Fit for Work? The Influence of Sick Pay and Job Flexibility on Sickness Absence and Implications for Presenteeism

Annie Irvine

Abstract

Recent developments in UK policy on health and employment have sought to change perceptions about what constitutes ‘fitness for work’. With the aim of reducing the incidence and duration of sickness absence, a range of initiatives, including the introduction of the ‘fit note’, are challenging the belief that it is necessary to be 100 per cent well in order to be at work. However, this article suggests that contextual factors independent of health may also influence people’s decisions about whether or not to attend work at times of reduced wellness. Drawing upon data from a qualitative study of mental health and employment, this article illustrates how the terms and conditions of a person’s employment may influence sickness absence decisions in a number of ways. It is argued that sick pay provisions, size of employer and nature of work may influence both decisions to take time off and decisions about when to return to work. The degree of flexibility to manage one’s workload around times of poorer health may also have a bearing on whether people feel able to carry on with their work without recourse to sickness absence. Therefore, it may be important for policy interventions to consider not only health circumstances but also structural/contextual influences on conceptualizations of being ‘fit for work’. The implications of such contextually-influenced decision-making for ‘presenteeism’ are also considered. It is suggested that current conceptualizations of presenteeism are somewhat ambiguous; employees coming to work despite ill health is simultaneously presented as a problem and an aspiration.

Keywords

Sickness absence; Presenteeism; Mental health; Fit note; Sick pay; Job flexibility

Introduction

The health of the working age population, and the associated economic and social costs, have been the focus of substantial policy attention in the UK for approaching two decades. Much of the focus has been on labour market
activation of sick and disabled people not presently in employment. However, there is increasing interest in reduction and management of workplace sickness absence of those in employment; this is the focus of the present article. In particular, the article considers individual decision-making about sickness absence in the context of specific employment conditions.

Ill health among people of working age is a concern by no means unique to the UK, as a recent review of sickness, disability and work across the Organisation for Economic Co-operation and Development (OECD) countries has highlighted (OECD 2010). Substantial research into causes, correlates and management of workplace sickness absence emanates from outside the UK, in particular Scandinavia and the Netherlands (see, for example, a special supplement of the Scandinavian Journal of Public Health 2004 [32, Suppl. 63] and the review by Seymour 2010). The Fit for Work Europe programme (http://www.fitforworkeurope.eu) provides another example of cross-national interest in addressing sickness absence and workplace rehabilitation.

Emphasis on reducing workplace absence in the UK context has been reinforced in recent years by Dame Carol Black’s review of the health of the working age population (Black 2008), which estimated the total economic costs of working age ill health to be over £100 billion. As well as a concern to reduce its financial impact, the government’s focus on workplace sickness absence (and longer-term economic inactivity due to ill health) is underpinned by the principle that ‘work is good for you’. A now much-cited review by Waddell and Burton (2006) concluded that, in general, work is good for physical and mental health and well-being. This message has been taken up by both the previous Labour government and the current Coalition government. However, the potential for work to cause or exacerbate ill health should also be recognized. Whilst statistics indicate that work-related physical injury is on the decline, work-related psychological distress, including stress, depression and anxiety, remains a significant cause of self-reported work-related ill health (HSE 2010). Work-related factors frequently identified as associated with poor mental health include: high job demands (long hours, unmanageable workload); low control over work; lack of involvement in decision-making; poor management; and low social support from supervisors or colleagues (e.g. Michie and Williams 2003; Sanderson and Andrews 2006). Indeed, an important proviso to Waddell and Burton’s findings is that in order to be good for you, ‘account must be taken of the social context, the nature and quality of work . . . Jobs should be safe and should also be accommodating for sickness and disability’ (Waddell and Burton 2006: 38).

In response to the Black Review, the then Labour government proposed a number of initiatives aimed at reducing the incidence and duration of workplace sickness absence. These were targeted at a number of levels, including employers and representative bodies, trade unions, healthcare professionals, training providers and individual employees (HWWD 2008). A strong theme within the Black Review was the need to radically address ‘the fallacy . . . that illness is incompatible with being at work and that an individual should be at work only if 100% fit’ (Black 2008: 21). Taking up the challenge set out by Dame Carol Black, a cross-cutting principle of the ensuing programme of activity was to alter perceptions of what constitutes fitness for work, changing
the ‘belief that we should always refrain from work when we have a health condition’ (HWWD 2008: 10).

