

Institute for Public Policy Research



# HEALTHY INDUSTRY, PROSPEROUS ECONOMY

IPPR discussion paper

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and **Chris Thomas**

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## DISCUSSION PAPER

This report is an IPPR submission of evidence and ideas to the Commission on Health and Prosperity. It does not necessarily reflect the full views of commissioners, and the commission will publish its full blueprint in 2024.

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## ABOUT THIS PAPER

This report advances IPPR's charitable objective of advancing physical and mental health.

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# SUMMARY

**The UK is sick and getting sicker.** Compared to other advanced economies, the UK lags on treatable and preventable mortality, obesity rates, alcohol harm, incidence of chronic long-term illness, symptoms of anxiety and depression, cancer, dementia, and cardiovascular disease survival.

**Our health and our economy can exist in either a vicious or virtuous circle.** This Commission has already shown that the onset of sickness increases the risk of employment exit by up to 112 per cent, and impacts annual earned income by up to £2,200 – meaning good health has the potential to strengthen the economy substantially: through productivity gains, higher growth, a stronger labour market, and a more regionally balanced economic model. The OBR, Bank of England and HM Treasury have come to similar conclusions. But we also need to recognise that the nature of our economy – from what jobs are available, to the level of workplace protections, to the products on our shop shelves – are key determinants of our health. It is possible for public health and the economy to either support or undermine each other.

**If we want health and prosperity, then public health and economic strategy need to work in lockstep – but this is not the case today.** The growth in insecure or low-paid work, a proliferation of health harming products (and lack of health-promoting alternatives), underinvestment in health-vital industries, and weak investment in public services are problematic. We are allowing negative health externalities to grow, while not taking the opportunities available to us to help health-vital industries – from the life sciences; to healthy food and agriculture; to active leisure and transport – to thrive.

**Both businesses and individuals could gain from a transition to a health-led economy.** Health can impact workers and employers in several ways – including more sick days, and reduced productivity among people working through their sickness. We estimate that if employees were as healthy in 2023 as they were in 2018, we would achieve gains worth £30 billion. Eighty-three per cent of this is from lower rates of employees detrimentally working through sickness (presenteeism). This could translate to higher business revenues and higher wages for workers – plus, given the link between working through sickness and long-term sickness, better population health outcomes.

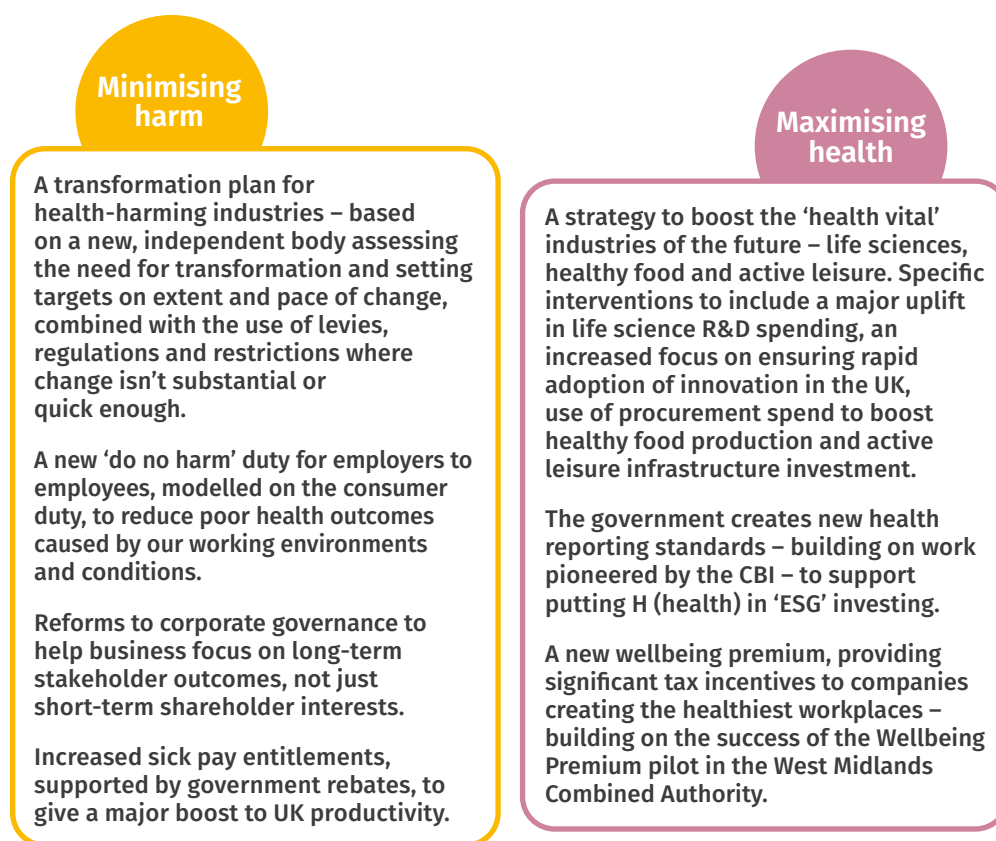
**The benefits of workplace health are likely to be progressively distributed.** We find that working through sickness is more common among people in lower-quality jobs, people with lower socioeconomic status, and from marginalised ethnic groups. This likely reflects broader health inequalities in the UK. Given working through sickness is bad for individuals as well as businesses, this indicates that the benefits of improving workplace health may be progressively distributed.

**Companies and markets are important to health and prosperity.** There is a tendency in health policy to focus on what government can do for health, through public service delivery (schools, healthcare, social security). This is vitally important. But it also overlooks the huge health-creating potential of businesses, which employ most UK workers and have far greater investment power than the state. Given better health is in UK businesses' self-interest, it is time for the state and industry to work together on delivering better health and, in turn, a stronger economy.

**Markets and businesses cannot ignore health.** While it might be tempting for some businesses to ignore health – or worse, to try to limit the number of employees they have with health conditions or disabilities – this approach is not viable. Twenty-six million people have long-term conditions in the UK. The number of working-age adults living with one or multiple health conditions is set to rise rapidly over the next decade. Businesses need to be part of the solution.

**We propose a new approach – what we call ‘Health in All Industries’ – to harmonise public health and industrial policy.** It is vital we harness the role of industry in supporting health. And this means we need a plan for both the kind of products and practices we should move *away from*, as well as what products, practices and industries we need to strengthen as part of a new plan for health, growth and prosperity – particularly relevant given the new government’s particular focus on economic growth. Our policy recommendations include the following.

**FIGURE S.1: POLICY RECOMMENDATIONS**



Source: Authors’ analysis

**This is a pro-business plan for a better future – with major public support.** While we recognise these policies will have winners and losers – as with all industrial strategy – this plan acknowledges that businesses can be the foundation of a healthier more prosperous country. And that partnership between state and business can drive the innovations, new brands, products, and workplace norms that will drive health and prosperity. Moreover, our new polling shows the public are behind government intervention on health. Seventy-four per cent of people think that the government should be doing more to support our health. This highlights that there is significant appetite for change across the political spectrum.

# 1. OUR HEALTH AND ECONOMY

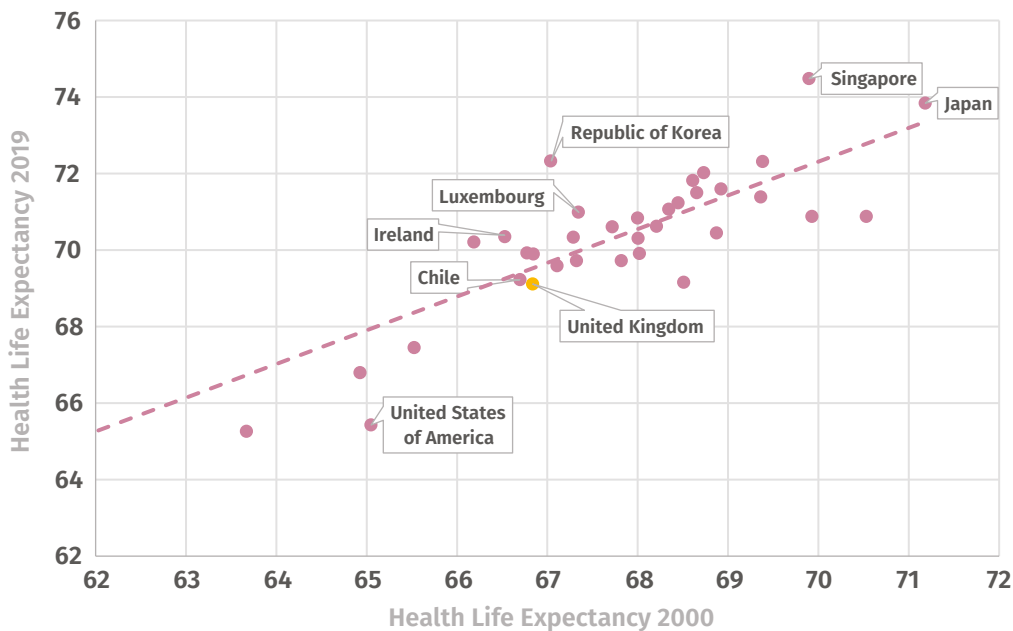
The UK is the (literal) sick man of Europe. On a range of measures, our health outcomes lag our peers: we have seen larger falls in life expectancy compared to comparative countries as a result of the pandemic (Raleigh 2023); since austerity, rates of depression and anxiety have been rising (Bell and Blanchflower 2019); and we have high cardiovascular, dementia and cancer mortality rates (Anandaciva 2023; Patel et al 2023a).

It is, therefore, unsurprising that we also lag substantially behind other advanced economies on healthy life expectancy.<sup>1</sup> In fact, not only are we behind most other advanced economies on overall healthy life expectancy, but also in improvement over time. The gradient (dotted line) in figure 1.1 shows that the UK is also improving more slowly than most other countries – where, by contrast, Ireland, the Republic of Korea and Singapore have all observed rapid improvement in the past 20 years.

**FIGURE 1.1.**

## The UK lags on healthy life expectancy

Healthy life expectancy at birth, 2000 and 2019 by high income countries



Source: IPPR analysis of Global Burden of Disease (2019)

The UK also has among the highest level of health inequality in Europe (Johns and Hutt 2023). Figure 1.2 shows both the disparity in healthy life expectancy at birth between regions in England – and devolved nations in the UK – as well as how much healthy life expectancy each would have gained, had rates of improvement

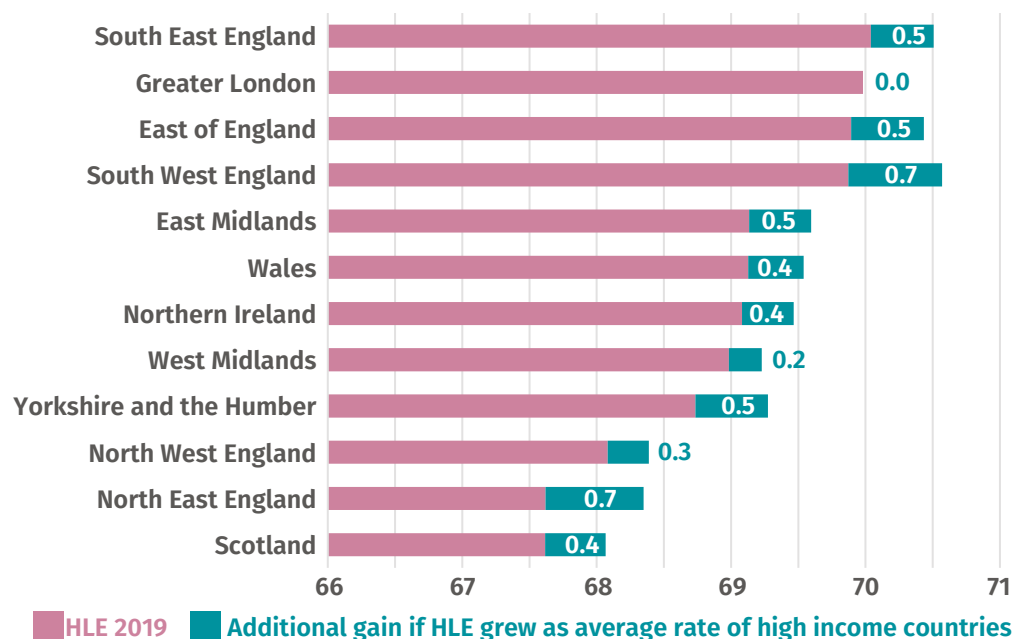
<sup>1</sup> The number of years an individual can expect to live in good health.

been the same as the average across all advanced economies. It shows only London has witnessed health improvements comparable to those seen in similar countries, with other English regions and UK nations falling further behind.

**FIGURE 1.2.**

**Healthy life expectancy has fallen behind international standards everywhere except London**

Healthy life expectancy (HLE) in 2019 by region or nation of the UK and expected HLE if each saw the same increase as an 'average' high-income country 2000–2019



Source: IPPR analysis of Global Burden of Disease (2019)

Going forward, the UK is set to fall even further behind on health. Analysis by Lynch et al (2022) suggests that in the two decades to 2035, men aged 50 can expect to gain 4 days per year in good health while women can expect to gain 18 days. By contrast, from 2000 to 2008 – men gained 70 days per year and women gained 44 days. This would constitute a large deceleration in progress – and one that threatens to leave our health, wellbeing, living standards and economy yet further behind that of other comparable nations.

**THIS IS A CRISIS**

Left unmitigated, growing sickness will increase both the length of time and proportion people can expect to live their lives in poor health. This would undermine wellbeing and happiness in the UK. But it is also a grave fiscal threat. Analysis by the OBR (2023) suggests the following economic implications of increased sickness since the Covid-19 pandemic.

- **Foregone tax revenue:** the rise in economic inactivity, due to sickness, combined with the rise in in-work sickness has already been associated with an £8.9 billion reduction in tax receipts annually (OBR 2023).
- **Higher welfare spending:** This corresponds to £6.8 billion higher welfare spending per year.
- **Higher healthcare spending:** It is projected that each person who becomes inactive due to ill health costs the NHS between £900 and £1,800 a year (ibid).



With the Health Foundation projecting a 2.5 million increase in the number of people living with a major illness by 2040, these already substantial costs could increase dramatically (Watt et al 2023). The flip side of this problem is an opportunity to deliver health for growth – one well aligned with the priorities of the new government.

When looking for solutions to these problems, policymakers, politicians and commentators often turn to the National Health Service. And indeed, the NHS has ongoing challenges with access, performance and quality which do contribute to the problem (Patel 2023). The IPPR Commission on Health and Prosperity outlined a plan for sustainable, high-quality and personalised health and care services late last year (ibid).

However, relying solely on treatment is not likely to resolve our health crisis. We need to broaden our problem definition and explore a wider range of solutions to tackle the UK's high and damaging rates of population sickness.

1. **Health drivers extend beyond treatment:** Health is influenced by factors beyond healthcare, with only 10–20 per cent attributed to it (Woolf 2017); a comprehensive health strategy would need to consider the other wider determinants.
2. **Prevention<sup>2</sup> and cure are both crucial:** Relying solely on cure is unlikely to be financially viable (ibid); we also need to focus on prevention where the UK already lags. We have 80 per cent more preventable deaths per capita than Japan, Israel and Iceland.

There is evidence that, when correctly implemented, preventative measures and accounting for wider drivers of health can have significant impacts on people's health. Japan has shifted from the shortest- to the longest-lived G7 country in 70 years. This is attributed to a blend of healthcare innovation, nutrition policies, childhood health initiatives and workplace programmes (Nakatani 2019). If the UK is to solve the grand challenge of growing sickness – and to reap the associated prosperity benefits – it will need to pull the full range of levers available to it, rather than try to treat its way out of its crisis.

### **'IT'S THE ECONOMY, STUPID'**

The core contention of this report is that enhancing health involves more than reforming a single public service (that is, the NHS);<sup>3</sup> in fact, it requires nothing less than a redirection of the economy, towards one that fosters and supports good lifelong health for all. Put another way, we need to put population health and economic strategy in lockstep – aligning the goals of faster growth and better health.

This might sound bold. But the reality is the health of our people and the health of our economy can either exist in either a virtuous or vicious circle. If people have good health the economy benefits; if the economy provides the means for a healthy life, health improves.

Whether we have a vicious or virtuous circle is defined by:

- What products and services we produce and consume: Including whether our shop shelves and high streets are dominated by health-creating or health-harming products, and whether we are innovating strategically in health-vital sectors, from the life sciences to food and health technology.
- Whether we distribute the resources necessary for good health: Whether people have enough money; access to good-quality, well-staffed public

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2 Our definition of prevention encompasses both primary prevention (preventing illness before it occurs) and secondary prevention (reducing the harm associated with a diagnosis).

3 Though this is itself important – we published our vision for NHS and social care reform in Patel et al 2023b.

services (including healthcare); access (enough) healthy food and decent housing; the means to maintain social relationships; and are free from debt and financial insecurity.

- What jobs are available, in what working conditions: Including whether people are able to get employment, and whether that employment is secure, rewarding, flexible and well paid.

In this report, we focus on the nature of work and employment – as well as what products and services are most prevalent in the economy – having covered approaches to inequality, the ‘social determinants of health’ and health and care services in other publications (Poku-Amanfo et al 2024; Patel et al 2023b)

### IS THE RELATIONSHIP BETWEEN HEALTH AND ECONOMY VICIOUS OR VIRTUOUS IN THE UK?

There are examples of sectors and companies within the UK economy that support good health: through good jobs, fair pay, health-creating products, low pollution manufacturing and fair tax revenues. But there are also large areas in the economy that currently pose risks to public health. More specifically, we point to four areas where alignment between public health and economic strategy is currently particularly lacking:

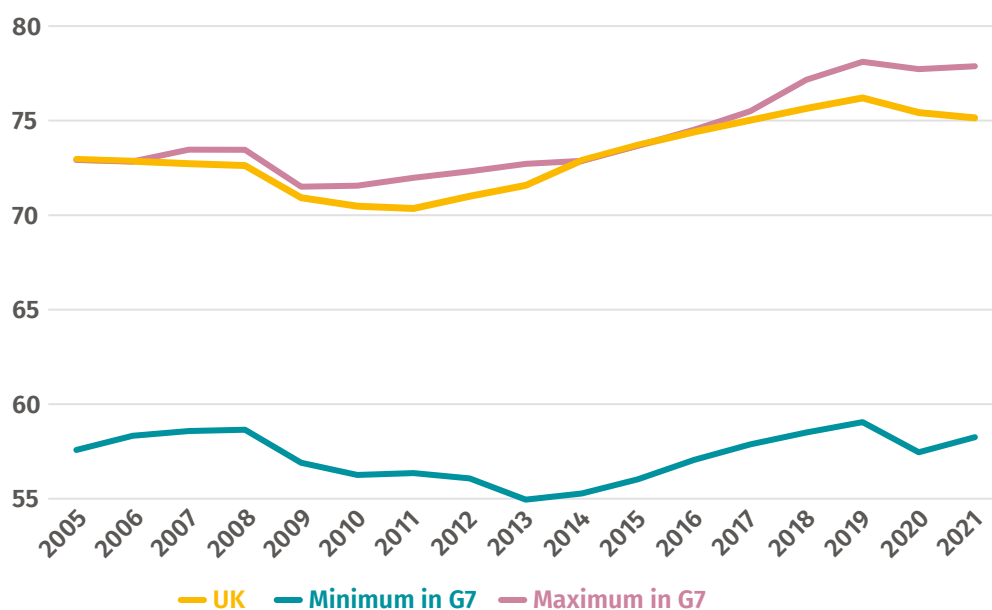
#### 1. High employment, but a considerable number of poorer-quality jobs

Since the 2008 financial crisis, the UK has managed to maintain a high level of employment, including compared to other G7 nations (figure 1.3). Yet, the employment rate says little about the quality of those jobs. In recent times there have been indications of faltering job quality – for example, there were over a million people on zero-hour contracts in 2023 compared to 190,000 in 2011 with younger workers being disproportionately affected (ONS 2024a).

