

Summary: Intervention & Options

Department /Agency: Department for Work and Pensions	Title: Impact Assessment of the Social Security (Medical Evidence) and Statutory Sick Pay (Medical Evidence) (Amendment) Regulations 2010	
Stage: Final	Version: 1	Date: 25 th January 2010
Related Publications: Dame Carol Black's Review 'Working for a healthier tomorrow'; The Government's response 'Improving health and work: changing lives'; Sallis, A., Birkin, R. & Munir, F. (in print) <i>Working towards a 'fit-note'. An experimental vignettes survey of GPs</i> ; Reforming the medical statement public consultation and the Government's response to the public consultation.		

Available to view or download at: <http://www.workingforhealth.gov.uk> & www.dwp.gov.uk

Contact for enquiries: Amy Lee

Telephone: 020 7449 5717

What is the problem under consideration? Why is government intervention necessary?

Dame Carol Black's review of the health of Great Britain's working-age population in 2008 estimated that sickness absence and associated worklessness costs the economy around £100bn per annum. It highlighted the importance of early intervention to prevent longer-term or repeated absences and a need to encourage medical professionals to explore options which could lead to an earlier return to work. Further evidence suggests that work is generally good for health. A medical professional's earliest intervention is usually when a medical statement or 'sick-note' is requested. The current statement does not encourage doctors' to discuss or advise patients about fitness for work. Reforming the statement to allow more helpful fitness for work advice will redress this problem. Regulations prescribe the format and rules for completion of medical statements.

What are the policy objectives and the intended effects?

This change is an important part of the Government's wider objective of keeping people well and in work. The policy objectives are to (i) improve communication between GPs, individuals and employers on what an individual can do, and how and whether an individual's condition can be facilitated in work; (ii) reduce sickness absence and support people with health conditions to stay in or return to work more quickly; and (iii) promote the benefits of work to health and contribute to creating a new perspective on health and work. The new medical statement is expected to result in an earlier return to work for some people with resulting improvement generally in health and well-being. This will reduce sickness absence and the numbers of people leaving work to claim health-related benefits such as Employment and Support Allowance.

What policy options have been considered? Please justify any preferred option.

1. Do nothing: retain the current medical statement. The current medical statement does not readily provide individuals or employers with information needed to help someone to return to work.
2. Legislative change: amend the current statement to shift focus onto what individuals can do.

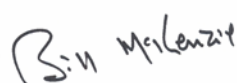
Option 2 is the preferred option as this meets the policy objectives. Option 1 focuses on individuals refraining from work thereby potentially hindering an early return to work and risking longer-term absence or worklessness.

When will the policy be reviewed to establish the actual costs and benefits and the achievement of the desired effects? An evaluation will be undertaken to be published in 2012/13. This will use a mixed methods approach and will involve qualitative research in the form of interviews, focus groups and case studies with GPs, individuals and employers, and quantitative research in the form of surveys and an impact evaluation (where possible).

Ministerial Sign-off For final proposal/implementation stage Impact Assessments:

I have read the Impact Assessment and I am satisfied that (a) it represents a fair and reasonable view of the expected costs, benefits and impact of the policy, and (b) the benefits justify the costs.

Signed by the responsible Minister:



Date: 25th January 2010

Summary: Analysis & Evidence

Policy Option: 2

Description: New medical statement

COSTS	ANNUAL COSTS		Description and scale of key monetised costs by ‘main affected groups’ The key one-off costs are estimated to be: (i) communication and IT costs, and increase in printing costs for government (£1m); and (ii) training costs for GPs (£2m). The average annual costs are from an increase in printing costs for GPs (£1m), ongoing costs of the policy for government (< £1m); and costs of job role/workplace modifications for employers (£21m-£69m) (note that the costs to employers are voluntary) .
	One-off (Transition)	Yrs	
	£ 3m	10	
	Average Annual Cost (excluding one-off)		
	£ 22m - £ 70m		
		Total Cost (PV)	£160m – 520m
Other key non-monetised costs by ‘main affected groups’			

BENEFITS	ANNUAL BENEFITS		<p>Description and scale of key monetised benefits by ‘main affected groups’ The overall economic benefit are expected to be: £41m to £137m per annum. The majority of this accrues to firms through an increase in output from early return to work (£37m-£123m) and to GPs through time savings as a result of fewer consultations and administrative savings (£4m-£14m).</p> <p>Individuals are also expected to see a benefit through increase in earnings (this is offset by a similar increase in salary costs for firms) and there will be a fiscal benefit to government/taxpayer through these earnings (a transfer payment).</p>
	One-off	Yrs	
	£	10	
	Average Annual Benefit (excluding one-off)		
	£ 41m – 137m		
	Total Benefit (PV)		
		£ 300m – 1,000m	
<p>Other key non-monetised benefits by ‘main affected groups’. Work is generally good for health. Worklessness is strongly associated with poor health, including higher mortality, poorer mental health and higher usage of medical services after taking into account of other factors. So an early return to work as a result of the new medical statement can improve health and well-being for individuals, prevent short-term sickness absence from progressing to long-term absence and ultimately worklessness, generating further fiscal benefits through a reduction in health-related benefit payments and increases in tax, and reduce usage of medical services.</p>			

Key Assumptions/Sensitivities/Risks Key monetised benefits are based on 3 scenarios - for medical statements issued to individuals with numerous/repeat and/or long sickness absence episodes (62% of medical statements), it is assumed an additional 3%, 5% and 10% of cases return to work early. It is further assumed - conservatively - that output increases by 50% for one extra week (valued at National Minimum Wage).

Price Base	Time Period	Net Benefit Range (NPV)	NET BENEFIT (NPV Best estimate)
Year 08/09	Years 10	£ 140m – 480m	£ 240m

What is the geographic coverage of the policy/option?	Great Britain			
On what date will the policy be implemented?	6 April 2010			
Which organisation(s) will enforce the policy?	HMRC			
What is the total annual cost of enforcement for these organisations?	No additional costs			
Does enforcement comply with Hampton principles?	Yes			
Will implementation go beyond minimum EU requirements?	N/A			
What is the value of the proposed offsetting measure per year?	£ 0			
What is the value of changes in greenhouse gas emissions?	£ 0			
Will the change have a significant impact on competition?	No			
Annual cost (£-£) per organisation (excluding one-off)	Micro £0	Small £0	Medium £0	Large £0
Are any of these organisations exempt?	No	No	N/A	N/A

Impact on Admin Burdens Baseline (2005 Prices)			(Increase - Decrease)
Increase of £	Decrease of £	Net Impact	£ nil

Key:

Annual costs and benefits: Constant Prices

(Net) Present Value

INTRODUCTION

1. In her review of the health of Great Britain's working-age population in 2008, the National Director for Health and Work, Dame Carol Black estimated the annual economic cost of health related worklessness and sickness absence to be around £100bn per year¹. Individuals, employers and tax-payers all bear these costs. As part of a number of recommendations to reduce these costs, Dame Carol highlighted the importance of the role of early intervention, and the need for the medical certification process to better support employers and employees by providing them the best possible advice from GPs on fitness for work. This, together with evidence that work is generally good for an individual's health and requests from businesses for better information on medical statements, led to a review of the format and completion of medical statements².

CONSULTATION

2. The Government engaged with a range of stakeholders, including representatives from health professions, employer organisations and trades unions to seek their views on the current medical statement. Following discussions with stakeholders and a trial of a prototype statement with over 500 GPs, the Government launched a three-month long public consultation in May 2009 to seek wider views on the proposed new medical statement³. The comments received were extremely valuable and have led to the development of a final new medical statement as described in the Regulations which this impact assessment supports.
3. The public consultation also sought views and further information, data or analysis which would be useful for improving the quality of the analysis in the impact assessment. Having considered the comments received, the Government has made a number of changes including:
 - Inclusion of (voluntary) costs for employers to facilitate an earlier return to work
 - Looking at the impact of an increase in the average training time for GPs to read the guidance on the new medical statements
 - A reduction in the numbers of individuals likely to be impacted by the change to generate even more conservative estimates of the benefits

Using more conservative benefits and including further costs have decreased the net benefits. However, the overall conclusions remain. The new medical statement is still expected to result in a net benefit for individuals, employers, government and the economy as a whole.

4. A number of assumptions used in the impact assessment are believed to be conservative including:
 - An additional 3%, 5% and 10% of 'impacted' cases return to work early. This is a lower proportion than implied by research carried out by the Department for Work and Pensions (DWP)⁴.
 - For those who return to work early, output increases by just 50% for one week and this is valued at the National Minimum Wage.

¹ Dame Carol Black's review of the Health of Britain's working age population - Working for a healthier tomorrow (2008)

² Waddell, G. and Burton A.K. (2006) Is work good for your health and well-being? The Stationery Office.

³ <http://www.dwp.gov.uk/docs/reforming-the-medical-statement-consultation-28may2009.pdf>

⁴ Sallis A., Birkin R. and Munir F. (in print) Working towards a 'fit-note'. An experimental vignettes survey of GPs.

MEDICAL STATEMENTS: BACKGROUND

5. Medical statements (more commonly known as medical certificates, doctor's statements or sick notes) are issued by GPs and other doctors to provide advice on fitness for work to their patients who develop a health condition or have a condition that has worsened. Employees may be required to provide to their employer, from the eighth day of their illness, some form of medical evidence about their sickness absence to support a claim for Statutory Sick Pay (SSP). This is normally provided by way of a medical statement. SSP is the minimum amount that employers are required to pay to employees who meet specified qualifying conditions and because of illness are unable to work. Similarly a medical statement is required by Jobcentre Plus to support a claim for health-related benefits such as Employment and Support Allowance (ESA).
6. There are a number of different medical statements:
 - Form Med 3 is issued by a doctor treating a patient and is based on an examination that has been carried out either that day or the day before.
 - Form Med 4 is a separate statement, which is issued by a doctor (if requested by DWP) to their patient in connection with their patient's first personal capability assessment (PCA) undertaken by DWP for those claiming Incapacity Benefit.
 - Form Med 5 has two functions. It is issued by a patient's GP and is based on an examination carried out more than 48 hours from the date of issue of the statement for which no previous statement has been issued for that examination. It is also used when a statement is issued based on a written report from another doctor who has carried out an examination.
7. The Social Security Administration Act 1992 provides the legislative base for medical statements. This provides for regulations to prescribe what evidence may be provided in support of any claim to benefit. It makes a similar provision for the evidence that may be required by employers for Statutory Sick Pay purposes. Doctors are contractually required to provide this evidence to their patients and to do so on forms set out in the Social Security (Medical Evidence) Regulations 1976 and in the Statutory Sick Pay (Medical Evidence) Regulations 1985.

