Occupational Medicine

Absenteeism and sickness absence

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Summary: The majority of time lost from work as a result of absenteeism is classified as due to sickness although only a small proportion of the total can be regarded as a result of unfitness for work for medical reasons. An occupational health service assists a business in minimizing absenteeism by promoting an early return to work, assists general practitioners and hospital specialists in tailoring return to work packages, and assists employees by liaising with both management and their medical specialists to facilitate a return to normal work.

Introduction

Absenteeism is the cause of considerable loss of production and a significant added cost burden to the whole of British industry. Significantly more time is lost through absenteeism than is lost through strikes and other causes. Sickness does not necessarily have a lot to do with absence from work but health, both mental and physical, does.

Absenteeism is most often classified as due to sickness. Consequently much of the blame for high rates of absenteeism is attributed to the workforce and to their general practitioners. This allocation of blame is basically wrong as the assumption that the vast majority of absences from work are due to sickness is erroneous. In actual fact only 20–25% of absence from work attributed to sickness is due to illness sufficient to render the individual unfit to attend work.

Control of absenteeism is of utmost importance to any organization to minimize the impact of absences on the efficiency and smooth running of the business. The procedures for this control must be well understood by all employees and must ensure consistency and fairness in the treatment of individuals. This management of human resources is essential to the health and well-being of any business or organisation.

An occupational health department and its staff can assist company managers greatly in the control of absenteeism but can do so only with the full cooperation and understanding of both the managers themselves and the workforce.

General considerations

The control of absenteeism and sickness absence is in the eyes of company management, often wrongly, seen as one of the most important roles of a company medical service. The loss in production due to absenteeism is a significant factor in the overhead costs of most industries and, although the mean absentee rate is 5.05% throughout the country, absentee rates in excess of 10% are not uncommon in manufacturing industry.

It must be stressed, however, that the control of absenteeism, along with the enforcement of any disciplinary measures necessary, remains firmly a responsibility of management and it is quite possible to reduce absentee rates to a level of 4–5% by active management including encouragement to remain at work or to return to work. This includes the responsibility for hiring and firing as appropriate.

A referral to see the company doctor was seen in 'olden' days as a method by which malingerers could be identified or where those with high absence records could be discharged or retired on medical grounds. Occupational physicians do not accept such a role and any such cases are usually referred back to management. The occupational health service is, however, a very important support service and in those instances where medical advice is sought, that advice must be seen to be both advisory and impartial.

Causes of absenteeism

In general, absenteeism covers any absence from work other than annual holiday entitlements or

planned absences for such things as courses and meetings which are normally excluded from absenteeism statistics. The majority of absences are covered by self certification or medical certificates and are therefore classed as 'sickness'. The remainder involve unauthorized absences, unpaid leave and authorized absences for reasons such as family bereavement.

As unauthorized absences and unpaid leave would be expected to involve disciplinary proceedings and/or loss of wages, it is understandable that anyone absenting themselves from work will attempt to ensure that the absences are classified as due to sickness whether or not this is the case.

Most absence from work is voluntary, especially absences of less than a week. Doctors are, in general, ignorant of the scope and demands of a patient's job and therefore have to accept the patient's assessment that he is not fit for work. Similarly, when a patient has been off for some time it is difficult for the doctor to decide when the patient has become fit to return to work without taking account of the patient's own assessment. Consequently it is frequently only when the patient feels fit for work, that a final certificate is issued.¹

When looking at rates of absenteeism it becomes immediately apparent that manual or blue collar workers have higher rates than executives. This can be partly explained by the fact that blue collar workers tend to have much more physically strenuous tasks, and tend to have less commitment to their job. Executives have a more cerebral approach to work and frequently can continue at work when they would not be able to do manual work. In addition the sick executive may be able to work from home without interfering with his or her effectiveness to the organization.

Younger employees tend to have more frequent short absences from minor causes with longer absences for sports type injuries whereas older employees have fewer short absences and their more lengthy absences tend to be due to serious and significant conditions.

Certification of absence

The first 7 days of a spell of sickness can be self certified by the individual but after this period the absence must be certified by a medical practitioner. It is not unknown for bizarre causes for absence or diagnoses to be entered on self certificates and, in many instances, accepted by the absentee's superior.

Since 1983 employees have been required to complete a self certification form for absences of 7 days or less. In most cases this also includes the first 7 days of a longer period of absence. The individual will indicate on the form what he or she considers to

be the cause of the absence and the supervisor will consider each case on its own merit.