**FIGURE 1.3**

#### The UK has a high rate of employment compared to peers in the G7

The rate of employment as proportion of working-age population (16–64 years old) of the UK and the lowest and highest of the G7 each year



Source: IPPR analysis of OECD (2024a)

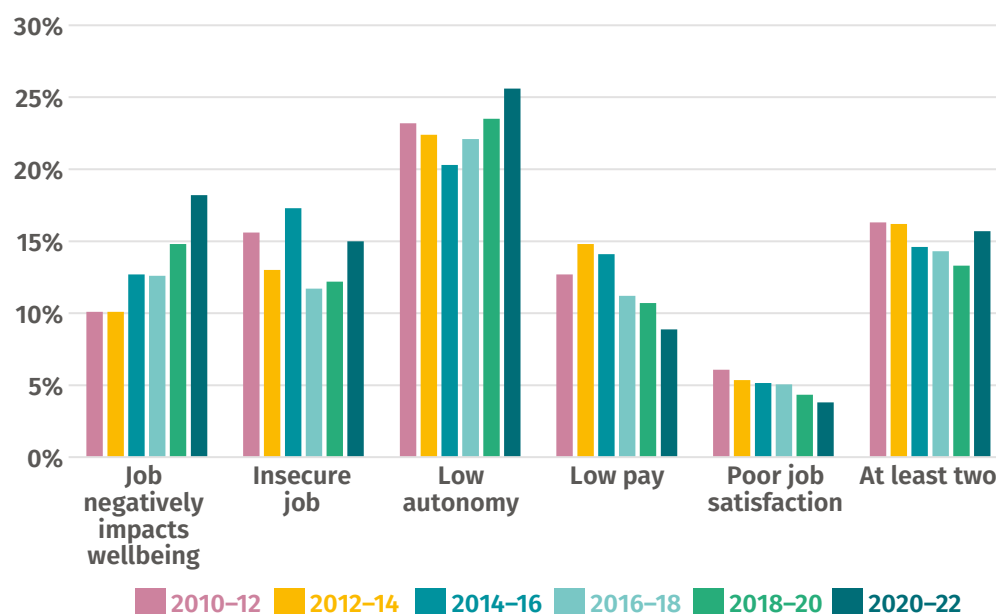
There is evidence that a bad job is at least as bad for our health as having no job at all (Chandola and Zhang 2018). Taking inspiration from their metrics of job quality, we find that there are a significant number of jobs in the UK that are of poorer quality.

Moreover, an increasing number of people note the impact of their jobs on their mental wellbeing. We define this impact as the consistent experience of feelings like tension, unease, worry, depression, gloom or misery because of their job. Between 2010 and 2012, 10 per cent of people reported negative effects on their wellbeing due to their jobs. This figure has risen to 18 per cent in the period 2020–22.

**FIGURE 1.4**

**Though there has been improvement in some job quality indicators, we are seeing increases in low autonomy jobs and jobs that negatively affect people’s wellbeing**

*The proportion of people with low-quality job indicators by wave of Understanding Society*



Source: IPPR analysis of University of Essex (2023)

Note: Low wellbeing is measured by people indicating that across the six measures of emotional perceptions of jobs (whether it inspires feelings of tension, unease, worry, depression, gloom or misery) they score an average score which indicates that they have these feelings some, most or all the time. Low job satisfaction is measured by employees who report feeling somewhat, mostly or completely dissatisfied with their job. Low job autonomy is measured across five dimensions of job autonomy, an average score indicating some or a lot of limitation. Low pay is measured by people having two-thirds or less of the median salary in each wave.

A notable trend has emerged in the proportion of workers reporting limited or no autonomy in their work. In 2020–22, one in four workers reported such limitations, a rise from the lowest point in 2014–16 when one in five workers faced this situation. Our findings also reveal that over 15 per cent of all jobs in the UK exhibit two or more of these indicators of poor quality. This underscores a significant prevalence of lower-quality jobs, raising red flags about the state of our labour market.

## 2. We overconsume some ‘health harming’ products and services

There is a susceptibility in UK policy to overly focus on GDP as a single, overarching measure of our success (or failure). As useful as this indicator is as a metric of output-growth, there is a bluntness to GDP that also carries risks. Growth has a direction as well as a magnitude. GDP is too blunt a measure to account for economic activity and output that either mitigates or accelerates climate change. In health policy, we must be equally aware that it does not differentiate economic gains that support or harm our health.

Of particular concern has been the rise in consumption of many products and services that harm our health:

- **Unhealthy food:** Six in ten of adolescents’ calories have come from ultra-processed food in 2019 (Chavez-Ugalde et al 2023).
- **Gambling:** Gambling revenues have increased substantially: rising by 80 per cent since 2008/09 (Gambling Commission 2024).
- **Alcohol:** 2021’s alcohol specific mortality was the largest since records began –close to a 30 per cent increase since 2019 (ONS 2022).
- **Smoking:** Though smoking is at its lowest proportion since 2011, 6.4 million adults still smoke in the UK (ONS 2023a).

Table 1.1 shows how much revenue from health-polluting businesses is derived from purchases above the government guidelines on consumption with tobacco, alcohol and unhealthy food sectors (£53 billion). This indicates that our economy may be over-reliant on products that are bad for our health.

TABLE 1.1

Estimated industry revenue from purchases above government guidelines of products in 2022

Products	Pre-tax revenue (£bn)	Post-tax revenue (£bn)	Estimated proportion of purchases over guidelines (%)	Post-tax revenue derived from above guidelines (£bn)
Tobacco	25.13	7.34	100.0	7.34
Alcohol	45.84	25.70	43.4	11.16
Food	126.74	118.65	28.8	34.17
<b>Total</b>	<b>197.71</b>	<b>151.69</b>	<b>-</b>	<b>52.67</b>

Source: Jawad and Reed (2023)

## 3. Investment is low and misdirected

Another facet of our ailing economy is our low rate of investment. Public investment trails behind the G7 average and business investment ranks at the bottom of the league (Dibb and Murphy 2023).<sup>4</sup> This can be seen in figure 1.5 – from 2000 to 2022, the UK had the lowest rate of investment as a proportion of GDP in the G7 for all but five years and even then, we had rates only marginally above the lowest.

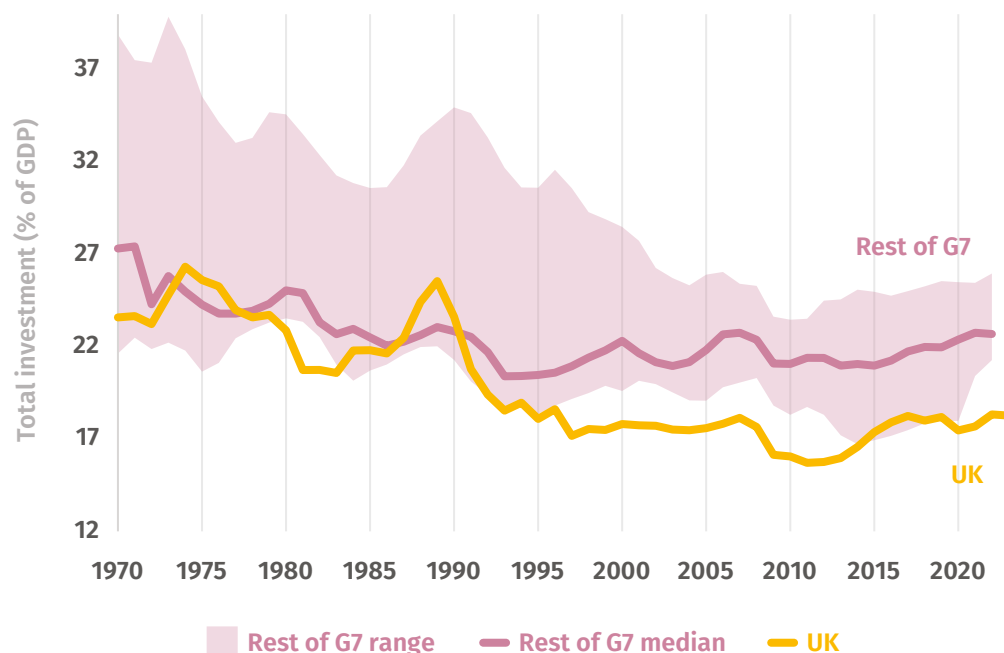
4 To give one example, foreign direct investment fell in the life sciences from £1.9 billion to £1 billion between 2021 and 2022 (OLS 2023).

Effective public investment can be transformative; it serves as a catalyst for supply-side benefits, the unlocking of future industries, technological advancements, and overall economic growth (ibid).

**FIGURE 1.5**

**The UK has low levels of investment compared to other G7 countries**

Gross capital formation (% of GDP) by G7 countries



Source: IPPR analysis of World Bank (2023)

However, the efficacy of investment hinges not only on its scale but also where this investment is directed. Butcher et al (2023) found that takeaway and grocery delivery firms garnered 60 per cent of global early-stage food tech investment between 2017 and 2021 – averaging £11.2 billion per year. Elsewhere, IPPR have shown that the UK lags behind on optimal life science investment – both in public investment, and attracting investment from the private sector (Nanda and Thomas 2023).

We might take some hope from a recent increase in patents dedicated to reducing calorie content in food, with an estimated 165 per cent increase over the past decade. However, simultaneously, UK public research funding for food reformulation<sup>5</sup> experienced a 33 per cent decrease (ibid). Beyond merely scaling up investments, there’s a pressing need to strategically direct funds towards areas with the most substantial public health impact. This includes investing heavily in prevention. In 2022 only £190 million was spent on prevention research, compared to £334 million in treatment development and £323 million in treatment management (UKHRA 2023).

**4. Our economy bakes in inequalities**

There is evidence that inequalities hold back economic prosperity. Increases to wage inequality have been shown to decrease productivity (Cohn et al 2011) and the introduction of the national minimum wage led to increases of productivity in low-paid sectors (Rizov et al 2016). Economies with more equal distributions of income

5 The process of altering the processing or composition of a food or beverage to improve its nutritional profile.

and wealth tend to have stronger and more stable paths of economic growth than those with greater inequality (Kibasi et al 2018).

These income and wealth inequalities also feed into health inequalities, by not allowing for people to make healthy choices. The poorest households have to spend half their disposable income on food to achieve a government-recommended healthy diet (Goudie 2023). Those on the lowest incomes also live in the poorest-quality housing, which has both physical and mental health consequences. The general quality of housing of the UK is poor – with one in four in the private rental sector living in houses that fail to meet the decent housing standard (Waters and Wernham 2023).

There are also significant inequalities in the environment in which people live. There are five times the number of fast-food shops in deprived areas compared to affluent areas (PHE 2017) which is then correlated to BMI (Han et al 2020).

Fewer than half of those with a household income of less than £15,000 lived close to green space but 63 per cent of those with a household income of more than £35,000 could find green space within five minutes' walk of their home (Holland 2021). This convergence of factors highlights the urgent need for systemic changes to foster healthier choices and lifestyles.

### IT'S TIME TO TRANSITION TO THE HEALTH-LED ECONOMY

This might sound a pessimistic assessment of the state of our health and our economy, but it also speaks to a unique opportunity: for the UK to become among the first advanced nations to make an (intentional) transition to what we call a 'health-led economy'.

This logic is better developed within climate policy. Faced with growing evidence that the economic status quo was not delivering long-term sustainability and responding to the scale and significance of climate breakdown, the climate sector developed the idea of a 'just transition' towards an economic model more conducive to the demands of climate emergency.

This has begun to have real bearing on industrial policies around the world. In recent years, both Europe and the United States have mobilised the state – in partnership with business and civil society – to further accelerate this transition. The US Inflation Reduction Act and the EU's Green Industrial Plan are ambitious articulations of industrial policy. In both cases, they have an overt commitment to growth – but also to a broader societal goal of a greener economy.

Far fewer of our peer countries have recognised the mutual benefits possible through a healthy industrial policy. Yet health shares much in common with climate. It is a global challenge; there will be huge, first-mover advantages for the country that creates the innovations that answer it; and it will not simply get better on its own, without new policy and investment. The UK should seize this opportunity and outline its own vision for a transition to a health-led economy.

We suggest that a health-led economy would have three key pillars:

- **A labour market that creates, and benefits from, good health:** Health should be a key part of our labour market strategy. The state has a central role in delivering good workplace health – indeed, the NHS was originally proposed as a primarily industrial policy. But in the 21st century, new levers are needed. In turn – in the context of a rising number of workplace-caused illnesses – employers should be expected to do more to ensure good workplace health across the economy.
- **Products and services that support health:** The products and services that dominate our high streets and our shop shelves, the adverts we see most

regularly, and the leisure activities we enjoy all determine our health. We need to tilt the real economy towards products and services that promote health – and that are genuinely accessible and affordable for all.

- **Investments in the health industries of the future:** Much of health policy is focused on state expenditure – specifically, whether the NHS and other health-critical public health services have enough money (or too much). But private investment and pension funds have access to more capital than the state. We need to think more carefully about how investments – including what our pensions are invested in – drive health and support the health industries of the future.

The rest of this report, the final major submission to the IPPR Commission on Health and Prosperity, explores the transition to a health-led economy. Chapter 2 outlines why we all have a vested interest in a healthier economic model – from individuals, to government, to businesses big and small. Chapter 3 explores what a health-led economy might look like – exploring case studies of employment practices, investments, innovations and new products that are already beginning to chart a path forwards. The report concludes by setting out a policy agenda to begin the transition (chapter 4).

## 2. QUANTIFYING THE BENEFITS

Good health is important. It enables us to work and fulfil a wider purpose in life – to take part in our community, see our friends, watch our children and grandchildren grow up.

The case to shifting to a health-led economy may be justified solely because it offers a route to significantly improve health, wellbeing and happiness for many. However, not exploring the potential economic benefits of this transition would underestimate the case for making it. Indeed, one of the strongest arguments for the transition is that it also has sizable economic benefits to a range of actors. This Commission has already demonstrated the benefit of health to individual prosperity and public finances (see Thomas et al 2023 and Patel et al 2023b).

In this report we focus on quantifying the benefits of a healthy workforce to UK businesses and workers. We do this for two reasons. First, to increase the completeness of this Commission's evidence on the whole-economy benefits for good health, having covered the relationship between health, earnings, employment and public finances elsewhere. Second, to test the more specific hypothesis that an economic transition towards health is in the mutual interest of businesses and industry, workers and government – and that all should be invested in collaborating to make better health a reality.

Specifically, this chapter focuses on quantifying the cost of poor health within workplaces. Elsewhere, we have covered the relationship between health and economic participation – another reason that businesses should care about health, particularly in the context of economic inactivity due to long-term sickness having reached record levels (see Poku-Amanfo et al 2024). We explore both the cost of sick leave (absenteeism), but also the productivity cost of attending work while sick (presenteeism). Combined, they provide an assessment of the impact of sickness on productivity – informed by the fact that productivity can support both business revenues, but also wage growth.

Throughout this report, we ascribe the cost of sickness to the structure of society and the economy, including workplaces. In line with the social model of disability, we do not believe that costs emerge from people's difference - but rather, the barriers society then creates. This is a report as orientated around what policy can do to create flourishing lives for people living with long-term conditions or impairments, as much as it is a report that explores the case for public health and prevention.

### HOW POOR HEALTH CAN DIRECTLY AFFECT THE EMPLOYEES AND THUS AFFECT BUSINESS

Poor health can impact businesses and employees in many ways. The three most direct ways in which poor employee health affects businesses are:

1. Employees can be absent from work due to sickness – we define this to be *absenteeism*.
2. Employees can attend work while sick (*presenteeism*) – which can then affect productivity. We recognise that attending work while sick does not always carry a cost – indeed, the literature has shown that attending work with some conditions can have a therapeutic impact, while job design can help others reach their potential (including adding value through diversity above and beyond). We focus on instances where attending work does



have a cost: either to individual productivity, recovery time from short-term illness, making others sick ('contagious presenteeism'), or other operational impacts. For simplicity from here, when we refer to presenteeism, we mean working through sickness when it has a negative impact.

3. Employees may leave the labour market prematurely due to sickness. We have already extensively explored economic inactivity substantially (see Poku-Amanfo et al 2024). Our attention for this report, therefore, is on absenteeism and presenteeism.

Our findings are based on the fact that 26 million people currently have a long-term condition, and 16 per cent of the English population experience acute sickness in a two-week period (NHS Digital 2023b). This demonstrates that sickness is currently and will increasingly, affect all workplaces – demanding a more thought through, inclusive and empathetic response.

### **INSIGHT 1: WORKERS IN THE UK ARE RELATIVELY UNLIKELY TO TAKE SICK DAYS, BUT LIKELY TO WORK THROUGH SICKNESS**

When employees are sick, they face the choice of taking time off (absenteeism) or continuing to work – which may lead to reduced productivity<sup>6</sup> (presenteeism). While the former has an obvious cost to business, there are significant 'hidden' costs associated with employees working through sickness.<sup>7</sup>

Continuing to work while sick, when that is not the appropriate choice for the worker and their specific needs, can not only reduce productivity – Stewart et al (2003) found that the onset of depression in employees significantly reduces productive time – it can also affect the long-term health of the employee. Skagen and Collins (2016) concluded in their literature review that presenteeism negatively impacts health and is a risk factor for future sickness absence and decreased self-rated health. The Whitehall II study (Kivimäki et al 2005) found that 'unhealthy' employees who took no sick leave had double the risk of serious coronary events compared to those with moderate sickness absence. Recent research by Stearns and White (2018) on mandatory paid sick leave in the US showed that it reduced overall leave taking and had public health implications by reducing the spread of contagious illnesses. That is, working through sickness – particularly, when sick leave would be appropriate – can have a cost to both business and employee.

There is evidence to suggest that the UK's balance between absenteeism and presenteeism is skewed towards the latter. Historically, absenteeism had been decreasing, since 2020 there has been a significant increase in the total number of days lost due to sickness, reaching a record high in 2022 (ONS 2023b). Despite this increase, the UK still has relatively low rates of sickness absence compared to other countries (OECD 2024b). This is surprising considering the UK's relatively poor health outcomes. The low number of sick days taken may contribute to higher rates of presenteeism in the UK. Data from the European Working Conditions Survey shows that the UK ranks high in presenteeism among European nations. In 2017, it ranked fourth (Bevan 2018), and in 2021, it ranked sixth<sup>8</sup> (EuroFound 2022).