IMPROVING THE MEDICAL CERTIFICATION PROCESS: RATIONALE FOR CHANGE

8. Sickness absence is generally lower than it was in the 1990s but it remains high. It is estimated that 2.5% of working time was lost due to illness in 2008⁵. Importantly a significant minority of those individuals who experience an episode of sickness absence will leave employment for inactivity. Indeed DWP survey data suggests that over half of all individuals claiming health-related benefits in any year had been in work before making a claim⁶. Evidence also suggests that the longer an individual is off work the lower the chances are of leaving benefits and returning to work⁷.
9. There is substantial evidence to suggest that people with health conditions can be better supported to enjoy the benefits of work. In a recent review of the efficacy of Vocational Rehabilitation, Waddell, Burton and Kendall estimate that with basic support more than 90 per cent of people with common health conditions can be supported to work⁸. Combined

⁵ Labour Force Survey, Q1-Q4 2008.

⁶ Kemp, P.A. and Davidson, J. (2007) Routes onto Incapacity Benefit: Findings from a survey of recent claimants. DWP Research Report 469.

⁷ Administrative data show the off-flow rate decreases as duration on IB increases from 3 months up to 6 months. In the quarter to February 2008, 26% of claimants who had been on IB for 3 months up to 6 months left IB compared with just 3% for those who had been on IB for 5 years or more. Further data on destination of leavers indicate that the proportions that find work decreases as duration on IB increases. In the year to February 2008, of those who had been on IB for less than 5 months and flowed off, 23% found work. This fell to 17% for those who had been on IB for 3-5 years and 11% for those on IB for more than 5 years. Once individuals have been on IB for more than 3 years, they are more likely to flow off IB due to retirement or death than they are to return to work.

⁸ Waddell, G, Burton A. K, and Kendall N, (2008), Vocational Rehabilitation: what works, for whom and when?, p.43.

with more structured interventions which may be appropriate for more complex cases they estimate that long-term sickness absence and the numbers of workers moving to long-term health-related benefits can be reduced by 20-60 per cent.

10. Waddell, Burton and Kendall also suggest that typically sickness absence management places too much emphasis on healthcare which tends to focus on the treatment of symptoms and may not in itself be enough to improve work outcomes. They conclude that '[there] is strong evidence for a more proactive approach to sickness absence and on the value of modified work and workplace accommodations'.
11. There is also growing evidence which shows that work is generally good for health; reversing the harmful effects of long-term unemployment and prolonged sickness absence. Of course the converse is also true. Worklessness is strongly associated with poor health, including higher mortality, poorer mental health and higher usage of medical services. Individuals moving off benefits into work experience improvements in their income, socio-economic status, mental and general health, and well-being.
12. GPs are typically the first medical professionals that people encounter when they are sick. The advice and support they provide can be pivotal when people are making decisions about whether or not they should return to work. However the current medical statement does not readily provide individuals or employers with information needed to help someone to return to work. The current statement provides only a binary choice - either a patient should or should not refrain from work. In doing so the current statement does not readily encourage or support GPs to consider what an individual, with the support of their employer, might be capable of achieving. Indeed evidence from qualitative surveys of doctors suggest that many believe that it is only possible to certify patients as able to return to work on the basis that they are fully fit to resume their full duties⁹.
13. As such, the current system does not fully support patients, healthcare professionals or employers. Given the mounting weight of evidence that more could and should be done to promote work as a means to better health, such a system is effectively a wasted opportunity. So there is a clear rationale for government to intervene and improve the current system.

THE NEW MEDICAL STATEMENT

Form Med 3 and Med 5

14. The new form Med 3 statement provides information on:
 - the date a doctor assessed their patient's case (this could be based on the date they had a face-to-face or telephone consultation with their patient; or based on the date they considered information from a written report from another doctor or healthcare professional);
 - the health condition of their patient;
 - whether their patient is '*not fit for work*' or '*may be fit for work taking account of the following advice*';
 - where a doctor considers their patient '*may be fit for work taking account of the following advice*' the doctor must provide information to support this. Further, if a doctor considers it appropriate that their patient may benefit from common workplace changes, the doctor should tick the relevant box;
 - the period for which the doctor considers their patient is '*not fit for work*' or '*may be fit*

⁹ Mowlam, A. and Lewis, J. (2005) Exploring how general practitioners work with patients on sick leave: a study commissioned as part of the Job Retention and Rehabilitation Pilot evaluation. DWP research report 257 (<http://research.dwp.gov.uk/asd/asd5/reports2005-2006/rrep257.pdf>).

for work taking account of the following advice’; and

- confirming whether or not they need to assess again their patient’s fitness for work.

15. Also presently doctors have to choose from two types of medical statements (form Med 3 and form Med 5); one based on an examination carried out on the date issued or the day before, the other based on an examination carried out more than 48 hours from the date of issue or based on a written report from another doctor. This is now streamlined and incorporated into one new statement.

Med 4

16. Doctors were also required (if requested by DWP) to issue to their patient a further type of medical statement in connection with their patient’s first medical assessment undertaken by DWP for those claiming Incapacity Benefit. With the introduction of ESA in October 2008 the requirement for this medical statement for Incapacity Benefit was removed to align this to the medical assessment process for ESA for which it is not required.

Computer-generated form

17. It is planned for the new style medical statement to be available in an electronic format. This will allow patients details, diagnosis and dates to be input on the form before printing the document for signature. The design will replicate the paper version and should be available as part of the software used in GP surgeries. Details from the statements would be retained on a GP’s patient records system. This would negate the need for transferring data from paper to electronic format or ordering and maintaining stationery stocks securely.

GROUPS AFFECTED BY CHANGE

18. These amendments affect GPs and other doctors who issue medical certificates, individuals and employers (voluntarily).

COSTS AND BENEFITS

19. Detailed calculations of the costs and benefits are set out in Annex D. Two options are considered:
 - ‘Do nothing’ – this has no additional costs or benefits and is the baseline for comparison.
 - New medical statement - costs and benefits for this option are additional costs and benefits over and above the do nothing option.
20. In 2008, DWP carried out a study comparing the current form Med 3 statement to a prototype Med 3 statement¹⁰. The results (the relevant sections of which are included at Annex A) showed that GPs completing the prototype were less likely to advise patients to refrain from work. However, it was also found that a smaller proportion of patients were deemed to be ‘fit for work’ under the prototype. Taking the drop in the percentage of people ‘fit for work’ from the decrease in the percentage ‘not fit for work’, there was still a net increase of between 15 to 44 percentage points in individuals considered to be ‘fit for some work’ as opposed to ‘not fit for work’ in the hypothetical cases.
21. Based on these findings, it is expected that with a new medical statement some individuals will return to work more quickly after a period of sickness absence resulting in

¹⁰ Source: Sallis A., Birkin R. and Munir F. (in print) *Working towards a ‘fit-note’. An experimental vignettes survey of GPs.*

improvements in general health and well-being. This is one of the key expected benefits of the policy change.

22. For the purposes of estimating this benefit in the impact assessment various scenarios were developed. The policy change is expected to have an impact on all patients with possibly the greatest benefit for individuals with numerous/repeat and/or long sickness absence episodes¹¹. Analysis of medical statements by Shiels, Gabbay and Ford found that¹²:

- 42.9% of all medical statements were issued for a sickness period lasting longer than 4 weeks and/or to patients with 5 or more statements in the year (long duration and/or high frequency);
- 19.4% of statements were issued to patients with just one statement in the year and duration of 4 weeks or less (low frequency and low/medium duration);
- 37.8% of statements were issued to patients with 2-4 statements in the year and duration of 4 weeks or less (medium frequency and low/medium duration).

Table 1: Analysis of medical statements

Proportion of medical statements issued to:					
Period certified on statement	Patients issued with one statement	Patients issued with 2-4 statements	Patients issued with 5-9 statements	Patients issued with 10 or more statements	Total
1 week or less	10.79%	14.60%	4.52%	0.55%	30.46%
2-4 weeks	8.56%	23.17%	15.58%	1.47%	48.77%
5-28 weeks	4.79%	11.40%	4.47%	0.10%	20.76%
Total	24.14%	49.17%	24.57%	2.12%	

Source: Analysis produced by Shiels using data collected from nine GP practices. See Shiels, C., Gabbay, M.B. and Ford, F.M. (2004) Patient factors associated with duration of certified sickness absence and transition to long-term incapacity. *British Journal of General Practice*, February 2004, 54, 86-91.

23. Conservatively, the impact assessment assumes that the medical statements most likely to be affected by the change are all those in the first category – those issued for a long duration of absence and/or those issued to individuals with numerous statements in a year. It is further assumed that half of the medical statements in the last category are impacted (medium frequency and low/medium duration). In total, this represents 62% of all medical statements in a given year. This assumption is tested in the sensitivity analysis in Annex C. Note that this assumption is more conservative than the one used in the consultation impact assessment. This is to take into account of comments received on the impact of the medical statement being over-estimated.

Scenarios

24. Building on the analysis above, it is further assumed that an additional 3%, 5% and 10% of the 'impacted' cases return to work early for one extra week and that individuals produce just 50% of their normal output that week. This is just 347,000 (2%), 579,000 (3%) and 1.2m (6%) cases out of a total of 18.7m cases returning to work early each year. This is a lower proportion than is implied by the DWP research referred to above. Output is conservatively valued at National Minimum Wage and is assumed to be below normal to account for a possible reduction in productivity and/or reduced hours.