One key initiative, which came into force in April 2010, was the introduction of a Statement of Fitness for Work, replacing the former medical certificate. In contrast to the old ‘sick note’, the new ‘fit note’ (as it is known) promotes a stronger focus on what residual capacity for work people have while unwell, as a guide for the individual and their employer. Under the old and the new certification systems, a General Practitioner (GP) (‘family doctor’) may issue a patient with a note which can be presented to their employer as evidence for entitlement to sick pay whilst absent from work. However, in contrast to the former ‘sick note’, the new ‘fit note’ enables the GP to record whether their patient is ‘not fit for work’ or alternatively ‘may be fit for work taking account of the following advice’. Subsequent areas of the form enable a GP to indicate what kinds of adjustments to their work (e.g. altered hours, amended duties or workplace adaptations) may benefit the employee, if their employer is able and willing to provide these. The government’s expectation is that the introduction of this new document will ‘result in a net benefit for individuals, employers, the Government and the economy as a whole’ (HWWD 2010: 5).

Also under way across England, Wales and Scotland are 11 pilot ‘Fit for Work Services’. The central aims of these services are to provide early intervention and personalized support to people who are off sick from their job, to assist people in their recovery and to support a more rapid and sustained return to work. Originally funded to run until April 2011, it has recently been announced that the pilots will receive a share of an additional £12 million investment to extend their operation (DWP 2011). An independent research evaluation of these services is currently in progress.

A variety of other Health, Work and Wellbeing initiatives were proposed in response to the Black Review. Throughout these initiatives, there is an awareness of the interrelatedness of health and work, and the key role that employers have in facilitating or obstructing successful job retention and return to work. The different and additional needs of smaller organizations have been clearly recognized and given targeted support throughout the programme of activity. The emphasis on mental health within many of these initiatives is also pertinent, given the significant impact of common mental health problems on workplace sickness absence (Sainsbury Centre for Mental Health 2007; HSE 2010).

However, one potentially important factor that does not, as yet, appear to have been directly or thoroughly addressed within the policy debate or ensuing activity is the role that an individual’s overarching employment conditions may have in influencing thoughts, behaviours or outcomes around sickness absence. These contextual factors include contractual status, salary and seniority, related sick pay provisions, job control and flexibility.

Previous research has identified a wide range of factors as being influential on individual decision making about whether or not to come to work when unwell. Reviewing a number of sources, Hansen and Andersen (2008) offer a three-level categorization of factors that may influence the decision to come to work when experiencing illness: work-related factors (including time pressure,
control over work tasks, relationships with colleagues and employment conditions; personal circumstances (financial situation, family life, psychological factors); and attitudes (commitment and work ethic). Similarly, Kristensen (1991) observes that factors at the company level, job level and individual level are all involved in absence behaviours and that ‘macro level’ considerations including sickness benefits and economic fluctuations must also be taken into account.

Ashby and Mahdon (2010) found that personal financial difficulties, work-related stress and perceived workplace pressures were significantly linked with employees coming to work when they felt that sickness absence would have been justified. Drawing upon the Theory of Planned Behaviour, Brouwer et al. (2009) concluded that ‘work attitude’, ‘social support’ and ‘willingness to expend effort in completing the behaviour’ were associated with quicker returns to work from absence.

Recent research among people who had experienced long-term sickness absence (BOHRF 2010) found that the medical condition itself was rarely cited as a barrier to returning to work. As such, the authors proposed that ‘it may be the organisational and social factors associated with returning that pose the largest problem to return to work, not the illness itself’ (BOHRF 2010: 33). In short, as observed by Kristensen (1991: 15), ‘sickness absence cannot be understood if it is viewed as a simple function of ill health’.

Qualitative interviews conducted for the study upon which the present article draws (Irvine 2008) revealed a similar range of factors influencing sickness absence patterns. The present article, however, focuses in particular on the roles played by sick pay entitlement and the extent to which people could exercise control and flexibility in managing their work patterns. It is argued that these features of an individual’s employment circumstances might influence the extent and duration of sickness absence in various ways. First, with regard to sick pay, it will be suggested that the availability, generosity and duration of occupational sick pay may play a role in both the perceived viability and consequences of taking time off sick and also the motivations involved in returning to work from sickness absence. Second, the article will provide evidence to suggest that sickness absence may be influenced by the scope an individual has for exercising control and flexibility over their work patterns. While these two aspects of a person’s work are not themselves necessarily related, their shared significance to the present discussion is that both are also unrelated to a person’s health, yet may exert an influence on sickness absence decisions. In turn, it will be suggested that the role and influence of sick pay and job flexibility have potential implications for the effectiveness of current government initiatives that seek to minimize sickness absence. Thus, the overarching provisions and specific features of an individual’s job may need to be explicitly considered alongside interpersonal and directly health-related interventions.