The rest of our insights explore the implications of this skew towards working through sickness. It also explores the characteristics of people more likely to work through sickness, helping to understand the interaction between workplace health, prosperity and inequality.

6 It is not a given that working through sickness will negatively impact productivity. In this report we define presenteeism to occur when people attend work while sick which negatively impacts their work.

7 We recognise this is not in all cases – but rather, in instances when working through sickness worsens the individual's health, causes large productivity losses, or risks passing an illness to colleagues.

8 This year was affected by Covid-19 and so may be less comparable.

## BRIEF METHODOLOGY<sup>9</sup>

### Insight 2

Insight 2 assesses the potential expenses associated with presenteeism and absenteeism. To do this, we use published statistics from Vitality's workplaces surveys from 2017 to 2023 (Vitality 2024). We are able to estimate what the costs of presenteeism and absenteeism in 2023 would have been if businesses had that year's rate of presenteeism and absenteeism.

### Insights 3 and 4

Here we extend previous analysis by Bryan et al (2021 and 2022). The first part of this insight investigates the role of long-term conditions and job quality on presenteeism and mental and physical long-term conditions on absenteeism. We use Labour Force survey (2014 to 2019) data to estimate absenteeism and the Understanding Society survey (2010 to 2018) to estimate presenteeism.

To estimate the likelihood of exhibiting presenteeism we use logistic regressions controlling for various control variables such as education, sector and age. To estimate the number of days lost due to absenteeism we use hurdle models where we first model the likelihood of taking sick leave using a logistic regression, then model the number of days taken using a generalised linear model with the log link and a gamma distribution.

Throughout these analyses we show the predictive margins from the regressions – which estimate the contribution of each variable to the likelihood of exhibiting presenteeism or the number of sick leave days taken. It is important to note that this analysis cannot be interpreted as causal as we are not able to control for all factors that may be driving variation in absence or presenteeism.

## INSIGHT 2: THE COMBINED COST OF IN-WORK COST IS LARGE – AND HEAVILY DRIVEN BY WORKING THROUGH SICKNESS RATHER THAN TAKING SICK LEAVE

There are relatively few estimates of the combined cost of absenteeism and presenteeism in the UK. There are official statistics produced by the ONS estimating the number of days lost due to absenteeism (ONS 2023b) yet there is limited evidence estimating the number of days lost due to presenteeism. This is a problem – this limits the ability of policymakers to intervene, but also puts greater emphasis on absenteeism due to the availability of data. This means that policy interventions on sick leave are thought about in isolation from policy on presenteeism, and the interaction between the two.

The data that does exist estimates that the prevalence of presenteeism far outweighs that of absenteeism. The most consistent source of data on this is published by Vitality through their Britain's Healthiest Workplace surveys (Vitality 2024).

Since 2014, we have seen increases both in the total of number of days lost to presenteeism<sup>10</sup> and absenteeism but also increases in the amount per employee.

<sup>9</sup> See the appendix for a detailed methodology.

<sup>10</sup> Vitality estimates the number of days lost due to presenteeism by using the 'work productivity and activity impairment' questionnaire. This estimates the proportion of working hours that are lost due to presenteeism and absenteeism.

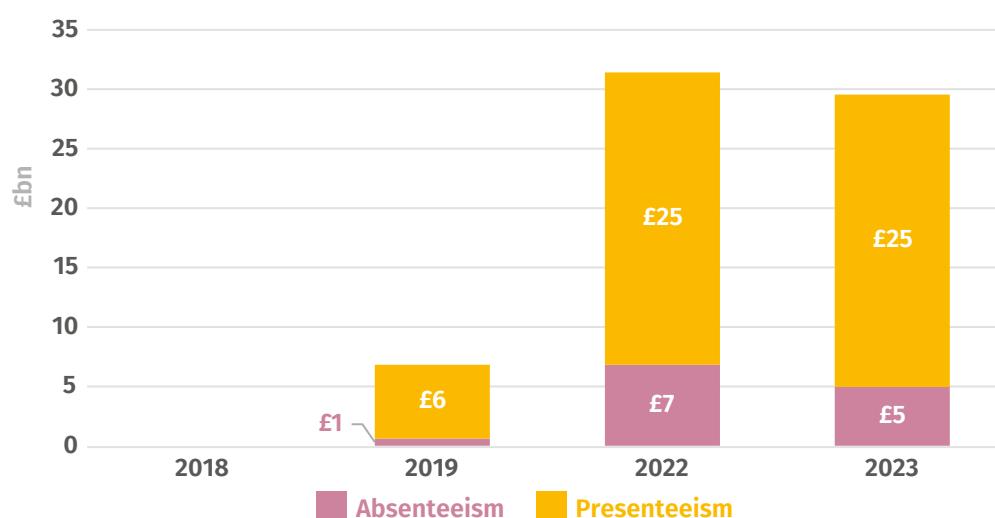
The most recent data found that employees lost 43.6 productive days<sup>11</sup> on average due to presenteeism but 6.7 days due to absenteeism. In 2018, 34.8 days were lost due to presenteeism, and 3.7 days lost due to absenteeism. These are drastic increases only in the past few years.

To demonstrate the sheer scale of this problem, we estimate the potential savings to businesses if we had the same rate of presenteeism and absenteeism as 2018. We estimate that if employees were as healthy in 2023 as they were in 2018, the gain would be worth £29.6 billion in 2023 alone. Moreover, 83 per cent of this gain would be achieved through lower rates of working through sickness, and just 17 per cent from fewer sick days taken.

**FIGURE 2.1**

**The estimated cost of working through sickness far outweighs that of taking sick leave**

*The change in the cost of presenteeism and absenteeism if we had the same rates as found in 2018*



Source: IPPR analysis of Vitality's Britain's Healthiest Workplace surveys (2014–2024)

**INSIGHT 3: THOSE WITH LONG-TERM CONDITIONS ARE MORE LIKELY TO TAKE SICK LEAVE AND CONTINUE WORKING THROUGH SICKNESS**

The risk of absenteeism or presenteeism is not equal across the workforce. Our research reveals that individuals with long-term conditions are approximately twice as likely to demonstrate presenteeism compared to those without such conditions (see figure 2.2). Twenty-seven per cent of women with a long-term condition exhibit presenteeism in a four-week period compared to 23 per cent of men. Whereas, men and women with a long-term condition are half as likely to exhibit presenteeism.

Additionally, our findings indicate that individuals with long-term conditions typically take between two to three times more sick leave compared to their counterparts without such conditions. Notably, men with long-term mental health conditions take the most significant amount of sick leave, as demonstrated in figure 2.3.

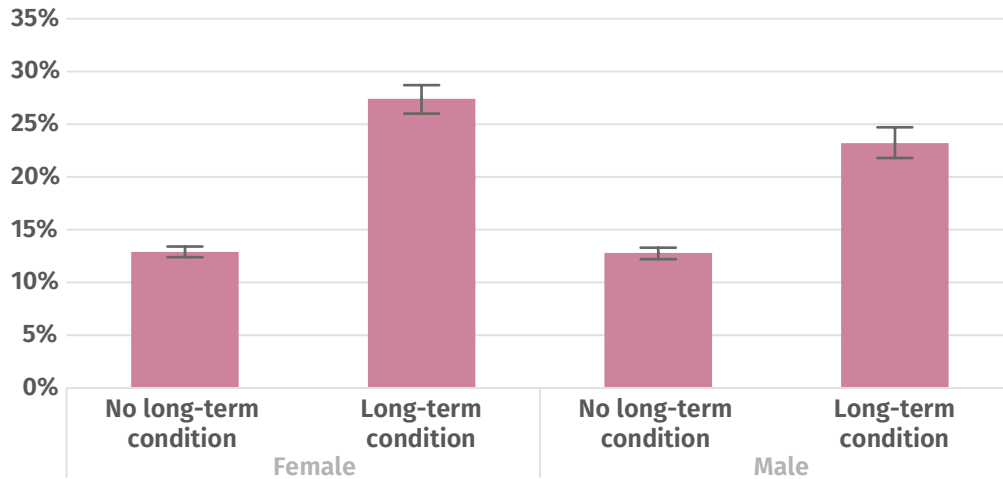
Men with a long-term mental health condition every four weeks would lose 1.7 days due to sickness absence – while men with a physical health condition would lose 0.9 days. For women it is 1.4 and 1.2 days respectively.

<sup>11</sup> Calculations of days lost due to presenteeism account for the fact that working at lower productivity may not mean a full day is lost.

**FIGURE 2.2**

**Those with long-term conditions are far more likely to work through sickness than those with no long-term condition**

*Predicted probabilities of exhibiting presenteeism in a four-week period for those with and without long-term health conditions, by sex, with 95 per cent confidence intervals*



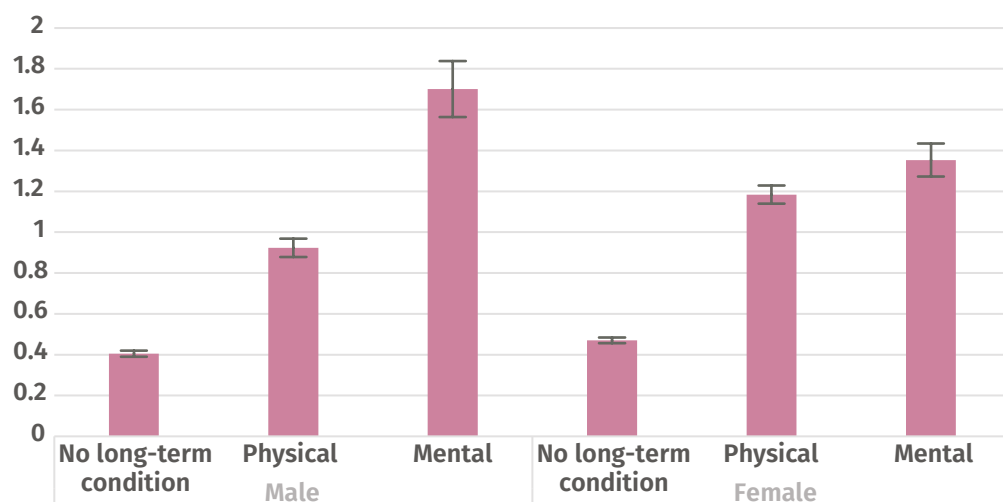
Source: IPPR analysis of University of Essex (2023)

Note: The point estimates show the predicted probabilities of exhibiting presenteeism by long-term condition and gender from the logistic regression as specified in the methodology section. We control for: sex, age, ethnicity, region, month, year, occupation, firm size, sector, income, job satisfaction, autonomy at work, level of job security, level of flexibility at work; and whether they have a long-term physical or mental condition.

**FIGURE 2.3**

**Those with long-term health conditions take more sick leave than those without long-term health conditions – especially men with mental health conditions**

*The predicted number of hours of sick leave taken per week by sex and type of long-term condition, with 95 per cent confidence intervals*



Source: IPPR analysis of ONS (2024)

Note: The point estimates show number of predicted hours of sick leave taken per week from combining probit results which estimates the likelihood of taking sick leave and a generalised linear model with a gamma distribution and a log link which estimates the number of hours of sick leave taken, conditional on taking at least on hour in a given week. We control for sex, age, region, month, year, ethnicity, occupation, firm size, sector, tenure, contract type, public or private company, part-time, education level and whether they are married.

This analysis shows that the status quo is not working, neither for businesses nor for employees. Those that have a long-term condition are not reaching their full potential. This should not be taken as an argument for businesses to employ fewer people with long-standing conditions. Twenty-six million people have at least one health condition in the UK, a number set to rise substantially over the next decade. Instead, it is an argument that providing people with appropriate, inclusive jobs – supported by appropriate sick pay policies – is likely to be good for employees and businesses alike. We discuss this in more detail in chapter 4.

Fixing this system will benefit everyone, including but not limited to those with long-term conditions. Increasing rates of productivity across firms could lead to improvements in wages and living standards (Carlsson et al 2016). There is a vested interest for all in preventing avoidable sickness and in supporting productivity among those with health conditions, through better job and workplace design.

#### **INSIGHT 4: WORKING THROUGH SICKNESS IS A GREATER CHALLENGE IN SOME INDUSTRIES; FOR THOSE WITH LOWER-QUALITY JOBS; AND THOSE FROM MINORITY ETHNIC BACKGROUNDS**

We also explore the impact of job quality, specific economic sectors and personal characteristics on presenteeism. We present evidence suggesting that employers have an opportunity to mitigate productivity losses by increasing job quality, as lower-quality jobs are correlated with increased rates of presenteeism.

Across all job quality indicators discussed earlier, we observe significant variations in the likelihood of presenteeism. The most impactful indicator is whether employees feel their job negatively affects their wellbeing – 26 per cent of those reporting such impact exhibit presenteeism, compared to 14 per cent of those without negative wellbeing impact as shown in figure 2.4.

The proportion of employees feeling their job has a detrimental effect on wellbeing is on the rise, nearing two in ten who are in employment. While disparities across other job quality indicators – such as job security, autonomy and job satisfaction – are smaller, ranging between six and two percentage points, they remain statistically significant. This underscores the argument that low-quality jobs not only adversely affect employees but also impact employers.

Disparities in presenteeism extend beyond job quality to personal characteristics, revealing associations with education and job level and ethnic backgrounds. In fields such as engineering and architecture, the incidence of such conditions is notably lower, whereas occupations such as elementary roles and process, plant and machine operatives, encompassing positions like bar staff, hospital porters and construction workers, tend to have higher rates.

Notably, individuals lacking formal qualifications are more prone to presenteeism than those with qualifications (GCSEs or above).

Furthermore, we find evidence that those from all minority ethnic backgrounds have higher rates of presenteeism than those who are white. Those who are Black or Black British, Asian or Asian British have twice the likelihood of exhibiting presenteeism compared to those who are white British, all else being equal.

This highlights a dual injustice. As these people with these characteristics are not only likely to experience presenteeism but are also at risk of being in lower-quality jobs, this contributes to the widening and entrenchment of health and economic inequalities.

These results are likely explained by several factors. First, they cohere with evidence on health inequalities (see Marmot 2005). Second, they cohere with

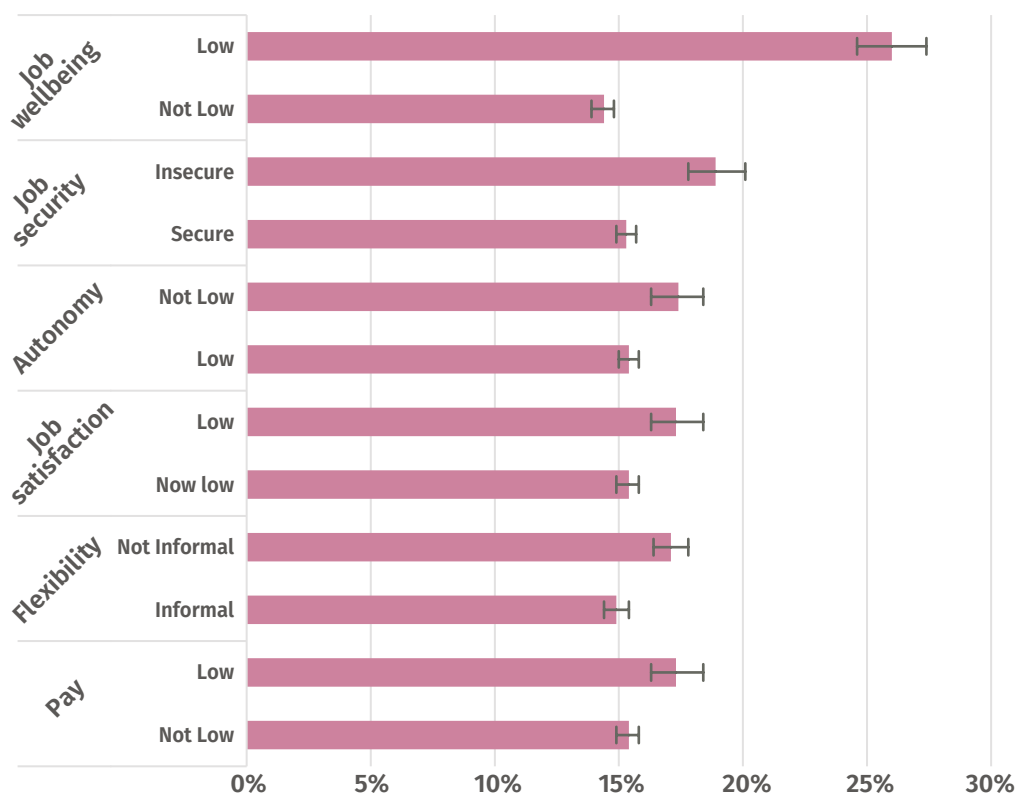
evidence – including IPPR research – on who lacks access to sick pay, which in turn increases the likelihood of presenteeism (see Patel and Jung 2022). And third, they align with the distribution of lower-quality jobs – with fewer workplace protections – across the UK economy (see Williams et al 2024).

To further test the role of low access to sick pay in presenteeism, we conducted polling to understand why individuals opt to go to work while unwell instead of taking sick leave. The findings reveal that nearly 3 in 10 respondents cited financial constraints as reason for not taking sick leave – as seen in figure 2.6.

**FIGURE 2.4**

**Job quality also matters – those in the low-quality jobs are far more likely to work through sickness**

*Likelihood of exhibiting presenteeism by job quality indicators, with 95 per cent confidence intervals*



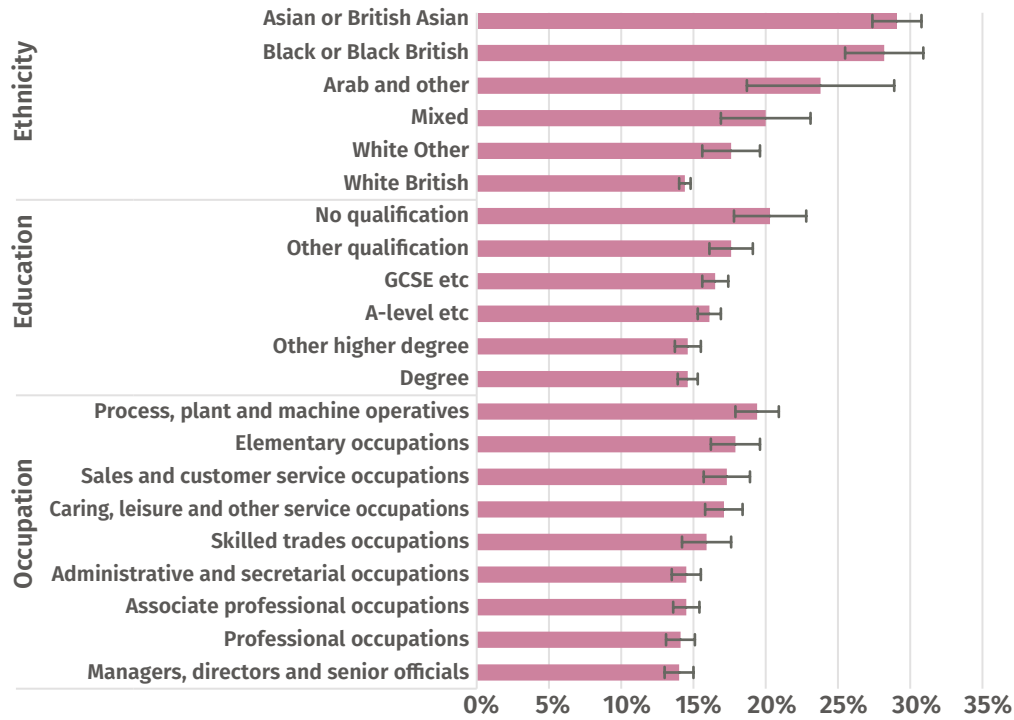
Source: IPPR analysis of University of Essex (2023)

Note: The point estimates show the predicted probabilities of exhibiting presenteeism by various measures of job quality from the logistic regression as specified in the methodology section. We control for: gender, age, ethnicity, region, month, year, occupation, firm size, sector, income, job satisfaction, autonomy at work, level of job security, level of flexibility at work; and whether they have a long-term physical or mental condition.