¹¹ Note that this is an assumption only used to produce conservative estimates of the potential benefits. An alternative view could be that the greatest impact will be for those individuals who believed their GP/employer had identified an appropriate work solution and return to work plan and this could occur across the categories.

¹² Shiels, C., Gabbay, M.B. and Ford, F.M. (2004) Patient factors associated with duration of certified sickness absence and transition to long-term incapacity. *British Journal of General Practice*, February 2004, 54, 86-91.

Table 2: Scenarios

Impacted cases	62% of all cases	62% of all cases	62% of all cases
Scenarios	3% early return to work	5% early return to work	10% early return to work
Numbers of early return to work cases	347,000 (3% x 62% x 18.7m)	579,000 (5% x 62% x 18.7m)	1.2m (10% x 62% x 18.7m)
% of total cases	2% (347,000 / 18.7m)	3% (579,000 / 18.7m)	6% (1.2m / 18.7m)

Note total number of cases = 18.7m

25. The results of the scenarios show that even with the conservative estimate of an additional 3% of 'impacted' cases returning to work, the increase in output to the economy is an estimated £270.5m over the ten year period 2009/10 – 2018/19 (present value). This rises to £901.8m if 10% of 'impacted' cases return to work early.
26. In addition to the increase in output, early return to work has a number of long-term benefits. Emerging evidence suggests that work is generally good for health and that for many people an early return to work helps to prevent short-term sickness absence from progressing to long-term sickness absence and ultimately worklessness¹³. Worklessness is strongly associated with poor health, including higher mortality, poorer mental health and higher usage of medical services. So an early return to work as a result of the new medical statement can improve health and well-being for individuals, as well as generate further increases in output, fiscal benefits such as a reduction in health-related benefit payments and increases in tax, and reduce usage of medical services. **The long term benefits of early return to work have not been monetised in this impact assessment as the exact impact of early return to work on long-term sickness absence and the flow onto health-related benefits are difficult to measure and quantify.**
27. The benefits of early return to work and the long-term benefits of good health accrue to different groups in society. These are discussed below for the main affected parties, together with other benefits and costs of the policy option.

Impact on main affected groups

Impact on individuals

Benefits

28. An early return to work for individuals will result in an increase in earnings (difference between earnings and SSP/Occupational Sick Pay (OSP) after tax). Based on the above scenarios, this is estimated at £60.8m to £202.6m over the ten year period from 2009/10 – 2018/19 (present value). Note that in the consultation impact assessment, it was assumed that all individuals received SSP when they are off sick. OSP was not taken into account. This has now been modified and the benefit to individuals has decreased¹⁴.
29. As well as the increase in earnings in the short-term, as discussed above, emerging evidence suggests that work is generally good for health and that for many people an early return to work helps to prevent short-term sickness absence from progressing to long-term sickness absence and ultimately worklessness. So, on average, individuals will also benefit from improvements in health and well-being, gain additional years in the labour market and experience further improvements in income and socio-economic status. These are not monetised in the impact assessment.

¹³ Waddell, G. and Burton, A. K. (2006) Is work good for health and well-being? *The Stationery Office*.

¹⁴ CIPD (2007) Annual Absence Management Survey Report 2007. See Annex D for calculations.

Impact on employers

Benefits

30. For employers, an early return to work results in an increase in output. Based on the above scenarios, this is estimated at £270.5m to £901.8m over the ten year period from 2009/10 – 2018/19 (present value).
31. A further benefit of the policy is savings from SSP/OSP not paid to employees previously off sick. This is estimated at £511.0m to £1,703.3m over the ten year period from 2009/10 – 2018/19 (present value).
32. An early return to work as a result of job role/workplace modifications may bring a reduction in other costs of sickness absence such as turnover costs, loss of skills base, re-training costs and poor staff morale. Higher staff morale could extend to the whole workforce. These benefits are difficult to estimate and will vary from firm to firm so they have not been monetised in the impact assessment.

Costs

[Please note that all costs to employers are voluntary. It is not mandatory for employers to take any action. It is expected that rational employers will take action where the benefits of doing so outweigh the costs].

33. Employers who choose to take action may incur some additional costs for job role/workplace modifications to facilitate an early return to work. It is expected that in the majority of cases, these will have no or minimal costs, for example, changes in work patterns or flexible working. Data on the cost of job role/workplace modifications for employees with health conditions that may keep them out of work is unavailable. However, research on reasonable adjustments made for disabled employees may help to provide some very rough indication¹⁵. This suggests that where adjustments were made, a substantial proportion had no costs (55%)¹⁶. One study found the average cost of reasonable adjustments for disabled employees to be £180¹⁷. This is high as it is likely to be distorted upwards by some costly adjustments such as workplace adaptations. The average costs of job role/workplace modifications for employees with a health condition are expected to be significantly lower due to the different nature/severity of health conditions and modifications required. For the purposes of the impact assessment, this is assumed to be simply a third of the cost of reasonable adjustments for disabled employees on average (i.e. £60). This is likely to be an over-estimate and equates to £153.1m to £510.4m over the ten year period from 2009/10 – 2018/19 (present value).
34. There will be an increase in salary paid to employees who return to work early (for employers who choose to take action). Note that it is assumed this is paid at 100% despite employees being only 50% productive. This may be an over-estimate as some employers may reduce salary paid to the employee, for example, if the employee returns on part-time hours. This is estimated at £610.3m to £2,034.5m over the ten year period from 2009/10 – 2018/19 (present value).

¹⁵ Note that reasonable adjustments for disabled employees are a legal requirement under the Disability and Discrimination Act. Job role/workplace modifications to facilitate early return to work for employees with general health conditions are at the discretion of employers. The former is expected to be significantly more costly due to the likely nature/severity of the health conditions and the required adjustments/modifications.

¹⁶ Goldstone and Meager (2002) *Barriers to employment for disabled people*. Department for Work and Pensions In-house Report 95, London: DWP.

¹⁷ Meager et al (2001) *Impact on small businesses of lowering the DDA Part II threshold*. Disability Rights Commission.

35. Where employers and their employees are unable to reach agreement about changes to an individual's working environment or role, this could lead to a dispute over payment of SSP and an increase in costs for employers (and for individuals and government). The SSP scheme has a formal disputes process managed by Her Majesty's Revenue and Customs (HMRC) to resolve disagreements over decisions relating to SSP. In some cases these disputes relate to issues around fitness for work. Any increase in disputes as a result of the policy is expected to be minimal and temporary as comprehensive guidance will be provided for employers. Over time, employers and employees will become familiar with the new statement and disputes will return to their current levels or lower as fewer medical statements will be issued. This cost is likely to be small and has not been monetised in this impact assessment.

Net benefits

36. The estimated net benefit of the policy change for employers is £18.1m – £60.2m over the ten year period 2009/10 – 2018/19 (present value). These figures are likely to underestimate the net benefit of an early return to work as some benefits discussed above are not monetized while costs maybe over-estimated as it is assumed that all employers pay full salary costs despite output increasing by only 50%.

Impact on public sector

Government/Taxpayer

Benefits

37. For government/taxpayer, there is additional revenue (income taxes and national insurance contributions) from more individuals being in work as opposed to being off sick. Based on the above scenarios, the fiscal benefit is estimated at £38.6m to £128.6m over the ten year period (present value).
38. A further benefit of the policy is savings in printing costs for central government for the computer-generated form. Printing, however, will not cease completely as some GPs may request paper medical statements from time to time, for example, during any home visiting and hospital doctors will continue to use the paper-based form. For the purposes of the impact assessment, it is assumed that 10% of statements will continue to be printed by central government, giving an estimated saving of £2.1m to £2.2m over ten years (present value).
39. In the long-term, with more individuals in work, improvements in the general health of the working age population are expected so there will be NHS resource savings from reduced use of healthcare. This covers the full range from GP consultation (see below) through to specialist care. Currently, the additional cost of treating health conditions that keep people out of work are estimated to be £5-11 billion per year¹⁸. Savings in health-related benefits and additional income taxes are also expected as more people are in work. Working age ill-health benefits are currently estimated at £29 billion a year. Government also loses income taxes of £28-36 billion a year as a result of lost productivity¹⁹. These long-term benefits have not been included in the impact assessment.

Costs

40. There are some set-up and ongoing costs for central government in communicating the changes to GPs, production of guidance for GPs, individuals and employers, and software

¹⁸ Dame Carol Black's review of the Health of Britain's working age population - Working for a healthier tomorrow (2008).

¹⁹ See footnote 16.

development for the computer-generated medical statement. These are estimated at £0.8m as a one-off cost in 2009/10 and £1.7m for the remaining nine years (present value).

41. There will be an increase in printing costs in the year prior to implementation as GPs are supplied with the new medical statement. This is estimated at £0.09m in 2009/10.

