Managing Black when in the red, challenges for general practice

Since the publication of the Black Report [1], there has been an increasingly intensive political focus on the costs of absenteeism and welfare arrangements for those unable to work due to ill health. This has intensified with the International financial crisis, the substantial reductions in state spending and the expectations of a private-sector led recovery, which will inevitably involve concerns about profitability and cost savings.

The wider perspective includes the continuing emphasis on measures to reduce health inequality through primary and secondary illness prevention initiatives, evidence that good work is good for health [2], and concerns that many of those in receipt of long-term welfare for ill health comprise the socially excluded, unskilled and thus represent a form of hidden unemployment [3]. Proposed National Health Service (NHS) reforms for England provide opportunities for general practitioners (GPs) to review their response to these challenges, through commissioning, collaborations with public health, and relationships with providers of services for those with: health-related work problems, work-related health problems and health problems complicating their availability for work. These issues (with the exception of the commissioning role) are relevant across the United Kingdom.

Some reforms prompted by the Black Report are already in place, such as the FitNote [4] and Fit for Work Service Pilots, with linked Department for Work and Pensions (DWP)-funded national evaluations. Incapacity Benefit (the long-term sickness benefit) was closed to new claimants in 2008, being replaced by the Employment and Support Allowance, linked to the Pathways to Work programme which seeks to support claimants back into work. It is intended that from 2011 this approach will be more actively extended to current incapacity benefit claimants who will be re-assessed for their fitness to work. The first of five annual independent reviews of this Work Capability Assessment [5] has recently been published, setting out a range of recommendations, since welcomed by the government, focusing in particular on: improving communication, transparency, empathy, recognizing complexity and the importance of benchmarking best practice. The report recognizes that claimants found fit for work often feel a sense of injustice, but highlights that work is good for health and that many ill or disabled people want to work. Future reviews plan to look at the content of the assessment (starting with cognitive features and fluctuating conditions) and ways to understand complexity in a more sophisticated way. There are longer-term plans to merge out-of-work benefits and in-work welfare support to a universal credit system, aimed to reduce disincentives to work.

The DWP and Department of Health have jointly funded a series of Fit for Work Service Pilots (FFWS). There are 11 of these across the United Kingdom using a variety of models emerging from local circumstances and needs, but all using a personalized, case manager approach, to prevent someone with health problems becoming absent from work, facilitating a return to work, and thus preventing loss of employment through ill health. They relate mostly to small and medium employers (SMEs). FFWS Pilots are funded for 1 year from April 2010 and are being formally evaluated, exploring the models of provision and their impact. These strategic shifts and scheme introductions are happening during an economic downturn, which is also affecting how employees and employers regard sickness absence, and associated factors such as redundancy risk, early retirement, costs and benefits of phased returns to work and accommodating disabled staff, the costs and benefits of occupational health advice and the emerging emphasis on health and well-being in the workplace [6,7].

This is therefore a period with shifting goals and expectations in terms of the welfare system, complicated by a prolonged economic downturn, whilst a number of initiatives are being introduced, both in terms of the mechanisms for certification, and options for services for patients relevant to absenteeism and presenteeism. So, as the key ‘gatekeepers’ and moderators of work capacity and hence absenteeism and presenteeism, through the provision of certificates providing evidence of work capacity for those absent from work for a week or longer through ill health, GPs (and to a lesser extent, other medical practitioners) are faced with a range of challenges and expectations from their patients, their employers and the state. The DWP has provided a variety of online resources, and in collaboration with the Royal College of General Practitioners has funded online and face-to-face education focusing on the process of certification and associated developments [8]. Whilst a minority of practitioners welcome these changes, many continue to express exasperation, bewilderment, despair or a desire to be removed from the process altogether.

There is some research to guide decisions, including NICE guidelines [9]. The key issues however remain that GPs have the motivation to actively address the request for sickness certification, a willingness to ask relevant questions, discuss options and negotiate plans and solutions.
This links to attitudes, and there have been a number of papers and reports covering GPs stated behaviours and beliefs in this regard. However much less is published about what actually happens during consultations where work, illness-health and sickness certification are discussed, to test whether stated behaviour is mirrored in practice. We also know that the costs of sickness absence are spiralling, costing the UK economy more than the NHS [1], that long-term worklessness is bad for health and leads to health inequalities linked to deprivation, and that GPs may be unwitting accomplices in these outcomes [10,11].

It is assumed that GPs are reluctant to challenge patient’s requests for sickness certification, but there is emerging evidence (as yet unpublished) that this can be done relatively straightforwardly, with GPs using a variety of ways to negotiate reviews and discussions about absenteeism and return to work. A planned evaluation of the new FitNote may also provide more evidence about the potential impact of new expectations of the interaction around a request for a certificate, with the linked expectation of workplace flexibility to accommodate ill-health. There remain concerns about GPs working beyond their expertise and straying into occupational health, but employers and patients do not expect this, and neither does the state; indeed, there is now an online occupational health advice service and a range of online resources to help employers manage ill-health and the workplace and to promote health and well-being in the workforce. GPs forget perhaps that many are themselves employers in SMEs, and experiences of presenteeism and absenteeism in their workplace can substantially shift attitudes to the process of certification and advice for working patients with health problems. GPs are in fact well placed to negotiate with patients and suggest ways to accommodate work and refer to local services that can support their patients and perhaps to be more willing to liaise with occupational health, in collaboration with the patients. Research has demonstrated important risk factors that can alert GPs to those at more risk of longer term absence and worklessness [10,11].

We know that welfare policy is changing, in the UK as well as elsewhere, and that this has consequences for GPs and their patients. We also know that the economic downturn will apply pressure on employers, employees and state funding, which will make it harder for the workless to find and sustain good work, add stress to work and increase the risk of job loss (and hence drive up presenteeism). It is less clear whether employees with health problems will find their employers more or less willing to accommodate them, but GPs can at least provide guidance about capability, and the decision remains the employer’s. We can be confident, however, that in the short to medium term a number of new policies and services to address the issue of presenteeism and long-term sickness absence will be introduced and that GPs are likely to frequently find themselves at the centre of these issues and possible tensions. Attempts to ignore these realities and carry-on regardless are not likely to serve our patients, our communities or ourselves well. Clearly the economic downturn presents many of our patients with substantial challenges, and we will be one of the groups they look to for help. There are a range of resources to guide GPs through these changes and processes and an increasing range of services available to support patients facing such difficulties (particularly if the caseworker approach is considered helpful). We can usefully focus on the economic, social and health benefits of work for most of our working age patients and recognize the potential for an empathic GP to discuss and negotiate options, signpost to relevant support and referrals before prolonged absence is established and work with other agencies and occupational health services where available. This will bring benefits for the individual, their dependants and communities, overall UK gross domestic product and hence NHS resources, and through the associated health benefits of tackling social exclusion and deprivation, reductions in health inequalities and enhanced health and well-being during the working age. An enhanced reputation of our skills in this area will also ensure that when we do consider that patients are unfit for work, or that work is worsening their health, our opinion in this regard will be more authoritative.

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References
8. http://www.healthyworkinguk.co.uk/