

Ministry of Health contribution to issues being considered by the Welfare Working Group: Supplementary paper

Introduction

1. This paper is a supplement to the paper the Ministry of Health provided to the Welfare Working Group (WWG) secretariat on 17 August 2010.¹ This supplementary paper addresses issues that were raised during and after a presentation to the WWG on Thursday 19 August 2010.
2. This supplementary paper provides:
 - an analysis of self-reported disability amongst people in receipt of either a sickness benefit (SB) or invalid's benefit (IB) compared to the employed population
 - further information on findings from *Te Rau Hinengaro – The New Zealand Mental Health Survey*, particularly in relation to substance abuse and depression
 - advice on what the Ministry of Health (the Ministry) knows about health of people in receipt of a domestic purposes benefit (DPB) or an unemployment benefit (UB) compared to the employed population
 - advice on what the Ministry knows about changes in the health status of people before, during and after receipt of benefit (particularly SB/IB)
 - further information on the provision of vocational rehabilitation and occupational therapy in New Zealand's public health and disability support system
 - further information on policies implemented in the United Kingdom (UK) in recent years to facilitate transitions from receipt of a welfare benefit to employment
 - information on what UK companies have done to maintain and/or improve the health of workers and/or to support workers to return to work after experiencing significant ill-health.

Self-reported disability amongst people in receipt of a sickness benefit or invalid's benefit

3. The Ministry's initial paper to the WWG clearly showed that in 1996/97, 2002/03 and 2006/07, the SB/IB population was consistently and significantly less healthy than the employed population. The SB/IB population has mortality rates three times higher than others and, when compared with the employed population, have much worse physical and mental health. Further, the inequality between these population groups did not narrow between 1996/97 and 2006/07, suggesting that the SB/IB population has not become any more or any less healthy relative to the employed population.
4. In the year ending June 1997, there were approximately 34,000 people in receipt of an SB and 46,000 people in receipt of an IB.² At the end of March 2003, there were more than 38,300 people in receipt of a SB and more than 66,500 in receipt of an IB. At the end of March 2007, there were more than 47,800 people in receipt of an SB and more than 76,600 in receipt of an IB.³ At the end of March 2007, approximately 57 percent of the SB population and 53 percent

¹ Ministry of Health. Unpublished. Ministry of Health contribution to issues being considered by the Welfare Working Group. Although this initial paper was provided to the WWG as an official paper, and may become available to the public via the WWG's website, it has not been formally published by the Ministry of Health.

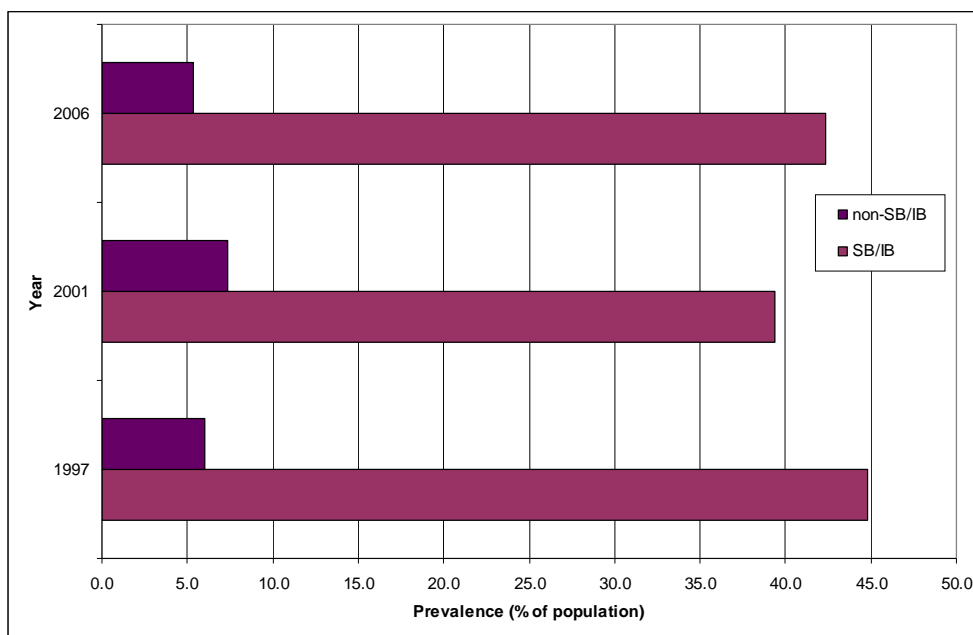
² Wilson M, McLeod K, and Sathiyandra S. 2005. Growth in numbers of Sickness and Invalids Benefit recipients 1993 – 2002: Cohort analysis technical report. Wellington: Centre for Social Research and Evaluation, Ministry of Social Development. Available from: <http://www.msd.govt.nz/about-msd-and-our-work/publications-resources/research/sbib-growth/index.html>.

³ Figures for 2003 and 2007 come from: Ministry of Social Development. 2010. '10 year trends in benefit numbers'. Wellington: Centre for Social Research and Evaluation, Ministry of Social Development. Available from: <http://www.msd.govt.nz/documents/about-msd-and-our-work/newsroom/factsheets/benefit/2010/march/10-year-benefit-time-series-mar-2010.doc>.

of the IB population was male. The finding that the SB/IB population was consistently and significantly less healthy than the employed population in 1996/97, 2002/03 and 2006/07 should be considered in the context of the significant growth in the size of that population (ie, the disparity remained despite the growth).

5. Since providing the initial paper to the WWG, the Ministry has completed an analysis of the (self-reported) level of disability in the SB/IB population compared to the non-SB/IB population. This analysis has been based on data from the 1997, 2001 and 2006 post-census New Zealand Disability surveys, which was provided to the Ministry by Statistics New Zealand (SNZ).⁴ The results of this analysis are presented in Figures 1 and 2 and Table 1. Importantly, Figures 1 and 2 do not show the prevalence of disability within these populations, but show the prevalence of disability that requires a 'medium' or 'high' level of support (based on self-reported need for assistance and/or special equipment relating to their disability). Those with a 'medium' level of support need (including having an unmet need for) some type of assistive device, aid or equipment (including work environment adaptation) and/or help with meal preparation, shopping, everyday housework, communication, washing or medication – provided that any help or support to meet these needs is required less often than daily. Those needing a 'high' level of support need any of these at least daily.
6. Figures 1 and 2 clearly show that the SB/IB population reports needing a medium or high level of support at much higher rates than the non-SB/IB population. This disparity remains significant after adjusting for differences in the age profile of the two populations (that is, the disparity would be significant if the two populations had the same age profile).⁵

Figure 1: Unadjusted prevalence of males self-reporting disability requiring a medium or high level of support – SB/IB and non-SB/IB populations

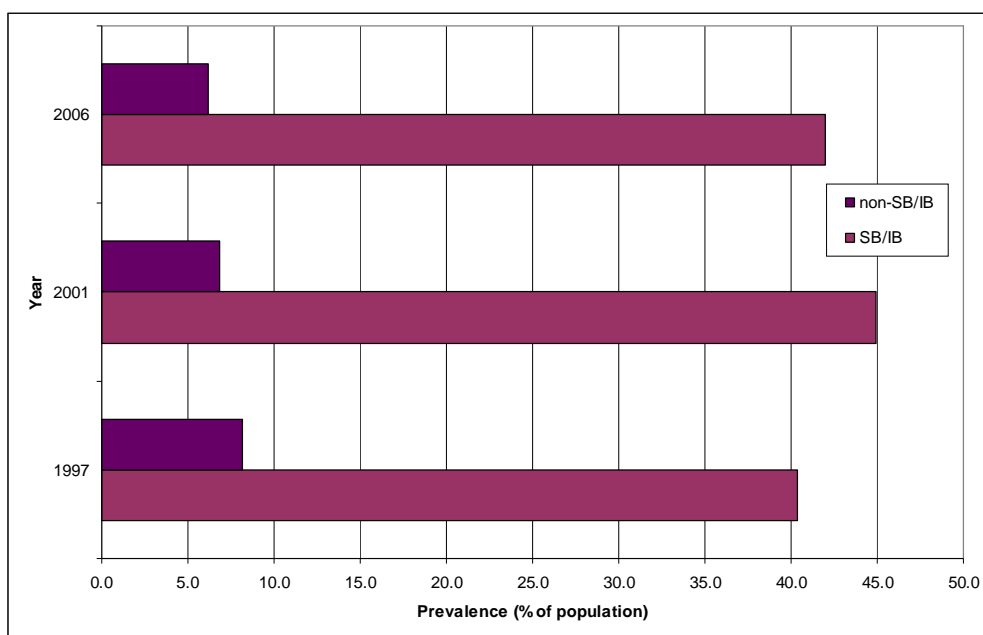


Source: Health and Disability Intelligence (HDI) unit, Ministry of Health, with New Zealand Disability Survey (NZDS) data supplied by Statistics New Zealand (SNZ)

⁴ For more information on the New Zealand Disability Survey (NZDS), see: http://www.stats.govt.nz/browse_for_stats/health/disabilities.aspx. The survey was undertaken in 1996, 2001 and 2006. Planning is underway for a survey following the 2011 census. The NZDS provides data on people aged 15-64 years; therefore, all data presented in this paper that is sourced from the NZDS is for people aged 15-64 years.

⁵ The Figures in this paper – with the exception of Figure 3 – show raw data that have not been adjusted for age. However, the commentaries/interpretations of the Figures refer to data that has been adjusted for age. Age adjustment is a statistical process used to model what the counts (or rates) would have been if the groups being compared had had populations with the same age composition. Adjustment allows the counts (or rates) to be compared free of any impact arising simply from differences in population age compositions. A similar process can be used to adjust for other demographic variables (eg, ethnic composition).