GPs

Benefits

42. Early return to work for some individuals is expected to result in improvements in general health and well-being so fewer GP consultations are expected. Based on the scenarios used above, it is estimated that for each case of early return to work, one GP consultation is saved. This generates savings of between £29.9m to £99.5m over the ten year period (present value). This assumption is tested in the sensitivity analysis. In terms of timing per consultation, in the DWP study, some GPs indicated they expect a longer discussion with patients considered 'fit for some work'²⁰. However, there is some uncertainty around this estimate and previous qualitative research with GPs indicates that some GPs already have discussions with individuals on fitness for work²¹. Further, the new computer-generated statement is expected to result in a time saving for GPs. It is believed that this could be quicker for GPs to complete, especially over time as GPs become more familiar with the system. Currently some GPs complete medical statements by hand and may choose to transfer some of the details onto their own electronic records. With the computer-generated statement, GPs will be able to record details electronically onto the medical statement straight away and retain a permanent record on their system. For the purposes of the impact assessment, it is assumed that there is no change in the average consultation time per medication certification case.
43. GPs will benefit from administrative savings from no longer having to regularly order medical statements (from 2010/11). No reliable estimates are available for this but the saving is likely to be small with little impact on the overall conclusions. For the purposes of the impact assessment, it is assumed that there will be a saving of one hour of practice staff time per practice per year, a total of £1.1m over the ten years (present value).
44. Abolishing form Med 5 as a stand-alone form and incorporating its functionality into the new version of form Med 3 will make the medical certification process simpler for GPs and potentially increase their efficiency. This benefit is likely to be small and has not been monetised in this impact assessment.
45. A computer-generated medical statement will provide GPs with a permanent record which they can refer back during future consultations with the patient. It will help to identify individuals with repeat sickness statements and patterns of illness enabling discussions on what job role/workplace modifications can facilitate an early and continuous period of return to work. Improved recording and analysis of statements will also allow GPs to compare standards of clinical practice and improve treatment of their patients resulting in better clinical outcomes. In addition, it will facilitate easier identification of regional or

²⁰ The DWP study found that the prototype new Med 3 statement may on average take an extra 1-2 minutes more to complete in a live consultation than the current Med 3 statement. However, there is some uncertainty around this estimate as it is based on speculative estimates only rather than a trial in a live consultation (this was not possible for legal and ethical reasons). It is also not possible to determine whether GPs answered the question with specific regard to potentially more complex cases that may require a 'fit for some work' bracket or whether they took an average of the expected cases they would see across the range of fit, fit for some work and not fit for work. Further, it is difficult to determine a precise estimate as there is a potential bias in the sample towards GPs being more willing to engage in discussions about work. Given the uncertainty in the estimate, it is not used in this Impact Assessment.

²¹ Hiscock, J. and Ritchie, J. (2001) The role of GPs in sickness certification. DWP research report 148 (<http://research.dwp.gov.uk/asd/asd5/rrep148.pdf>); Mowlam, A. and Lewis, J. (2005) Exploring how general practitioners work with patients on sick leave: a study commissioned as part of the Job Retention and Rehabilitation Pilot evaluation. DWP research report 257 (<http://research.dwp.gov.uk/asd/asd5/rports2005-2006/rrep257.pdf>).

health issues, public health surveillance and service planning. These benefits have not been monetised in the impact assessment.

Costs

46. There is a one-off training cost for each GP to read the new guidance on the form Med 3 statement and to familiarise themselves with the computer-generated version. It is estimated that on average each GP will spend one hour to train costing a total of £2.4m in 09/10. Comments received from the consultation suggest that this may not be sufficient. This assumption is increased to an average of two hours in the sensitivity analysis (see Annex C). The results indicate that there is still a net benefit to GPs.
47. There will be an increase in printing costs for GPs. This is estimated at £5.4m to £5.7m over ten years (present value)²².

Net benefits

48. The estimated net benefit of the policy change for GPs is between £23.0m to £92.9m over the ten year period 2009/10 – 2018/19 (present value).
49. For the public sector as a whole, the estimated net benefit is between £61.2m – £221.2m over the ten year period 2009/10 – 2018/19 (present value).

SUMMARY

50. **The analysis indicates that the new medical statement is likely to generate a net benefit.** Even based on the scenario of only an additional 3% of 'impacted' medical statement cases returning to work and producing 50% of previous output for one extra week, there is a net benefit to the economy of £140.0m over the ten year period 2009/10 to 2018/19 (present value). The net benefit rises to £483.9m (present value) if 10% of cases return for an extra week. In reality, the net benefits are likely to be substantially greater due to the long-term benefits of early return to work which have not been monetised in this impact assessment (see Annex B and C for a full summary of the monetised costs and benefits and the sensitivity analysis).

IMPLEMENTATION

51. The changes outlined in this impact assessment will be implemented from 6 April 2010. The computer-generated element will be implemented during 2010/11 subject to satisfactory contractual negotiations with IT suppliers.

MONITORING AND EVALUATION

52. The outcomes will be subject to an evaluation. The evaluation will use a mixed methods approach and will involve qualitative research in the form of interviews, focus groups and case studies with GPs, individuals and employers. Quantitative research in the form of surveys and an impact evaluation (where possible) will also be carried out. The research will be published in 2012/13.
53. In addition to the research, internal monitoring of sickness absence data using the Labour Force Survey will be undertaken to assess changes in general sickness absence levels

²² Note that the unit cost for printing a medical statement has decreased from 10 pence to 5 pence due to further information being available.

from 12 months after implementation. The findings will be used to inform any future changes to the medical statement as part of an ongoing commitment to help as many people make an early return to work and perform effectively when in work through helping employers with the necessary advice. Each evaluation strand will consider the impact on different regions and countries, and on different health conditions where possible, as well as impact by gender, age, disability and race.

SPECIFIC IMPACT ASSESSMENTS

Competition assessment

54. The changes do not affect competitiveness between companies.

Small firms impact test

55. All costs to employers are voluntary. It is not mandatory for employers to take any action. It is expected that rational employers will take action where the benefits of doing do outweigh the costs.
56. Sickness absence rates are generally lower in small businesses though each incident maybe more costly. An absent employee in a small business could be more disruptive and cause greater productivity loss if there are fewer replacements available amongst existing staff due to lack of appropriate skills and/or time to take on the additional work. Generally job role/workplace modifications to facilitate an earlier return to work are expected to have minimal or no additional costs to employers. Where there are significant extra costs to the employer, this could be a particular concern for small businesses that may be less able to afford the increase. However, as noted above, it is not mandatory for employers to take any action. It is for each individual employer to consider whether such investments are worthwhile. Note that access to public funding via schemes like 'Access to Work' may be available, where appropriate, and employers are required to continue to comply by the requirements set out in the Disability Discrimination Act.
57. The Federation of Small Businesses which represents small businesses has been involved in all steps in the development of the new medical statement. It has been supportive for a number of years on a new medical statement focusing on what a person can do.

Legal aid impact test

58. As there are no criminal or new civil penalties related to these changes there is no impact on Legal Aid.

Sustainable development/carbon assessment/other environment

59. It is estimated that there will be a small increase in printing medical statements in 2009/2010 followed by a decrease in subsequent years as fewer medical statements are expected to be issued.

Health impact assessment test

60. An initial screening of the possible impact of the policy change on medical statements showed that there is likely to be a significant positive impact on human health by virtue of its effect on employment which is a determinant of health. It also showed that a significant positive impact is likely on primary care. A health impact assessment was therefore undertaken to assess the impact and consider how the policy could be used to have a positive impact.

Are the potential positive and/or negative health and well-being impacts likely to affect specific sub-groups disproportionately compared with the whole proportion?

61. The policy is thought likely to impact positively on all people with health conditions who require medical statements with the greatest benefit for individuals with numerous/repeat and/or long sickness absence episodes.
62. A study of medical statements by Shiels, Gabbay and Ford²³ found that 28.0% of individuals' first medical statements were issued for a mild mental health disorder (including anxiety, stress, depression, 'mixed anxiety and depression', bereavement reaction and addiction), making this the biggest cause of incapacity for work. Mild mental health disorder also accounted for the highest proportion of sickness absence days lost (39.7%) and it was more likely to result in long-term incapacity. This is supported by evidence from other surveys on sickness absence.
63. The annual absence management survey conducted by the Chartered Institute of Personnel and Development (CIPD) found stress and mental ill-health (such as clinical depression and anxiety) to be a significant leading cause of both short and long-term absence as shown in the table below. Stress is the biggest cause of long-term absence, among non-manual workers followed by acute medical conditions then mental health conditions. Similar results were found by the Confederation of British Industry (CBI)²⁴.

Table 3: Percentage of respondents citing stress and mental ill-health as a leading cause of absence

Cause of absence	Short-term		Long-term	
	Manual workers	Non-manual workers	Manual workers	Non-manual workers
Stress	42.9	53.9	50.9	65.8
Mental ill-health	23.0	26.0	42.6	51.4

Source: CIPD (2008) Absence management: annual survey report 2008.

NB: Long-term absence is defined at four weeks or longer.

64. Data on incidence and duration of sickness absence suggest that employees with mental health conditions could benefit most from these changes. However, the DWP study on the prototype medical statement indicates that the difference in terms of fitness for work between the current and prototype statements was smallest for the depression vignette case. For the depression case, 91% and 74% of GPs completing the current and prototype statements respectively, found the individual to be 'not fit for work' (a difference of 15 percentage points (accounting for the fewer assessed as 'fit for work' using the prototype Med 3)). The largest change in terms of fitness for work was seen for the back pain vignette case. This may be due to differences in return to work for mental and physical health conditions. This suggests that it is difficult to determine at this stage if the policy change will impact more on employees with mental health conditions though a positive outcome is expected overall.
65. Evidence from Waddell and Burton's review (referred to above) show that '*work is not harmful to the psychiatric condition or mental health of people with severe mental illness although, conversely, it has no direct beneficial impact on their mental condition either. However, the balance of the indirect evidence is that it is beneficial for their overall well-being*' (pg 21). There is limited evidence about the impact of or return to work on people with mild/moderate mental health problems, though there is much more evidence on stress. The main conclusion is that '*on balance, any adverse effects of work on mental health*

²³ Shiels, C., Gabbay, M.B. and Ford, F.M. (2004) *Patient factors associated with duration of certified sickness absence and transition to long-term incapacity*. British Journal of General Practice, February 2004, 54, 86-91.

²⁴ CBI (2008) At work and working well? CBI/AXA absence and labour turnover survey 2008.

appear to be outweighed by the beneficial effects of work on well-being and by the likely adverse effects of (long-term) sickness absence or unemployment' (pg 24).

Are the potential positive and/or negative health and well-being effects likely to cause changes in contacts with health and/or care services, quality of life, disability or death rates?

66. The policy change is expected to result in early return to work. Emerging evidence suggests that work is generally good for health and that for many people an early return to work helps to improve health conditions and prevent short-term sickness absence from progressing to long-term sickness absence and ultimately worklessness²⁵. This indicates that some individuals will have less contact with health services in the future and will enjoy a better quality of life.

Are there likely to be public or community concerns about potential health impacts of this policy change?

