Review of Irish Civil Service sickness absence referrals 2008–10

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Introduction

The consequences of long-term sickness absence for both individuals and their employers are well documented. Evidence shows that absence from work for an extended period is associated with poorer health [1,2], with an increased risk of financial difficulties and social exclusion. The negative impact of sickness absence on employing organizations includes additional managerial work dealing with absences, reduced productivity, lower customer satisfaction and increased demands on colleagues [3].

In the Irish Civil Service a long-term absence is defined as a continuous absence of more than 20 working days. At the time of this study civil servants received 6 months’ full pay followed by 6 months’ half pay within a rolling 4 year period when on medically certified sick leave. Subsequently, they may then be entitled to pay at pension rates once there is a reasonable prospect of their return to work. According to a report published by the Irish Comptroller and Auditor General (C&AG) in 2009, sick pay cost the Irish Civil Service €64 million per annum. When indirect costs are included, the actual financial cost to the organization may be twice that of sick pay alone [3].

Repeated short-term absences and long-term absences tend to have different underlying causes and are therefore managed differently. This study focused only on the latter and we investigated the management of long-term sickness absence, the epidemiological profile, medical causes and outcomes of a series of referred cases.

Methods

The study involved a retrospective review of consecutive new sickness absence cases referred to the Civil Service Occupational Health Department (CSOHD) between January 2008 and April 2008, followed up until July 2010.
Cases were drawn from a workforce of approximately 38,000 encompassing most occupational groups in the Irish Civil Service, excluding prison officers. Ill-health retirement applications were excluded from the study.

All cases were referred to occupational health by managers using a case referral form that required relevant background workplace information to be provided. There was no self-referral facility.

Referral forms were reviewed by an occupational health physician (OHP) or nurse (OHN). Depending on the complexity of the case, an appointment was made with either an OHN or an OHP. If the employee lived at a distance from the OH department a report from the treating doctor was obtained prior to the appointment.

A detailed consultation, typically lasting up to 1h or longer, was conducted at the OH appointment. Where necessary the treating doctor, local manager or employee assistance programme (EAP) provider were contacted by phone. Multiple OH appointments were arranged if required.

Each case’s medical records were reviewed and personnel departments were asked to identify case outcomes. Information on age at referral, gender and civil service grade was also collected. The medical causes of absence were coded into nine categories (mental, musculoskeletal, injury/fracture, infections, pregnancy related, cancer, circulatory, respiratory and other physical), based on a shortened version of the Sickness Absence Recording Tool (SART) [4]. The outcome of each case (e.g. resumption of work, continuing sickness absence and ill-health retirement) was recorded.

As the study was based on retrospective review of case records and completely anonymous aggregate data, ethical approval and patient consent were not deemed necessary. However, clearance to conduct the study was sought in advance from senior Civil Service management.

### Results

The dataset for analysis consisted of 301 cases. The average age of subjects was 46.8 years, against the average Civil Service population age of 43.7 years (P < 0.001). Thirty two per cent of subjects were male and 68% female, whereas the Civil Service employee gender ratio is 41% male and 59% female (P < 0.001). Clerical officer grades were over represented (50% of referrals versus 39% of the subject population (P < 0.001)). The most common illness category was mental illness (30%); 12% of all referrals had a diagnosis of depression and 7% of stress, of which half were work attributed. Musculoskeletal disorders were the second most common category (13%), with only one referral involving work-related upper limb disorder. Cancers (11%) and circulatory disorders (8%) were the next most common illness categories (Table 1).

<table>
<thead>
<tr>
<th>Illness category</th>
<th>Sub-category</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental</td>
<td>Depression</td>
<td>37 (12)</td>
</tr>
<tr>
<td></td>
<td>Anxiety</td>
<td>13 (4)</td>
</tr>
<tr>
<td></td>
<td>Stress–Work attributed</td>
<td>10 (3)</td>
</tr>
<tr>
<td></td>
<td>Other stress</td>
<td>10 (3)</td>
</tr>
<tr>
<td></td>
<td>Other mental health</td>
<td>21 (7)</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>91 (30)</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>Back pain/Back surgery</td>
<td>13 (4)</td>
</tr>
<tr>
<td></td>
<td>Joint replacement surgery</td>
<td>5 (2)</td>
</tr>
<tr>
<td></td>
<td>WRULD</td>
<td>1 (&lt;1)</td>
</tr>
<tr>
<td></td>
<td>Other musculoskeletal</td>
<td>20 (7)</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>39 (13)</td>
</tr>
<tr>
<td>Cancer</td>
<td>Breast cancer</td>
<td>11 (4)</td>
</tr>
<tr>
<td></td>
<td>Prostate cancer</td>
<td>3 (1)</td>
</tr>
<tr>
<td></td>
<td>Colorectal cancer</td>
<td>3 (1)</td>
</tr>
<tr>
<td></td>
<td>Other cancer</td>
<td>17 (6)</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>34 (11)</td>
</tr>
<tr>
<td>Circulatory disorders</td>
<td></td>
<td>25 (8)</td>
</tr>
<tr>
<td>Pregnancy related</td>
<td></td>
<td>20 (7)</td>
</tr>
<tr>
<td>Injury</td>
<td></td>
<td>18 (6)</td>
</tr>
<tr>
<td>Respiratory disorders</td>
<td></td>
<td>12 (4)</td>
</tr>
<tr>
<td>Infections</td>
<td></td>
<td>3 (1)</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>59 (20)</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>301 (100)</td>
</tr>
</tbody>
</table>

Percentages may not add up to 100% due to rounding up. WRULD, work-related upper limb disorder.