Figure 2: Unadjusted prevalence of females self-reporting disability requiring a medium or high level of support – SB/IB and non-SB/IB populations



Source: HDI unit (Ministry of Health) with NZDS data supplied by SNZ

7. No trends are clear from Figures 1 and 2. The Figures suggest that, in 2006, a slightly lower proportion of males in receipt of SB/IB required a medium or high level of support compared to 1997; and that, in 2006, a slightly higher proportion of females in receipt of SB/IB required a medium or high level of support. However, when the level of disability in the SB/IB population is compared to the non-SB/IB population for 1997, 2001 and 2006, there are some notable results (due to changes in the level of disability reported by the non-SB/IB population).
8. In 1997, males in receipt of SB/IB were 7.4 times more likely than the male non-SB/IB population to report needing a medium or high level of support; in 2006, this had increased to 7.9 times more likely. The change for females was even more pronounced: in 1997, females in receipt of SB/IB were 4.9 times more likely to report needing a medium or high level of support; in 2006, this had increased to 6.8 times more likely. These results are presented in Table 1.

Table 1: Age-adjusted ratio of SB/IB population reporting needing a medium or high level of disability support relative to the non-SB/IB population

	Year	Ratio (95% confidence interval)
Males	1997	7.4 (6.2 – 8.6)
	2001	5.3 (4.4 – 6.3)
	2006	7.9 (6.9 – 8.8)
Females	1997	4.9 (4.1 – 5.8)
	2001	6.5 (5.6 – 7.5)
	2006	6.8 (5.9 – 7.8)
All	1997	6.0 (5.3 – 6.7)
	2001	5.9 (5.2 – 6.5)
	2006	7.3 (6.5 – 8.0)

Source: HDI unit (Ministry of Health) with NZDS data supplied by SNZ

9. As shown in Table 1, the overall (age-adjusted) SB/IB population was 6 times more likely than the non-SB/IB population to report needing a medium or high level of support in 1996. In 2001,

this had decreased slightly, to 5.9 times more likely. However, in 2006, the SB/IB population was 7.3 times more likely than the non-SB/IB population to report needing a medium or high level of support to live with disability (or disabilities). The change from 1997 (6.0) to 2006 (7.3) for the total SB/IB population is statistically significant.

10. Therefore, as for the health status of the SB/IB population, the Ministry considers there to be no evidence that that the SB/IB population became any less disabled between 1997 and 2006 relative to the non-SB/IB population (despite the growth in the SB/IB population).

Further information on *Te Rau Hinengaro – The New Zealand Mental Health Survey*

11. The Ministry's initial paper to the WWG presented information from *Te Rau Hinengaro – The New Zealand Mental Health Survey* (2006).⁶ As noted in that paper, *Te Rau Hinengaro* found that, in any 12-month period, 21 percent of the population (one in five people) could be expected to have met diagnostic criteria for a mental health disorder. Further, *Te Rau Hinengaro* found that co-morbidity of mental and physical health disorders was common (and disabling), and that the prevalence of mental disorder in the past 12-months can be expected to be higher for:
 - younger people (28.6 percent for people aged 16-24 years and 25.1 percent for people aged 25-44 years)
 - women (24 percent)
 - Māori (29.5 percent)
 - Pacific people (24.4 percent)
 - people with low education levels, people on low incomes and people living in deprived areas.
12. *Te Rau Hinengaro* also found that, of the 20.7 percent of the population that can be expected to experience a mental disorder in any 12-month period, 4.7 percent could be expected to have experienced a 'serious' disorder, 9.4 percent a 'moderate' disorder and 6.6 percent a "mild" disorder. Further, the 4.7 percent of survey respondents who had experienced a "serious" disorder in the preceding 12-months had had a mean of 60.1 days out of their usual role (defined as being totally unable to carry out their normal daily activities because of that disorder). People who experienced a moderate disorder had a mean of 10.3 days of being unable to carry out their usual role and people who experienced a mild disorder 1.4 days.
13. With regard to substance use disorder, *Te Rau Hinengaro* found that, in any 12-month period:
 - 3.5 percent of the population can be expected to have met diagnostic criteria for a substance use disorder
 - 5.0 percent of men and 2.2 percent of females can be expected to have met diagnostic criteria for a substance use disorder
 - 9.1 percent of the Māori population can be expected to have met diagnostic criteria for a substance use disorder
 - 9.6 percent of the population aged 16-24 years can be expected to have met diagnostic criteria for a substance use disorder
 - 4.2 percent of the population aged 25-44 years can be expected to have met diagnostic criteria for a substance use disorder.

⁶ Oakley Brown MA, Wells JE, Scott KM (eds). 2006. *Te Rau Hinengaro: The New Zealand Mental Health Survey*. Wellington: Ministry of Health. *Te Rau Hinengaro* was published in 2006, although the data presented in it was collected in 2002/03.

14. As with people who experience mental disorder, experience of substance use disorder is also strongly associated with experiencing other mental and physical disorders (ie, co-morbidities and multiple co-morbidities are common).
15. *Te Rau Hinengaro* (and the data from the survey itself) continues to be the subject of numerous articles in significant international journals. Most recently, the August 2010 edition of the *Australian and New Zealand Journal of Psychiatry* includes an article on the prevalence and impact of major depressive episodes in New Zealand.⁷ The authors found that, for the 6.6 percent of the population (8.1 percent for females and 4.9 percent for males) aged over 16 years who met diagnostic criteria for having experienced at least one major depressive episode in the preceding 12 months, 69 percent reported 'severe' impairment in at least one domain of functioning (close relationships, home life, work life or social life). The authors concluded that there was 'little support' for the suggestions 'that depression is over-diagnosed and over-treated' and/or 'that current diagnostic thresholds allow the inclusion of too many mild episodes in community surveys'.
16. The Ministry's initial paper to the WWG noted that monitoring of primary health organisations' (PHO) provision of primary mental health services to people affected by common mental health disorders has indicated that, since 2005, there has been an upward trend in the monthly rate of new diagnoses of depression. All 80 PHOs are now funded to provide a primary mental health service. Funding has increased progressively from \$5 million in 2005/06 to \$24.5 million in 2009/10. In general, PHOs use the funding to provide:
 - extended consultations with a general practitioner (or practice nurse)
 - primary mental health coordinators
 - training and education for primary mental health practitioners
 - packages of care for patients (including access to talking therapies).
17. Since being published in 2008, *Identification of common mental disorders and management of depression in primary care* guideline and an associated electronic decision support tool have been progressively rolled out to PHOs to assist GPs to better identify, diagnose severity and manage depression.⁸ At the same time, the National Depression Initiative (including television commercials fronted by John Kirwan) has raised public awareness of depression, its effects, coping strategies and sources of help.⁹ The upward trend in diagnoses of depression in primary care since 2005 has occurred at the same time as these initiatives; the trend may therefore be at least partly explained by this increased awareness and/or services meeting previously unmet need.
18. The same monitoring of primary mental health services provided by PHOs has also shown a clear upward trend in the prescribing of anti-depressants since 2005, although this trend has started to plateau in more recent years.¹⁰ Nonetheless, the ongoing upward trend in the prescribing of antidepressants is a continuation of a domestic trend that is also part of an international trend.¹¹

⁷ Scott KM, Oakley Browne MA and Wells JA. 2010. Prevalence, impairment and severity of 12-month DSM-IV major depressive episodes in Te Rau Hinengaro: New Zealand Mental Health Survey 2003/4.

⁸ New Zealand Guidelines Group. 2008. *Identification of Common Mental Disorders and Management of Depression in Primary Care. An Evidence-based Best Practice Guideline*. Wellington: New Zealand Guidelines Group. Available from: <http://www.moh.govt.nz/moh.nsf/indexmh/national-depression-initiative-publications>.

⁹ For more information in the National Depression Initiative, see: <http://www.moh.govt.nz/moh.nsf/indexmh/national-depression-initiative>.

¹⁰ CBG Health Research Limited. Unpublished. 'Primary Care Mental Health Monitor: 2010 Q1 Report'. For more information, see: <http://www.healthstat.co.nz>.

¹¹ For an analysis of prescriptions for anti-depressants in New Zealand up to 2005, see: Ministry of Health. 2007. *Patterns of Antidepressant Drug Prescribing and Intentional Self-harm Outcomes in New Zealand: An ecological study*. Wellington: Ministry of Health. For an example of the international trend, see: Moore M, et al. 2009. Explaining the rise in antidepressant prescribing: a descriptive study using the general practice research database (*British Medical Journal*, 2009; 339: b3999) and/or Reid S and Barbui C. 2010. Long term treatment of depression with selective serotonin reuptake inhibitors and newer antidepressants (*British Medical Journal*, 3 April 2010, 340: 752-756). Importantly, both

The health of people receiving a domestic purposes or unemployment benefit

19. The Ministry's initial paper to the WWG showed that in 1996/97, 2002/03 and 2006/07, the SB/IB was consistently and significantly less healthy than the employed population. This section discusses the health of people in receipt of a DPB or UB.
20. In a study drawing on data from *Te Rau Hinengaro*, sole parents were found to be much more likely to experience mental disorder than partnered parents in a given 12-month period.¹² Sole parents in receipt of a benefit were slightly more likely than employed sole parents to experience a mental disorder in a 12-month period – although this difference was not statistically significant (44.5 percent of sole parents in receipt of a benefit, 39.7 percent of sole parents not in receipt of a benefit). However, 15.2 percent of sole parents were found to meet criteria for a serious disorder (compared to just 4.7 percent of the total population). After adjusting for demographic variables, sole parents (whether receiving a benefit or not) were more than 2.5 times as likely as partnered parents to experience a serious mental disorder (7.1 percent compared to 2.7 percent).
21. Sole parents were also more likely to experience anxiety, substance use and multiple (co-morbid) mental disorders than partnered parents. In fact, sole parents were more than 3.6 times as likely as partnered parents to experience a substance use disorder. The authors also found that, in itself, employment did little to reduce the risk of sole parents experiencing mental disorder; higher income (rather than employment alone) was found to reduce the likelihood of a sole parent experiencing a mental disorder (though still at twice the rate of partnered parents). Thus the authors concluded that in addition to having serious implications for providing primary (mental) health care to sole parents, 'policymakers and their advisors need to consider a wider array of policy responses, designed to enhance social support for sole parents as well as improving their incomes'.
22. The Ministry's Health and Disability Intelligence (HDI) unit has undertaken an analysis of the health status of (female) DPB and (female and male) UB recipients.¹³ This analysis is similar to the analyses undertaken of the health status of the SB/IB population presented in the initial paper the Ministry provided to the WWG secretariat.
23. Figure 3 suggests that the profile of mean SF-36 scores of female DPB recipients is broadly similar to that of employed females.¹⁴ However, for each indicator (other than for 'bodily pain' and 'physical functioning'), the mean SF-36 scores for DPB recipients are significantly lower than those of employed females (ie, the difference is statistically significant). Therefore, for each of those indicators, DPB recipients are significantly less healthy than their employed

these studies concluded that the rise in antidepressant prescribing is mainly explained by small changes in the proportion of patients receiving long term treatment (rather than a large increase in the overall number of people being prescribed antidepressants).