67. The only concern raised during stakeholder engagements and the public consultation was about individuals returning to work when they clearly are not fit. This is a result of removing the 'fit for work' option. It is the responsibility of the employer to carry out a risk assessment in all cases to determine whether their employees may be able to work. Please refer to the Government's response to the public consultation at <http://www.dwp.gov.uk/consultations/2009/>.

Equality Impact Assessment

68. DWP has carried out an equality impact assessment (EIA) on the new medical statement to meet the requirements of the:

- Race Equality Duty
- Disability Equality Duty
- Gender Equality Duty

Impact by age is also considered.

69. This process helps to make sure:

- DWP's strategies and policies are free from discrimination;
- due regard is given to equality (specifically disability, gender and race) in decision-making and subsequent processes; and
- opportunities for promoting equality are identified.

70. Overall, the policy change is expected to have a positive impact. Impact on different sub-groups is, however, very difficult to determine at this stage. This is due to a number of factors:

- Currently medical statements are paper-based, so robust information is not readily available making detailed analysis for sub-groups more difficult. The most comprehensive existing data are captured in studies by Wynne-Jones et al and Shiels, Gabbay and Ford²⁶. These are used in the analysis below where possible. General sickness absence figures from the Labour Force Survey (LFS) are also used because of this lack of information.

²⁵ Waddell, G. and Burton, A. K. (2006) Is work good for health and well-being? *The Stationery Office*.

²⁶ Wynne-Jones G., Mallen C. D., Mottram S., Main C.J., and Dunn K.M. (2009) Identification of UK sickness certification rates, standardised for age and sex. *British Journal of General Practice*, July 2009. Shiels, C., Gabbay, M.B. and Ford, F.M. (2004) Patient factors associated with duration of certified sickness absence and transition to long-term incapacity. *British Journal of General Practice*, February 2004, 54, 86-91.

- Information on current medical statements issued and sickness absence data will provide some indication of those who may be disproportionately affected by the policy change. However, the actual impact of the policy change on these groups will be dependent on a number of factors including what advice GPs give and how employers respond, which may differ by sector, size and occupation of the individual employee. Information on the latter is not available.

The EIA focuses on understanding the groups that may be disproportionately affected by the policy change rather than the final impact of the change (e.g. impact on early return to work, reduction in sickness absence and flows onto health-related benefits, and improvements in health) as this is unknown.

Gender

71. Certification and absence data by gender shows mixed findings. Although more women are off sick at any one time, figures on the duration of absence are less clear.
72. Wynne-Jones et al collected electronic records from 14 practices included in the Keele GP Research Network during 2005 for working-age adults aged 20-64. They found the overall rate of sickness certification was 101.67 statements per 1,000 persons. The rate of certification was statistically higher for women than men - 109.76 certificates per 1,000 persons compared to 93.68 certificates for 1,000. This is supported by analysis of general sickness absence from the Labour Force Survey²⁷.
73. Data on duration is not available from the Wynne-Jones et al study but the study by Shiels, Gabbay and Ford which collected information from the nine Merseyside Primary Care Research and Development Consortium practices found the mean duration of sickness episodes was lower for females (a mean of 9.0 weeks compared with 10.9 weeks for males). A significantly higher proportion of males were also certified sick for more than 24 weeks (11.6% for males and 8.4% for females).
74. Based on the above data that a greater proportion of women take time off work but are absent for shorter periods due to illness, it is not possible to draw any firm conclusions on whether changes to the medical statement may affect this group disproportionately. The exact impact of the policy change also remains to be seen.

Disability

75. Disability is a physical or mental condition that has lasted, or is likely to last, at least 12 months and a condition or disability that has a substantial (more than a minor or trivial) effect on the ability to carry out normal day-to-day activities (including work-related activity) as defined by the Disability Discrimination Act (DDA).
76. Data on medical statements by disability is not available. However, analysis of sickness absence data from the Labour Force Survey indicates that there are differences in the sickness absence behaviour of disabled and non-disabled employees. In the year to September 2009, 4.2% of disabled employees had at least one day of absence from work in the reference week because of sickness or injury compared with 2.0% for non-disabled employees²⁸. Of those who were sick, the proportion of usual working time lost in the reference week was 82.3% for disabled employees compared with 66.7% for non-disabled employees.

²⁷ According to the Labour Force Survey (LFS), in the period October 2008 to September 2009, the sickness absence rate for women was 2.7% compared with 1.9% for men. This means 2.7% of women had at least one day of absence from work in the reference week because of sickness or injury, a greater proportion than that for men. Of those who took time off from work, percentage of working time lost was higher for men (71.1%) than women (70.9%).

²⁸ DDA disabled definition.

77. Given that a greater proportion of disabled employees take time off work and are absent for longer due to illness, changes to the medical statement may affect this group disproportionately. The exact impact remains to be seen, though a positive outcome is expected overall.

78. An extensive review of scientific evidence undertaken by Waddell and Burton (as referred to above)²⁹ found that work is generally good for the health and well-being of disabled people:

'There is a broad consensus that, when possible, sick and disabled people should remain in work or return to work as soon as possible because it:

- *is therapeutic;*
- *helps to promote recovery and rehabilitation;*
- *leads to better health outcomes;*
- *minimises the deleterious physical, mental and social effects of long-term sickness absence and worklessness;*
- *reduces the changes of chronic disability, long-term incapacity for work and social exclusion;*
- *promotes full participation in society, independence and human rights;*
- *reduces poverty;*
- *improves quality of life and well-being' (pg 20).*

79. It is possible that significant job role/workplace modifications or 'reasonable adjustments' are already made for disabled employees to comply with the Disability Discrimination Act so the new medical statement will have a smaller additional impact on earlier return to work for this group relative to non-disabled employees.

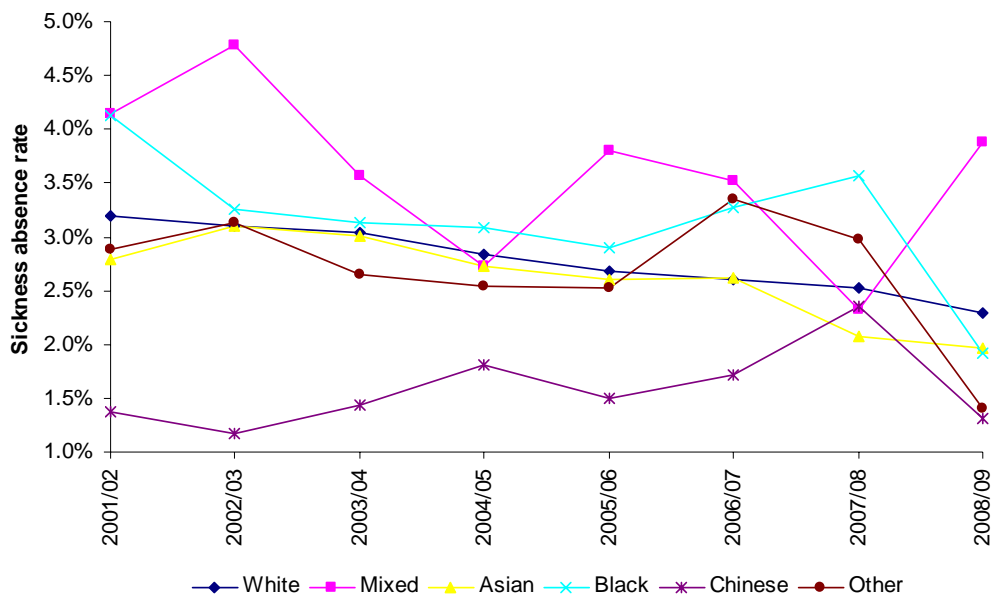
Race

80. Data on medical statements by ethnicity is not available. Analysis of general sickness absence data using the LFS show the Chinese/Chinese British and Asian/Asian British ethnic groups generally have low sickness absence rates and time lost from work. In the year to September 2009, absence rates were 1.3% for the Chinese/Chinese British and 2.0% for Asian/Asian British compared with 2.3% for whites. Over the same period, percentage of working time lost due to sickness/injury was 64% and 69.5% for the Chinese/Chinese British and Asian/Asian British respectively compared with 71% for whites.

81. The Black/Black British ethnic group generally has high average sickness absence rates and time lost from work. Data for 2008/09 show an absence rate of just 1.9% which is significantly lower than previous years. This may be due to small sample sizes. In the year to September 2008, the absence rate for the Black/Black British was 3.6% and percentage of working time lost was 74.4%. For the mixed group, absence rates are generally high but percentage of working time lost is relatively low compared with other groups. In the year to September 2009, the absence rate and percentage of working time lost were 3.9% and 59% respectively.

²⁹ Waddell, G. and Kim Burton, A. (2006) *Is work good for your health and well-being?* London: TSO.

Figure 1: Sickness absence rates of working-age employees by ethnicity*

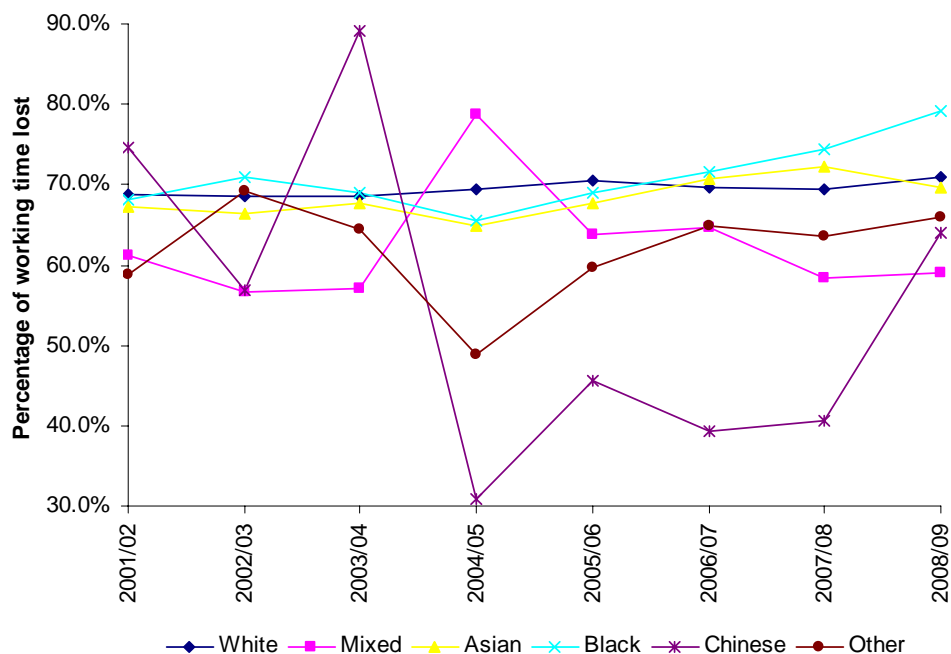


Source: LFS, various quarters (Oct-Sep of each year; 2005-2006 based on Jan-Sep 2006 only)

* Proportion of employees that took at least one day off work in the reference week.

