and work. In general, such policy is underpinned by a belief that multi-agency working is the best way of achieving positive changes and consequently the responsibility for implementation has been given to a wide range of Government Departments and Agencies. The 'Choosing Health' white paper has workplace health as one of its six major priorities. The responsibility for implementation of 'Choosing Health' lies with local Directors of Public Health. In addition, Local Authorities have a duty to assist in the integration of health into the workplace as outlined in the 'Health, work and well-being – Caring for our future' strategy. The implementation of such policy is starting to show benefits across the country. However, in the North West it is happening slower than nationally, resulting in continued health inequalities. Furthermore, particularly as the average age of employees increases, the implementation of policies relating to safety at work will become increasingly important with opportunities offered by workplaces to promote healthier lifestyles a vital factor in health improvement. However, the intelligence systems currently operating across workplaces are focused largely on injury prevention and new systems are required to monitor the effectiveness of health promotion interventions in the workplace.

continued overleaf ►►►

Nationally, and particularly in the North West:

- *There is a need for Primary Care Trusts (PCTs), Local Authorities and regional Government Offices to raise awareness of the links between work, health and well-being and to support workplaces in their development as environments in which to promote healthier lifestyles*
- *PCTs should implement best practice associated with providing work focussed treatment and health promoting interventions and collect data around the up take and effectiveness of these services within the workplace settings*
- *To support the implementation of 'Choosing Health', PCTs and Local Authorities should engage with public or private employers at strategic levels and provide information on the benefits to business and workforce of implementing health improving measures. These include reduced sickness, increased productivity, insurance benefits and enhanced recruitment and public profile*
- *Local Authorities should be encouraged to sign the forthcoming Charter for health, work and well-being, which will identify roles and contributions and detail action plans to progress health and well-being*
- *While the movement of workplaces from injury prevention to health promoting is essential, it is still a major responsibility of employers to ensure that they are providing a safe working environment. The NHS and Local Authorities must be seen to be engaging in this area while utilising such engagement to help broaden occupational support for employees onto a health improving basis*
- *There is an urgent need to better understand what health intervention can be implemented in workplace settings and their relative effectiveness. This requires systematic collection of data on a wider range of issues related to work and health including workplace initiatives for health promotion or health services; areas and environments that pose considerable risks to employees working in the community; working days lost to parents with sick children; health risks posed by behaviours associated with work (e.g. driving)*

Government Offices, Local Authorities and PCT's will be instrumental in contributing information enabling surveillance and evaluation of local work and health patterns and the NWPHO will support the regional collation and analysis of local datasets to improve the intelligence related to working life and health.

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Footnotes

- ⁱ Claimants of Incapacity Benefit (IB) may be paid if a claimant's statutory sick pay (SSP) period has ended, if SSP is not paid or where a claimant has been unable to work for at least 28 weeks in a row because of illness or disability. Severe Disablement Allowance (SDA) may be paid where a claimant is over 16, under 65, and unable to receive incapacity benefit. It may also be payable if a claimant has never been able to work. Jobseeker's Allowance (JSA) may be paid if a claimant is under 65 (for men) or under 60 (for women), not working, or working on average less than 16 hours a week, and actively seeking work. Claimants must be available and capable of work.
- ⁱⁱ Diagnostic categories are detailed as:
Certain infectious parasitic diseases (A00-B99); Neoplasms (C00-D48); Diseases of the blood and blood forming organs and certain diseases involving the immune mechanism (D50-D89); Endocrine, nutritional and metabolic diseases (E00-E90); Mental and behavioural disorders (F00-F99); Diseases of the nervous system (G00-G99); Diseases of the eye and adnexa (H00-H59); Diseases of the ear and mastoid process (H60-H95); Diseases of the circulatory system (I00-I99); Diseases of the respiratory system (J00-J99); Diseases of the digestive system (K00-K99); Diseases of the skin and subcutaneous system (L00-L99); Diseases of the musculoskeletal system and connective tissue (M00-M99); Diseases of the genitourinary system (N00-N99); Pregnancy, childbirth and the puerperium (O00-O99); Certain conditions originating in the perinatal period (P00-P96); Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99); Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99); Injury, poisoning and certain other consequences of external causes (S00-U23); Factors influencing health status and contact with health services (Z00-Z99).
- ⁱⁱⁱ Standardised ratios for benefit claimants are calculated by dividing the actual number of claimants by the expected number of claimants. The expected number of claimants is determined from the national percentage of claimants by age category applied to the Local Authority population age profile.
- ^{iv} Attendance Allowance (AA) is a benefit for people over the age of 65 who are so severely disabled, physically or mentally, that they need a great deal of help with personal care or supervision.
- ^v Disability Living Allowance (DLA) is a benefit for people who become disabled before the age of 65. It replaced and extended Mobility Allowance.
- ^{vi} Sources include:
RIDDOR 95: The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995, under which fatal and non-fatal injuries to workers and members of the public arising from work activity are reported
- Reported major injuries: Specified serious injuries to workers, including fractures, amputations and other injuries leading to resuscitation or 24 hour admittance to hospital
- Reportable injuries from the Labour Force Survey (LFS): Injuries which meet the criteria to be reportable under RIDDOR, as estimated from the LFS (a national survey of 60,000 households each quarter)
- Self-reported work-related illness (SWI): People who have conditions which they think have been caused or made worse by their current or past work, as estimated from the LFS

We welcome your feedback on both content and style.

This report is also available on our website www.nwpho.org.uk

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