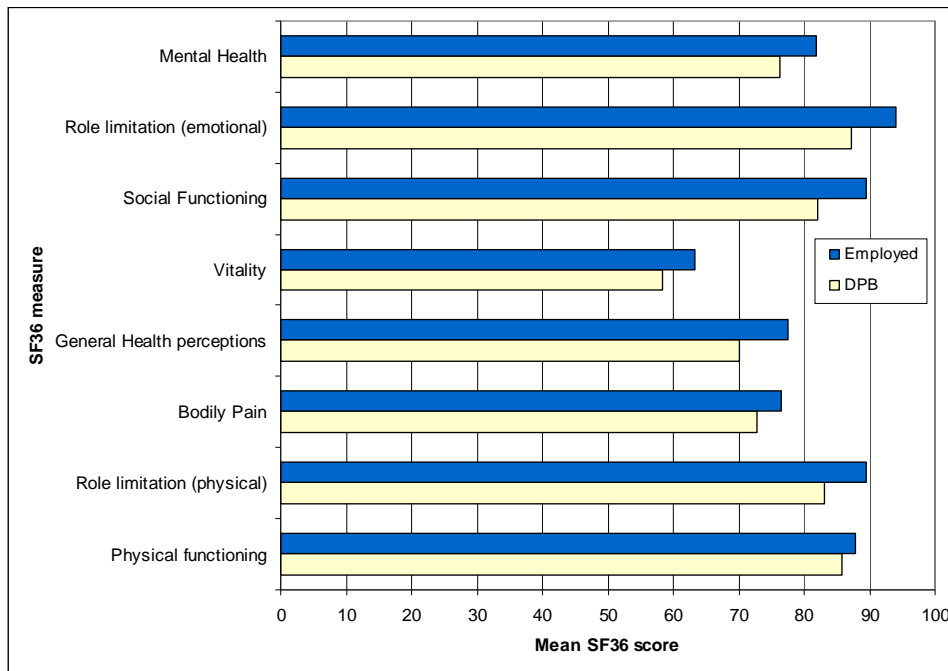
¹² Tobias M, et al. 2009. Psychiatric illness among a nationally representative sample of sole and partnered parents in New Zealand. *Australian and New Zealand Journal of Psychiatry*, 43 (2): 136-144.

¹³ Although men are eligible to receive the DPB, male DPB recipients were excluded from this analysis as there were too few male DPB recipients in the 2006/07 New Zealand Health Survey (NZHS) sample to undertake a robust analysis of their health profile. Further, although the comparator group is 'employed', this group changes very slightly when it is the comparator for UB, DPB or SB/IB recipients. The NZHS asks about receipt of benefits over the past 12-months and about current employment status. Hence one person can report having been on a benefit at some point during last year and also be currently employed. When 'employed' is used as the comparator group, it includes people who are employed and not having received the benefit in question within the last year. Similarly, the employed group comparator has not received the UB in the last year. This ensures the group of interest and the comparator groups are mutually exclusive. However, it does mean that the rates and mean SF-36 scores for 'employed' can vary slightly between the UB, DPB and SB/IB analyses and figures.

¹⁴ The Medical Outcomes Study Short Form 36 questionnaire (SF-36) is one of the most widely used questionnaires for measuring self-reported physical and mental health status in adults. The SF-36 consists of 36 questions measuring physical and mental health status in relation to eight health domains: physical functioning, role limitation (physical), bodily pain, general health perceptions, vitality (energy/fatigue), social functioning, role limitation (emotional), and general mental health. Each domain is measured on a scale of 0 – 100 and a high score indicates a favourable status in relation to that domain. For more information on the use of the SF-36 in the NZHS, see Ministry of Health. 2008. *A Portrait of Health. Key Results of the 2006/07 New Zealand Health Survey*. Wellington: Ministry of Health. Available from: <http://www.moh.govt.nz/moh.nsf/indexmh/portrait-of-health>.

counterparts. This disparity remains significant after adjusting for differences in the age profile of the two populations.

Figure 3: Mean SF-36 scores, DPB compared to Employed, Females, 2006/07



Source: HDI (Ministry of Health) with 2006/07 New Zealand Health Survey (NZHS) data

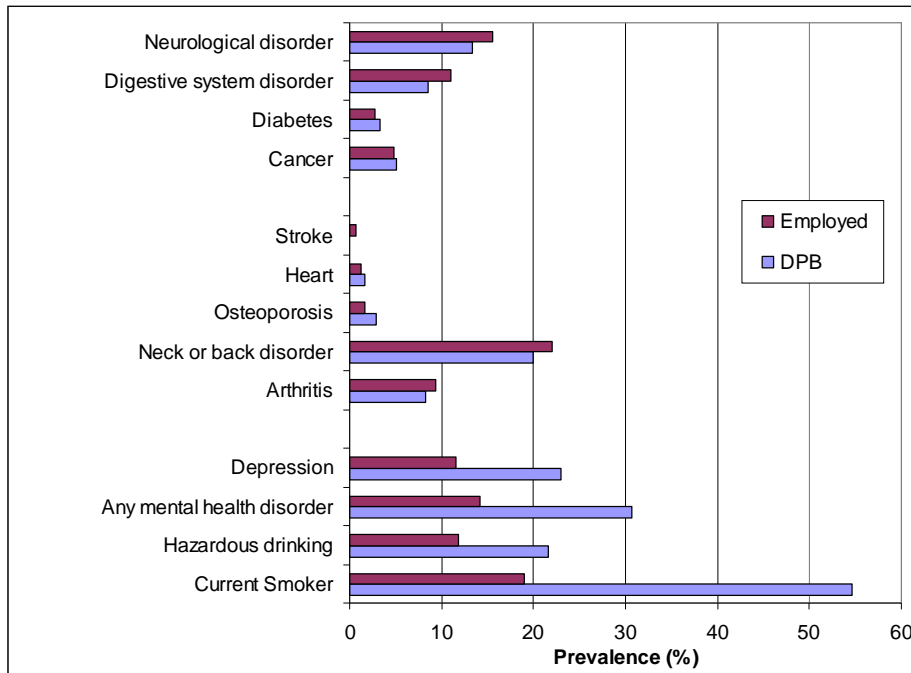
24. Figure 4 shows that, for key health conditions other than mental health disorders, the health profile of female DPB recipients is broadly similar to that of employed females. However, the figure shows that mental health disorders are far more prevalent amongst female DPB recipients than employed females, and DPB recipients are almost twice as likely to drink “hazardously” than employed females and are almost three times more likely to be a current smoker. Both of these behaviours, particularly smoking, are strongly associated with poor health outcomes.

25. The finding that female DPB recipients have significantly poorer mental health than employed females is consistent with the research identified above, which found that the prevalence of mental health disorders amongst sole parents is significantly higher than amongst partnered parents.¹⁵ In addition, there is a strong evidence-base that shows the children of sole mothers are themselves more likely to have poorer mental health than children of partnered mothers. For example, one study of data from the 2006/07 New Zealand Health Survey (NZHS) found that the children (aged 5 to 14 years) of sole mothers ‘were more than twice as likely to exhibit low mental/emotional and behavioural health than children of partnered parents’ (although were only slightly more likely to have poorer physical health).¹⁶ The authors of that study also found that much of the disparity was attributable to the mother’s mental health, the socio-economic position of the mother and child(ren) and housing-related factors (eg, security of tenancy and over-crowding). The authors also discussed how their findings were largely consistent with international research literature, including a Swedish study of more than one million children and research from the United Kingdom.

¹⁵ Tobias M, et al. 2009. Psychiatric illness among a nationally representative sample of sole and partnered parents in New Zealand. *Australian and New Zealand Journal of Psychiatry*, 43 (2): 136-144.

¹⁶ Tobias M, et al. 2010. ‘The health of children in sole-parent families in New Zealand: results of a population-based cross-sectional survey.’ *Australian and New Zealand Journal of Public Health*, 34 (3): 274-280. This article identifies a wealth of other resources that analyse and discuss the health of children in New Zealand.