82. Analysis of sickness absence data suggests given that a greater proportion of Black/Black British employees take time off work and are absent for longer due to illness, changes to the medical statement may affect this group disproportionately. The policy change is, on average, expected to have a positive impact so Black/Black British employees may see a disproportionate positive effect. The exact impact, however, remains to be seen.

Figure 2: Percentage of working time lost due to sickness absence, working-age employees by ethnicity (%)



Source: LFS, various quarters (Oct-Sep of each year; 2005-2006 based on Jan-Sep 2006 only)

* Percentage of working time lost (hours) for those who have had any time off due to sickness/injury

Age

83. Certification and absence data by age show mixed findings. While evidence suggests that the length of absence is directly related to age (older people have longer sickness

absence), the rate of certification is highest for those of middle age and lower for younger and older employees.

84. The medical certification analysis by Wynne-Jones et al. found that the rate of sickness certification was higher for people of middle age than for younger and older people as shown in the table below. The certification rate was 126.38 and 123.21 statements per 1,000 persons for the age groups 45-49 and 50-54 respectively, compared to 83.94 statements per 1,000 persons for the age groups 20-24 and just 60.81 certificates per 1,000 persons for people aged 60-64.

Table 4: Certification rate by age band

Age band	Certification rate (per 1,000 persons)
20-24	83.94
25-29	87.14
30-34	101.93
35-39	99.72
40-44	104.72
45-49	126.38
50-54	123.21
55-59	114.26
60-64	60.81
All ages	101.67

Source: Wynne-Jones et al

85. Turning to duration, analysis of medical statement by Shiels, Gabbay and Ford found a linear relationship between age and length of sickness episode. For the four age groups, <30, 30-44, 45-59, >=60 years old, mean sickness duration were 7.9, 9.0, 11.5 and 17.0 weeks respectively. Those with long-term sickness absence (>28 weeks) were also older with a mean age of 44.0 compared with 39.6 years for those with absence duration of 28 weeks or less.

Table 5: Average length of medical statements (weeks)

Age Group	Length of sickness
<30	7.9
30-44	9.0
45-59	11.5
>=60	17.0

Source: Shiels, Gabbay and Ford

86. The above data indicates that a smaller proportion of older employees take time off work but their duration of absence tends to be longer on average. So, it is not possible to draw any firm conclusions on whether changes to the medical statement may affect this group disproportionately. The exact impact of the policy change also remains to be seen.

Monitoring and evaluation

87. Please refer to the section above on monitoring and evaluation. Each evaluation strand will consider the impact of the new medical statement by gender, age, race and disability as far as possible.

Human Rights

88. These changes will not contravene individuals' human rights.

Rural Proofing

89. Particular rural communities will not be adversely affected by these changes which are beneficial regardless of locality.

Specific Impact Tests: Checklist

Use the table below to demonstrate how broadly you have considered the potential impacts of your policy options.

Ensure that the results of any tests that impact on the cost-benefit analysis are contained within the main evidence base; other results may be annexed.

Type of testing undertaken	<i>Results in Evidence Base?</i>	<i>Results annexed?</i>
Competition Assessment	Yes	No
Small Firms Impact Test	Yes	No
Legal Aid	Yes	No
Sustainable Development	Yes	No
Carbon Assessment	Yes	No
Other Environment	Yes	No
Health Impact Assessment	Yes	No
Race Equality	Yes	No
Disability Equality	Yes	No
Gender Equality	Yes	No
Human Rights	Yes	No
Rural Proofing	Yes	No

Annexes

Annex A

RESULTS OF DWP STUDY ON PROTOTYPE MED 3 STATEMENT

In 2008, the Department for Work and Pensions carried out a study comparing the current form Med 3 statement to a prototype new form Med 3 statement. The study involved 583 GPs from 9 primary care organisations. GPs were randomly assigned to receive either the prototype statement (intervention group) or the current statement (control group). They were then invited to complete and return the statement for three vignettes or hypothetical sick leave scenarios. Each vignette presented a patient with a different health condition: (i) back pain; (ii) depression and (iii) back pain and depression. The characteristics of the vignette patients were chosen to reflect those known to be associated with an increased risk of long-term incapacity.

The results of the study showed that GPs completing the prototype statement were less likely to advise the vignette patient to refrain from work as shown in table A1 below. For the back pain vignette, 77% of GPs completing the current statement declared the individual to be 'not fit for work' compared with 20% completing the prototype statement, a difference of 57 percentage points. However it should also be noted that fewer cases were assessed as 'fit for work' using the prototype statement (24% compared to 11%, a difference of 13 percentage points). Taking account of this, there is a difference of 44 percentage points.

For the depression case, 91% and 74% of GPs completing the current and prototype statements respectively, found the individual to be 'not fit for work' (a difference of 15 percentage points (accounting for the fewer assessed as 'fit for work' using the prototype Med 3)). Finally for the combined vignette, 88% of GPs completing the current statement declared the individual to be 'not fit for work' compared with 58% (a difference of 22 percentage points (accounting for the fewer assessed as 'fit for work' using the prototype statement)).

Table A1: Fitness for work: results of DWP study

	Current Med 3 (%)	Prototype new Med 3 (%)
Back pain		
Fit for work	24	11
Fit for some work	-	70
Not fit for work	77	20
Total	100	100
Depression		
Fit for work	9	7
Fit for some work	-	19
Not fit for work	91	74
Total	100	100
Combined back pain and depression		
Fit for work	12	4
Fit for some work	-	38
Not fit for work	88	58
Total	100	100

Source: Sallis A., Birkin R. and Munir F. (in print) Working towards a 'fit-note'. An experimental vignettes survey of GPs.

Note: Figures may not sum to 100 per cent due to rounding.

Annex B

SUMMARY OF MONETISED COSTS AND BENEFITS

Table B1: Scenario 1 (An additional 3% of 'impacted' cases returning to work early (£m))

	2009/10	Average Annual benefit/cost 2010/11-2018/19	Total benefit/cost 2009/10-2018/19	Total benefit/cost 2009/10-2018/19 (PV)*
Economy				
Benefits				
Increase in output	-	36.8	331.3	270.5
Savings in printing costs (for central government)	-	0.3	2.6	2.1
Time saving (for GPs) due to fewer forms Med 3	-	4.1	36.6	29.9
Administrative savings (for GPs)	-	0.1	1.3	1.1
Total benefits	-	41.3	371.8	303.6
Costs				
Set-up costs (for central government)	0.8	0.2	2.7	2.4
Increase in printing costs (for central government)	0.09	-	0.09	0.09
One-off training cost (for GPs)	2.4	-	2.4	2.3
Increase in printing costs (for GPs)	-	0.8	7.0	5.7
Costs of job role/workplace modifications	-	20.8	187.5	153.1
Total costs	3.2	21.8	199.6	163.6
Net benefits	- 3.2	19.5	172.1	140.0
Individuals				
Total benefits	-	8.3	74.4	60.8
Increase in earnings		8.3	74.4	60.8
Total costs	-	-	-	-
Net benefits	-	8.3	74.4	60.8
Central Government				
Total benefits	-	5.5	49.9	40.7
Increase in revenues	-	5.2	47.2	38.6
Savings in printing costs (for central government)	-	0.3	2.6	2.1
Total costs	0.8	0.2	2.7	2.5
Set-up costs (for central government)	0.8	0.2	2.7	2.4
Increase in printing costs (for central government)	0.09	-	0.09	0.09
Net benefits	-0.8	5.3	47.1	38.2
Employers				
Total benefits	-	106.3	956.9	781.5
Increase in output	-	36.8	331.3	270.5
Saving in SSP/OSP	-	69.5	625.7	511.0
Total costs (note: these are voluntary)	-	103.9	934.8	763.5
Costs of job role/workplace modifications	-	20.8	187.5	153.1
Additional salary paid	-	83.1	747.3	610.3
Net benefits	-	2.5	22.1	18.1
GPs				
Total benefits	-	4.2	37.9	30.9
Administrative savings (for GPs)	-	0.1	1.3	1.1
Time saving (for GPs) due to fewer forms Med 3	-	4.1	36.6	29.9
Total costs	2.4	0.8	9.4	8.0
One-off training cost (for GPs)	2.4	-	2.4	2.3
Increase in printing costs (for GPs)	-	0.8	7.0	5.7
Net benefits	- 2.4	3.4	28.5	23.0

*PV = present value (discounted rate = 3.5%)

Table B2: Scenario 2 (An additional 5% of 'impacted' cases returning to work early (£m))