**FIGURE 2.5**

**Those with the lowest education, income, less skilled occupations and minority ethnic backgrounds are more likely to work through sickness**

*Likelihood of exhibiting presenteeism by rate of education, household income and occupation, with 95 per cent confidence intervals*



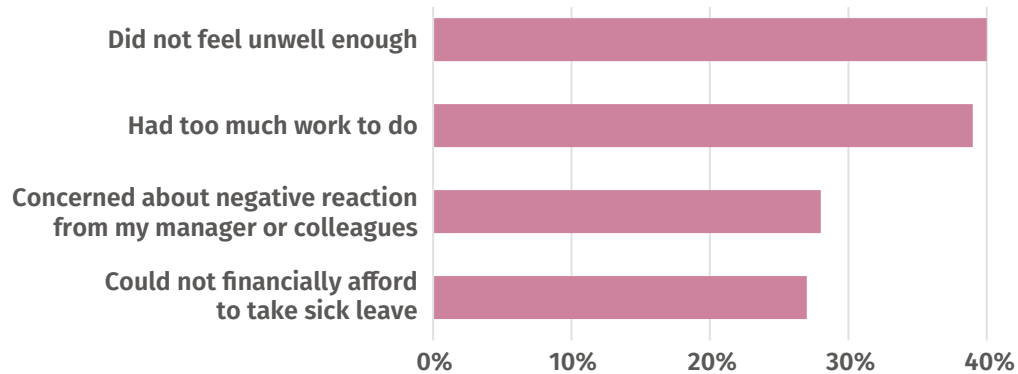
Source: IPPR analysis of University of Essex (2023)

Note: The point estimates show the predicted probabilities of exhibiting presenteeism by various measures of job quality from the logistic regression as specified in the methodology section. We control for: gender, age, ethnicity, region, month, year, occupation, firm size, sector, income, job satisfaction, autonomy at work, level of job security, level of flexibility at work; and whether they have a long-term physical or mental condition.

**FIGURE 2.6**

**Many people felt that their workload and their financial constraints were reasons why they did not take sick leave**

*Why did you choose to work rather than take sick leave?*



Source: IPPR analysis of YouGov polling

Note: Sample size of 619 who have worked whilst experiencing physical or mental sickness in the last four weeks. Don't know, was not allowed to take sick leave, have had a lot of sick leave recently, and other are not shown due to low number of observations.

### 3.

## BUSINESS INNOVATIONS AND THE GREEN SHOOTS OF A HEALTH-LED ECONOMY

This report has explored both the need for, and the benefits of, a transition to a health-led economy. In this chapter, we explore where the green shoots of the health-led economy are already visible.

We find that there are many exciting areas where health is being prioritised – to create healthier workplaces, through investment in healthy innovation and in healthy brands and products. The challenge is not that this innovation does not exist – it is that it is often isolated, either within individual businesses or sectors.

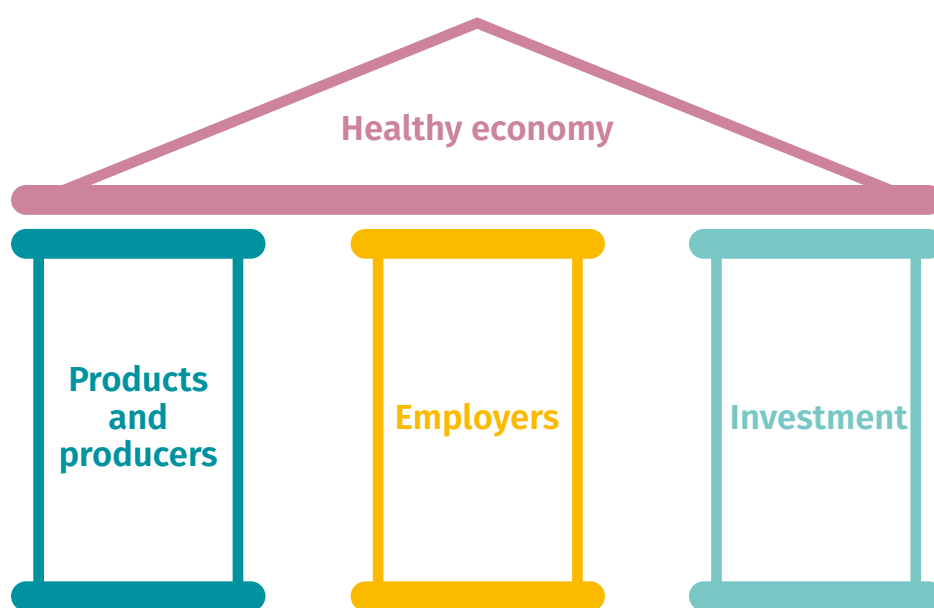
As such, the case studies presented in this chapter help provide a more tangible vision of what a health-led economy might look like. It identifies innovation that we should look to spread across the whole economy. And it contextualises the policy recommendations in chapter four, which focus on how state and industry can work together to make these kinds of innovations the norm.

We outline case studies across the three pillars of a health-led economy:

- **Healthy employment:** Job opportunities that support our lifelong health.
- **Healthy products and production:** A real economy where healthy choices are a genuine reality for everyone.
- **Healthy investment:** A country where private investment – from private equity through to pension funds – ‘price-in’ the health impacts of a business.

---

FIGURE 3.1: THREE PILLARS OF A HEALTH-LED ECONOMY



Source: Authors' analysis



## HEALTHY EMPLOYMENT

### The opportunity

- Seventy-five per cent of the UK working-age population are employed (ONS 2023c) and spend more time at work than on any other, single activity (ONS 2023d).
- Studies have shown that work – including both employment status (van der Noordt et al 2014) and job quality (Henseke 2018) – are important drivers of health.
- This then has significant economic benefits through supporting employee health and wellbeing which helps to maximise engagement and retention.

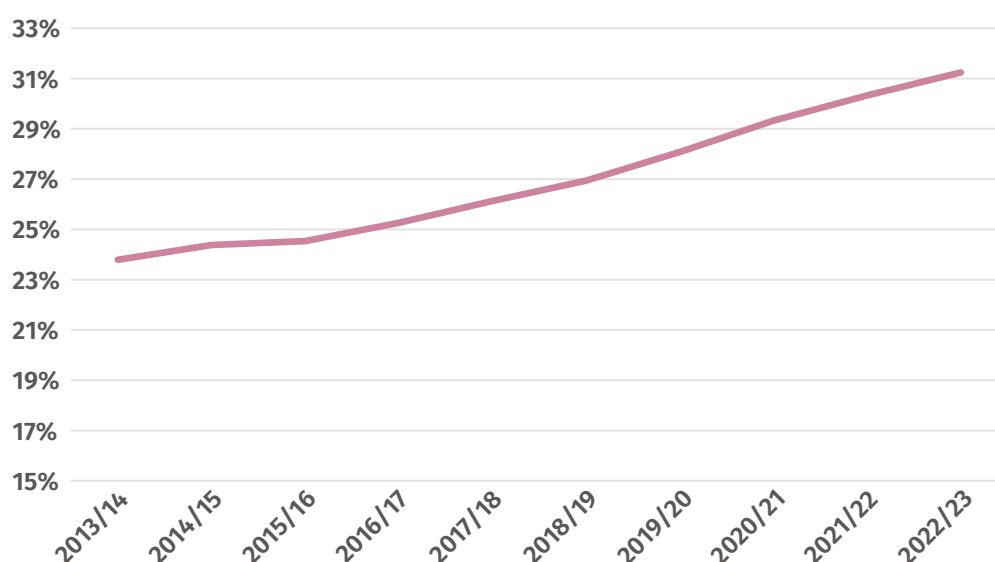
### The challenge

- Some jobs in the UK economy are not conducive to good health. The Health and Safety Executive reports that nearly two million workers suffered a work-related illness in 2022/23 (HSE 2023).
- The UK economy has maintained a high employment rate since the 2008 financial crash, and through the Covid-19 pandemic. Yet this is partially buoyed by low-paid, high-insecurity jobs: around 24 per cent of workers are in low-paid work (Cominetti et al 2022), while nearly 11 per cent are in insecure jobs (TUC 2023).
- The UK working-age population is increasingly likely to have a long-term condition – this is accentuated by having an ageing workforce and a rising state pension age. Workplaces that work for people with health conditions will grow in importance in the coming decades – and that is likely to require change by employers (see figure 3.2)

**FIGURE 3.2**

#### We are seeing far more people with long-term conditions in work

Percentage in employment with health conditions or illnesses lasting more than 12 months (aged 16+)



Source: IPPR analysis of ONS (2024)

Note: October to September each period.

# CASE STUDY: GETTING IT RIGHT

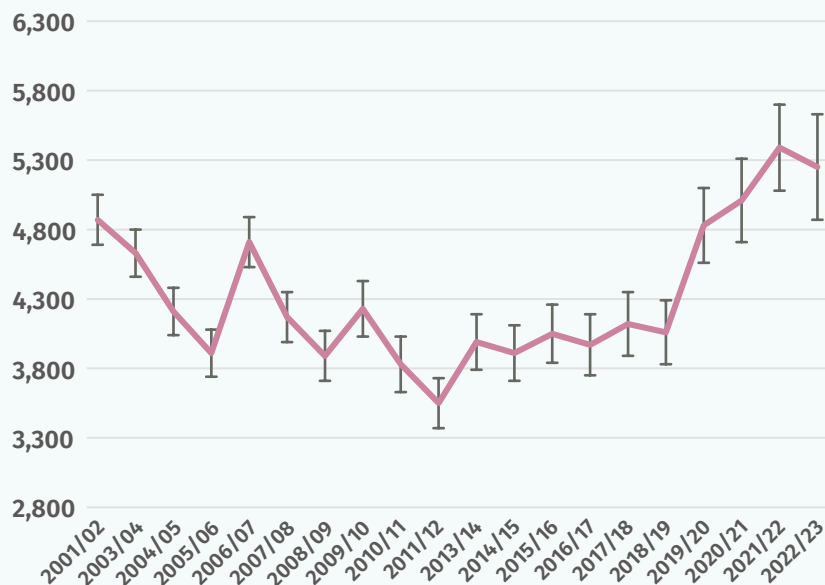
## 1. A SHORTER WORKING WEEK: FOUR-DAY WEEK TRIAL

### The challenge

1.8 million workers were suffering from work-related ill health (new or long-standing) in 2022/23 and the prevalence has been on the rise since 2010/11.

**FIGURE 3.3**

**The rate of employees suffering from work-related ill-health is growing**  
*Estimated rates of self-reported illness per 100,000 employees caused or made worse by work, by type of illness, for people working in the last 12 months, Great Britain*



Source: IPPR analysis of LFS (2023)

### The intervention

- One way in which to reduce work-related ill health and stress is to reduce working hours.
- At the start of 2022, the 4 Day Week Campaign, 4 Day Week Global and Autonomy began recruiting companies and non-profit organisations to participate in a six-month trial.
- 60 UK companies engaged in a trial of a 4-day working week – employing over 2,900 people (Lewis et al 2023).
- It was based on the 100–80–100 principle – where workers got 100 per cent of their pay for 80 per cent of their hours with a commitment to maintain 100 per cent productivity.

### The results



**Employees**

60 per cent of employees reported it was easier to balance care responsibilities and work.

71 per cent of staff reported a decrease in their level or burnout.

57 per cent of staff reported a reduction in negative emotions.

73 per cent reported an increase in life satisfaction

Source: Lewis et al (2023)



**Employers**

57 per cent reduction in the number of resignations.

There was a reported 65 per cent reduction in the number of sick days taken.

No evidence of impact on revenues.

## CASE STUDY: GETTING IT RIGHT

### 2. WELLBEING AT WORK: THE JOHN LEWIS PARTNERSHIP

#### *The challenge*

#### Musculoskeletal conditions

0.5m suffer from these work related conditions in 2022/23

23.4 million days lost due to these conditions (13 per cent of the total)

#### Work-related stress, depression or anxiety

0.9 million are suffering from these work related conditions in 2022/23

18.5 million days are lost due to these conditions (10 per cent of the total)

Source: HSE 2023 and ONS 2023d

#### *The firm*

The John Lewis Partnership has launched the Working Well Initiative – which aims to address mental health and musculoskeletal conditions through early clinical intervention and fostering a healthy workplace culture.

#### *The change*

In the financial year 2020/21, the partnership dedicated £21 million towards enhancing the health and wellbeing of its workforce, recognising this as a strategic investment.

The partnership aims to be recognised as ‘Britain’s Healthiest Workplace by 2025’, with a targeted boost in productivity, equivalent to over 1 million additional working days by 2025.

#### *The results*

Over 1,300 free occupational health services were provided in 2020/21 which were tailored for musculoskeletal and mental health conditions.

During this period, they also delivered close to 6,000 psychological therapy sessions and 450 managers attended mental health awareness training.

7 in 10 of the employees were at work while starting psychological or physical therapy – while after treatment close to 100 per cent were in work (98 and 96 per cent respectively).

This indicates that these were preventative interventions which allow for a healthier and more productive workforce.

## CASE STUDY: GETTING IT RIGHT

### 3. NIGHT-TIME WORKERS: THE NIGHT CLUB'S IMPACT ON NIGHT-TIME WORKERS AT VEOLIA

#### **The challenge**

There is growing evidence that night shift work increases the risk of mental health issues, such as depression (Okechukwu et al 2023), sleep issues, depressed mood and anxiety, substance use, impairments in cognition, lower quality of life, and even suicidal ideation (Brown et al 2020). The International Agency for Research on Cancer (IARC 2019) has deemed it to be a carcinogen. Yet over recent years we have seen an increase in the number of female night shift workers (ONS 2023e).

#### **The business**

The Liminal Space collaborated with Veolia, a refuse and recycling company employing around 300 individuals at their Southwark centre.

#### **The change**

The Liminal Space introduced 'The Night Club'. The programme delivers an immersive training experience to support night workers and shift workers to improve their sleep health and wider wellbeing.

Night Club also supports organisations to provide better working environments for these workers and, more broadly, supports policymakers to make changes at the systems level.

#### **The results**

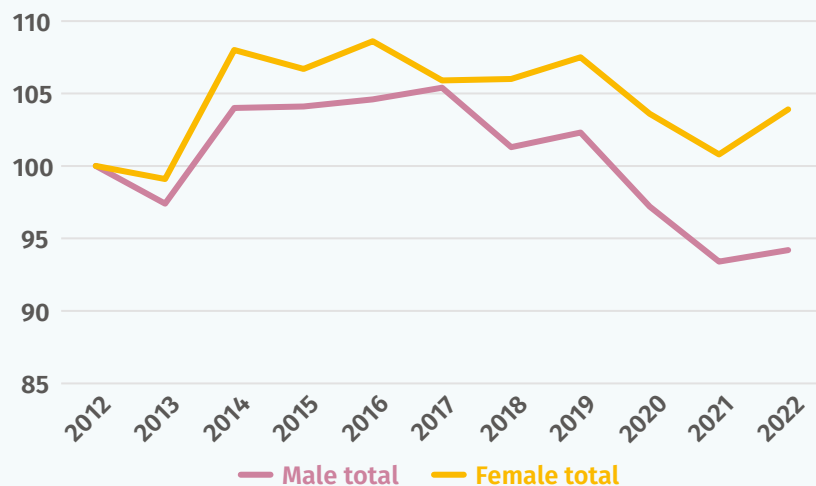
**Health awareness:** Over 90 per cent of participants at Veolia reported learning new insights about safeguarding their health through the Night Club initiative.

**Behavioural changes:** Eighty-five per cent expressed an intention to alter their behaviours based on the knowledge gained, indicating a positive stated impact on their approach to health and wellbeing.

**FIGURE 3.4**

**There have been increases in the number of female night-time workers since 2012**

*The change in the number of night-time employees (100 = 2012)*



Source: ONS (2023f)

## PRODUCTS AND PRODUCTION

### The opportunity

- The type of products that we consume greatly affect our health and the economy, yet the current status quo is not conducive to good health:
  - poor diets contribute to around 64,000 deaths every year in England alone and cost the economy an estimated £74 billion yearly (Dimbleby 2021)
  - harms associated with gambling cost at least £1.27 billion in 2019 to 2020 (PHE 2019)
  - alcohol is estimated to cost UK society more than £27 billion per year (Piper 2023).
- The way in which we also produce does not always yield positive outcomes:
  - Current agricultural management practices are the main driver of biodiversity change in the UK (Burns et al 2016). Farm practices such as fertiliser and pesticide use, the decline of mixed farming and changes in crop rotations, increased field size and the removal of hedgerows have contributed to precipitous declines of animal and insect populations (Hayhow et al 2019; Boatman et al 2007).
- The latest estimates show that construction is responsible for about 18 per cent of the large particle pollution in the UK and this share is growing. In London it is more than 30 per cent (Pearce 2022).

### The challenge

- The producers of these unhealthy products dominate our shelves, high streets and advertising spaces:
  - About a third of all food and soft drink advertising is still invested in promoting unhealthy foods compared to fruit and vegetables (Goudie 2023); this leads to children being exposed to over 15 billion adverts for products high in fat, sugar and salt online every year (DHSC and DCMS 2020).
  - There are 1.8 million adults and children at risk of problem gambling (NAO 2020) and one in five gambling premises were based within the most deprived decile of areas in the country, compared to just one in 50 in the least deprived decile (Evans and Cross 2021).
  - The uptake of more sustainable and organic farming practices have been slow – in 2022 only 3 per cent of all cattle were raised organically (Defra 2023a) and in 2019 only 7 per cent of arable farms were using no tillage practices (Alskaf et al 2019).
- By contrast, we do not always do enough to maximise creation and consumption of healthy products. Healthy food brands struggle to scale; housing providers that create dwellings of high-quality face competitive disadvantage; farmers struggle to transition to regenerative farming practices; and the UK approves and adopts innovative medicines, technologies and vaccines at a far slower pace than comparable nations.