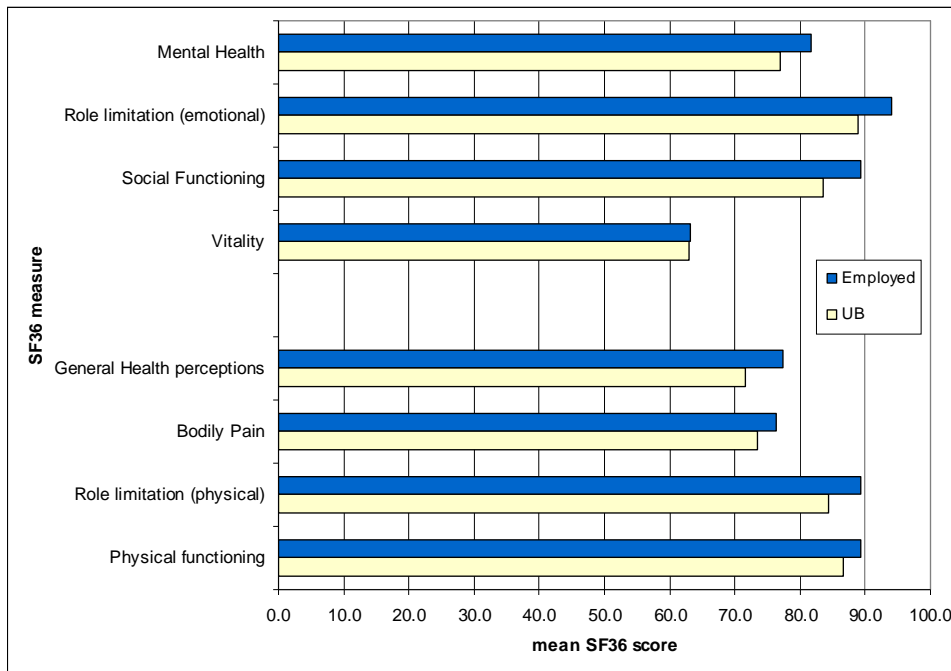
Figure 4: Unadjusted prevalence of key disorders/conditions and behaviours, DPB recipients and Employed, Females, 2006/07



Source: HDI (Ministry of Health) with 2006/07 NZHS data

26. Figure 5 shows that the mean SF-36 scores of unemployed females are lower or the same as those for employed females. However, none of those that are lower are significantly lower. Further, even after adjusting for age differences, there are no statistically significant differences across indicators of the health status of unemployed females compared to employed females.

Figure 5: Mean SF-36 scores – Unemployed and Employed – Females – 2006/07

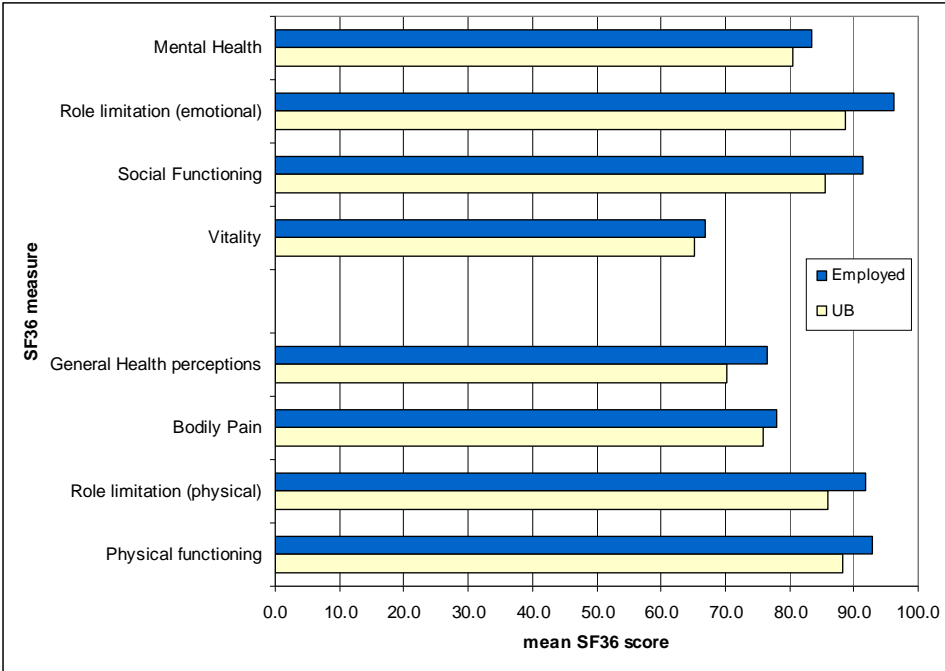


Source: HDI (Ministry of Health) with 2006/07 NZHS data

27. Similar to the profile of indicators for unemployed and employed females, Figure 6 shows that unemployed males report slightly lower mean SF-36 scores. However, as for females, none of

these differences are statistically significant (including after adjusting for age differences). That is, there appear to be no statistically significant differences across indicators of the health status of unemployed males compared to employed males.

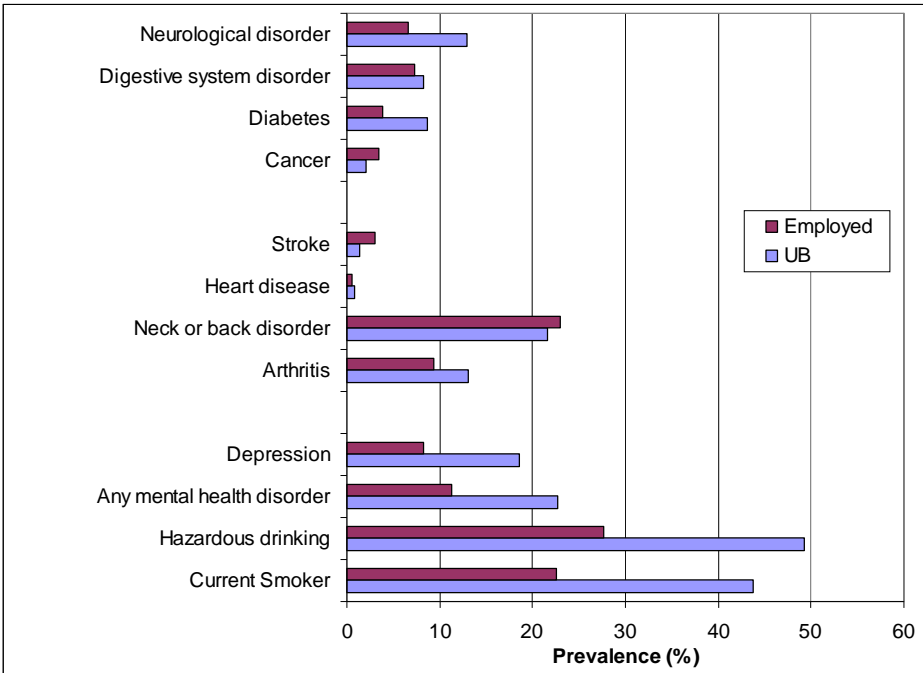
Figure 6: Mean SF-36 scores – Unemployed and Employed – Males – 2006/07



Source: HDI (Ministry of Health) with 2006/07 NZHS data

28. Figure 7 shows that the prevalence of mental health disorders, hazardous drinking and smoking is significantly higher amongst unemployed males than amongst employed males. Figure 7 also shows a slightly higher prevalence of neurological disorders, diabetes and arthritis amongst unemployed males than amongst employed males.

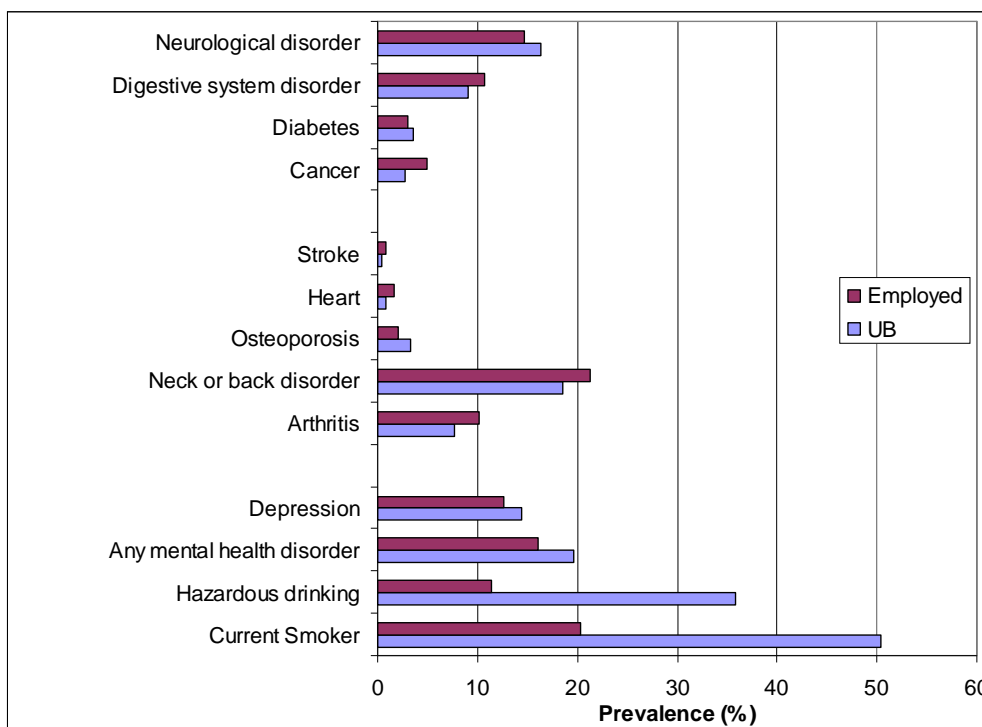
Figure 7: Unadjusted prevalence of key disorders/conditions and behaviours – Unemployed and Employed – Males – 2006/07



Source: HDI (Ministry of Health) with 2006/07 NZHS data

29. Figure 8 shows that the prevalences of key health conditions in the population of unemployed females are broadly similar to those in the employed female population. However, unemployed females are much more likely than employed females to be hazardous drinkers and be current smokers. These differences remain significant after adjusting for differences in the age profile of the two populations.