	2009/10	Average Annual benefit/cost 2010/11-2018/19	Total benefit/cost 2009/10-2018/19	Total benefit/cost 2009/10-2018/19 (PV)*
The Economy				
Benefits				
Increase in output	-	61.3	552.1	450.9
Savings in printing costs (for central government)	-	0.3	2.6	2.1
Time saving (for GPs) due to fewer form Med 3	-	6.8	60.9	49.8
Administrative savings (for GPs)		0.1	1.3	1.1
Total benefits	-	68.6	617.0	503.9
Costs				
Set-up costs (for central government)	0.8	0.2	2.7	2.4
Increase in printing costs (for central government)	0.09	-	0.09	0.09
One-off training cost (for GPs)	2.4	-	2.4	2.3
Increase in printing costs (for GPs)	-	0.8	6.9	5.6
Costs of job role/workplace modifications	-	34.7	312.5	255.2
Total costs	3.2	35.7	324.6	265.6
Net benefits	- 3.2	32.9	292.5	238.3
Individuals				
Total benefits	-	13.8	124.0	101.3
Increase in earnings	-	13.8	124.0	101.3
Total costs				
Net benefits	-	13.8	124.0	101.3
Government/taxpayers				
Total benefits	-	9.0	81.4	66.4
Increase in revenues	-	8.7	78.7	64.3
Savings in printing costs (for central government)	-	0.3	2.6	2.1
Total costs	0.8	0.2	2.7	2.5
Set-up costs (for central government)	0.8	0.2	2.7	2.4
Increase in printing costs (for central government)	0.09	-	0.09	0.09
Net benefits	- 0.8	8.8	78.6	64.0
Employers				
Total benefits	-	177.2	1,594.9	1,302.6
Increase in output	-	61.3	552.1	450.9
Saving in SSP/OSP	-	115.9	1,042.8	851.7
Total costs (note: these are voluntary)	-	173.1	1,558.0	1,272.5
Costs of job role/workplace modifications	-	34.7	312.5	255.2
Additional salary paid	-	138.4	1,245.5	1,017.2
Net benefits	-	4.1	36.9	30.1
GPs				
Total benefits	-	6.9	62.3	50.9
Administrative savings (for GPs)	-	0.1	1.3	1.1
Time saving (for GPs) due to fewer forms Med 3s	-	6.8	60.9	49.8
Total costs	2.4	0.8	9.3	7.9
One-off training cost (for GPs)	2.4	-	2.4	2.3
Increase in printing costs (for GPs)	-	0.8	6.9	5.6
Net benefits	- 2.4	6.1	52.9	42.9

* PV = present value (discounted rate = 3.5%)

Table B3: Scenario 3 (An additional 10% of 'impacted' cases returning to work early (£m))

	2009/10	Average Annual benefit/cost 2010/11-2018/19	Total benefit/cost 2009/10-2018/19	Total benefit/cost 2009/10-2018/19 (PV)*
The Economy				
Benefits				
Increase in output	-	122.7	1,104.2	901.8
Savings in printing costs (for central government)	-	0.3	2.7	2.2
Time saving (for GPs) due to fewer forms Med 3s	-	13.5	121.9	99.5
Administrative savings (for GPs)	-	0.1	1.3	1.1
Total benefits	-	136.7	1,230.1	1,004.6
Costs				
Set-up costs (for central government)	0.8	0.2	2.7	2.4
Increase in printing costs (for central government)	0.09	-	0.09	0.09
One-off training cost (for GPs)	2.4	-	2.4	2.3
Increase in printing costs (for GPs)	-	0.7	6.7	5.4
Costs of job role/workplace modifications	-	69.4	625.0	510.4
Total costs	3.2	70.4	636.8	520.6
Net benefits	- 3.2	66.3	593.2	483.9
Individuals				
Total benefits	-	27.6	248.0	202.6
Increase in earnings	-	27.6	248.0	202.6
Total costs	-	-	-	-
Net benefits	-	27.6	248.0	202.6
Government/taxpayers				
Total benefits	-	17.8	160.1	130.7
Increase in revenues	-	17.5	157.4	128.6
Savings in printing costs (for central government)	-	0.3	2.7	2.2
Total costs	0.8	0.2	2.7	2.5
Set-up costs (for central government)	0.8	0.2	2.7	2.4
Increase in printing costs (for central government)	0.09	-	0.09	0.09
Net benefits	- 0.8	17.6	157.4	128.3
Employers				
Total benefits	-	354.4	3,189.8	2,605.1
Increase in output	-	122.7	1,104.2	901.8
Saving in SSP/OSP	-	231.7	2,085.6	1,703.3
Total costs (note: these are voluntary)	-	346.2	3,116.1	2,544.9
Costs of job role/workplace modifications	-	69.4	625.0	510.4
Additional salary paid	-	276.8	2,491.1	2,034.5
Net benefits	-	8.2	73.7	60.2
GPs				
Total benefits	-	13.7	123.2	100.6
Administrative savings (for GPs)	-	0.1	1.3	1.1
Time saving (for GPs) due to fewer forms Med 3	-	13.5	121.9	99.5
Total costs	2.4	0.7	9.1	7.7
One-off training cost (for GPs)	2.4	-	2.4	2.3
Increase in printing costs (for GPs)	-	0.7	6.7	5.4
Net benefits	- 2.4	12.9	114.1	92.9

* PV = present value (discounted rate = 3.5%)

Annex C

SENSITIVITY ANALYSIS

The key unknown variables in the impact assessment are:

- proportion of medical statements impacted
- the number of medical statements issued per year (forms Med 3 and 5)
- time savings to GPs from fewer consultations
- printing costs for GPs
- GPs one-off training costs

The estimates used are tested below to determine if the conclusions of the analysis will alter given the likely range of values that the key variables may take.

Proportion of medical statements impacted

One of the key assumptions in the impact assessment is the proportion of medical statements that will be impacted. The central assumption used is 62% of the total based on:

- 42.9% of all medical statements were issued for a sickness period lasting longer than 4 weeks and/or to patients with 5 or more statements in the year (long duration and/or high frequency);
- half of the 37.8% of statements issued to patients with 2-4 statements in the year and duration of 4 weeks or less (medium frequency and low/medium duration)

Note that the remaining 19.4% of statements were issued to patients with just one statement in the year and duration of 4 weeks or less (low frequency and low/medium duration).

Varying this assumption and assuming that just the first category of medical statements is affected (42.9% of the total) – long duration and/or high frequency, the new policy still generates a net benefit of between £95.0m to £333.7m for the economy over ten years (present value).

Numbers of forms Med 3 and Med 5

Currently the sickness certification scheme is paper-based which has resulted in a lack of robust and accurate information on how many medical statements are issued. The central estimate used in the impact assessment is based on an analysis of printing orders giving an estimated figure of 18.7m form Med 3s and form Med 5s per year. Other estimates indicate a different numbers of statements:

- A study by Shiels and Gabbay based on reporting by nine GP practices found that GPs issue an average of six Med 3 and Med 5 statements per week, an estimated total of 11.5m per annum³⁰.
- A survey by Norwich Union Healthcare estimate GPs issues an average of 11 medical statements per week giving a total of approximately 21.1m³¹.
- Another study report, on average, GPs will issue 20 medical statements per week, an estimated total of 38.4m³².

³⁰ See Shiels, C. and Gabbay, M. (2007) *Patient, clinician and general practice factors in long-term certified sickness*, Scandinavian Journal of Public Health, 35:3,250-256. Number of Med 3 statements = number of Med 3 statements per GP per week x number of GPs in England, Wales and Scotland (WTE/FTE used where available). Calculation: 11.5m = 6 per GP per week x 37,000 GPs.

³¹ Norwich Union Healthcare (2004) *Doctor's orders: The third Health of the Nation Index* from Norwich Union Healthcare (www.healthofthenation.com).

³² Sawney, P. (2002) *Current Issues in fitness for Work Certification*. British Journal of General Practice 52, 117-22.

An increase on the central estimate of the numbers of forms Med 3 and 5 will result in (i) a rise in output; (ii) a rise in GP consultation savings; (iii) a reduction in printing cost savings for central government; and (iv) an increase in printing costs for GPs. The rise in output and in GP consultation savings dominates the latter two effects, thus generating even higher net benefits. The reverse is true for a decrease in the central estimate. An estimate of 11.5m medical statements per annum, however, still generates a net benefit of between £84.6m to £295.7m for the economy over ten years (present value).

Time saving for GPs from fewer consultations

The impact assessment assumes that for each case of early return to work, one GP consultation is saved. If this saving was halved so that half a GP consultation is saved per case of early return, there would still be a net benefit for GPs (£8.0m to £42.9m over ten years (present value)) and for the economy as a whole (£125.1 - £434.0 over ten years (present value)).

Printing costs for GPs

The assumptions used in the impact assessment for printing costs for GPs are 5 pence per statement. A doubling of costs to 10 pence still does not alter the conclusions of a net benefit for GPs (£17.3m to £87.4m over ten years (present value) and for the economy as a whole (£134.3 to 478.5) to over ten years (present value)).

GPs one-off training costs

The impact assessment assumes that GPs will need one hour of training to familiarise themselves with the new statement. If the training time doubles, there is still be a net benefit for GPs (£20.7m to £90.6m over ten year (present value)) and for the economy as a whole (£137.7 - £481.7).