Any absence of more than 7 days duration requires a medical certificate signed by a medical practitioner (except for those in hospital) stating that the patient is unfit for work. The Fisher Committee (1973)² decided that this system was the best available despite British Medical Association evidence that in the majority of cases medical certificates were given on demand. It is difficult for a general practitioner to refuse a medical certificate as this would require evidence of fitness for work.³

As diagnosis relies to a great extent on verbal information from the patient, such information is frequently not forthcoming or misleading. A large proportion of certificates are requested on the historical basis of having already been off sick for a week and recovering. Consequently, it must be accepted that in the majority of cases of sickness absence it is the patient who really decides whether or not he is fit for work. Absences tend to be for a whole week or multiples of a week and general practitioners seem to regard a week as a unit of time. This does lead to considerable abuse of the system but the general practitioner can in no way be expected to 'police' an individual's absenteeism. The causes of absenteeism are much more complicated than purely illness, but the method of certification recognizes neither the scope of the problem encountered nor the degree of incapacity.

Control of absenteeism

The control of absenteeism is outwith the remit of an occupational health service and rests squarely with the business's personnel section or the line manager. A standard procedure for dealing with absence from work is necessary to ensure even treatment of all cases and to set down formally and in writing the rules with which employees have to comply.⁴

Any breaches of the rules can then be identified and dealt with accordingly. Organizations with an occupational health service can and should, as part of the disciplinary procedure, encourage referral to the service to the employee, especially if there is a possibility that he or she may be suffering from a significant illness which might have a bearing on the outcome of the disciplinary proceedings.

In cases where a significant illness or condition is found the facts can be put to the formal disciplinary hearing for consideration before any decisions are made. In these circumstances the medical officer has to act ethically and any revelation to the tribunal would only be possible with the informed consent of the individual concerned.

In most industrial concerns the control of self certification depends upon the immediate super-

visor interviewing the employee on return to work in order to ascertain whether the absence can be authorized as due to sickness. This provides the supervisor with the opportunity to manage his department and in many instances the new system has resulted in a closer understanding of work-related problems although in others the opportunity has been taken to harass any employee taking time off for genuine reasons. The change in legislation has, in the main, not resulted in the increase in absence rates predicted when they were first announced. Abuse of the system, however, continues and the absentee's manager should satisfy him or herself that the absence is for genuine reasons before sanctioning it. Self certificates have been known to include diagnoses such as 'knackered' and 'sleeplessness due to an all night reggae party next door'. In both instances the absences were sanctioned.

Certificated sickness absence is slightly more complicated to deal with as it implies that a medical practitioner has concluded that the individual is not fit for work. As indicated above it does not necessarily follow that this is the case but managers are frequently reluctant to take any action against employees who are in receipt of a medical certificate. The fact that a medical certificate has been provided does not negate any responsibilities of management and they remain entitled to manage their business as necessary.

Attitudes of management

Management has both the right and the responsibility to manage the affairs of their company. This includes the control of absenteeism including, if necessary, disciplinary action or even dismissal for persons with a poor attendance record. Legislation does not force any employer to continue to employ any person unable to do the job he or she is employed to do. The high level of absenteeism, frequently in the region of 8–12%, is blamed on the medical profession because a great proportion of these absences are covered by medical certificates. There is also a great reluctance on the part of management to shoulder their responsibilities and many companies accept higher rates of absenteeism rather than risk being taken to an industrial tribunal for unfair dismissal.

Causes of sickness absence

It is quite understandable for the layman to assume that any period of certificated sickness absence is due to genuine illness sufficient to render the claimant unfit to attend work. This, however, is frequently not the case.

The reasons for absence may fall into one of the following general categories: (a) *Genuine illness*. Sickness absence may be, and frequently is, due to a genuine personal medical problem that makes the individual unable for some reason to attend work. (b) *Occupational causes*. Occupational causes for absence from work will mostly be due to work-related illness or injury, but in addition may include problems with social relations at work and will be influenced by the individual's attitude to working, to the general level of morale at the workplace, to his or her level of job satisfaction as well as his or her relationship with work colleagues and supervisory staff. (c) *Social ailments*. Social reasons for absence I would limit to problems within the family or close social circle and include such things as bereavement, having to stay at home to look after a sick relative, problems with looking after a new baby or other home problems. (d) *Miscellaneous*. It is difficult to categorize those who for multitudinous reasons are, or feel, unable to attend work routinely. In this group, however, will be found those who malingering as well as those with undiagnosed or unrecognized psychological or psychosocial problems.

Identification of problem areas

In many instances it is possible in an occupational health department to identify a problem area at the workplace due to an increase in certain types of symptoms (such as dermatological or respiratory) or by analysis of the diagnoses on medical certificates. Similarly, where there is increased stress in departments or problems with morale or interpersonal relationships such problems can be identified and investigated. It is extremely important to have accurate diagnoses for such assessments to be valid and regrettably all too often identification of these problem areas is made only in retrospect.