Figure 8: Unadjusted prevalence of key disorders/conditions and behaviours – Unemployed and Employed – Females – 2006/07



Source: HDI (Ministry of Health) with 2006/07 NZHS data

30. In summary, the data presented in this section has shown, first, that indicators of health status show that DPB recipients' health is, in many domains and after adjusting for demographic differences, lower than for those of their employed counterparts, suggesting that the overall health status of DPB recipients is poorer than the overall health of employed females. In particular, the prevalence of mental health disorders amongst DPB recipients is much higher than amongst employed females. With regard to the health status of unemployed females relative to their employed counterparts, there appear to be no statistically significant differences. However, unemployed males are significantly more likely to experience mental health problems than employed males. However, the DPB, unemployed female and unemployed male populations appear to be much more likely to be current smokers and hazardous drinkers than their employed counterparts.

Changes in the health of people prior to, during and after receipt of a sickness or invalid's benefit

31. The Ministry's data collection sources do not routinely collect data on benefit status and the NZHS ascertains the health status (and other information) from a random sample of New Zealanders. That is, the Ministry does not hold longitudinal data which could be analysed to investigate changes in the health status over time of individual people. Therefore, the Ministry is unable to comment with any certainty on the health status of people prior to, during and after receipt of a sickness or invalid's benefit (including whether or not receiving a benefit coincided with an improvement or deterioration in health status).

32. The Ministry considers the Ministry of Social Development (MSD) to be better-placed to comment on the circumstances of people who are receiving or have received SB or IB – including with regard to changes in circumstances prior to, during and after (where applicable) receipt of SB or IB. The Ministry understands that MSD has provided the WWG with advice on the dynamics of clients of the benefit system.¹⁷ Research undertaken by MSD in the mid-2000s also offers further information on the circumstances and dynamics of benefit-receiving populations.¹⁸
33. Other research has also been undertaken in New Zealand that provides valuable information about the circumstances (including health status) of individuals (including benefit recipients), including changes in circumstances over time. Key studies/projects are:
- the Dunedin Multidisciplinary Health and Development Study (DMHDS)¹⁹
 - the Christchurch Health and Development Study (CHDS)²⁰
 - the Survey of Family, Income and Employment (SoFIE) – particularly the SoFIE-Health component of it.²¹
34. Both the DMHDS and CHDS have produced publications that comment on the relationship between health status and labour market participation; the Ministry's initial paper to the WWG drew on a recent *British Journal of Psychiatry* article based on CHDS data to show that experiencing psychiatric disorder between the ages of 18 and 25 years significantly influenced socioeconomic outcomes (including labour market participation and benefit dependence) at age 30.²²
35. SoFIE is an 8-year longitudinal study of income, labour force participation, educational training, asset accumulation and family structure. It commenced in October 2002 and is being run by SNZ. The SoFIE-Health component aims to investigate the associations and causal pathways between social and economic position and health using the nationally representative SoFIE population sample of approximately 20,000 adults.
36. The Ministry understands that analysis of data from SoFIE-Health is not yet at a stage where the investigators can comment on changes in the health and employment status (and the circumstances explaining those changes) amongst the survey participants. The Ministry also understands that the Treasury has provided (or will soon be providing) the WWG with reports drawing on data from SoFIE and SoFIE-Health. One of these papers shows that poor health is strongly associated with a reduced likelihood of labour market participation.²³ This paper also presented an analysis to show that improvement in average health could increase labour market participation. Another paper shows that poor health is associated with low personal wealth.²⁴

¹⁷ Ministry of Social Development. 2010. Who uses the benefit system and for how long? Paper prepared for the Welfare Working Group by the Ministry of Social Development. June 2010. Wellington: Centre for Social Research and Evaluation, Ministry of Social Development. Available from: <http://ips.ac.nz/WelfareWorkingGroup/Downloads/Working%20papers/CSRE-Who-uses-the-benefit-system-and-for-how-long.pdf>.

¹⁸ See, for example: Beynon, P. and Tucker, S. 2006. 'Ill health, disability, benefit and work: A summary of recent research' (*Social Policy Journal of New Zealand*, 29 (2006): 78-101).

¹⁹ See: <http://dunedinstudy.otago.ac.nz/>.

²⁰ See: <http://www.chmeds.ac.nz/research/chds/>.

²¹ See: <http://www.uow.otago.ac.nz/academic/dph/research/HIRP/SoFIE/SofieIndex.html>.

²² SJ Gibb, DM Fergusson and LJ Horwood. 2010. Burden of psychiatric disorder in young adulthood and life outcomes at age 30. *British Journal of Psychiatry*. 197 (2010): 122-127.

²³ Holt H. (Forthcoming). Health and Labour Force Participation. Working Paper 10/01. Wellington: New Zealand Treasury.

²⁴ Anastasiadis S. (Forthcoming). Health and Wealth. Working Paper 10/05. Wellington: New Zealand Treasury.

Further information on the provision of vocational rehabilitation and occupational therapy in New Zealand's public health and disability support system

37. The Ministry's initial paper to the WWG presented a high-level description of the public health and disability support system's roles in and funding of rehabilitation services and commented on the funding of vocational rehabilitation. The paper concluded that while it is clear that significant Vote Health resources (\$628.6 million in 2008) are invested in rehabilitation, it is difficult to quickly discern what is specifically directed toward vocational rehabilitation. Since meeting with the WWG on 19 August 2010, the Ministry has sought to disaggregate expenditure by the Ministry itself and by DHBs on vocational rehabilitation and on occupational therapy.
38. Funding of services by the Ministry and DHBs is facilitated through the use of service specifications and purchase unit codes. A service specification outlines a high-level description of the service to be funded and delivered and incorporates the relevant purchase units and reporting requirements. While there is a service specification for occupational therapy, and various specifications for the range of activities that comprise rehabilitation, disclosing the amount of funding associated with each of them will not provide a significantly more accurate picture of vocational rehabilitation (and the contribution of occupational therapy to vocational rehabilitation) as the specifications used are too high-level. Furthermore, the Ministry's and DHBs' own funding of such services will not represent the full extent of their provision of those services, as other agencies (eg, ACC) may also fund DHBs to provide them (as well as also funding other service providers to do so).

Further information on policies implemented in the United Kingdom (UK) in recent years to facilitate transitions from receipt of a welfare benefit to employment

39. The UK benefit system and its interface with the UK health system has been the subject of significant research in recent years.²⁵ A recent (August 2010) article published online in the *British Medical Journal* concluded that it is possible to identify people who are likely to transition to a long term benefit due to mental health problems up to three years before they do – with the implication being that that transition may be preventable.²⁶ Those who were likely to transition from work to a long term incapacity benefit were frequent visitors to their GP in the 2-3 years leading up to that transition. The authors noted that the proportion of the people receiving incapacity benefits due to a mental health problem has increased from 32 percent to 45 percent in the preceding decade. The authors also noted concerns about the consistency of GPs' decisions to issue 'statements of incapacity for work', but found that variation across GP practices in Scotland could be explained by differences in the population characteristics.
40. The study discussed immediately above was, however, based on data from no later than 2007. The Ministry understands that the WWG and its secretariat are well aware of many of the initiatives that have been implemented by government in the UK since to support people to avoid needing the equivalent of SB/IB or to assist people receiving the equivalent of SB/IB back into labour market participation. Nonetheless, this section provides an overview of those initiatives – but does so without discussing the wider structure and range of benefits that exist within the UK system.
41. Key to developments in the UK in recent years was the work of the cross-government Health, Work and Well-being Programme (www.workingforhealth.gov.uk) and its publication (in 2008)

²⁵ See, for example: Shiels C, Gabbay MB, Ford FM. 2004. Patient factors associated with duration of certified sickness absence and transition to long-term incapacity. *British Journal of General Practice*, 54(499): 86-91.

²⁶ Whittaker W, Sutton M, et al. 2010. 'Predicting which people with psychosocial distress are at risk of becoming dependent on state benefits: analysis of routinely available data.' *British Medical Journal*, 341 (7769). Available from: <http://www.bmj.com/content/341/bmj.c3838.abstract>.

of *Working for a Healthier Tomorrow* (also known as Dame Carol Black's Review).²⁷ Other documents commissioned as part of the programme included:

- *Mental Health and Work* (by the Royal College of Psychiatrists)²⁸
- *Avoiding long-term incapacity for work: Developing an early intervention in primary care* (by the Peninsula Medical School of the Universities of Exeter and Plymouth)²⁹
- *Building the Case for Wellness* (by PricewaterhouseCoopers).³⁰

42. The Health, Work and Well-being Programme also involved (or coincided with) the publication of a consensus statement on the benefits of work by more than 30 organisations representing health professionals working in the UK.³¹ Signatories to this consensus statement included the British Medical Association, British Psychological Society, British Society of Rehabilitation Medicine, Royal College of General Practitioners and the Royal College of Psychiatrists. The statement asserted:

People who have never worked, but who have the potential, should be encouraged and helped to gain the necessary skills and experience to get a job, and be supported throughout this process. Similarly, those who have been unable to work because of illness or disability, but who have the potential to work, should be supported to make a timely return to appropriate work.

43. Further, the statement declared that: "The crucial relationship between work and health dictates that, where appropriate, remaining in or returning to suitable work must be a critical outcome measure for success in the treatment and support of working age people"; and "Supporting employees' occupational health is also a fundamental responsibility for employers. It is central to good management and - through its impact on productivity - good business."

44. The UK government responded to Dame Carol Black's Review in November 2008 with *Improving health and work: changing lives* and the subsequent development and implementation of a range of initiatives.³² The following paragraphs provide an overview of initiatives implemented or piloted in the UK in recent years. Where possible, the costs of those initiatives are indicated.