## CASE STUDY: GETTING IT RIGHT

### 1. THE GOOD FOOD PROGRAMME: CATALYSING CHANGE IN THE FOOD INDUSTRY

#### **The challenge**

Healthier food options are nearly three times as expensive per calorie as less healthy alternatives, posing a significant barrier, particularly for families with lower incomes.

During the cost-of-living crisis – healthy foods grew more in absolute terms than unhealthy foods.

#### **The change**

Led by Mission Ventures, the Good Food Programme is backed by Impact on Urban Health. The programme offers 10 founders the opportunity to receive up to £15,000 of equity-free funding along with two years of practical brand and business support provided by industry experts.

#### **The results**

The pilot cohort of 13 brands showcased noteworthy results, including an average calorie reduction of 42 compared to core rivals, reformulations to reduce sugar, salt and fat contents, and achieving HFSS compliance.

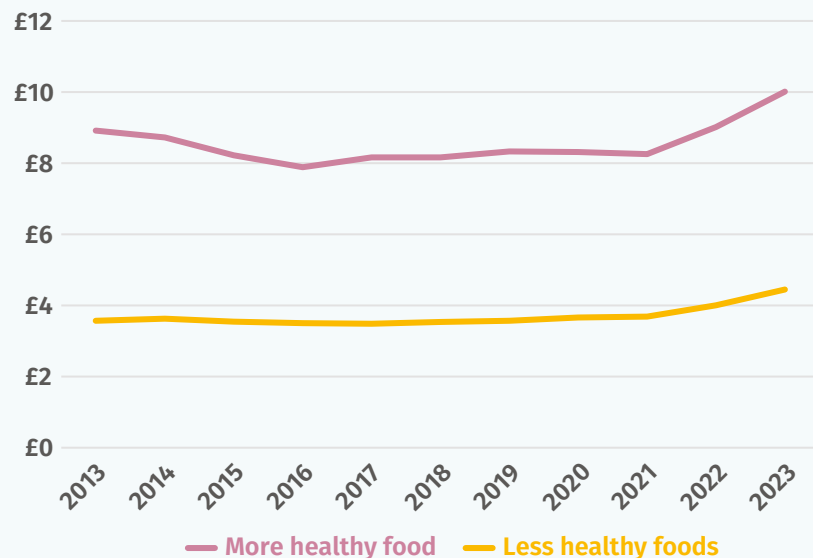
The brands collectively raised £6.5 million in the first year, with seven securing supermarket listings and experiencing a revenue increase of 63 per cent in the initial 12 months.

Nearly half of the brands achieved affordability, exemplified by one brand's reformulation resulting in a 56 per cent price saving for consumers. Despite being in the early stage, brands were able to demonstrate switching behaviour at shelf: one brand achieved 61 per cent of their sales in a top four UK retailer from customers switching away from less-healthy products. The programme is set to continue its impactful journey, fostering healthier innovation in the food and drink industry.

**FIGURE 3.5**

#### **Healthier foods grew in price more than unhealthy foods in 2023**

Mean price of foods (£/100 kcal) by healthiness category per year from 2013 to 2023



Source Goudie (2023)

## CASE STUDY: GETTING IT RIGHT

### 2. REFORMULATION FOLLOWING THE UK SOFT DRINKS INDUSTRY LEVY ON CHILDHOOD OBESITY

#### **The challenge**

Obesity among children has emerged as a global public health crisis, with significant implications for long-term health. In England, alarmingly one in 10 reception age children and over one in five children in year 6 are living with obesity (NHS Digital 2023c). Health problems associated with childhood obesity include high blood pressure, type 2 diabetes and depression.

This burden is also not shared equally in society – those in the most deprived parts of England are twice as likely to be living with obesity than those in the least deprived parts both for children in year 6 and in reception.

#### **The change**

To address the rising tide of childhood obesity and excessive sugar consumption, the UK government implemented the Soft Drinks Industry Levy in April 2018. This two-tier sugar tax targeted soft drink manufacturers, incentivising them to reduce sugar content in their products.

#### **The results**

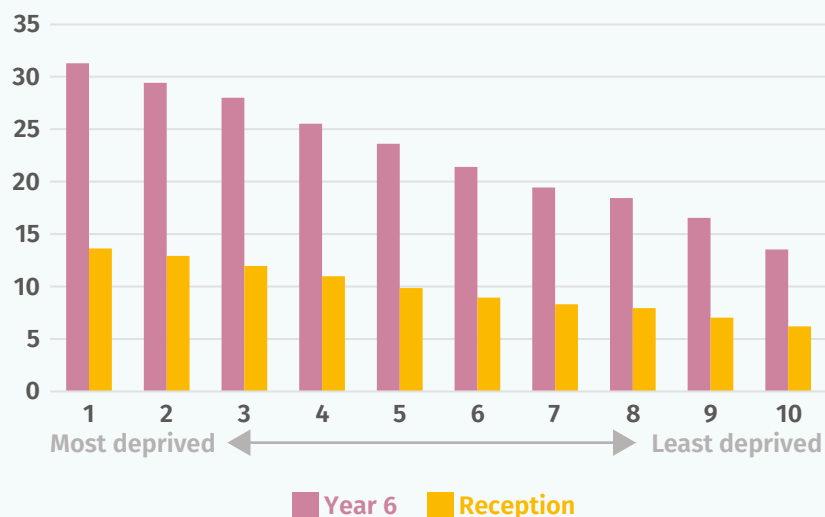
The Levy has been widely regarded a success. The total sugar sold in soft drinks by retailers and manufacturers decreased by 30 per cent from 2015 to 2018 (Bandy et al 2020). Recipe reformulation had driven this (Dickson et al 2021). This then had significant public health effects – a recent evaluation revealed an 8 per cent relative reduction in obesity levels among year 6 girls, preventing approximately 5,234 cases of obesity annually (Rogers et al 2023). The reductions were most pronounced in girls attending schools in deprived areas, with a 9 per cent reduction observed in the most deprived regions.

While no overall change in obesity prevalence was observed in year 6 boys, the study highlighted the importance of focusing on older girls from deprived areas. The findings indicated a positive step towards reducing health inequalities in this vulnerable group.

**FIGURE 3.6**

**Those in the most deprived areas of England are twice as likely to be living with obesity**

*The proportion of children in year 6 and reception living with obesity by deprivation in 2022/23*



Source: NHS Digital (2023d)

## CASE STUDY: GETTING IT RIGHT

### 3. PASTURE-FED LIVESTOCK FARMING PRACTICES CAN IMPROVE THE ECOLOGY OF GRASSLANDS

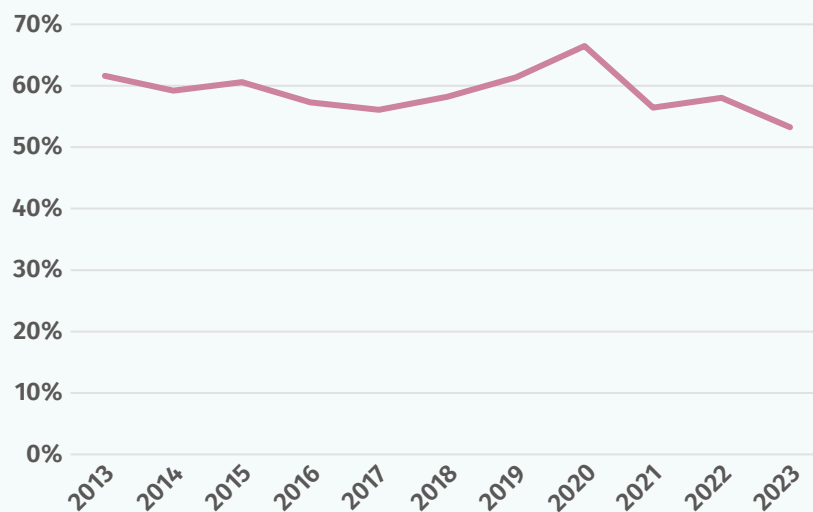
#### **The challenge**

We need to create an economy which is sustainable both for our health but also the planets health. Therefore, we need to minimise the harm of not just what we produce but how we produce it.

In 2021 agriculture contributed 71 per cent of all nitrous oxide and 49 per cent of methane emissions – and 11 per cent of the total greenhouse gas emissions – we need to create a farming system which supports our own health and that of nature. Yet the proportion of holdings taking action to reduce emissions is falling.

**FIGURE 3.7**

**Fewer farmers are taking actions to reducing greenhouse gas emissions**  
*Proportion of holdings currently taking action to reduce GHG emissions*



Source: Defra (2023b)

#### **The change**

The UKs most extensive land over type is grasslands – they are important for both farmers and the wider public both in terms of food production and the wider ecosystem which the grasslands provide (UKNEA 2011).

There is a need to ensure that farming practices are able to maximise the beneficial impact they can have on biodiversity and environmental sustainability.

The Pasture-Fed Livestock Association (PFLA) is actively pursuing relevant research to evidence their practices. The PFLA has its own set of certification standards that address a wide range of environmental and animal health concerns including effective management and monitoring of soil health.

#### **The results**

A recent study by Norton et al 2022 analysed over 940 large plots from the GB Countryside Survey (CS) to assess relationships between key grassland sward and soil variables and farming method.

They found that pasture-fed livestock approaches may be particularly beneficial for grassland and wider ecosystems.

It led to higher species richness in grasslands which is associated with positive measures of soil health. PFLA plant communities contain relatively high species richness and tall vegetation, which is positive for biodiversity.



## CASE STUDY: GETTING IT RIGHT

### 4. THE FRONTIERS OF LIFE SCIENCE

#### *The challenge*

Shifting towards a health-led economy does not only mean thinking about products on our shop shelves, and the shops on our high streets. It also means thinking about new frontiers of life science and the impact they can have on the NHS. Yet, the NHS has been relatively slow in shifting towards ‘secondary’ prevention – while it has well-known challenges with the adoption and diffusion of innovation, more broadly (see Patel et al 2023b).

In that context, life sciences have been the source of a range of exciting new preventative interventions. mRNA vaccines, genomics and wearables are all examples of exciting product innovation, made possible by active partnership between state and industry.

#### *The change*

Against the background of challenges with innovation adoption at pace and scale, genomics is a UK success story. Genomics is the study of genes in our DNA – and has the potential to make it possible to predict, diagnose and treat diseases more precisely and personally.

The UK is recognised as a global leader on genomics – with this leadership attributed to deep partnership between small and large business, academia and government. The latter has invested in schemes like the 100,000 genomes project – an enabling programme that has laid the foundation for the use of genomics in routine clinical care – as well as the formation of Genomics England, and direct investment in infrastructure and skills.

#### *The results*

The use of genomic medicine in the NHS has enabled patients to access over 12 newly licensed precision medicines more quickly, including treatments for medicine and for patients with rare conditions that could not otherwise have existed. Genomics has also enhanced diagnostics for some cancers and for rare and inherited conditions. In turn, knowledge about personalised risk of a condition has allowed for precision public health – that is, primary prevention interventions targeted at populations shown to be at higher risk

## INVESTMENT

### The opportunity

- In 2021, the UK held the second highest levels of foreign direct investment stock in the world (~£2.1 trillion) (NAO 2023) yet this has not led to greater capital formation as our public and business investment rates are some of the lowest in the G7 (Dibb and Murphy 2023).
- In 2021 – UK Pension funds have \$2.5 trillion in assets – the second largest in the OECD (OECD 2024c).
- Increasing inward investment – and better utilising capital (such as pension funds) – could support health creation. However, UK investments rarely differentiate healthy vs unhealthy investments – indicating this potential is not being realised.

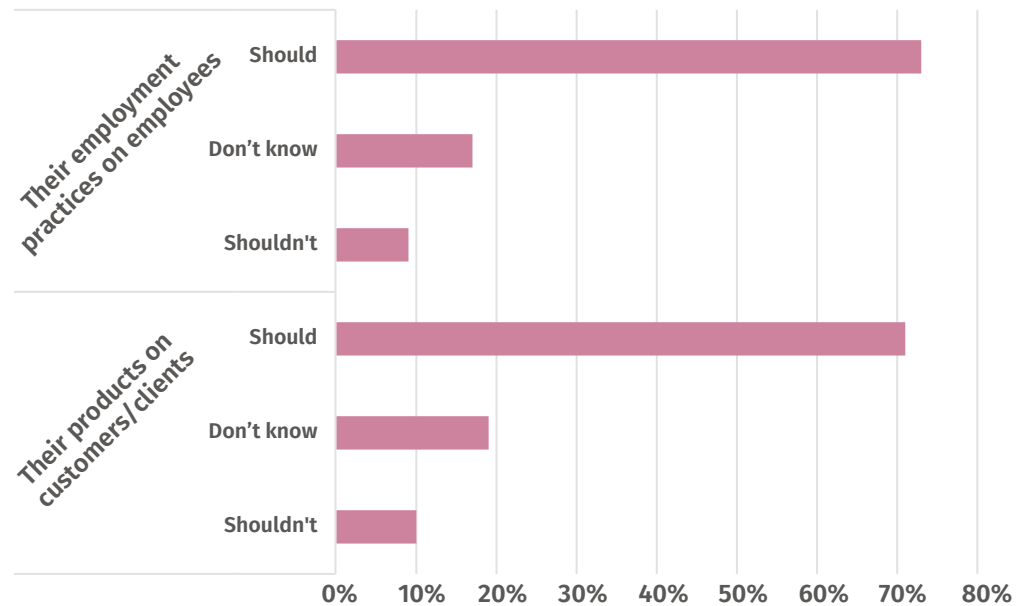
### The challenge

- An inability to differentiate investments on their health impacts has tangible impacts. Many pension funds invest in tobacco, alcohol and ultra-processed food companies – while ShareAction has shown that tobacco companies often rate highly on existing ESG (environment, social, governance) criteria.
- People want more transparency over the health impacts of business and employers – which could, in turn, provide the foundation to differentiate investments and health, and get more investment in health creating industries, products and sectors.
- While the UK’s low levels of government investment in R&D and the life sciences – in turn – undermines private investment in research and health innovation (see Nanda et al 2022; Thomas and Nanda 2020).

FIGURE 3.8

#### The public support businesses reporting on their health impacts

*In general, do you think employers and businesses should or should not be required to report on the health impact of their products and their employment practices?*



Source: IPPR analysis of YouGov polling

## CASE STUDY: GETTING IT RIGHT

### 1. EMBRACING SUSTAINABLE INVESTING FOR LONG-TERM GROWTH: NEST

#### **The challenge**

The impact investing industry has grown rapidly over the past five years. The size of impact investment worldwide was \$715 billion (Hand et al 2020). It is estimated that only 3 per cent of this is held by pension funds and insurance companies. Pension funds in the UK have huge potential to have large impact – as of 2022, pension funds have assets that are the equivalent of 80 per cent of the UK's GDP.

#### **The business**

Nest is a defined contribution pension scheme in the UK that manages assets of more than £21.4 billion on behalf of 11.1 million members, who make up a third of the UK workforce.

#### **The change**

Recognising the growing importance of environmental, social and governance (ESG) factors, Nest has integrated sustainability into its investment strategy.

Focusing on renewable energy projects with stable, long-term returns, Nest has achieved compelling yields, outperforming traditional equity investments.

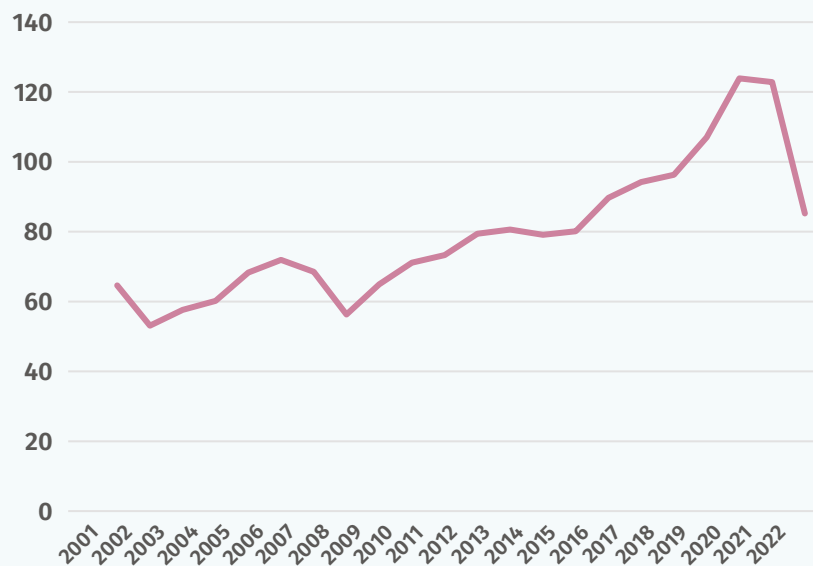
Furthermore, by actively managing risks associated with illiquid assets and pricing challenges, Nest mitigated potential drawbacks, ensuring the scheme's financial stability.

#### **The results**

Nest has paved the way for other defined contribution schemes to embrace responsible investing beyond public markets. By demonstrating the feasibility of accessing private markets and achieving competitive returns while addressing ESG concerns, Nest has positioned itself as a catalyst for positive environmental impact and long-term growth in the global economy.

**FIGURE 3.9**

**UK Pension funds have been growing steadily before the pandemic**  
*Pension fund assets as proportion of GDP*



Source: OECD 2024

## CASE STUDY: GETTING IT RIGHT

### 2. INVESTORS DRIVE CHANGE: SHAREACTION DRIVES TESCO'S HEALTH COMMITMENT

#### **The challenge**

The 11 largest food retailers make up 95 per cent of the grocery market – and hence have a huge impact on what we eat. Yet more needs to be done to make sure they are improving our health.

This can be indicated by the Access to Nutrition Initiative's UK Retailer Index 2022 (Access to Nutrition 2022) which scores supermarkets on governance, the production and placement of healthy, affordable products, and how the retailers influence customer choices and behaviour, both online and in-store.

The average score across all retailers is 3.3 out of 10 – indicating that supermarkets need to be doing more to support our health.

#### **The firm**

ShareAction is a registered charity that promotes responsible investment and aims to improve corporate behaviour on environmental, social and governance issues; its vision is to create a financial system that serves our planet and its people.

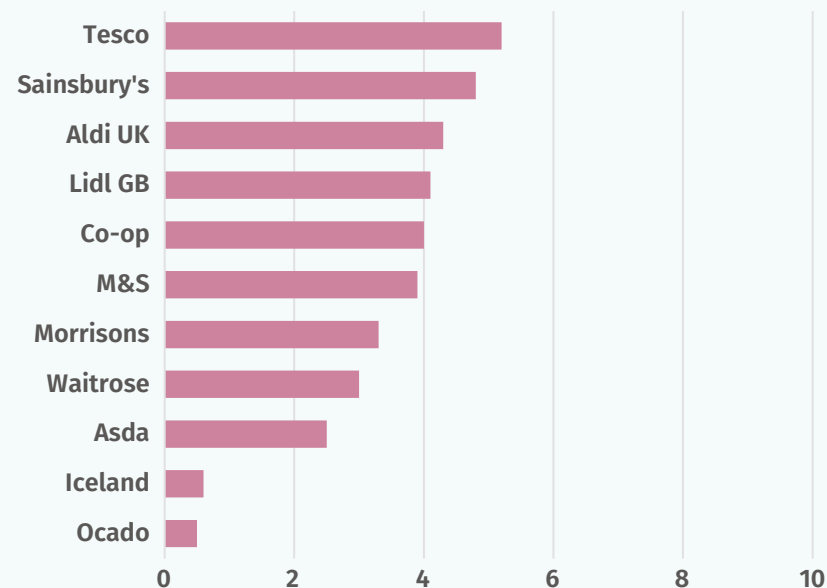
#### **The change**

ShareAction played a pivotal role in filing a landmark shareholder resolution targeting Tesco, the UK's largest supermarket group. This was coordinated with institutional investors such as Robeco, J O Hambro, and the Guy's and St Thomas' health charity, along with 101 individual Tesco shareholders.