The following section outlines the method used in the study upon which this article draws. Findings on the role played by sick pay and job flexibility in decisions about sickness absence are then presented. Discussion and conclusion sections consider these findings in the context of current policy on fitness for work and reflect on the potential implications for ‘presenteeism’.
Method

The data drawn upon in this article are taken from a study of people’s experiences of managing mental health and employment (Irvine 2008). The study involved qualitative interviews with 38 individuals who considered themselves to have experience of a mental health condition and had sustained employment for at least the past 12 months. A range of recruitment strategies was used, including approaches via employers and employment support organizations. This resulted in a large geographical spread, including participants living and working in Scotland and various regions of England. Most people lived in urban or suburban areas. Slightly more than half were female and a majority were in their mid-30s to late 40s. There was a range of household types, with couples slightly outnumbering single people. Half the study group had dependent children living with them, a third of whom were lone parents. Table 1, above, provides an overview of the study group characteristics.

Data were gathered through individual in-depth qualitative interviews. A semi-structured topic guide was used, covering key areas of: personal, employment and health background; managing in work and experiences of absence from work; talking to others about mental health problems; support from others (in and outside work); long- and short-term impacts on employment and income; suggestions for improvements and future plans. Most interviews
were conducted face to face, either in participants’ homes or at their workplace (according to participant preference) with a small number being conducted by telephone.

Interviews were audio recorded (with participants’ permission) and transcribed verbatim. Data were then summarized under a set of thematic headings and managed using the qualitative data analysis programme MaxQDA. Analysis involved detailed examination of the data for emerging themes and categories within each of the study’s research questions. Analysis and reporting remaining grounded in the narratives and language of the study participants.

There were no preset health/medical criteria for the sample selection; volunteers participated according to their own assessment of whether their personal experience of mental health difficulties fitted with the broad study objectives. The majority of participants recounted experiences of anxiety and/or depression, which they often associated (at least in part) with work-related stress. A small number of people had diagnoses of bipolar disorder or had experienced episodes of psychosis. At the time of the research interviews, some people were reflecting on past experiences of anxiety or depression from some distance in time, while others felt that they continued to experience episodes of poorer mental health as part of an ongoing, fluctuating condition. For most people, however, there was a key episode in their narratives – the time when they had been most acutely affected by mental ill health – which some people described as a ‘breakdown’. At this point, many people in the study group had taken a relatively long period of time off sick from their job. Just under half had spent a period of one month or more off sick, several having been absent for four to six months and some for up to 12 months. However, some people had not taken any time off sick due to mental ill health.

Although the study had endeavoured to include participants in a range of employment circumstances, variable response rates from the various recruitment routes meant that the achieved study group predominantly comprised people who worked for large employers (in the private and public sectors), many of whom had been with their employer for several years (see table 1) and had reached relatively senior positions. Virtually everyone in the study group had a permanent contract of employment and an entitlement to six months’ occupational sick pay at full salary, with a further period at half pay before moving to statutory sick pay or social security benefits. Thus, these individuals could be seen as having ‘secure employment’ (Davidson and Kemp 2008) to the extent that they benefited from a contractual and financial safety net at times when they felt too unwell to be at work. Additionally, most of the participants in this study were in desk-based managerial or administrative roles and had a relatively large amount of autonomy and control in organizing and managing their workload.

The following sections present data from the qualitative interviews which illustrate how this particular combination of structural/contextual employment factors influenced people’s decisions around sickness absence in various ways, including: taking time off at all; returning from absence; and remaining in work when absence may, under other circumstances, have been deemed
necessary. Quotations are in participants own words, but have been edited for anonymity, brevity and clarity in some cases.