Employment and Support Allowance and Work Capability Assessment³³

45. From 27 October 2008, the Employment and Support Allowance (ESA) replaced the UK's Incapacity Benefit and Income Support for people assessed as having "limited capacity to

²⁷ Black C. 2008. *Working for a Healthier Tomorrow: Dame Carol Black's Review of the health of Britain's working age population*. London: The Stationery Office. Available from: <http://www.dwp.gov.uk/health-work-and-well-being/resources/>.

²⁸ P Lelliot and S Tulloch et al. 2008. *Mental Health and Work*. Commissioned by the cross government Health Work and Well-being Programme. London: The Royal College of Psychiatrists. Available from: <http://www.dwp.gov.uk/health-work-and-well-being/resources/>.

²⁹ Campbell J and Wright C, et al. 2007. *Avoiding long-term incapacity for work: Developing an early intervention in primary care*. A report of scoping work carried out by the Peninsula Medical School, Primary Care Research Group, on behalf of the Department for Work and Pensions (Health Work and Wellbeing). Universities of Exeter and Plymouth Peninsula Medical School. Available from: <http://www.dwp.gov.uk/health-work-and-well-being/resources/>.

³⁰ PricewaterhouseCoopers. 2008. *Building the case for wellness*. PricewaterhouseCoopers LLP. Available from: <http://www.dwp.gov.uk/health-work-and-well-being/resources/>.

³¹ Healthcare Professionals' Consensus Statement. 2008. Healthcare Professionals' Consensus Statement: Statement of Health and Work. Available from: <http://www.dwp.gov.uk/health-work-and-well-being/resources/>.

³² Secretaries of State of the Department for Work and Pensions and the Department of Health. 2008. *Improving health and work: changing lives*. The Government's Response to Dame Carol Black's Review of the health of Britain's working-age population. London: The Stationery Office. Available from: <http://www.dwp.gov.uk/health-work-and-well-being/resources/>. For an overview of the subsequent initiatives, see: <http://www.dwp.gov.uk/health-work-and-well-being/our-work/>.

³³ The text in this paragraph is adapted or paraphrased from: <http://www.dwp.gov.uk/employment-and-support/>; and Department of Work and Pensions. 2008. *Employment and Support Allowance: Equality Impact Assessment*. Available from: <http://www.dwp.gov.uk/docs/equalityimpactassessment.pdf>.

work” because of a health condition or disability (for new applications). The key components of the ESA are:

- an assessment phase – a 13 week period in which nearly all applicants undergo a Work Capability Assessment (WCA)
- a main phase – wherein applicants are, on the basis of the WCA, assigned to a work-related activity group or a support group.

46. The Department of Work and Pensions (DWP) expected that 90 percent of applicants would be assigned to the work-related activity group. This group is required to engage in work-related activity, and may be subject to sanction if they do not participate in these conditionality requirements. The remaining 10 percent in the support group – those severely limited by health or disability conditions – are not subject to conditionality requirements.

47. The WCA is a medical assessment undertaken by an approved healthcare professional (a doctor or nurse accredited by DWP’s Chief Medical Advisor)³⁴ and has three components:

- consideration of whether a person has “limited capability for work”, and is therefore entitled to ESA, and the work-related activity component
- consideration of whether a person who has “limited capability for work” also has “limited capability for work-related activity”, and is therefore entitled to the support component of ESA
- for those entitled not in the support group, consideration of the interventions or actions that may be required in each person’s case to help them move back to the workplace (through a work-focused health-related assessment).

48. The work-focused health-related assessment (a ‘discussion’ between the individual and their approved health professional about how the individual’s ill-health and/or disability impacts on their ability to work) identifies health-related interventions that could help to support a return to work. It identifies what an individual can do themselves and the help and support they need to manage their condition and increase the likelihood of a return to work.³⁵ Combined with advice from the health care professional carrying out the assessment, a plan of support tailored to the individual's needs is developed.

49. With regard to conditionality, those in the work-related activity group are required to engage in a mandatory work-focused interview each week from week eight of their assessment phase through to the end of that phase. Non-attendance of a work-focused interview, without showing good cause, can result in a portion of the client’s ESA benefit being deducted, with the deduction increasing once more than four interviews are missed.

50. The rationale for, and the costs and benefits of, the shift to the ESA and the WCA are outlined in regulatory impact assessments/statements that were completed by DWP (as the changes required legislative amendments).³⁶ The impact assessment for implementing the ESA did not include an extensive cost-benefit analysis, but argued that the likely net effect of the change would be savings for Government.³⁷

³⁴ For more information, see: ‘The Work Capability Assessment (ESA214) [‘A detailed 31 page guide’]’, available from: <http://www.dwp.gov.uk/employment-and-support/>.

³⁵ However, the guide to the WCA (see previous footnote) does not comment on how, or whether, the WCA includes facilitates access to those interventions. Further, DWP’s Impact Assessment for the new medical statement (see the next section) outlines the immediate costs and benefits of the new approach (including for GPs) and describes scenarios of the possible increase in the number of people assessment as able to undertake some form or work or work-related activity. However, the Impact Assessment does not analyse the impact on the UK’s health system of greater identification of health interventions that would enable a person to undertake or return to work.

³⁶ Department of Work and Pensions. 2009. Impact Assessment of Welfare Reform Bill 2009. Available from: <http://www.dwp.gov.uk/docs/welfare-reform-bill2009-imp-assess.pdf>.

³⁷ Department of Work and Pensions. 2006. Welfare Reform Bill 2006 – Regulatory Impact Assessment. Available from: <http://www.dwp.gov.uk/docs/welfare-reform-ria.pdf>.

51. The impact analysis for the introduction of compulsory work-focused interviews estimated that, from 2008/09 to 2013/14, administering the interviews and providing additional skills training would cost £91m, while direct economic benefits would be £92m. The direct benefits included consideration of increased economic output and taxation revenue from additional employment and fewer beneficiaries. The assessment emphasised that there would be indirect ('non-monetised') benefits attributable to the WCA and wider suite of changes, particularly over the longer term, including reductions in health spending, reduced crime, reduced child poverty and increased integration of disadvantaged groups in society. However, the likely extent of the reduced health expenditure (and other indirect benefits) was not quantified in the impact assessment (in part because it concentrated on quantifying how the changes would impact on expenditure by DWP rather than the Department of Health and National Health Service (NHS)).

Statement of Fitness for Work³⁸

52. Under this initiative, the DWP reformed (with effect from 6 April 2010) the medical certificate issued by a GP to verify an individual's inability to work due to ill-health or disability. The intention of the change was to shift the focus of the certificate away from sickness and what the individual couldn't do, to what the person could do – a shift from providing a 'sick note' to providing a 'fit note' (officially it is known as a 'Statement of Fitness for Work'). The fit note encourages GPs to provide useful advice to their patients about the effects of their health condition and how they might be able to work while they recover. GPs can also indicate if person is either 'not fit for work' or 'may be fit for work'. Further, GPs can also record details of the functional effects of their patient's condition - so individuals and employers can discuss changes to the work environment or job role or other steps to help the employee return to work earlier.

53. Implementing the 'fit note' initiative required amending the UK's Social Security (Medical Evidence) and Statutory Sick Pay (Medical Evidence) Regulations, which required DWP to produce an Impact Assessment outlining the rationale for making the change and the benefits and costs likely to result from the change.³⁹ This Impact Assessment found that the average annual costs of the fit note would be £22m–£70m and average annual benefits of £41m–£137m. Over a ten-year period, the present value of the total cost was found to be £160m–£520m and the present value of the total benefits £300m–£1000m. The wide range in the costs and benefits is because they were based on calculations of whether three, five or ten percent would be able to return to work just *one week* earlier than they would have otherwise and produce only 50 percent of their usual output.

54. The bulk of the costs were forecast to fall on employers as they became more flexible and supportive of assisting people who may have previously been absent from (or unable to) work. The majority of the benefits were forecast to come from increased economic output for employers due to people returning to work earlier and/or staying in work. The assessment also noted that there would be benefits (in terms of time saved) for GPs. Further, the assessment noted that the increased wages/salaries paid by employers would benefit individuals and that there would be additional taxation revenue for the Government due to these earnings. The assessment did not quantify the potential long term impact of earlier returns to work and/or staying in work for longer on individuals' health and productivity or on health services. Thus the assessment concluded that the *net benefit was likely to be greater* than the £140m – £480m that had been calculated.

³⁸ For more information, see:

<http://www.dwp.gov.uk/health%2Dwork%2Dand%2Dwell%2Dbeing/our%2Dwork/statement%2Dof%2Dfitness%2Dfor%2Dwork%2Dfit/>.

³⁹ Department of Work and Pensions. 2010. Impact Assessment of the Social Security (Medical Evidence) and Statutory Sick Pay (Medical Evidence) (Amendment) Regulations 2010. Available from: <http://www.dwp.gov.uk/publications/impact-assessments/>.

Fit for Work Services⁴⁰

55. Under this initiative, pilot projects have been established in some UK counties and across Scotland to provide support to people who are at risk of spending long periods away from work due to health problems. Although each pilot is different, the general focus has been to provide a case-management approach to ensuring that people are able to access support and treatment for health conditions as well as a wider set of employment-related and other social services, in order to reduce:

- the amount of time people take to return to sustained work (ie, quicker than they would under 'usual care' conditions)
- the number of people losing employment as a result of ill-health and flowing onto welfare benefits as a result of prolonged sickness absence from work.

56. In particular, the Fit for Work Services are expected to provide services to help people affected by common conditions (including mental health and musculoskeletal conditions) access treatment, vocational rehabilitation and other supports they may need (eg, assistance to manage debt or access appropriate housing).

