

Sickness absence

THE publication last year of an Office of Health Economics Briefing (1981) entitled "Sickness absence—a review" has focussed attention on an area of considerable interest to general practitioners but which has, nevertheless, been relatively neglected as a subject for research.

Sickness absence is by far the most important cause of lost working time in the UK. In 1978/79, for example, there were 371 million days of absence due to certified incapacity compared with 15 million days arising from industrial injuries or prescribed diseases and only 9.4 million days due to industrial stoppages. Moreover, official figures on sickness absence are subject to some limitations. They do not generally include about half of married women because they have opted out of the national insurance system. Some occupational groups and members of the armed forces are not covered and there are an unknown number of absences which are not recorded because no benefit is claimed. Upper levels of management, for instance, do not necessarily have to account for short-term sickness to the same degree as shopfloor employees.

There was an increase of about one third in total days of certified incapacity between 1954/55 and 1978/79. All of this is accounted for by an increase in certified incapacity for males; only about 20 per cent of the increase appears to be due to demographic changes. The mean duration of sickness absence over a year, per 100 persons at risk, has increased for both males and females by about 54 and 20 per cent respectively. This change is due mainly to an increase in the number of spells of absence. In particular, there has been an increase in the proportion of spells lasting less than one week and a small increase in those lasting more than 12 months.

These overall trends do not give obvious clues to the causes of the observed changes and may contain within them sub-groups of particular interest. Regional differences exist: Wales and the North of England have considerably higher rates of incapacity amongst males than the national average. International comparisons are made difficult by differences in criteria for certification, although Taylor (1969, 1972), who studied sickness absence rates in eight European countries and the USA up to the end of the 1960s, showed a consistently rising trend. The aetiological determinants of sickness absence are likely to include cultural, organizational, personal and medical factors (Taylor, 1979). Rising trends in sickness absence do not therefore necessarily reflect underlying patterns of morbidity. However, we, as general practitioners, should note that nearly 30 per cent of all days of certified absence are attributable to ischaemic heart disease, hypertensive disease, chronic bronchitis and arthritis rheumatism. The general prac-

itioner has an important role in managing all these conditions, and in the case of at least the first three there is also potential for preventive measures (Royal College of General Practitioners, 1981). It is not clear how much sickness absence could be reduced by more discussion between general practitioners, occupational physicians and their patients, with a view to matching working conditions to patients' medical needs. This area requires further investigation.

The process of the return to work following sickness absence is sometimes unsatisfactory from a medical point of view in that it often assumes a sudden transition from sickness to health. It would be more appropriate in some cases to allow patients to return to part-time working or to assume light duties for a period.

The increase in short-term spells of absence may reflect the increasing acceptability of taking time off for relatively minor conditions. This is often viewed as an adverse trend. However, before accepting this judgement uncritically, it may be prudent to determine whether those who tend to take short-time sickness absence actually produce less than their fellow workers over a long period. It may be relevant that during the three-day week in 1974, production fell by less than was predicted, on the basis of the reductions in time spent working, and productivity per working day actually increased (Department of Industry, 1976). Once the three-day week was over, productivity increased even further.

We sometimes make value judgements about the validity or otherwise of some sickness certification. It would be interesting to know whether such value judgements might be modified if doctors were to experience at first hand the monotony on the production line. The relationship between job satisfaction, the organization of the workplace and sickness absence requires clarification. Perhaps the discipline of the randomized controlled trial should be applied to industrial organizations just as it has been to medical treatment.

There is some controversy over whether unemployment is likely to affect the volume of certified incapacity (Plummer and Hinkle, 1955; Enterline, 1965; Taylor and Pocock, 1969). It is possible that even though the levels of unemployment reached in the UK in the 1950s and 60s did not have a measurable effect, the continued increase will have a demonstrable influence on sickness absence both by creating job insecurity and because those with poorer health will find it more difficult to gain employment. The disabled are particular victims of trends in unemployment, and perhaps general practitioners should be more vociferous in support of appropriate employment for the disabled before the role of the Disablement Resettlement Officer becomes entirely symbolic. It has been shown that in adults with long-

term disability and undergoing rehabilitation, early return to stable employment is related to the duration of unemployment beforehand. General practitioners should therefore refer such patients at the earliest opportunity for medical and vocational rehabilitation (Sheikh and Mattingly, 1981).

Recently, it has been proposed by the Government that responsibility for sick pay during the first eight weeks of incapacity should be borne by employers (Department of Health and Social Security, 1980). The objectives of this new policy are to enable sickness payments to be taxed and to avoid duplication of provisions by the state and the employer. It was calculated that the saving in public expenditure would be over £400 million. However, there have been objections to these proposals. The Confederation of British Industry criticized them for offering inadequate compensation to industry. Other criticisms include the difficulty of ensuring that small firms comply with the regulations, the lack of safeguards against unscrupulous employers and the extremely low level of the proposed statutory sick pay. In addition, those who suffer from chronic ill health or disability will find it even more difficult than at present to gain employment, because employers will be more reluctant to take them on. It is disturbing to note that the proposals do not contain any reference to the needs of the sick. Major changes of the kind suggested require careful consideration on the part of doctors to ensure that the interests of patients are not neglected.

Considering its importance to the country in economic and medical terms, sickness absence has been the subject of remarkably little research. Within this appar-

ently mundane and unglamorous field of study it is likely that there are important clues both to future directions of public health policy and to causative factors in illness behaviour. General practitioners and their colleagues in occupational medicine should undertake collaborative investigations in this area.

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Episiotomy: has familiarity bred contempt?

EPISIOTOMY has been described by Llewellyn-Jones (1977) as one of the least considered and most painful of all operations performed on the human female; far too many women leave hospital with the memory of perineal pain which they say is far worse than the pain of parturition. A series of essays published by the National Childbirth Trust (Kitzinger, 1981), together with the recent studies by Kitzinger and Walters (1981), on the attitudes of 1,800 women to episiotomy, and by Reading and colleagues (1981) of women's views of post-episiotomy pain, has focussed attention on this further example of a medical practice which has become routine on the basis of assumptions rather than evaluation. Although episiotomies are now undertaken in 30 to 70 per cent of all deliveries (and approach 100 per cent in certain units), there is apparently no scientific evidence that the procedure has any of the benefits

claimed for it. Extraordinarily enough, no study has been undertaken to compare the effects on mother or baby of doing or not doing episiotomies, and there had been no previous research into women's experiences of the procedure.

Amongst the reasons for performing an episiotomy are that it has been thought to reduce the likelihood of a tear, but not only is this unproven, there is indeed some evidence to suggest the contrary (Fox, 1979). Post-episiotomy pain is frequently significant and prolonged and Kitzinger and Walters (1981) found that mothers having an episiotomy suffered more discomfort a week following delivery and had a higher incidence and duration of dyspareunia than those with lacerations. An episiotomy cuts across natural skin fold and muscles—factors which are associated with poor healing—and House (1981) has stressed that if the complications of