Findings

Viability and consequences of time off – the role of sick pay and organizational structures

As described above, most study participants worked for large employers and had contracts of employment that entitled them to at least some occupational sick pay, followed by statutory sick pay (if required). In the case of the following participant, when the combined pressures of work, lone parenting and fluctuating depression became unmanageable, time off sick presented as a viable option:

‘When I came out of work it’s a case of you’ve got so many things that you’ve got to carry around with you, the easiest thing to drop is work. It’s a simple thing to do. You can’t drop family. You can’t drop your home and whatever but you can drop work for a time, quite simply.’ (male, 50s)

Another participant, who also experienced fluctuating depression, recounted a time when his wife was recovering from an operation, meaning additional domestic workload for himself. This led to him feeling stressed (which he described as distinct from his experiences of depression) and he had found it helpful to be able to approach his GP and request a sick note for this reason:

‘I just said I was kind of feeling pretty stressed and I would like a couple of weeks off... I mean it’s partly just because when you feel a bit overwhelmed and that, when you’ve sort of too much to do, then that’s when it helps you’ (male, 50s)

For these two individuals, taking a period of time off sick in order to better manage their broader life circumstances did not have critical consequences for their overall employment status and was evidently considered a feasible option. However, research with claimants of incapacity benefits has shown that, for some people, going off sick can effectively amount to the loss of employment (Davidson and Kemp 2008). For people who are in insecure employment, for example, hired via employment agencies, on a freelance basis, or on temporary or ‘zero hours’ contracts, ‘the consequences of ill health can be much more drastic’ (Davidson and Kemp 2008: 226). Going off sick can result quickly, or immediately, in unemployment, with incapacity benefits then acting as the ‘functional equivalent’ of sick pay (Davidson and Kemp 2008; Davidson 2006). Thus, it is possible that people who do not have a safety net of sick pay may decide to keep going to work despite ill health (Hansen and Andersen 2008; Virtanen et al. 2001).

The provision of (typically) six months on full salary occupational sick pay was cited by some study participants as providing reassurance during the periods where they had been unwell, as illustrated in the following quotes:
'I suppose, in the back of my mind, I knew full well that, although I can say lots of nasty things about [name of employer], they are, in essence, quite good. So I had the six months on full pay, and I could have taken more on half pay, so, you know, I felt protected by that, by the fact that they’d keep paying me, that I wouldn’t be, you know, out desperately trying to search for ways of getting food and so on.’ (male, 40s)

‘When you have some kind of breakdown, you just need a break, and knowing that your company’s still paying your salary is huge . . . You have to try and keep it at bay and accept that if you are depressed then you are depressed and you’re lucky enough to have a company that will pay for you being off sick.’ (female, 40s)

For people in less secure employment, who may have only limited entitlement to statutory sick pay, or no provision whatsoever, this peace of mind experienced by the participants above is not so readily available. Again, this may play a part in decision-making about taking time off sick.

When asked during interviews what they considered to be the main things that had kept them in employment throughout periods of mental ill health, some participants cited the overarching organizational features of their employment. Here, size and sector of the employer were noted as having a bearing on the viability and consequences of long-term sickness absence. As well as consideration of their own financial and employment circumstances, some people were also mindful of the impact (or lack thereof) that their absence would have on their employer and colleagues:

‘I think I was lucky to be working for [name of employer] when I had it . . . Because it’s such a big organisation it can carry people. A small organisation, if I’d gone back after six months off – and been barely effective for another six months – I think I’d have been out of work in a lot of companies . . . [This] company can sustain it . . . My inadequacies would have been much more obvious in a small company and they’d have done something about it.’ (male, 40s)

In summary, these data suggest that people’s thoughts and decisions about going off and staying off work can be influenced by financial considerations and by the perceived implications for their own and for others’ workload. These two factors are not health-related; rather, they are underpinned in large part by contextual features of the job, including employment terms and the size and structure of organizations. In the following section, it is suggested that finances also play a role in decisions to return from absence.

Motivation to return from absence – the role of sick pay

As noted earlier, almost half of the study participants had spent a period of one month or more off sick while with their current employer. However, only two had remained absent from work beyond the point at which their entitlement to full salary occupational sick pay ended. A number of people described how the imminent ending of their period of entitlement to full pay was an
influential factor in their decision to return to work. Some people did not feel they had really been ready to go back to work at this point, but financial factors had been a stronger motivation:

‘To be brutally honest, I came back because I was gonna go down to half pay by six months, so there was a sort of pressure thing there . . . I wasn’t particularly com- pos mentis when I came back, I don’t think.’ (male, 40s)

‘After about four months I said “I’ve got to get back into work” because you only get six months on full pay, which is a big incentive.’ (male, 50s)

There was also evidence that wider household circumstances played a role in these deliberations. The following comments from two women, the first living alone, the second with a partner, illustrate how the perceived viability of staying off sick can differ according to the extent of wider financial support available:

‘It would have gone onto half pay, that was another big driver for me to get back to work because unlike a married person where there’s potentially another income coming in, there was only me to pay bills, and I was very much aware that I had quite a big mortgage . . . it was still bills that had to be met, and I had to get back to work within that six months.’ (female, 50s).