Employment Advisers in the Improving Access to Psychological Therapies programme⁴¹

57. The UK Department of Health's Improving Access to Psychological Therapies (IAPT) programme enables people affected by depression and anxiety disorders to access evidence-based 'talking therapies'.⁴² Since January 2009, employment advisors have been progressively deployed as part of IAPT services. In March 2009, the Department of Health and DWP announced additional funding to address an expected increase in demand for psychological support (due to the impact of the global recession) and plans for every IAPT service to have employment support workers to provide vocational assistance for people with common mental health problems.

58. The employment advisers work alongside therapists, to provide information, advice, guidance and practical support to help working people using the IAPT service to remain in work, or return to work as quickly as possible. Employment advice providers work with local businesses to raise the profile of the service and the availability of coordinated health and employment support for employees. For IAPT service users who are out of work, the employment advisers help with access to Jobcentre Plus or other local employment services to facilitate the transition from welfare to work.

Pathways Advisory Service⁴³

59. At the end of October 2008, ten GP practices in the UK were funded as pilots to have employment advisors present to offer vocational advice and support to people with health problems who were temporarily absent from work or in receipt of longer-term welfare support due to being unable to work. The positions included acting as a link, or 'gateway', between individuals and the range of services and support available through Jobcentre Plus and other organisations. An evaluation of earlier pilots had reached favourable conclusions regarding the services and assistance that was offered (both for individuals with health problems affecting their labour market participation and for health professionals), and also noted that although

⁴⁰ The text in these paragraphs is adapted or paraphrased from:
<http://www.dwp.gov.uk/health%2Dwork%2Dand%2Dwell%2Dbeing/our%2Dwork/fit%2Dfor%2Dwork%2Dservices/>.

⁴¹ The text in these paragraphs is adapted or paraphrased from:
<http://www.dwp.gov.uk/health%2Dwork%2Dand%2Dwell%2Dbeing/our%2Dwork/employment%2Dadvisers%2Din%2Diapt/>.

⁴² For more information on the wider IAPT programme, see: www.iapt.nhs.uk. The IAPT programme is a population-level programme available to all people – ie, employed and unemployed people (with the latter including people unable to work due to ill-health or disability).

⁴³ See: Sainsbury R and Nice K et al. 2008. The Pathways Advisory Service: Placing employment advisers in GP surgeries. Department for Work and Pensions Research Report No 494. Available from:
<http://research.dwp.gov.uk/asd/asd5/rports2007-2008/rrep494.pdf>.

people often had wider information and support needs beyond employment, the employment advisor was also able to offer assistance in meeting these wider needs.

National Educational Programme for GPs⁴⁴

60. DWP has funded the Royal College of General Practitioners (RCGP) to run workshops focussed on evidence about work and health and providing skills and strategies for GPs to manage difficult consultations, make decisions that are in the long term interests of their patients and raise GPs' awareness of other services and supports that may help their patients stay in or return to work. The workshops are scheduled to continue until March 2011, with the aim of reaching 3,000 to 4,500 GPs.⁴⁵ There are, however, more than 35,000 GPs in England (excluding locums and registrars).⁴⁶
61. GPs in England, Scotland and Wales are also able to access advice on occupational health issues, including advice they can provide to their patients via help-lines and websites.⁴⁷

Working our way to better mental health: a framework for action

62. On 7 December, 2009 the UK Government launched *Working our way to better mental health: a framework for action* (the framework), the first ever national mental health and employment strategy.⁴⁸ The framework has two aims:

- maintain and/or improve the mental well-being employees
- deliver significantly better employment results for people with mental health conditions – including supporting them to find work, helping them to stay in work and assisting them to return to work more quickly after sickness absences.

63. Three other inter-related documents were released in conjunction with the framework:

- *Realising Ambitions: Better employment support for people with a mental health condition* – a DWP-commissioned independent review of how to strengthen employment, health and wider state support to help people with mental conditions move from receiving a benefit to employment.⁴⁹
- *Work, Recovery and Inclusion: Employment support for people in contact with secondary mental health services* – a cross-government service delivery plan to support people in contact with secondary mental health services to move into work.⁵⁰
- *New Horizons: A shared vision for mental health* – a cross-government report produced by the Department of Health outlining actions to be implemented by 11 government departments to realise the twin aims of improving people's quality of life and well-being and improving the quality and accessibility of services for people with poor mental health.⁵¹

⁴⁴ Text for this section has been adapted from:

<http://www.dwp.gov.uk/health%2Dwork%2Dand%2Dwell%2Dbeing/our%2Dwork/national%2Deducation%2Dprogramme>.

⁴⁵ See: http://www.rcgp.org.uk/news_and_events/courses__events/health_and_work_training.aspx.

⁴⁶ The NHS Information Centre - Workforce and Facilities. 2010. General and Personal Medical Services England 1999-2009. The NHS Information Centre for health and social care. Available from:

http://www.ic.nhs.uk/webfiles/publications/workforce/nhsstaff9909/General_Practice_Bulletin_1999_2009.pdf.

⁴⁷ See: <http://www.dwp.gov.uk/health%2Dwork%2Dand%2Dwell%2Dbeing/our%2Dwork/oh%2Dadvice/line/>.

⁴⁸ Secretaries of State of the Department for Work and Pensions and the Department of Health. 2009. *Working our way to better mental health: a framework for action*. Produced by the cross-government Health, Work and Well-being Programme. London: The Stationery Office. Available from: <http://www.dwp.gov.uk/docs/hwwb-working-our-way-to-better-mental-health.pdf>.

⁴⁹ Perkins R, Farmer P and Litchfield P. 2009. *Realising Ambitions: Better employment support for people with a mental health condition*. London: The Stationery Office. Available from: <http://www.dwp.gov.uk/docs/realising-ambitions.pdf>.

⁵⁰ HM Government. 2009. *Work, Recovery and Inclusion: Employment support for people in contact with secondary care mental health services*. London: National Mental Health Development Unit. Available from: <http://www.cabinetoffice.gov.uk/media/314039/work-recovery-inclusion.pdf>.

⁵¹ Department of Health. 2009. *New Horizons: A shared vision for mental health*. London: Department of Health. Available from:

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_109708.pdf.

Initiatives of new Government

64. In May 2010, a new Government was elected in the UK. The new government has released several documents signalling welfare reform, culminating in the publication of *21st Century Welfare*, a consultation document outlining specific proposals for welfare reform.⁵² Consultation on the proposals commenced on 30 July 2010 and is scheduled to close on 1 October 2010.
65. The key options presented in the consultation are:
- a single integrated Universal Credit, which could bring together out-of-work benefits, Tax Credits and payments for needs such as housing costs
 - a Single Unified Taper, which would ensure that all of someone's earnings are taken into consideration when determining their benefit eligibility
 - possible changes to the conditionality rules for people getting benefits.⁵³
66. The Government will also consider proposals from a number of external organisations, including a Single Working Age Benefit, a family allowance and a negative income tax model. The *21st Century Welfare* document notes that the Department of Health will assess the impact of the proposals and will produce a full Impact Assessment at the appropriate time.
67. DWP has also commissioned an independent review of Work Capability Assessment (WCA).⁵⁴ As part of this review, a "call for evidence" document has been published.⁵⁵ The call for evidence period began on 28 July 2010 and was scheduled to close on 10 September 2010. Responses to the call for evidence will inform an independent report that will be presented to Parliament.
68. In addition to the above, the new Government has already announced that, starting in October 2010, all people who are receiving Incapacity Benefit, Income Support paid on the grounds of disability and Severe Disablement Allowance will be reassessed to see if they are fit for work.⁵⁶

Further information on initiatives implemented by government and individual companies in the UK to keep employees well and assist employees back to work during and after sickness

69. Supporting people who are either off work or unable to work due to ill-health and/or disability to move into (or return to) employment has been one part of range of initiatives that have commenced in the UK following the publication of Dame Carol Black's Review, which identified the extent of productivity and economic output lost to ill-health (eg, sick-days). A range of initiatives have also been implemented or piloted to maintain and/or improve the health of the employed workforce and therefore reduce the incidence of 'sick days' across the UK economy. In particular, initiatives have sought to assist employers to maintain and/or improve the health of their employees.
70. The initiatives established in response to Dame Carol Black's Review also included:
- A Workplace Well-being Tool – a free web-based tool to help employers improve the health and well-being of people in their organisation⁵⁷

⁵² Secretary of State for Work and Pensions. 2010. *21st Century Welfare*. London: The Stationery Office. Available from: <http://www.dwp.gov.uk/docs/21st-century-welfare.pdf>.

⁵³ From: <http://www.dwp.gov.uk/policy/welfare-reform/>.

⁵⁴ For more information, see: <http://www.dwp.gov.uk/policy/welfare-reform/employment-and-support/wca-independent-review/>.

⁵⁵ Department for Work and Pensions. 2010. *The Work Capability Assessment: A Call for Evidence*. Available from: <http://www.dwp.gov.uk/docs/work-cap-ass-call-for-evidence.pdf>.

⁵⁶ See: <http://www.dwp.gov.uk/adviser/updates/ib-reassessing-claims/ib-reassessment-process/>.

⁵⁷ For more information, see:

<http://www.dwp.gov.uk/health%2Dwork%2Dand%2Dwell%2Dbeing/our%2Dwork/workplace%2Dwell%2Dbeing%2Dtool/>. The Workplace Well-being Tool itself can be found at: <http://www.businesslink.gov.uk/wwt>.