ANNEX D

DETAILED CALCULATIONS FOR COSTS AND BENEFITS

Benefits	Calculation (08/09 prices)	Source(s)/Notes
Increase in output (based on scenarios of 3%, 5% and 10% of impacted statements returning to work for an extra week and the output is 50% of assumed wage (NMW))	<p>Numbers of impacted medical statements = proportion of all statement impacted x total number of statements</p> <p>$11.6\text{m} = 62\% \times 18.7\text{m}$</p> <p>Earnings (p.w) = NMW x hours worked per week</p> <p>$\text{£}212 = \text{£}5.73 \times 37 \text{ hours}$</p> <p>Increase in output = % of cases x number of impacted medical statements x earnings x 0.5</p> <p>$\text{£}36.8\text{m}/\text{£}61.3\text{m}/\text{£}122.7\text{m} = 3/5/10\% \text{ of cases} \times 11.6\text{m} \text{ medical statements} \times \text{£}212 \times 0.5$</p>	<p>Proportion of all statements impacted: please see table 1.</p> <p>Total number of statements: analysis of printing orders</p> <p>Hours worked per week (median): ONS (2008) <i>Annual Survey of Hourly Earnings</i>. The Stationery Office.</p> <p>NB: Output is valued at national minimum wage (NMW) rather than average earnings as survey data indicates that sickness absence is higher amongst the low skilled.</p>
Savings in printing costs for central government (number of Med 3s saved due to fewer consultations + 90% of remaining Med 3s)	<p>Annual average printing cost savings = (number of Med 3s saved due to fewer consultations + (number of remaining Med 3s x 0.9)) x printing cost per Med 3</p> <p>$0.3\text{m} = ((3/5/10\% \text{ of cases} \times 11.6\text{m} \text{ statements}) + ((18.7\text{m} - (3/5/10\% \text{ of cases} \times 11.6\text{m} \text{ statements})) \times 0.9)) \times \text{£}0.02$</p>	Printing cost assumed to be 2p per statement – lower than cost for GPs due to economies of scale.
Savings in GP consultation time (one consultations per case of early return to work)	<p>Savings in GP consultation time = % of cases x number of Med 3 statements for impacted group x cost of GP time per consultation</p> <p>$\text{£}4.1\text{m}/\text{£}6.8/\text{£}13.5\text{m} = 3/5/10\% \text{ of cases} \times 11.6\text{m} \text{ Med 3 statements} \times \text{£}11.7$</p>	<p>Cost of GP time = £60 per hour for salaried GP; £80 per hour for contractor GP from data provided by Department of Health. Lower cost used in impact assessment.</p> <p>11.7 minute per consultation: PSSRU (2008) <i>Unit Costs of Health and Social Care 2008</i>, University of Kent.</p>
Administrative savings for GPs (from 2010/11 onwards)	<p>Admin. savings = Number of GP practices x cost of one hour of an administrators time</p> <p>$\text{£}0.1\text{m} = 10,000 \times \text{£}15.00$</p>	<p>Number of GP practices: NHS workforce data</p> <p>Cost of administrator per hour: £15 per hour from data provided by the Department of Health.</p> <p>NB: it is assumed that each GP practice orders statements twice a year taking 30 minutes each time.</p>
Increase in earnings for individuals (based on scenarios of 3%, 5% and 10% of impacted statements returning to work for an extra week and the output is 50% of assumed wage (NMW))	<p>Total increase in earnings = % of cases x number of impacted medical statements x (((earnings for one week – SSP) x proportion receiving SSP) + ((earnings for one week – OSP) x proportion receiving OSP)) x (1-tax and NIC rate)</p> <p>$\text{£}8.3\text{m}/\text{£}13.8\text{m}/\text{£}27.6\text{m} = 3/5/10\% \text{ of cases} \times 11.6\text{m} \text{ statements} \times (((\text{£}212 - \text{£}75.4) \times 25\%) + ((\text{£}212 - \text{£}212) \times 75\%)) \times (1-31\%)$</p>	<p>Tax and NIC = 31% (11% NI and 20% tax) assuming annual salary at NMW. Rates are assumed to be at 08/09 levels throughout.</p> <p>75% receive OSP and 25% receive SSP: calculations on figures from the CIPD Annual Absence Management Survey Report 2007 (see below).</p>

Benefits	Calculation (08/09 prices)	Source(s)/Notes
Fiscal benefit (based on scenarios of 3%, 5% and 10% of impacted statements returning to work for an extra week and the output is 50% of assumed wage (NMW))	<p>Fiscal benefit = (employee NI/tax rate + employer NI rate) x % of cases x number of impacted medical statements x 0.5 x (((earnings for one week – SSP) x proportion receiving SSP) + ((earnings for one week – OSP) x proportion receiving OSP))</p> <p>£5.2m/£8.7m/£17.5m = (31%+12.8%) x 3/5/10% of cases x 11.6m Med 3 statements x 0.5 x (((£212 - £75.4) x 25%) + ((£212 - £212) x 75%))</p>	Employee tax and NIC = 31%; employer NIC = 12.8%; Rates are assumed to be at 08/09 levels throughout.
Reduction in SSP/OSP paid	<p>SSP/OSP saved = % of cases x number of impacted medical statements x ((SSP x proportion receiving SSP) + (OSP x proportion receiving OSP)) x (1+NIC rate)</p> <p>£69.5m/£115.9m/£231.7m = 3/5/10% of cases x 11.6m statements x ((£75.4 x 25%) + (£212 x 75%)) x (1+12.8%)</p>	

Costs	Calculation (08/09 prices)	Source(s)
Increase in printing cost to central government in 09/10 prior to implementation of policy change (50% of existing Med 3s)	<p>Increase in printing cost = number of Med 3s x 0.5 x printing cost</p> <p>£0.09m = 18.7m x 0.5 x £0.01</p>	Printing cost of 1p per statement used – lower than on-going printing costs due to economies of scale from printing a large order.
One-off training cost to GPs (assumed to be one hour per GP)	<p>Training cost = number of GPs in England, Wales and Scotland (headcount) x 1 hour x cost of GP time per hour</p> <p>£2.4m = 40,000 GPs x 1 hour x £60</p>	<p>Training time of 1h is an assumption only. This is tested in the sensitivity analysis.</p> <p>Number of GPs: NHS workforce data of staff numbers</p> <p>Cost of GP time = £60 per hour for salaried GP; £80 per hour for contractor GP from data provided by Department of Health. Lower cost used in impact assessment.</p>
Increase in printing costs for GPs (90% of remaining Med 3s)	<p>Annual average printing costs = number of Med 3s remaining x 0.9 x printing cost per Med 3</p> <p>£0.8m/£0.8m/£0.7m = ((18.7m – (3/5/10% of cases x 11.6m Med 3 statements)) x 0.9) x £0.05</p>	Printing cost of 5p per statement is an assumption only. This is tested in the sensitivity analysis. Lower printing costs per statement are used for Government due to benefit of economies of scale.
Cost of bob role/workplace modifications	<p>Modification costs = % of cases x number of impacted medical statements x average cost of modification</p> <p>£20.8m/£34.7m/£69.4m = 3/5/10% of cases x 11.6m statements x £60</p>	Average cost of modification is assumed to be 1/3 of the average cost of reasonable adjustments for disabled employees (£184) as reported in Maeger et al. (2001).
Increase in labour costs for employers	<p>Salary paid = % of cases x number of impacted medical statements x earnings for one week x (1+NIC rate)</p> <p>£83.0m/£138.4m/£276.8m = 3/5/10% of cases x 11.6m statements x £212 x (1+12.8%)</p>	

Other	Calculation (08/09 prices)	Source(s)/Notes																											
Proportion of employees covered OSP/SSP	<p data-bbox="497 185 976 217">Proportion of employees covered OSP:</p> <table border="1" data-bbox="497 244 976 651"> <thead> <tr> <th data-bbox="497 244 719 275">A</th><th data-bbox="719 244 847 275">B</th><th data-bbox="847 244 976 275">A x B</th></tr> </thead> <tbody> <tr> <td data-bbox="497 275 719 405">% of employers</td><td data-bbox="719 275 847 405">% of employee coverage (midpoints of ranges)</td><td data-bbox="847 275 976 405"></td></tr> <tr> <td data-bbox="497 405 719 436">84.0</td><td data-bbox="719 405 847 436">1.00</td><td data-bbox="847 405 976 436">84.0</td></tr> <tr> <td data-bbox="497 436 719 468">3.0 (= 16% x 19%)</td><td data-bbox="719 436 847 468">0.05</td><td data-bbox="847 436 976 468">0.2</td></tr> <tr> <td data-bbox="497 468 719 499">3.2 (= 16% x 20%)</td><td data-bbox="719 468 847 499">0.18</td><td data-bbox="847 468 976 499">0.6</td></tr> <tr> <td data-bbox="497 499 719 530">2.9 (= 16% x 18%)</td><td data-bbox="719 499 847 530">0.38</td><td data-bbox="847 499 976 530">1.1</td></tr> <tr> <td data-bbox="497 530 719 562">1.9 (= 16% x 12%)</td><td data-bbox="719 530 847 562">0.63</td><td data-bbox="847 530 976 562">1.2</td></tr> <tr> <td data-bbox="497 562 719 593">4.8 (= 16% x 30%)</td><td data-bbox="719 562 847 593">0.88</td><td data-bbox="847 562 976 593">4.2</td></tr> <tr> <td colspan="2" data-bbox="497 593 719 651">SUM</td><td data-bbox="847 593 976 651">91.3</td></tr> </tbody> </table> <p data-bbox="497 685 976 806">75% = 91.3% x 91% of employers providing OSP x 90% of employers providing OSP at the same level as employees' full wage/salary.</p> <p data-bbox="497 840 976 871">Proportion of employees covered SSP:</p> <p data-bbox="497 904 976 936">25% = 100% - 75%</p>	A	B	A x B	% of employers	% of employee coverage (midpoints of ranges)		84.0	1.00	84.0	3.0 (= 16% x 19%)	0.05	0.2	3.2 (= 16% x 20%)	0.18	0.6	2.9 (= 16% x 18%)	0.38	1.1	1.9 (= 16% x 12%)	0.63	1.2	4.8 (= 16% x 30%)	0.88	4.2	SUM		91.3	<p data-bbox="1005 152 1458 217">Source: CIPD Annual Absence Management Survey Report 2007.</p> <ul data-bbox="1005 244 1458 920" style="list-style-type: none"> 91% of employers provide OSP. Of employers paying OSP, 84% pay it to all employees. For employers that do not pay OSP to all employees: <ul style="list-style-type: none"> 19% pay it to 0-10% of employees (midpoint – 5%); 20% pay it to 11-25% of employees; (midpoint – 18%) 18% pay it to 26-50% of employees (midpoint – 38%); 12% pay it to 51-75% of employees (midpoint – 63%); 30% pay it to 76-100% of employees (midpoint – 88%). 90% of employers provide OSP at the same level as employees' full wage/salary. It is assumed that all other employees receive SSP.
A	B	A x B																											
% of employers	% of employee coverage (midpoints of ranges)																												
84.0	1.00	84.0																											
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