‘It [dropping to half pay] was a challenge but it wasn’t a challenge like financially . . . I had no foundation to worry about it financially. [Researcher: is that because, you know, the overall household income was enough?] Yeah. But again, if you were in the position where you would have to come back to work, oh it would have just been too dreadful to think about.’ (female, 40s).

Moreover, some people who had had long periods of absence were now mindful of the limited amount of occupational sick pay that remained available to them and said that this was a deterrent to their taking any further time off, should they feel the need:

‘I feel now if I do need time off I’ve got to be a bit – you know, I’m looking at losing a lot of money here and the temptation is to struggle in to work when you’re not actually well enough to do so but unwilling to go off on the sick because you’re gonna dip out on a lot of money. Because you still actually have commitments, you know, you’ve got mortgages and kids . . . and things need to be done and provided.’ (male, 50s)

Recalling the observations made in the previous section, time off sick apparently became less ‘viable’ for some people, as the monetary value of occupational sick pay entitlement reduced.

Staying in work – the role of job control and flexibility

As well as influencing absence from work, the study revealed ways in which the terms and conditions of people’s employment could be supportive of
staying in work and avoiding or minimizing sickness absence. Key in this respect were flexibility and job control. In many cases, people explained that having flexible working arrangements, including flexitime, time off in lieu, and the option to work from home, enabled them to manage their work around times when they were feeling less well. Important to the present discussion is that these were not generally provisions that had been made specifically in response to the person’s mental health difficulties, for example as ‘reasonable adjustments’ under the Disability Discrimination Act 2005.5 Rather, these were options that were available to any employee in the same or an equivalent role.

These flexibilities could be used responsively, for example, having a later start to the day when morning medication caused nausea, or working from home during periods of more severe anxiety or depression. They could also be used pre-emptively, for example, by deliberately accruing time off in lieu in order to take rest and recuperation days at regular intervals. Both of these approaches were cited as helpful in avoiding the need for repeated or prolonged periods of sickness absence:

‘The nature of the job that I do, as a project manager, you are in a sense your own boss, so you’ve got a lot of flexibility . . . So say I’ve had, in quotes, an “off day”, I may only do two or three hours actual registered work, but I’ll catch up with it in the evening or at the weekend.’ (male, 40s)

‘I am lucky and fortunate to be able to manage how I work and that makes a big difference . . . If I was in an operational situation, say you’re on call or you have to work shifts or you have to be there in say a centre or whatever, I would think it would be very hard.’ (female, 40s)

As illustrated by the above quotes, flexible working was generally seen as advantageous. However, some participants described how there could also be complexities and tensions inherent in such flexible and autonomous work situations. It was often the case that people had not disclosed mental health problems to their employer and flexible working assisted in keeping their health circumstances concealed:

‘Some days, I’d just stare at the computer screen and not do anything, not be very productive at all. And I think, in those situations . . . when you’re in a position I am, it’s sometimes easy to camouflage that you’re not doing very much.’ (female, 50s)

‘There are days where I can just take all day and I’ve like written a paragraph, and I’ve just sat there and I’ve not really done anything . . . I’ve literally just sat there quietly giving all the impression of working but my mind’s been so agitated I’ve actually achieved virtually nothing by the end of the day.’ (female, 40s)

The above quotes illustrate the potential for people in more autonomous and flexible roles to appear to be working whilst not actually being very productive, due to the impact of ill health. As such, they exemplify the concept of ‘presenteeism’ which will now be considered in the discussion below.
Discussion: Sickness Absence Decisions in Context

A stated policy objective of the Statement of Fitness for Work is to ‘empower individuals to make their own positive decisions to return to work’ (HWWD 2010: 10). The above research findings illustrate how people’s thoughts and actions around sickness absence may be influenced by structural and contextual aspects of their employment as well as self-evaluations of their state of health. The first suggestion of this article is that people in secure employment, particularly with large employers, may feel more able to go off sick and to stay off sick when they become unwell, because of the extent of sick pay available to them and the ability of their employer to ‘bear’ their absence. The perceived viability and consequences of time off may be quite different for people in insecure employment or who work for smaller organizations.