- Health, Work and Well-being Co-ordinators – 11 co-ordinators across England, Wales and Scotland aim to facilitate an integrated approach to health and employment at a local level to reduce the overall incidence of work related ill-health and to promote best practice and innovation on health, employment and skills ⁵⁸
- Occupational Health Adviceline for Small Businesses and GPs – advice phonelines in England, Wales and Scotland that provide small business owners and managers with early and easy access to high quality, professional advice, to help small business managers to retain employees at work or help them back to the workplace as soon as possible following a period of sickness absence, including mental health issues ⁵⁹
- A Health Work and Well-being Challenge Fund – a £4 million fund administered by DWP to fund innovative projects that improve employees' health and welfare at work and is aimed at local partnerships and small and medium sized businesses. ⁶⁰

71. In addition to these, the response to Dame Carol Black's Review has included specific public sector initiatives:

- Public Sector as Exemplar initiative – a focus on ensuring the public sector leads the way in maintaining and improving the health and well-being of its employees, prevent illness, intervene early to help employees who develop a health problem and accelerate the rehabilitation of employees who need time off work ⁶¹
- NHS Health and Well-being Review – a wide-ranging review of the NHS (the UK's largest employer) to: gather evidence on the health of NHS staff; identify barriers to effective human resource management and occupational health services; build a comprehensive evidence-base of potential ways to improve health and well-being; and make practical recommendations for improvements across the NHS. ⁶²

72. In addition to the initiatives led by the Government and public sector in the UK, several large UK companies have established in-house health services to better identify employees' health problems, help them maintain and/or improve their health and, therefore, reduce the number of days employees are sick (absenteeism) or unproductive at work while being unwell (presenteeism). ⁶³ One of the key examples is British Telecom (BT), which has a workforce of more than 150,000. ⁶⁴ Its "WorkFit" programme began in 2005 by engaging employees in weekly tasks involving activities such as improving diet and increasing exercise to reduce their risk of developing heart disease. Staff were also given free pedometers, a health information booklet and a tape measure to record waist size; every week they were asked to record three sets of data – their weight, waist circumference and total number of steps taken. Those who wished to could get personal support from a lifestyle adviser. A follow-up survey showed that

⁵⁸ For more information, see:

<http://www.dwp.gov.uk/health%2Dwork%2Dand%2Dwell%2Dbeing/our%2Dwork/hwwb%2Dco%2Dordinators/>.

⁵⁹ For more information, see:

<http://www.dwp.gov.uk/health%2Dwork%2Dand%2Dwell%2Dbeing/our%2Dwork/oh%2Dadviceline/>.

⁶⁰ For more information, see:

<http://www.dwp.gov.uk/health%2Dwork%2Dand%2Dwell%2Dbeing/our%2Dwork/challenge%2Dfund/>.

⁶¹ For more information, see:

<http://www.dwp.gov.uk/health%2Dwork%2Dand%2Dwell%2Dbeing/our%2Dwork/public%2Dsector%2Dexemplar/>.

⁶² For more information, see:

<http://www.dwp.gov.uk/health%2Dwork%2Dand%2Dwell%2Dbeing/our%2Dwork/nhs%2Dhealth%2Dand%2Dwell%2Dbeing/>. The final report resulting from the review is available from:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_108799.

⁶³ See, for example: Cooper C and Dewe P. 2008. 'Editorial: Well-being—absenteeism, presenteeism, costs and challenges'. *Occupational Medicine*, 58: 522–524; or Bergström G, Bodin L, et al. 2009. 'Sickness Presenteeism Today, Sickness Absenteeism Tomorrow? A Prospective Study on Sickness Presenteeism and Future Sickness Absenteeism'. *Journal of Occupational & Environmental Medicine*, 51 (6): 629-638. For an analysis of the financial cost of absenteeism and presenteeism due to mental health problems, see: Hilton MF, Scuffham PA, Vecchio N and Whiteford HA. 2010. 'Using the interaction of mental health symptoms and treatment status to estimate lost employee productivity'. *Australian and New Zealand Journal of Psychiatry*, 44: 151–161.

⁶⁴ The following information regarding British Telecom's initiatives was adapted from:

<http://www.idea.gov.uk/idk/core/page.do?pagelid=8223613>.

six months later 75 percent of those who had taken part had maintained lifestyle improvements. The average weight loss was 2.3kg.

73. In 2006 BT launched an initiative to help employees maintain good mental health and help improve the mental health of employees who experienced common mental health problems.⁶⁵ The programme gave advice on how personal relationships, relaxation techniques, healthy eating and exercise could relieve depression, stress and anxiety. Those who needed more intensive help were given advice by counsellors. Over the last four years, BT's rates of sickness absence due to mental health problems have fallen by 30 percent.
74. In more recent years BT has developed and implemented initiatives to help current and retired employees better identify early warning signs of diabetes and cancer and how to reduce their risk of developing these chronic conditions.⁶⁶ BT's WorkFit programme has also targeted and promoted smoking cessation amongst its employees in order to improve their short and long term health (and productivity).
75. New Zealand's Department of Labour, through its website, provides an overview of evidence-based approaches to keeping workplaces healthy for employees (with consequential impacts on productivity and employees' absences from work due to ill-health).⁶⁷
76. The issues and initiatives outlined above, and the *British Medical Journal* article identified earlier,⁶⁸ are part of the growing base of evidence that suggests that one of (if not *the*) best indicators of future long term absence from employment (ie, non-participation in the labour market due to ill-health) is frequent short term absences from work. A brief review of relevant literature suggests that much of the research that forms this growing evidence-base emanates from Scandinavian countries. For example, a longitudinal study of more than 8,200 men and women in Sweden concluded that an employee's 'sick-leave track record was the most important predictor of the probability of being granted a disability pension [in the future], even when the influences of other variables affecting the outcome were taken into account'.⁶⁹ As such, this evidence-base suggests that preventing employees from becoming sick, and effectively treating and/or promoting self-help for those who do become sick, may have a positive impact on the severity of future ill-health.

Summary

77. This paper has shown that the prevalence of disability that requires a 'medium' or 'high' level of support (based on self-reported need for assistance and/or special equipment relating to their disability) is much higher amongst male and female SB/IB recipients than amongst the employed population, as one would expect. However, the analysis presented in this paper showed that the overall SB/IB population was 6 times more likely than the non-SB/IB population to report needing a medium or high level of support in 1996; but, in 2006, the SB/IB population was 7.3 times more likely than the non-SB/IB population to report needing a medium or high level of support to live with a disability (or disabilities). Therefore, as for the health status of the SB/IB population, there is no evidence that that the overall SB/IB

⁶⁵ For more information, see: <http://www.dwp.gov.uk/health-work-and-well-being/case-studies/bt-mental-health/>.

⁶⁶ See, for example, <http://www.medicalnewstoday.com/articles/127246.php>.

⁶⁷ Regarding organisational well-being and its relationship to organisational performance, see: <http://www.osh.dol.govt.nz/publications/booklets/stress-tools2008/organizational-wellbeing.asp>. Regarding creating a healthy workplace, see: <http://www.osh.dol.govt.nz/publications/booklets/stress-tools2008/healthy-place-work.asp>. Regarding preventing workplace stress, see: <http://www.osh.dol.govt.nz/publications/booklets/stress-tools2008/prevention-methods.asp>.

⁶⁸ Whittaker W, Sutton M, et al. 2010. 'Predicting which people with psychosocial distress are at risk of becoming dependent on state benefits: analysis of routinely available data.' *British Medical Journal*, 341 (7769). (Note: this is an open-access article and is immediately available from: <http://www.bmj.com/content/341/bmj.c3838.abstract>.)

⁶⁹ Wallman T, Wedel H, et al. 2009. 'Sick-leave track record and other potential predictors of a disability pension: A population based study of 8,218 men and women followed for 16 years'. *BMC Public Health*, 9: 104. (Note: this is an open-access article and is immediately available from: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2674437/pdf/1471-2458-9-104.pdf>).

population became any less disabled between 1997 and 2006 relative to the non-SB/IB population (despite the significant growth in the SB/IB population).

78. This paper has also presented and interpreted further data from *Te Rau Hinengaro – The New Zealand Mental Health Survey*. In particular, it was noted that the 4.7 percent of survey respondents who had experienced a “serious” disorder in the preceding 12-months had a mean of 60.1 days out of their usual role (defined as being totally unable to carry out their normal daily activities because of that disorder). The paper has presented findings from *Te Rau Hinengaro* regarding substance use disorders: 3.5 percent of the population can be expected to meet diagnostic criteria for a substance use disorder, but prevalence is higher, for men, for Māori and for younger people. Further information relating to common mental health problems such as depression and anxiety disorders has also been presented, as well as detail on current initiatives to better identify and treat these problems in primary care.
79. An analysis of indicators of the health status of domestic purposes benefit (DPB) and unemployment benefit (UB) recipients has shown that DPB recipients are less healthy than employed females (particularly with regard to the prevalence of mental health problems). Although female UB recipients appear to have a similar profile of health indicators to their employed counterparts, unemployed males are significantly more likely to have poor mental health. UB recipients appear to engage in detrimental behaviours (heavy drinking and smoking) more so than their employed counterparts – as do DPB recipients when compared to employed females.
80. The paper has noted that, at this stage, the Ministry is unable to provide further detail regarding changes in health status when people from a benefit to employment (or vice-versa). While domestic and international literature may suggest there would be causal effects, the Ministry does not hold data that would enable analysing and testing such relationships. The Ministry is also unable to provide further detail at this stage regarding expenditure on occupational and vocational therapy as distinctive components of expenditure on rehabilitation.
81. A high-level overview of initiatives implemented in recent years in the United Kingdom (UK) has also been presented. The footnotes to this paper provide references to highly relevant and influential papers as well as to more information on specific initiatives. In short, the challenges facing the welfare system in the UK are broadly similar to those facing New Zealand’s welfare system. Thus the initiatives implemented there may be of relevance to the New Zealand context. Furthermore, the new Government in the UK is currently continuing the search for innovative solutions to those challenges, particularly with regard to the role of employment in improving people’s health and assessing people’s ability to engage in employment and supporting those who are able to find work and then remain in employment.