ShareAction spearheaded the first health-based shareholder resolution at a UK-listed company. The resolution, which aimed to compel Tesco to set targets for selling a higher proportion of healthy food, initially prompted Tesco to commit to increasing sales of healthy products in its UK and Irish stores. ShareAction kept the resolution active to encourage similar steps in Tesco's central European stores and Booker wholesale subsidiary.

**FIGURE 3.10**

**Major supermarkets can be doing more to support healthier choices**  
Overall ranking of the UK Retailer Index 2022



Source: Access to Nutrition (2022)

#### **The result**

Following Tesco's agreement to expand these commitments, ShareAction withdrew the resolution, emphasising the importance of health and positive impacts on consumers' food choices. The engagement between Tesco, ShareAction and investors in the Healthy Markets Coalition now involves implementing commitments covering £52 billion of revenue.

## CASE STUDY: GETTING IT RIGHT

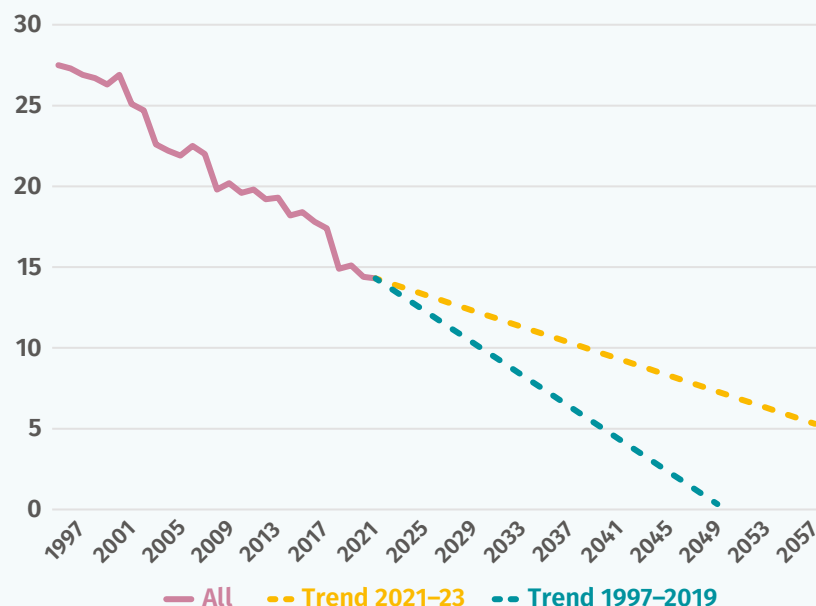
### 3. GENDER PAY GAP: PUBLIC REPORTING CAN LEAD TO SIGNIFICANT REDUCTIONS IN INEQUALITIES

#### **The challenge**

The gender pay gap is an important indicator of gender and pay differentials within firms, and serves as a significant factor in determining environmental, social and governance (ESG) scores for businesses. Yet in recent times the gap has not been closing as fast as previously.

**FIGURE 3.11**

**The rate at which the gender pay gap is narrowing is slowing**  
*The gender pay gap with projects from 2021 to 2023 and 1997 to 2019*



Source: ONS (2023f)

During the 1970s and 1980s, the gender pay gap in the UK witnessed a rapid decline. However, from 2010 onwards, this rate of decline began to stagnate, as noted by Blundell (2021). Analysis suggests that had the rate of decline remained consistent from 2010 to 2016, it would take more than 40 years to achieve full closure of the gap.

Despite female enrolment in higher education surpassing that of men and a notable increase in female representation in legislative bodies, persistent pay gaps persist, indicating a continued disparity.

#### **The change**

In response to these concerning trends, the UK government implemented mandatory gender pay gap reporting in 2017 for firms employing over 250 individuals. This initiative aimed to eliminate the pay discrepancy between men and women.

The gender pay gap matters to investors; they are more willing to invest in firms that disclose gender pay equity compared to those that don't disclose a pay gap (Austin et al 2021).

This regulatory measure heightened the potential for reputational risk among non-compliant firms and increased transparency, empowering investors to make more informed investment decisions.

#### **The results**

Recent findings by Blundell (2021) indicate that the introduction of mandatory reporting led to a notable 1.6 percentage point reduction in the gender pay gap. Notably, this reduction stemmed primarily from a decline in male wages within affected employers, rather than changes in gender balance within companies.

This evidence underscores the positive outcomes associated with increased transparency. By elevating the salience of the gender pay gap in corporate boardrooms, firms were prompted to take active measures to address and rectify pay differentials.

## 4.

# HEALTH IN ALL INDUSTRIES

We are unlikely to transition to a health-led economy if we continue to define health policy – narrowly – as solely about delivery of a single public service (that is, the NHS). While an excellent public healthcare service is of vital importance, real aspiration requires a bolder and broader health policy: one as much about industrial and economic strategy, as it is about service delivery.

We are not the first to argue for a broader health policy. There have long been calls for a ‘health in all policies approach’ (see Ståhl 2018). This describes an approach where health is a feature in everything government does – from its approach to schools in the Department for Education, to its approach to industrial strategy and innovation in the Department for Science, Innovation and Technology – rather than siloed in the NHS-oriented Department of Health and Social Care.

This Commission has already argued that we need to move towards ‘health in all policies’ if we hope to make the UK a genuine world leader on population health. This Commission’s first major report *Healthy People, Prosperous Lives* recommended a new approach to making health in all policies a reality – including recommendations for a statutory new health target (equivalent to net zero), a health-equivalent to the Climate Change Committee, a what works centre for population health, and a range of other measures (Thomas et al 2023).

Yet, there is a tendency to interpret ‘health in all policies’ as ‘health in all government policies’. This risks overlooking the role of businesses and employers (including public sector employers) in determining health (for worse, and for better), and the significant potential of British industry, businesses, innovators, entrepreneurs and investment managers to support better health.

As such, we contend that optimising the health of the UK does not only depend on health in all policies, but also on our ability to achieve **Health in All Industries (HiAI)**. We define HiAI as a policy agenda that aims to create incentives that encourage all businesses to prioritise health – and, more strategically, to focus our growth strategy around those that make the strongest contribution to population health. While we focus on profit-making businesses in this report (having covered public services and government in detail elsewhere in the commission), most of our recommendations will be relevant more widely.

Health in All Industries is largely about the state nurturing and developing the innovations, technologies, companies and sectors that have both high potential for growth, and a high potential to support better population health. However, in other cases, it will also mean either the transformation of, or possibly even planned downsizing of industries, products or practices that harm our health. Much as climate policy needs a plan to maximise green industry, and to reduce reliance on fossil fuels, so health policy needs a plan to maximise health innovation, while also reducing our reliance on, for example, tobacco, ultra-processed food and gambling.

To that end, we split our policy recommendations into two broad categories:

- **The transition towards:** Policies designed to increase incentives for health-creating practices, brands and sectors – including healthier workplaces, healthier shop shelves and a greater role for sectors like the life sciences within the UK economy.
- **The transition from:** Policies designed to steer the UK away from practices, products or industries that threaten long-term health. In some cases, that will mean a full transition away from some industries (such as tobacco), and in other cases the transformation of industry (such as reformulation in the food and beverage sector).

We have translated this idea across each of the three pillars this report has already outlined. In employment, we need a transition from lower-quality jobs – and a coercive approach where people are expected to work through sickness, at any cost – towards a healthy future of work. In the case of products and services, we need a transition from our economic dependency on health-harming products and services – and towards a growth model founded on health-creating ones. And we need public and private investment that incorporates health returns, as well as financial ones. We cover each of these themes in the recommendations that follow.

There is strong alignment between analysis in chapter 2 and our recommendations here. In chapter 2, we implicated lack of sick pay, avoidable sickness and low-quality jobs in the cost of sickness to businesses and employees. Each are covered in the recommendations that follow. Yet, our focus is not narrowly on insulating businesses from the cost of sickness – rather, we take the possible benefit of health as business as a platform to explore how business and British industry can make the maximum possible positive contribution to the nation's health.

While industrial strategy has winners and losers, we put this forward as a pro-business agenda: one in which a minority might be restricted around health externalities, but the majority benefit from a healthier labour market, stronger economic conditions, and the reduced costs to productivity and profits this report has already linked to poor population health.

### **STEP ONE: THE TRANSITION TOWARDS...**

#### **Introduce a workplace premium to support and reward innovation in UK workplaces**

As this report has already argued, we need healthier jobs, not just more jobs – and job design could be crucial in reducing the cost of in-work sickness to businesses and workers.

To some extent, the government has accepted this. In summer 2023, it launched a consultation on how best to use tax incentives to support occupational health provision and access. This is welcome – occupational health is underutilised in the UK, with government estimating that only 45 per cent of workers have access to occupational health services in their current job (DWP 2023). Indeed, the government might consider tax relief for employee assistance programmes and an occupational health subsidy for SMEs, as proposed by the CBI (CBI 2023).

But while more occupational health is a positive step, it is not a full strategy. Occupational health is only one of the routes through which employers can support good health. There are numerous facets of job quality that will have demonstrable effects on individual health such as pay, voice, autonomy and work-life balance, among others. There is a role for the state to foster good work by providing incentives to encourage the uptake and spread of healthy workplace innovations and standards.

As such, our first recommendation is that the government introduces a new **Healthy Work Premium**. This would see the government outline a new suite of interventions that constitute the ‘gold standard’ for better workplace health. In the first instance we recommend that the ‘gold standard’ is tied to both NICE criteria for healthy workplaces (NICE 2017) and the Taylor Review on job quality (Taylor et al 2017).

This will ensure that we are incentivising the bettering of the job market that improves the quality of jobs and maximising the health of employees. Companies that demonstrably meet these standards would be eligible for a temporary reduction in their employer National Insurance Contributions for a five-year period.

In table 4.1, we provide examples of areas of job quality and potential indicators that could serve as the basis for the creation of this incentive. Larger firms are likely already gathering data on process-related indicators such as leave taken, though they may not be leveraging this information to assess the quality of their employment standards. However, there are other crucial indicators where data collection might be lacking, such as employee satisfaction with their line manager or with career progression opportunities where an employee survey would have to be used.

It would not be appropriate for the companies not doing the fundamentals to be eligible for the wellbeing premium. Therefore, we propose that while the incentive is designed around encouraging ‘gold standard’ approaches, that the incentive is also dependent on basics: like paying the national living wage, compliance with sick pay and occupational health legislation, and meaningful provision of flexible working.<sup>12</sup> Moreover, we suggest companies that predominantly produce or profit from health-harming products are not eligible for the incentive – namely, those that predominantly manufacturer, create or sell unhealthy food and drink,<sup>13</sup> tobacco or gambling products.

**TABLE 4.1**

**Possible areas of job quality and their indicators for the Healthy Work Premium**

	Job quality metrics	Indicator
Fundamentals	Pay	Payment of the Real Living Wage
	Sick pay	Access to sick pay at 80% of previous earnings
	Flexible working	Flexible working offered by default (unless there’s a business reason not to) and access to self-rostering for shift workers
Work-life balance	Holiday entitlement	Average number of hours holiday to number of hours worked
	Gap between holiday entitlement and taken	The proportion of days of leave not taken
	Satisfactory hours	Proportion of employees with satisfactory hours
	Unpaid overtime	Proportion of employees reported working unpaid overtime

12 The fundamentals are intended as a criteria to exclude those not doing the basics – we do not suggest that tax incentives are the best way to ensure that the fundamentals are in place across the economy. To that end, we suggest a more systematic approach to regulation later in this chapter. See our policy on a ‘do no harm’ regulation.

13 This could be established based on sales – with firms where unhealthy food and drink represents 50 per cent or more of overall sales considered ineligible for the incentive. In this way, this policy may encourage reformulation.



Employment	Job Security	Proportion of staff on zero hours and fixed term contracts
	Autonomy	Proportion of staff feeling they have autonomy over: tasks, pace, manner, order, and hours
	Satisfactory hours	Proportion of staff satisfied with hours
	Health and Safety (Physical and Psychosocial) Supervisory Social Support	Proportion of staff happy with mental and physical health support
Line management	Employee satisfaction with supervisor	Proportion of staff satisfied with line manager
	Management training	Proportion of line managers who have undertaken management training
Voice	Staff engagement forums	Evidence of staff engagement forums
	Trade union presence	Evidence of trade union presence
	Trust in management	Proportion of staff trusting management
Overall indicators	Staff retention	The turnover rate
	Staff satisfaction rates	Proportion of staff that have high rates of satisfaction
Healthcare	Time off for healthcare	Paid staff time off for vaccines and other appointments
	Direct provision of healthcare	Employer provided access to occupational health and healthchecks

Source: Author's analysis

As table 4.1 suggests, eligibility for the incentive should be decided on both inputs (for instance whether staff engagement forums are in place) and outcomes (for instance whether the firm is performing well on staff satisfaction). The premium should be conditional on annual certification that these standards continue to be met. There should be added stipulations regarding the response rate to surveys as to ensure that all workers in the firms get to have a say.

Policymakers should ensure that the approach is appropriate for businesses of all sizes and all sectors. The choice of indicators should be constructed such that it is not overly burdensome or costly to implement. The use of data that businesses are already likely to be collecting helps with this – though this may need to be supplemented with other data.

One way of collecting this additional data would be through a staff survey. We propose that many of the indicators chosen are taken from current longitudinal surveys such as Understanding Society (see University of Essex 2023) – this allows us to use the general public as a counterfactual and ensures that the questions have been well researched previously and means that businesses do not need to spend time nor money on survey design.

We suggest the incentive is time limited – receipt should last five years. The intent of the incentive is to encourage businesses to make up-front investment that eventually benefits their balance sheet, as well as their employees. To that end, the incentive should be initially large enough to encourage action – and the time-limited nature may allow for a larger initial incentive – but does not need to run past the point the benefits have been realised.

Within the scope of a time-limited incentive, and as more evidence emerges around what works on employee health, the government may design new incentive packages – that go beyond those outlined here. Where changes are sufficiently extensive, the policy would allow for firms that have already received one payment to become re-eligible. In this way, our policy design may allow for continuous improvement over the long term.

The idea of a workplace health incentive builds both on similar recommendations made previously by NHS England, and local pilots of similar incentives. In 2016, the then CEO of NHS England, Lord Simon Stevens, proposed that employers should be offered incentives where they provide NICE recommended health programmes for employees (West 2016). Around the same time, a Wellbeing Premium piloted by the West Midlands Combined Authority provided a small number of SMEs with a reduction in their business rates in exchange for a commitment to improving health in their workforce.

Evaluation of the programme found that business behaviour change did occur (where the incentive was sufficiently high). It also found that both employers and employees were positive about the initiative (Al-Khudairy et al 2023)

Our qualitative research with businesses also suggested that an incentive would be popular if rolled out nationally. However, it also highlighted that small businesses may have higher barriers in achieving the standards needed to be eligible for the incentive payment. To alleviate this, the government could reduce eligibility requirements for smaller employers by lowering the minimum outcomes needed to receive the premium. Alternatively, it could provide an ‘improving small business’ premium – with a lower incentive tied to demonstrating continuous improvement in worker health outcomes, even if the very highest overall outcomes are not achievable (immediately).

**Recommendation:** The UK government should introduce a new workplace health premium, cutting employer NICs for meeting guidelines based on NICE and the Taylor Review’s indicators of good work. This incentive should last five years, before standards change, to incentivise continuous improvement. Companies receiving the subsidy should be able to display their accreditation in promotional and recruitment materials.

## 2. Support investment in healthy markets and products

Investors and fund managers are increasingly interested in health. Catalysed by Covid-19, there is an increasing understanding that economic and business performance depends on population health.

There are two reasons why investors are right to focus on health. First, as this report has already demonstrated, because good health is important to long-term economic performance. Health supports growth, pay and profits, and so good population health is likely to mean the economy performs better.

Second, because companies linked to health harms are at increasing risk of becoming ‘stranded assets’. Stranded assets are companies that have suffered unanticipated write-downs, devaluations, or conversions to liabilities. This can happen when government introduces new regulation, when demand for a product changes, or (possibly) as a result of legal action.

Stranded assets is a term more often used in relation to coal mines and climate change, as governments accelerate fossil fuel regulation and demand grows for green energy. But as more high-income nations grapple with poor health, and either seek to introduce regulation or support consumer behaviour change towards healthy products, health considerations could equally lead to new

stranded assets. As ShareAction has argued: “companies that are over-reliant on the sale of high fat or sugar products [risk] becoming the equivalent of stranded assets” (Christiansen 2022).

The power of supporting investors to channel their funds into healthier companies could have significant transformative potential. For example, in 2023, a group of investors led by Rathbone Greenbank Investments – and worth £3 trillion in assets – called for the UK government to enforce mandatory reporting on nutrition and sustainability metrics in the food industry. Even a relatively modest consideration of health by such large investment funds could support both transformation in the approach to health by existing companies, and the emergence, scale and competitiveness of healthy companies.

Rathbone’s call for mandatory reporting reflects the central ask of investment companies identified in IPPR’s qualitative research with businesses: the data to differentiate between unhealthy and healthy investment choices. Without transparent and comparable data, it was argued, it is very hard to bring health to bear on investment decisions.

To make this a reality, we recommend that health reporting is introduced across the economy. The plausibility of health reporting across the whole economy has begun to be demonstrated by initiatives such as the CBI’s Work Health Index, McKinsey’s Organisational Health Index and Mind’s Workplace Wellbeing Index. Each of these is already in use within a range of UK businesses, helping to identify successes and challenges, and to pursue continuous improvement.

Like compulsory carbon emissions and energy use reporting, we suggest that this reporting is compulsory for companies (in their directors’ report) and Limited Liability Partnerships (through a health report). Smaller businesses should be encouraged and supported in reporting similarly, though this should remain voluntary. This common set of reporting standards for all businesses could be supplemented by sector-specific reporting requirements, where there is strong evidence of a unique and definable health challenge (such as the link between ultra-processed food and obesity). Again, there is precedent for this: the Global Reporting Initiative has additional reporting requirements for oil and gas, as well as mining and metals.

This new flow of data would support the incorporation of health within ESG – or ‘ESHG’ – criteria. As it stands, a lack of inclusion of H within ESG can lead to some perverse outcomes. For example, British and American Tobacco was recently rated by one data provider as having the third highest ESG rating in the FTSE 100, despite the health impacts of tobacco (ShareAction 2021). In line with recommendations made by ShareAction, Legal & General and the Institute for Health Equity, we suggest health is incorporated into ESG scoring and declarations, with a duty for ESG data providers to incorporate health indicators. Government and regulators could support them in doing so by providing digestible information on consumer trends and health regulatory changes.