Second, this article has suggested that people who have occupational sick pay available to them for a certain period of time may be more inclined to return to work when sick pay arrangements become less favourable. The influence of reductions in sick pay has been noted in previous research. For example, the evaluation of the DWP Job Retention and Rehabilitation Pilots (Farrell et al. 2006: 57) found ‘a clear pattern of people returning to work either shortly before or after a drop in income, particularly at six months when occupational sick pay schemes were commonly reduced by half’. In a recent survey exploring the views of occupational health professionals about employee absence, generous sick pay/private health insurance entitlements emerged in the top five most common ‘obstacles to recovery’ (Ballard 2009).

This is not to suggest that the people in this and previous studies were not genuinely experiencing ill health, nor that they were going off sick unduly. For many people in this study, a period of absence was seen as unavoidable and a necessary part of their recovery – and thus they drew on the provisions to which they were entitled. Neither is there an inference that participants in this study made a calculated – or even necessarily conscious – decision about duration of absence at the time they went off sick. It is important to acknowledge that finances were not the only motivation to return to work cited by study participants. Once over the most acute phase of their illness, some people recognized that getting back to work would be better for them socially and psychologically. For some people, the personal investment of time and effort that they had made in building their career to date was also a factor in not allowing themselves to ‘give up’ in the face of ill health. However, in the retrospective accounts offered to researchers, employment security and sick pay entitlement were two factors which some people cited as influential in determining their patterns of absence and return. Therefore, what this article highlights is the need for policy to consider not only health circumstances but also structural influences on conceptualizations of being ‘fit for work’.

The third suggestion of this article is that people in certain types of employment, particularly those in more autonomous roles, may be more able to reduce the need for absence through the exercise of personal control over workflow and flexible working arrangements. The scope for flexible and independent ways of working clearly varies according to such things as overall job type, specific duties and the individual’s level of experience or seniority.
Johanssen and Lundberg (2004) describe this as ‘adjustment latitude’. As they explain:

Loss of function will affect work ability but work ability is likely to be determined also by the work conditions people meet. While some people may always have to work fully if they attend work others may be able to choose among work tasks, work at a slower pace or shorten their working day. Adjustment latitude... describes the opportunities people have to reduce or in other ways alter their work effort when e.g. feeling ill. The likelihood of retaining the ability to work should be greater where there is high adjustment latitude compared to where there is low. (Johanssen and Lundberg 2004: 1858–59)

At the same time, this article has also highlighted how the positive aspects of flexibility and autonomy (or ‘adjustment latitude’) can potentially become negative forces in managing mental health and employment, leading to ‘hidden illness’ and an associated lack of productivity and increased strain for the individual. Some research findings have called into question the idea that flexibility is universally positive for employees, highlighting how it can in some circumstances become detrimental to work–life balance (Blair-Loy 2009; Hyland et al. 2005). The present study also pointed to potential negative implications associated with sick pay provision, with people coming back due to financial pressures when not – by their own account – ‘compos mentis’ (see also Ashby and Mahdon 2010; Farrell et al. 2006). This leads to one further point for consideration – the notion of sickness presence or ‘presenteeism’. Presenteeism may be understood as the action of being at work while unwell and so not performing one’s role to full effectiveness. To take a more formal definition provided by the Sainsbury Centre for Mental Health, presenteeism is: ‘The loss in productivity that occurs when employees come to work but function at less than full capacity because of ill health’ (Sainsbury Centre for Mental Health 2007: 11).

Presenteeism carries substantial financial implications for employers. The Sainsbury Centre for Mental Health has estimated a cost of £15.1 billion per year to employers in the reduced productivity of employees experiencing mental ill health at work. This is almost twice the estimated cost attributable to sickness absence (Sainsbury Centre for Mental Health 2007). It has also been suggested that presenteeism risks further detriment to the individual’s health, resulting in more substantial absence in the longer term (Hansen and Andersen 2009).

There appear to be three responses to tackling presenteeism; which of these is preferable depends on policy aims. One response is to encourage people simply to stay off work while they are unwell and not return until they are fully better. The concept of presenteeism appears to have been originally posited in relation to physical health, where attending work while experiencing a physical illness risked both spreading infection to others and delaying one’s own recovery. In the case of short-term and contagious physical illnesses, the benefits of taking sufficient time off work seem fairly clear and presenteeism in this context is arguably ‘a bad thing’. However, when applied to mental health
and other prevalent health problems such as musculoskeletal conditions, this is evidently not the desired policy solution. The current question seems to be a more subtle one of the balance that is desired between ‘cure’ and ‘management’. A second response to presenteeism, therefore, which forms one strand of current policy, is to address the health condition more rapidly and more effectively, so that people return to health more quickly. In relation to mental health, this is exemplified through the government’s substantial financial investment in the Improving Access to Psychological Therapies (IAPT) programme. However, the strongest message contained in current policy presents a third type of response: enabling people to function more effectively in their job *whilst in reduced health*. Indeed, it is an explicit aim of recent government policy to encourage people to be at work while not in full health:

A key plank of our health, work and well-being strategy is to change broader cultural norms around sickness and work, in particular, the erroneous belief that if you are not 100% fit you should not be in work (HWWD 2010: 10)

In short, through the use of the fit note, the goal is to keep people in work while performing a modified or reduced role, which in effect equates to the definition of presenteeism. Thus, there currently appears to be a degree of ambiguity around the concept of presenteeism. The term itself continues to have predominantly negative connotations, typically appearing alongside references to the financial burden on employers, negative drivers of such behaviour and further detriment to employee well-being (e.g. Ashby and Mahdon 2010; Hansen and Andersen 2008, 2009; Sainsbury Centre for Mental Health 2007). At the same time, current policy appears in essence to be *advocating* presenteeism as the desirable outcome for employees with health problems. The key difference between these two perspectives seems to be whether this presenteeism takes place in a context of openness, whereby an employee can be constructively supported in work or in a context of concealment and ‘struggling on’ (Sainsbury and Davidson 2006).

The UK government has recently announced an independent review of the sickness absence system. This will ‘explore radical new ways on how the current system can be changed to help more people stay in work and reduce costs’ (DWP 2011). The review will consider sickness absence trends and practices across different businesses sectors and sizes. The present findings suggest, however, that alongside attention to macro-level trends, a focus on individual decision-making and the way that micro- and meso-level factors (such as roles and responsibilities, sick pay and job flexibility) affect individual behaviour should also be taken into account as key influences on sickness absence.

The present findings also have relevance to current UK policy which seeks to support people to move back to work from incapacity benefits. The need to take into account the interplay of health with the ‘real world’ context of workplaces was highlighted in the Harrington Review of the Department for Work and Pensions’ Work Capability Assessment (Harrington 2010). Similar concerns have been raised by Citizen’s Advice (Royston 2010) and Mind, Mencap and the National Autistic Society (2010). For example, Royston (2010)
argues that the Work Capability Assessment ‘takes no account of how the illness or impairment affects a particular individual’s chances of finding work in the actual context of the workplace environment’ (Royston 2010: 15; emphasis added).

Overall, it would seem that there can be no definitive state of fitness for work; in all cases it is the interplay of health and employment that must be carefully thought through, with detailed attention to the specifics of an individual’s role. This study and others have shown that, when making decisions about whether or not to come to work ill, people do not solely consider their state of health. Alongside attention to individual health perceptions and the provision of medical care, it will therefore be important for the current ‘Fit for Work’ policy agenda also to take into account the influence of structural employment factors, including security of employment and availability of occupational sick pay, if it is to succeed in its aims of reducing the incidence and duration of sickness absence. The particular features of an individual’s work – in particular the scope for flexibility – are also crucial to the success, or otherwise, of sustained job retention. Therefore, Fit for Work Services, occupational health practitioners and others tasked with supporting individuals to remain in work or return from absence, may need to bear in mind the structures of the individual’s employment as much as the individual’s (objective or subjective) health circumstances.

**Conclusion – ‘It all depends on the job’**

This article has sought to highlight how the context of an individual’s employment will be an important influence on the perceived feasibility or necessity both of taking time off sick and of staying at work at times of poorer health. While this article has drawn on the case of mental ill health – and predominantly common mental health problems – it is likely that the considerations discussed here may apply similarly to other common health problems such as back pain. Qualitative data presented above showed how being in a position of secure employment, with generous occupational sick pay provision and a degree of autonomy and flexibility could influence absence behaviours in various ways. While people with these employment circumstances sometimes felt more able to take time off sick and to stay off sick, there was equally evidence that – other than at times of acute illness – the flexibility and autonomy that came with certain types of job and a certain level of seniority meant that people could manage mental health and employment effectively without recourse to (further) periods of sickness absence. In contrast, for people without the security of occupational sick pay or perhaps even statutory sick pay, the viability and consequences of taking time off sick may be very different. Likewise, people working at different grades or in different types of occupation such as personal care services, retail, catering or unskilled manual work may not have the scope to manage their work flexibly (be that responsively or pre-emptively) around their experiences of mental or physical ill health.