The average time from a subject commencing sick leave to being referred was 3.2 months. Fourteen per cent of individuals resumed work before their CSOHD appointment on being invited for assessment.

The final medical assessment was that 210 subjects (70%) were medically fit for work and 49 (16%) temporarily unfit. Twenty three (8%) were assessed as permanently unfit and advised to apply for ill-health retirement. Nineteen (6%) did not engage with the OH assessment process.

At follow-up in July 2010, 83% (249) had returned to work, 8% (24) were ill-health retired, 2% (7) remained on sickness absence, 2% were deceased and the remaining 5% were on special leave or had left employment for other reasons, e.g. retirement on age grounds or resignation (Table 2).

### Discussion

In this study population the most frequent outcome of long-term sickness absence was eventual return to work,
with only a relatively small number retiring on ill-health grounds. The main reasons for absence, mental health disorders, musculoskeletal disorders and cancer, broadly reflect the prevalence of these conditions among the Irish working population [5]. The study also showed long-term absence to be more prevalent among older employees, female employees and clerical officer grades.

The outcome of sickness absence cases was determined in 100% of the study population. A further strength of the study is that we were able to follow-up sickness absence cases for up to 30 months from first referral. The exclusion of pre-existing long-term chronic sickness absence cases and of cases involving ill-health retirement applications on first referral may, however, represent limitations of this study.

The Irish Civil Service has not previously conducted a long-term sick leave outcomes study. We have not identified any comparable study in a large public sector organization, and we are unaware of any similar published studies in other European countries. We are therefore unable to compare our findings with those of similar studies. The study did not consider the complete sickness absence workload of the CSOHD but was concerned only with new cases referred between January and April 2008. However we believe it gives a representative picture of the illness patterns, case management and long-term outcomes of sickness absence cases referred to CSOHD.

The majority of subjects (70%) were considered medically fit following OH assessment, which may have involved single or multiple consultations. At follow-up, 83% of subjects had resumed work. The greater number who had resumed work at follow-up reflects the fact that some individuals deemed temporarily unfit for work had subsequently improved sufficiently to return to work without needing further OH referral. Only 2% of subjects remained on sick leave at follow-up around 30 months later.

The significant number (14%) who resumed work on being invited to attend CSOHD may simply be due to their recovery in the interim, or the invitation may have influenced a decision to return to work. This was previously noted in an early referral project for low back pain sufferers claiming social insurance benefits, run by the Irish Department of Social Protection, in which a significant number came off benefits and returned to work on being invited for assessment [6].

It is not surprising that mental health disorders were the most common illness category (30%) since this reflects their high prevalence in Western society, with a 12 month incidence rate of 27.4% and a point prevalence rate of 9.6% in the general EU (European Union) population aged 18–65 [7].

Depression affected 12% of subjects referred, making it the most common mental health disorder. This broadly matches the EU working population of whom 10% are believed to be affected by depression [8]. It is also in keeping with the C&AG Audit of Civil Service Sick Leave in 2007, which found that 10% of absences were due to stress or depression [3].

Musculoskeletal disorders were the second most common reason for absence. Cancer, the third most common illness category, affected 11% of subjects, with breast cancer being the single most common cancer (4% of all referrals), reflecting the female predominance in the Civil Service and the age profile of subjects. There were no identified work-related cancers.

The average time in 2008 from the start of sick leave to case referral was ~12–13 weeks. In 2010, the Irish Civil Service issued an HR circular requiring referral of most sick leave cases at 4–6 weeks [9], except for specified absences such as elective surgery with longer recovery periods. Almost all referrals now take place at 4–6 weeks, improving the prospect of successful workplace rehabilitation.

This study focused on the outcomes of sickness absence cases. It would additionally be useful to look at the outcomes of ill-health retirement applications, which were not covered by this study, and to investigate whether new Irish Civil Service sick leave arrangements introduced since this study have had any impact on outcomes.

In conclusion the study shows that the majority of subjects eventually resumed work with only a small number failing to do so at extended review around 30 months later.

### Table 2. Long-term case outcomes

<table>
<thead>
<tr>
<th>Outcome</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resumed work</td>
<td>249 (83)</td>
</tr>
<tr>
<td>Ill-health retired</td>
<td>24 (8)</td>
</tr>
<tr>
<td>Remained on sick leave</td>
<td>7 (2)</td>
</tr>
<tr>
<td>Deceased</td>
<td>5 (2)</td>
</tr>
<tr>
<td>Other</td>
<td>16 (5)</td>
</tr>
<tr>
<td>Total</td>
<td>301 (100)</td>
</tr>
</tbody>
</table>

Key points

- In this study population long-term sickness absence was more prevalent among older employees, female employees and clerical officer grades.
- Over an extended period of review the majority of subjects on long-term sick leave returned to work, with only 2% remaining unresolved at follow-up at 30 months and 8% retiring on ill-health grounds.
- The main reasons for absence, mental health disorders, musculoskeletal disorders and cancer, broadly reflect the prevalence of these conditions among the general population from which study subjects were drawn.
Acknowledgements
The authors wish to acknowledge the help of the occupational health nurses of the Civil Service Occupational Health Department.

Conflicts of interest
None declared.

References

Top 10 most cited papers from 2012
1. Sensitization and irritant-induced occupational asthma with latency are clinically indistinguishable
P. S. Burge, V. C. Moore and A. S. Robertson
2. Health and safety of the older worker
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