**Recommendation:** The UK government should build on advances in health reporting to set common health reporting standards. They should use this data as a basis to put health into ESG (ESHG) – with new standards for ESG data providers.

### 3. Support ‘health-vital industries’

In recent decades, the state has often limited its role in markets to ‘fixing market failures’. But it is increasingly clear that this is an artificial and unnecessary constraint on the government’s ability to shape and make markets that support big

socioeconomic goals: from the transition to net zero, to an economy that supports good health. Put plainly, it is a constraint that harms social and economic outcomes.

That is not to say government should not fix market failures: we discuss its role in correcting negative health externalities in the following section (Step 2). However, it should also use the full range of levers available to it to support the emergence of ‘health-vital industries’ and make them a foundational part of our strategy for (long-term) growth.

That does not necessarily mean a scatter-gun approach, where the government ploughs investment indiscriminately in every sector with the potential to boost health. Industrial strategy is inevitably about making strategic choices – about what UK industries are best suited to thrive and provide the best social and economic returns. To that end, we recommend the government delivers a coherent, healthy economy industrial strategy – linked towards an overarching goal of making the UK the healthiest country in the world over the next 30 years. This should sit above the individual industry strategies otherwise published by government, such as the Life Science Vision.

In the first instance, this strategy should be focused on three key sectors – based on potential impact on growth and health outcomes. First, the **life sciences**: an historic UK strength, with significant potential for growth, global competitiveness and for supporting health advances. Second, **food and drink**: where, despite the fact diet is the most important individual determinant of our health, healthy options struggle to compete. Third **healthy leisure and transport**: in the context of a service industry where gambling thrives, but sport struggles.

We outline a shortlist of policies to support growth in each of these sectors in tables 4.2 to 4.4 below. These ideas are designed to typify the sheer breadth of options available to government to support healthy industries (beyond fixing market failures) through:

- guaranteed markets, including through public sector spending and procurement
- price support, including by subsidising healthy products (namely healthy food)
- direct investment in innovation through R&D
- building essential infrastructure (such as cycle lanes)
- creating public sector skills and expertise to support partnership.

These tools are informed by previous IPPR work on market shaping (see Alvis et al 2023).

**TABLE 4.2**  
**Options to strengthen the life sciences**

Area	Problem	Solution
<b>Level of public R&amp;D investment</b>	Public investment is one of the clearest determinants of private R&D spend. 2022 estimates from IPPR predicted that £8.5 billion public R&D investment would crowd-in £8.3 billion private investment (Nanda et al 2022).	The UK should look to be a genuine world leader on life science R&D investment. While matching Israel – by the far the OECD’s largest R&D investor – may be challenging, matching the US (the top G7 investors) is a reasonable goal (relative to GDP). This would require 0.542 per cent of GDP or £12.3 billion more investment per year (OECD 2023b). We also suggest we match US public expenditure on health research relative to GDP (c.0.23 per cent in 2020) – by doubling public health research investment.

<p><b>Direction of R&amp;D investment</b></p>	<p>There are three key oversights in public investment in life science research. First, some conditions that are vital to health and prosperity receive less research funding than their burden of disease would predict. Second, only around £1 in every £8 life science research investment goes into prevention and early diagnosis (Thomas and Nanda 2020). Third, most investment is concentrated in the South East of England leaving untapped potential beyond the 'golden triangle'.</p>	<p>In the context of an increased R&amp;D investment envelope, the government could direct more public life science research spend to high potential life science clusters outside the South East; to prevention and early diagnosis; and to conditions on which we have historically underinvested. The crowding-in effect of public investment should help direct and crowd-in private investment to those same priorities.</p>
<p><b>Adoption of innovation in the NHS</b></p>	<p>Innovation means little if people and patients do not benefit. As a national system, the NHS has theoretical advantages in adopting and spreading innovation – but in reality, we lag well behind international standards on innovation adoption. This weakens the UK as a market and reduces our attractiveness for global investment, early roll-out of new technologies and clinical trials.</p>	<p>One of the key barriers to better uptake and diffusion of innovation is a combination of a) risk aversion across the NHS, and b) little internal NHS capacity for change management or transformation. Answers to this could include:</p> <p>a) Addressing the management capacity challenge in the NHS by hiring 10,000 new managers.</p> <p>b) Aligning clinical excellence incentives to genuine innovation. For example, evidence shows the clinical excellence award rewards status quo rather than disruptive thinking: this could be relaunched as an innovation award.</p>
<p><b>Capacity for partnership in the NHS</b></p>	<p>As the creation of the Oxford vaccine showed, innovation works best with strong public-private partnership. Yet, outside of pandemics – when significant frontline capacity was reallocated to clinical research – the NHS has little innovation capacity. Indeed, the UK public sector employs only 9,500 public sector researchers (lowest in the G7), compared to over 70,000 in Germany.</p>	<p>The UK should look to employ more clinical research and innovation staff. Means to do this could include:</p> <p>a) Ensuring at least 20 per cent of staff have at least 20 per cent of their time linked to innovation or adoption.</p> <p>b) Creating paid opportunities for GPs to spend more of their working week on research, change management and innovation adoption, as part of portfolio roles.</p>
<p><b>Pricing in long-term value</b></p>	<p>Many medicines have long-term benefits – including cell and gene therapies. Yet, the current discount rate (3.5 per cent) makes it hard for these long-term benefits (including societal benefits) to be valued. As IPPR has argued elsewhere, higher discount rates prioritise interventions with immediate payback, over those with long-term pay back – and can entrench government short-termism (see Laybourn-Langton et al 2019)</p>	<p>NICE has already concluded an evidence base exists for a change of the reference case discount rate from 3.5 per cent to 1.5 per cent. Implementing this change would help ensure the full value of long-term good health is costed in – and would signal UK ambition on medicines.</p> <p>NICE should also consider evaluating new healthcare innovations on their economic benefit. This would require a review of the HTA methodology.</p>

Source: Authors' analysis

**TABLE 4.3**

**Opportunities to support a health transition in food and drink**

Area	Problem	Solution
<b>Price and profit margins of healthy food and drink</b>	The production costs of healthy food and drink are much higher, and the profit margins much lower. This underpins a status quo where a) 1,000 calories of healthy food costs more than double 1,000 calories of unhealthy food, and b) where companies are incentivised to focus R&D and product development on ultra-processed products.	Price support for healthy food is an underutilised and highly effective way to encourage healthy eating. Cash payments, food vouchers, subsidised healthy food within workplaces and free, healthy school meals all have a strong evidence base.
<b>Use of public procurement</b>	The government procures significant amounts of food and beverages, including in schools, hospitals, care homes and prisons. This gives it significant power to create markets for healthy products and brands. However, it does not make best use of this potential: government reviews of both prison and hospital food have identified problems with the nutritional value of food provision (Woods-Brown et al 2023), while recent estimates suggest 61 and 71 per cent of calories in school-provided lunches came from ultra-processed food (Parnham et al 2022). Beyond meals provided for patients, unhealthy multinational coffee chains have increasing numbers of concessions in UK hospitals.	Public procurement offers the government two levers. First, it can use procurement to increase the amount of food and drink provision provided through the government – by implementing free school lunches, increasing catering resources for schools and hospitals, and by ensuring NHS non-patient food provision is delivered in house. Second, it can use that increased procurement to ensure public services provide a market for sustainable, healthy, ideally domestic food and drink providers – through more rigorous food standards, better data collection on public service nutrient profiles, and tighter controls on the calorie content that can come from ultra-processed food.
<b>Scale to scale and compete</b>	While many unhealthy or ultra-processed foods are well established, many healthy food and drink innovations are located in small companies. These companies may have potential to scale and challenge more established brands but are likely to be limited by access to long-term capital. Low access to patient capital is a well-established barrier to scaling start-ups and small businesses in the UK.	The Good Food Programme – supported by Impact on Urban Health and Mission Ventures – has shown that even relatively small amounts of capital can deliver excellent outcomes. The initial £1.4 million fund has been matched with £6 million of further investment – with initial evaluation showing that brands that went through the accelerator increased revenue 63 per cent in their first 12 months and often achieved supermarket listings. As well as access to capital, business mentorship and coaching was found to be important. Similar schemes could be replicated at far greater scale by institutions such as the Better Business Bank.

Source: Authors' analysis

**TABLE 4.4**

**Opportunities to support healthy leisure and transport**

Area	Problem	Solution
<b>Loss of community infrastructure</b>	<p>While leisure activities associated with worse health (such as gambling) have increasingly migrated online, healthy leisure often requires a physical space. These spaces are increasingly under threat in the UK – with leisure centres, sports fields and swimming pools all under threat (LGA 2023; GMB 2023; Community Leisure 2023).</p> <p>This compounds a very real problem that many sports in the UK are facing difficulties at the grassroots. Evidence suggests falling youth participation in rugby (Statista 2024a), cricket (Platform Cricket 2023) and football (Statista 2024b). This threatens the long-term health of these sports as part of UK culture and the UK economy alike.</p>	<p>The closure of leisure outlets is a wider reflection of the pressure faced on local authority budgets over the past 13 years. To rectify closures and ensure a vibrant active leisure economy, IPPR North has previously proposed:</p> <p>A fair funding formula for local government, to ensure it can invest in areas and projects that need it</p> <p>Common good property registers, to increase transparency of public asset ownership and to protect communities from continual losses</p> <p>Participatory budgeting, to allow citizens to direct funding in ways that meet their needs and priorities.</p>
<b>'Health-washing'</b>	<p>The health benefits of sport and leisure are undermined by the prevalence of advertising of unhealthy food, gambling and alcohol brands – including on major broadcasts and through sponsorship. This is made more worrying by the fact that sport broadcasts have a high audience of under-18s, who evidence shows to be more influenced by unhealthy product advertising (Rossi and Nairn 2021).</p>	<p>The government should restrict gambling, alcohol and ultra-processed food advertising on sports broadcasts and sponsorship. However, we recognise that this may reduce much-needed revenue flowing into sports. To help mitigate this, the government could introduce a £100 million health campaign budget, ringfenced for healthy eating advertising and sponsorship. There is evidence that, done skilfully, such public health measures are an effective way to support healthy behaviour change (Yom-Tov et al 2018)</p>
<b>Cars over bikes</b>	<p>Cycling could be a far bigger part of the UK economy. Estimates from 2016 suggest that cycling and mountain biking contribute £500 million to British tourism each year and contribute over £1 billion in health benefits, while a 2023 study put the estimated benefit of the cycle industry at over £7 billion. This is despite the fact that the country is not set up for bikes. Indeed, the prioritisation of cars in the UK has seen cycling fall from accounting for 37 per cent of traffic in 1949 to just 1 per cent in 1973 – a fall it has not recovered from. As of 2020, the UK has one of the lowest rates of cycling according to the Eurobarometer survey (see Singer Hobbs and Frost 2023).</p>	<p>With the right infrastructure, cycling in the UK could be to the 21st century what the motor industry was in the 20th century. Yet, this requires ensuring cycling infrastructure is good, that cyclists feel safe, and that biking is promoted as a leisure activity. To begin to achieve this, we reiterate previous IPPR recommendations for an active travel network, including: a phased increase in spending to £50 per head by 2029; a new national cycle network to deliver nationwide, safe cycle lanes; and proper enforcement of highway code rules on overtaking of cyclists by cars.</p>

Source: Authors' analysis

**Recommendation: The UK government should deliver an industrial strategy for health**, focused on industries where growth, wellbeing and health gains most strongly intersect. We suggest an immediate focus on the life sciences, food and drink, and active leisure. Priorities should include:

- increasing public capacity in the life sciences – through more research staff and more public R&D expenditure – while reducing the discount rate on innovative medicines and realising the wider value of treatments
- increasing public procurement on food to increase food quality in schools, hospitals, care settings and prisons – while using that spend to support healthy products and brands
- increasing capacity for active leisure and transport: including sports pitches, leisure centres, active transport infrastructure and cycle lanes.

## STEP TWO: THE TRANSITION FROM...

### Reduce health harms and catalyse transformation in health-harming industries

As the first chapter in this report showed, we overconsume some products that harm our health. In some cases, this is because there is no safe level of consumption of some products: tobacco, for example. In other cases, it is because markets have enabled consumption of products – that might not threaten health in small quantities – at unsustainable levels: ultra-processed food, for example.

This is incompatible with delivering world leading health and, in turn, prosperity. For example, differences in diet are one of the clearest explanations for much stronger progress on healthy-life expectancy in Japan, France and Italy, compared to countries like the UK and the US. That we have a food system that has facilitated a rise in UK obesity childhood rates from just 1 or 2 per cent in the 1970s, to 22.7 per cent in the latest data, is among the clearest case studies in a dissonance in public health and economic strategy (Stamatakis 2005; NHS Digital 2023a)

Overconsumption of products that harm population health is down to a mix of government and market failure. On the one hand, the government has shown a reticence to intervene in the market. Whether because the lure of short-term economic gain is more powerful than the long-term returns possible by prioritising health, or because of the political risks of implementing policies perceived as ‘nanny statism’, the government has generally failed to intervene in markets in support of public health. Indeed, one review of obesity policy in the UK found that the vast majority of 689 policies were designed in a way that prioritised individual responsibility over market intervention, or otherwise in ways that made implementation unlikely (Theis and White 2021).

At worst, the state has actively facilitated the rise of practices and products that undermine population health. For instance, while the Blair government is widely remembered for a ban on smoking in public places, the same government also oversaw a significant liberalisation of gambling policy. This deregulation led to a wide range of harmful innovations – aggressive advertising, highly addictive fixed-odds betting terminals, and an increase in the number and sophistication of online casinos. Today, a lack of coherence in public health and economic strategy is summed-up by the fact that the most harmful<sup>14</sup> gambling products usually have the lowest tax rates.

The market failure is that the companies that profit from products that harm human health often do not cover their full societal cost. While duties or other forms of differential tax might go some way towards this, it is insufficient: tobacco costs £49.2 billion, four times the £11.3 billion tax take (ASH 2023); alcohol has at

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14 As judged by accessibility, addictiveness and betting limits.



least a £27 billion societal cost, compared to £13 billion raised in duties (Burton et al 2017); the societal cost of obesity is estimated at approximately £74 billion, and ultra-processed food has no additional duty (Bell et al 2023).

Defenders of these industries often note that these companies are sources of good jobs, create value beyond tax receipts and support growth. But this ignores a core unfairness: they do not pay for the societal costs they create. As the second chapter of this report has already suggested, those costs are subsidised by other businesses, as well as by public services and individuals. This is unfair and threatens the level playing field of UK markets.

If we are to create an economy that optimises health, and in turn prosperity, we will need to support transformation in these industries. That does not necessarily mean downsizing them (though in cases like tobacco, or fossil fuels, it will). But it does mean recognising that the government has a role in catalysing that transformation. The government's proposed ban on energy drinks for under 16s, junk food advertising before the watershed, and to phase out tobacco are good starts on this agenda – but further intervention will still be needed.

The potential for government intervention to support transformation has been shown by policies like the Soft Drinks Industry Levy. As shown in chapter 3, this encouraged drink reformulation while also increasing long-term value of the companies it impacted. Yet, while few in our business consultation questioned the efficacy of policies like these, they did express concerns about the piecemeal approach it represents. Targeting individual products – based on political whims – was seen to undermine competition. A level playing field demands a more systematic approach.

This Commission has already proposed that the government should introduce a long-term, legislated health mission – supported by a mission delivery board, modelled on the Climate Change Committee (a Health and Prosperity Committee) (see Thomas et al 2023). Then, we recommended that the committee focused on cross-Whitehall mission coordination. Here, we add that it should take a role in coordinating private sector contributions to delivering national health aspirations, through three new functions.

- **Setting mandatory transition targets:** The Health and Prosperity Committee should set long-term targets for transformation, with remit to cover any product category, industry or part of the economy where significant health harms exist.
- **Rigorously monitoring progress:** The Health and Prosperity Committee should monitor progress on transformation – ranging from reformulation of food to meaningful protection of problem gamblers, to the reduction in sales of high strength/low-cost alcohol.
- **Advising on regulatory recourse:** Where progress is not sufficiently fast, the committee should advise on a range of interventions, ranging from levies to restrictions to bans (in extremis). The expectation should be that government adopts these measures by default (a similar expectation to recommendations by the Low Pay Commission, independent pay review bodies, and so on).

We describe options for targets, levy and regulation across areas of health concern in table 4.5.

**TABLE 4.5**

**Potential areas for targets, levy and regulation in health harming industries**

	Targets	Levy	Regulation
<b>Ultra-processed or HFSS products</b>	A reduction in the proportion of sales from ultra-processed or 'high fat, salt and sugar' categories.	A high salt, fat and sugar levy, modelled on the Soft Drinks Industry Levy.  A tax on antimicrobial drugs for livestock animals.	Use of clear labelling designations for ultra-processed food (as increasingly common in South American countries) and banning marketing of unhealthy foods pre-watershed and total online advertising ban, and banning the giving out of toys when purchasing ultra-processed foods.
<b>Gambling</b>	A reduction in gambling-related harm by 50 per cent within five years.	A gambling harms levy, based on proportion of profits derived from high frequency/high stakes users.	Gambling advertising of sports teams and during sports broadcasting.
<b>Alcohol</b>	A 30 per cent reduction in alcohol-related mortality by 2029.	A levy on high-strength, low-cost alcohol products to encourage reformulation.	Alcohol advertising of sports teams and during sports broadcasting.
<b>Online harms</b>	A reduction in the number of children who see harmful, extreme or inappropriate material on social media.	An industry levy on social media platforms, linked to the overall exposure of children to online harms.	Legal liability for exposure to extremely harmful material.
<b>Vapes/E-Cigarettes</b>	An increase in the number of vapers quitting nicotine-based products altogether.	A levy on vape sales, determined by the use of vapes among under 18-year-olds.	Standardised packaging to reduce the appeal of vape devices and fluids to children.
<b>Tobacco</b>	The government already has a smokefree generation ambition and has brought forward legislation to that end.	A polluter pays levy on tobacco manufacturers, to align tax receipts with societal costs of cigarettes.	An increase in the age of sale to 21, alongside the government's stated ambition to phase out tobacco for children who turned 14 in 2023, or younger.

Source: Author's analysis

While these might sound like 'nanny state' interventions, the use of targets combined with regulation is intended to give space for industries and firms to transform and innovate, before state intervention – but with a recognition that voluntary schemes, where there is high doubt government will intervene if needed, have often failed. And if the alternative is poor health, shorter lives and less wealth, we would rather the nanny. The public are ahead of politicians and policymakers on this: indeed, our polling suggests that where taxes or regulation is needed, it would be popular.