The key implication to draw from this is that it is not only the nature or severity of an individual’s health condition that determines their perceived or actual ‘fitness for work’. Considering health status alone, or in isolation from
the specific context and characteristics of a given job, will not provide a meaningful picture of an individual’s capacity to carry out their work. As summed up by one study participant, ‘the difficulty, managing the condition while working, it all depends on the job’. For policy interventions and provider organizations seeking to support job retention and minimize sickness absence, perhaps the key question should not be whether an individual is fit for work, but whether the work is fit for the individual.

In summary, this article has illustrated how the scale and extent of sick pay entitlement available to an employee may figure in their thoughts and behaviours in both taking time off sick and returning to work. At the same time, it has suggested that there is potential to minimize the ‘need’ for sickness absence through flexibility and job control. For large employers, there may well be scope to offer such autonomous organization of work, particularly for individuals in roles of a certain type or sufficient level of seniority. However, in smaller organizations or roles which do not easily lend themselves to adaptation, there are potential challenges for people whose employers may not be so willing or able to explore potential adjustments. Negotiating such circumstances is likely to be an important part of the role of new Fit for Work Service providers, existing organizations which provide vocational rehabilitation and employer mediation (e.g. Mind and The Shaw Trust) and occupational health services advising smaller employers. There is also a potential role for GPs, who now have the ability to suggest workplace adjustments via the ‘fit note’. However, both the willingness and ability of GPs to make effective use of this has been questioned (BMA 2010; BMJ 2009). Moreover, recent evidence suggests that primary care-based interventions to hasten the return to work show minimal effectiveness (Seymour 2010).

Finally, this article has shed light on some tensions and complexities that may arise from flexible working conditions, in that they may in fact contribute to presenteeism, risking further detriment to the mental health of the individual and associated consequences for the employer. In doing so, the article has also pointed to a lack of conceptual clarity around the notion of presenteeism in current policy debate; employees coming to work despite ill health is presented both as a problem and an aspiration. If presenteeism is as detrimental to productivity as has been suggested, then it seems that success for the fit note may simultaneously bring challenges for the workplace, particularly in smaller firms.

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Notes
3. It could be argued, however, that there is presently little in the way of robust challenge to employers to commit to supporting people with health problems in the workplace. Most employer-focused policy on the management of mild to moderate health problems at work presently consists of guidelines and helplines, rather than legislative measures compelling employers to implement return-to-work support plans, such as exist in the Netherlands and Sweden.

4. In the UK, ‘Statutory Sick Pay’ (SSP) is available to employees whose earnings are at or above a level at which they pay National Insurance contributions. SSP (currently £79.15 per week) is payable for up to 28 weeks. After 28 weeks, an employee who is still unable to return to work will need to make a claim for a social security benefit. However, some employers offer more generous ‘Occupational Sick Pay’ (OSP) schemes. Although schemes vary, typical OSP provisions will match the employee’s usual salary for a certain number of weeks, reducing to a proportion of salary (e.g. 50 per cent) for a further period, before entitlement ends. OSP may be paid for more than 28 weeks.

5. The Disability Discrimination Act 2005 (recently superseded by the Equality Act 2010) required employers to make ‘reasonable adjustments’ to recruitment procedures and employment conditions for people with disabilities, including mental health conditions that have a substantial and long-term effect on the individual.

6. A second, subtly different conceptualization of presenteeism is also currently in use. This takes as its definition a situation in which an employee goes to work but perceives that sickness absence would have been legitimate given their self-assessment of health (e.g. Ashby and Mahdon 2010; Hansen and Andersen 2008). As such, the primary interest of studies taking this definition is to explore the motivations underpinning work attendance in spite of a sense of justifiable absence. As is recognized by authors using this definition, a concept of presenteeism which relies on individual perceptions is inherently challenging to apply as a systematic measure. While this raises further interesting questions and challenges for research, discussion in the present article is based upon the definition of presenteeism more commonly encountered in the current UK debate, which is primarily concerned with the impact of reductions in workplace productivity. See also NICE (2009: 45) for a brief outline of presenteeism concepts.

7. The Work Capability Assessment (WCA) is a test of an individual’s physical and mental functional capabilities, used to assess eligibility for Employment and Support Allowance (ESA). The outcome of the WCA determines whether the individual will be eligible for ESA at all, and if so, whether or not they will be required to undertake work-related activity as a condition of their benefit.

8. At the time of writing, there does not appear to be any published evidence on the extent to which the new ‘fit note’ is changing GPs’ approaches to certification or their focus on the vocational rehabilitation of their patients. However, a DWP-commissioned research evaluation is in progress.

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