It is realized that there are circumstances where it is not in the patient's best interests to put an accurate diagnosis on the sickness certificate. This would include ailments where the general practitioner may not wish the patient to know the diagnosis as well as where the patient would not wish the cause of his absence to become generally known. It, however, may be important that the possible relationship of factors at the workplace be investigated and the occupational physician is covered by the same rules on medical confidentiality as all medical practitioners. In such circumstances a dialogue between the occupational physician, the general practitioner and/or the hospital specialist will facilitate diagnosis and treatment.

It is well understood that a general practitioner cannot be expected to understand the scope and

demands at a patient's workplace. Company occupational physicians will be delighted to discuss individual cases with their general practitioner or hospital specialist and will be able to make arrangements for an earlier return to work in many instances, with appropriate short-term restrictions on working hours or specific tasks. Such an early return to work will be beneficial both to the patient, by tailoring his or her return to normal working, and to the business by shortening the total length of absence.

The role of the occupational physician

Although, as has already been stressed, it is not the function of the occupational physician to act in a disciplinary role it is quite possible that he can assist in the reduction of overall absence due to incapacity.

The occupational physician can provide advice to both management and to the individual concerned. For the individual he will assess the current state of health, provide advice on the suitability of his or her job and advise on any limitations on working ability. He can also advise the employee on the suitability of alternative work to take account of any permanent disabilities. For management he can confirm the genuine nature of absences and advise on the likelihood of a return to normal work. He will advise on the suitability of the work the individual is given, on any work restrictions, protective equipment and protective clothing required and on action necessary to prevent or reduce the likelihood of a recurrence of the ailment if it is occupationally related. Such advice will frequently promote an early return to work as well as benefit the patient's recovery.⁵

The duties of the occupational physician include the promotion of an early return to work and liaison with personnel and supervisory staff to ensure the suitability of the individual's work. Conferences between management, personnel and occupational health staff frequently find alternative solutions for employees no longer fit for their current job – either on a temporary or permanent basis. Cases of genuine illness or incapacity are easily dealt with and are usually treated with understanding by management.

Access to Medical Reports Act 1988

The Access to Medical Reports Act 1988 came into force at the beginning of 1989 and requires patients to be given the opportunity to see reports concerning their health; reports to employers by general

practitioners or hospital specialists are included in the Act.

The occupational health service will obtain consent for a report before it is applied for and will forward the completed form with the request for a report. The general practitioner will then, if the patient has requested to see the report, keep it for up to 21 days to allow the patient an opportunity to read it before it is forwarded to the occupational health service.⁶

Interrelationship between the occupational physician, the general practitioner and the hospital specialist

The occupational physician provides an at work service to individuals who already have their own general practitioner and it is not the intention of the occupational physician to interfere in that relationship.⁷ He or she will, however, have an understanding of the environment in which the patient works and will therefore be in a good position to assess the fitness of the employee for the work on which he is employed.

In cases where a possible work-related problem arises, such as an occupational dermatitis, work-related upper limb disorder or asthma, the occupational physician may wish to refer the employee directly for a specialist's opinion. He will be able to give detailed information to the specialist on the hazards encountered, but if contemplating such a referral he should contact the general practitioner prior to doing so and should also ensure that any reports are copied to him.

The occupational physician is similarly happy to cooperate as far as possible with hospital and other specialists in encouraging an early return to work by providing any assistance necessary in the investigation and will advise and discuss the possibility of short-term restrictions which could be used as part of the rehabilitation process.

Conclusion

Many of the problems relating to sickness absence are caused by the abuse of the system by individual employees and by the lack of control over absenteeism exercised by management.

Although an occupational health service will not act in a policing role, advice and assistance will be given both to the employer and the employee in dealing with genuine cases of illness and on promoting an early return to work where this is feasible.

A company occupational health service is avail-

able to advise general practitioners and hospital specialists on the demands of an individual's employment and will in many cases be able to tailor

a return to work package which will reduce the total length of absence as well as promote recovery and rehabilitation.

References

1. Waldron, H.A. *Lecture Notes on Occupational Medicine*, 3rd ed. Butterworths, London, 1985.
2. Fisher Committee 1973. *Report of the Committee on Abuse of Social Security Benefits*, Cmnd 5228. H.M.S.O., London.
3. Searle, S.J. Sickness absence. In: Waldron, H.A. (ed.) *Occupational Health Practice*, 3rd ed. Butterworths, London, 1989, pp. 341–358.
4. Gardner, A.W. & Taylor, P. *Health at Work*. Associated Business Programmes, London, 1975.
5. Edwards, F.C., McCallum, R.I. & Taylor, P.J. *Fitness for Work. The Medical Aspects*. Oxford Medical Publications, Oxford, 1988.
6. Access to Medical Reports Act 1988. H.M.S.O., London.
7. *Guidance on Ethics for Occupational Physicians*, 3rd ed. Faculty of Occupational Medicine, Royal College of Physicians of London, 1986.