**TABLE 4.6**

**Public attitudes on tax and regulation of health-harming industries**

	More tax	Less tax	Current taxes
Tobacco companies	71	7	12
Ultra-processed food or drink manufacturers	52	9	25
Gambling companies and products	76	3	9

	More regulation	Less regulation	Current regulation
Tobacco companies	64	5	21
Ultra-processed food or drink manufacturers	59	4	23
Gambling companies and products	73	2	14

Source: Authors' analysis of IPPR/YouGov polling

**Recommendation:** We recommend a CCC equivalent for health – the Health and Prosperity Committee – is formed with an oversight function for health-harming products, markets and industries. This body should set mandatory targets for transformation in these industries, monitor progress, and recommend evidence-based intervention where progress is not sufficiently rapid. The expectation should be that government comply with those recommendations.

**2. Create a new a ‘do no harm’ worker health duty**

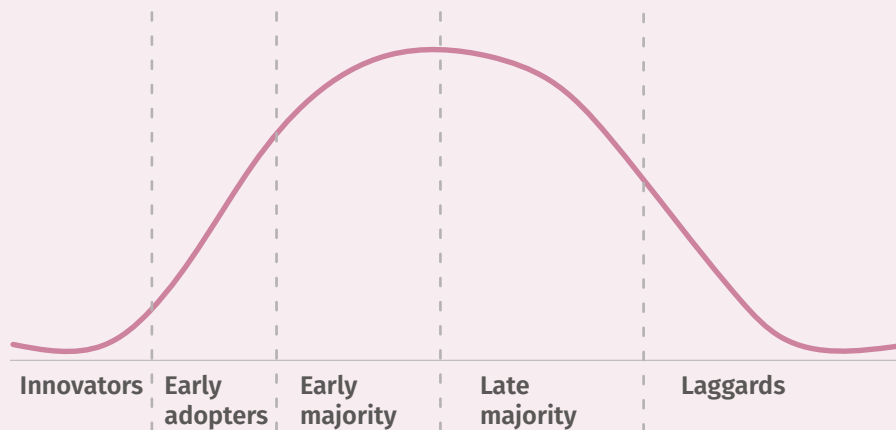
This report has argued for a new incentive to boost workplace health. However, we recognise that this is unlikely to be a silver bullet on its own. Without some form of regulation, to set minimum standards, it would risk simply encouraging those already minded to support employee health (such as in sectors with high-skilled, well-paid jobs), without changing the norms in sectors with a higher propensity to resist (such as gig economy industries). As in public sector reform, incentive is best combined with (proportionate) regulation.

## HOW INNOVATION DIFFUSION WORKS

The adoption of innovation is a process, rather than an event. And studies of how innovation diffuses through systems suggests that the process happens on a bell curve.

**FIGURE 4.1**

**Innovation diffusion curve**



Source: Authors' analysis of Beale and Bohlen (1956)

This helps to understand the interplay between incentive and regulation. For innovators, early adopters and early majority actors – that is, those with a propensity to adopt rather than resist innovation – regulation is unlikely to be the most effective policy measure: it is a poor method to support individual actors to transition from 'good to great'. This process is better supported by the worker premium already outlined in this report. However, for laggards – those with a higher propensity to resist change – regulation may be necessary to ensure minimum standards (and to increase overall propensity to adopt innovation).

In the UK, the focus of 'health and safety' regulation has been skewed heavily in favour of 'safety'. We have had some major success on workplace safety since the first occupational safety legislation was passed in 1802. Since 2000, Health and Safety Executive figures have shown downward trends in the rate of both non-fatal and fatal injuries to workers in the workplace: the former having halved since 2000, the latter having reduced over 97 per cent since 1900 (when records respectively begin).

Yet, their own figures also show that 1.8 million workers were suffering from work-related ill health in 2022–23 – with half the cases down to stress, depression or anxiety (HSE 2023). There will be an ongoing need to continue prioritising workplace safety – any level of injury or fatality is too many. However, that does not detract from the need to give mental health parity in our approach to health and safety.

An effective health regulatory regime is likely to look different to an effective safety regulatory regime. Safety can often be achieved with a focus on inputs: regulation on the kinds of protective equipment provided, the kind of processes followed by managers, the kind of substances a worker should not encounter at work. Health is more complicated: it is determined by a more complicated set of causal factors, and describes a more diverse set of outcomes, making it less easily governed by a

'tick box' approach. In other words, putting 'health' into 'health and safety' is likely to require a shift to an outcome-focused approach.

There is good precedent for both the viability and efficacy of an outcome-led approach to regulation. One particularly promising, recent example has been the introduction of the Consumer Duty by the Financial Conduct Authority (FCA). This regulation stipulates, first and foremost that "firms must deliver good outcomes for all retail customers", by taking "all foreseeable steps to avoid harm". The FCA measures this duty against four key outcomes:

- products and services
- price and value
- consumer understanding
- consumer support.

With financial and legal recourse where firms are non-compliant.

While the Consumer Duty is relatively new (it came into force in July 2023), there is already some early evidence of impact. An FCA evaluation of how firms in different sectors are implementing price and value requirements found substantial efforts to comply with the duty (FCA 2023). Elsewhere, there are signs of firms changing behaviour in positive ways: St James's Place (a wealth management company) scrapped early withdrawal penalties and reduced client fees.

An approach modelled on the Consumer Duty could be applied to workplace health in the UK: what we term the **Employee Health Duty**. This approach would begin from the statement that "firms must deliver good health outcomes for all their employees" by taking "reasonable steps to reduce any current harm, avoid any new and foreseeable harm, and by acting in good faith towards customers and employees". That is, it would form a 'hippocratic oath' of 'first do no harm' for employers. The associated outcomes could include:

- overall safety in the workplace
- physical health outcomes
- mental health outcomes
- inclusive health practices.

The fourth outcome is particularly important. It is vital, in any move to outcomes-based regulation, that employers are not incentivised to either 'manage out' – or otherwise not hire – people with long-term health conditions or disabilities. This outcome should put the onus on employers to demonstrate how they are supporting people into appropriate work and supporting them to stay in that work long term.

**Recommendation:** The UK government should resource the Health and Safety Executive to oversee a new employee health 'do no harm' regulation – based on a set of new outcome measures for employee health.

### **3. Strengthen sick pay to shift the UK from a high-presenteeism, low-productivity country**

When first introduced in 1911, National Insurance was among the most ambitious social policies ever implemented in the UK. It provided workers with a new range of much-needed health protections: access to healthcare, unemployment insurance and – vitally – sick pay.

Yet, neither the rate nor the flexibility of sick pay has evolved, sufficiently, over the past 100 years. As of 2024, the UK has one of the lowest rates of Statutory Sick Pay of any comparable country – £109.40 per week, beginning from the fourth day of sickness and covering only employees earning over £123 per week. This equates

to £2.70 to £3.70 per hour – or around a quarter of what the Living Wage Foundation calculate as the real living wage (£12/hour).

The low entitlement to sick pay means that workers have a relatively low incentive to avoid work when sick. This is a problem. Evidence from other countries, including from during Covid-19, shows that more generous sick pay entitlements reduce presenteeism. Even if that reduction in presenteeism comes at the expense of an increase in sick days, this report has already shown that presenteeism costs the UK economy more than absenteeism and that increasing absenteeism can be net positive for businesses. That is, weak entitlements to inadequate sick pay are likely to harm firms as well as workers.

Beyond the rate sick pay is set at, there are two other limitations in its design that undermine its efficacy. First, the fact that an employee needs to earn over a certain threshold to be eligible leaves an estimated two million employees without any entitlement to statutory sick pay – a group that IPPR and UCL analysis has shown is far more likely to be working class, BAME and/or female (Patel and Jung 2022).

#### UNINTENDED CONSEQUENCES OF UK SICK PAY POLICY

A 2022 IPPR report on vaccine uptake found that one of the major reasons for unwillingness to get routine vaccines – such as the winter flu vaccine – was difficulty getting time off for an appointment, or a worry that any subsequent symptoms might mean taking sick days from work. This indicates that the UK's weak sick pay policies may interact with routine healthcare uptake (Poku-Amanfo and Thomas 2022).

Second, sick pay entitlements lack flexibility as Statutory Sick Pay does not currently allow for a phased return to work. For example, if a worker felt they could return to work part-time – say, working 20 instead of 40 hours – there is no provision for the employer to pay 20 hours as wages, as usual, with the rest paid as statutory sick pay. To that end, Statutory Sick Pay is an all or nothing deal.

Given these challenges, we propose three key changes to sick pay in the UK.

1. We recommend that **statutory sick pay is increased to 80 per cent of previous earnings for all workers earning under £2,500 per month** (full-time equivalent). We recommend that this entitlement begins from day one rather than from day four.
2. We recommend that **the lower earnings limit is abolished**, giving an estimated 2 million working people entitlement to paid sick leave. As well as reducing presenteeism, we would expect this to have lifelong health benefits for this group, as well as facilitating access to preventative healthcare (GP appointments, dentists, vaccination) during working hours.
3. We recommend that **the government allow people to take phased returns to work** – by allowing those off work with sickness for longer than two weeks to return to work part-time, with sick pay covering lost hours, and wages covering worked hours as usual.

**TABLE 4.7**

**Sick pay entitlements in select European countries**

Country	Sick pay policy
France	50 per cent of salary, following three waiting days
Germany	100 per cent of salary for six weeks, 70 per cent until fit to work
Spain	60 per cent of salary for first 15 days, three-quarters thereafter
Netherlands	70 per cent of salary for up to two years
Italy	50 per cent of salary for 20 days, two-thirds of salary thereafter
Poland	80 per cent of salary
Sweden	80 per cent of salary following one waiting day

Source: Authors' analysis

International practice differs in who pays for sick pay costs. Options include:

- Full coverage of costs by the state in Finland, where Kela<sup>15</sup> either pays the employee sick pay, or compensates the employer if they maintain that employee's pay (particularly in cases where sickness has led to an employee reducing their hours but remaining on payroll).
- Shared costs as in France, where a mix of social security and employee contributions cover sick pay, or in Germany where employers cover sick pay for six weeks, after which health insurers take over (Germany has compulsory health insurance, with a mix of public and private providers).
- Predominantly employer paid as in Netherlands, where state social insurance only covers the self-employed or temporary staff.

An additional option is government rebate of sick pay costs for smaller employers, but not larger corporations. Given that benefits from higher productivity will benefit state and businesses, we prefer models that share costs between government and firms – with increased support for small businesses, particularly in the early years of a more extensive sick pay policy. We project that rebating 50 per cent of sick pay costs (up to a maximum salary of £1900 per month) for the smallest businesses (under 25 staff) – with government rebate then gradually decreasing with employee headcount – would cost £4.0 billion in the first year.

Again, we find that this is a popular policy with the public. IPPR/YouGov tested attitudes to increasing sick pay to 80 per cent of earnings among a representative sample of British adults. We found that 72 per cent felt this would effectively protect employees from the consequences of sickness, while 66 per cent backed sick pay beginning on the first rather than the fourth day of sickness.

**Recommendation:** The UK government should align the UK with best European practice and increase sick pay to 80 per cent of earnings, beginning from day one and with far greater flexibility to reduce working hours (rather than leave work entirely) in cases of longer-term illness.

15 Kela is Finland's social insurance institution.

#### 4. Help business leaders prioritise long-term outcomes through corporate governance reform

One of the tensions in tilting the British economy towards health is a tension between businesses' duty towards their shareholders and towards their stakeholders. The British model of corporate governance gives overwhelming primacy to the rights and interests of shareholders. In the UK, only shareholders have voting rights to appoint the board of directors and to make strategic decisions at general meetings, while the duties of directors (as set out in the 2006 Companies Act) are explicitly focused on shareholder interests. By contrast, many of the corporate governance systems in Europe take a more balanced approach, providing other stakeholders (notably, employees) powers alongside shareholders.

Theoretically, shareholder primacy may not be a problem in transitioning the UK economy towards health if shareholders have incentives to focus on the long-term viability and strength of businesses. The real challenge is that the UK model of shareholder primacy has coupled with an increasing short-termism among business shareholders. In a review of why shareholder short-termism has risen, one report by EY points to:

- reduced transaction costs, allowing investors to reallocate their funds more quickly
- new technologies, which allow investors to respond almost immediately to changes in market situations – including in pursuit of short-term profits
- the rise of institutional investors – in the mid-1960s, 46 per cent of all publicly listed stocks in the UK were owned by institutional investors; by the 2010s, that had risen to 89 per cent. In turn, institutional investors often feel greater pressure to deliver short-term returns (such as in order to retain clients).

In turn, the average holding period for stocks in professionally managed funds has dropped from about seven years in the 1960s to less than one year today (EY 2021).

As such, while prioritising health carries a significant upside for firms in the 21st century (and not doing so a significant downside over the same period), better health is a long-term project – and one that publicly listed firms can find difficult to achieve.

Danone provides a case study of this challenge in practice. In the years preceding the Covid-19 pandemic, CEO Emmanuel Faber turned Danone into an 'entreprise à mission' – a category of corporation in France similar to 'B-Corp'. The designation allowed Danone to expand its purpose beyond profits – to better health and greater sustainability. Most notably, Danone created a carbon-adjusted earnings per share indicator – formally measuring the company's success by its environmental performance, as well as its profits.

However, during the Covid-19 pandemic, Danone's short-term performance was relatively poor. Its shares lagged behind key competitors – including Nestlé and Unilever. Under pressure from shareholders, Faber was removed as CEO – reportedly under pressure from just two activist shareholders.

The experience of Danone provides a range of lessons. Most notably, it shows how challenging it is for businesses to successfully prioritise their long-term operating environment and sustainability of growth, particularly where competitors are not doing so. It also shows that giving individual firms the ability to expand their purpose beyond growth – through designations like B-Corp or France's 'entreprise à mission' – is not a guaranteed antidote to shareholder short-termism.

Two reforms, previously recommended by the IPPR Commission on Economic Justice, could help make this a reality. First, director's duties in company law should be reformed. Section 172 of the Companies Act 2006 could be amended



to make explicit that it is the promotion of the long-term success of a company that is the primary duty of directors. The law should make clear that the interests of shareholders, while critical, do not necessarily take priority over the interests of employees, consumers or wider stakeholders. This would make it more difficult for directors to be pressured towards short-term decisions by stakeholders and would make personnel changes (such as the removal of the Danone leadership) a less effective form of activism overall.

However, a change in corporate governance legislation will do little to change practice without enforcement. As such, we also reiterate IPPR's recommendation (Lawrence 2017) to establish a Companies Commission to oversee and strengthen corporate governance standards among both listed and private companies. An independent regulator with investigative and legal powers would not only help to ensure a realignment between shareholders and stakeholders happens in practice but would also help restore public trust in major businesses. The Companies Commission could either be an entirely new body, or an extension of the Financial Reporting Council, which currently oversees the governance code.

**Recommendation:** The UK government should update the Companies Act 2006 to make long-term success a core duty of directors and to strengthen consideration of stakeholders as well as stakeholders.

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# APPENDIX

## METHODOLOGY INSIGHT 2

Insight 2 assesses the potential expenses associated with presenteeism and absenteeism.

To do this, we use published statistics from Vitality's workplaces surveys from 2018 to 2023 (Vitality 2023). We estimate what the costs of presenteeism and absenteeism in 2023 would have been if businesses had that year's rate of presenteeism and absenteeism.

To estimate this cost, we use a similar approach as taken when measuring the cost of taking a sick day. We estimate that the net daily wage for a worker with a median salary in 2023 to be £62.80 after accounting for differing income tax rates in Scotland compared to the rest of the UK. We then multiply the number of productive days lost by the number of people in employment in the UK.

As we use average earnings data this cost is likely to be an underestimate – this is because employees would not be remunerated for their entire output. If an employee is paid £35,000 a year, they would have to produce over £35,000 to have received that salary.

There are limitations to this approach – we do not consider whether there would be differences in costs for those who are part-time or self-employed. There is not sufficient evidence for use to distinguish any differences in costs. We also do not distinguish between sectors and job level – again due to lack of data. This is a similar approach taken by Cardoso and McHayle (2024) when they estimated the cost of presenteeism of mental health.

## INSIGHTS 3 AND 4

Here we extend previous analysis by Bryan et al (2021 and 2022). The first part of this insight investigates the role of long-term conditions and the likelihood of exhibiting presenteeism, and the amount of sick leave taken.

We use data from the UK Household Longitudinal Survey from 2010 to 2018 and estimate the likelihood of presenteeism. Respondents were considered to exhibit presenteeism if they indicated that their physical health limited both the amount and kind of work, they could do, their mental health affected their productivity and work precision, and if pain interfered with their job performance. Our indicator of presenteeism can be interpreted as an indicator of self-assessed productivity loss due to health.

To investigate the association between health and job quality on presenteeism we use a probit regression as specified below:

$$\Pr(Pres_{it} = 1 | H_{it}, X_{it}) = \Phi(H_{it}\beta_1 + X_{it}\gamma_1)$$

*Pres* is a binary variable indicating whether an individual is exhibiting presenteeism due to their health, where controls include gender, age, ethnicity, region, month, year, occupation, firm size, sector, income, job satisfaction, autonomy at work, level of job security, level of flexibility at work, and whether they have a long-term physical or mental condition.

The next finding uses data from the Labour Force Survey (LFS) from 2014 to 2019 and it estimates the number of sick days people take due to ill-health. We estimate

the number of sick days lost in the same method as the ONS – where we take the difference between usual and actual hours if the reason for this difference was due to health.

To untangle this relationship, we use hurdle models which are used commonly in estimating sickness absence (Duchemin and Hocine (2020)). This is because very few people take sick leave which means there are excessive zeros in the outcome variable of interest, thus we break the question into two parts: how likely individuals are to miss work due to sickness; and if they do, how many hours they take.

To estimate the likelihood of taking a sick day we use a probit model, and to estimate the number of hours taken we use a generalised linear model with a gamma distribution and a log link.

The regression equations used can be seen below:

#### Equation 1

$$\Pr(\text{Sick}_{it} = 1 | H_{it}, X_{it}) = \Phi(H_{it}\beta_1 + X_{it}\beta_2)$$

*Sick* is a binary variable indicating whether an individual took absence leave because of health;  $H_{it}$  is an indicator if the individual has a long-term physical health and mental health condition;  $X_{it}$  is a vector of control variables which are gender, age, region, month, year, ethnicity, occupation, firm size, sector, tenure, contract type, public or private company, part-time, education level and whether they are married at time  $t$ .

#### Equation 2

$$Y | X \sim \text{Gamma}(\alpha, \beta)$$

$$g(\mu) = \eta = H_{it}\beta_1 + X_{it}\beta_2$$

$$\text{Where } \mu = E(Y | Y > 0, X) = \alpha / \beta$$

$Y | X$  represents the number of hours lost to sick days taken conditional on the control variables following a gamma distribution with  $\alpha$  and  $\beta$  parameters.

$g$  is the log link function which links the mean  $\mu$  to the linear predictor  $\eta$  using a linear combination of the control variables and the variable representing the effect of long-term health conditions.

$X_{it}$  is the same vector of controls as used in Equation 1 and  $H_{it}$  is the long-term health condition indicator.

For ease of interpretation, we combine the results of these two models and estimate for the number of hours lost due to sickness. To achieve this, we use the Two-Part Model as written by Belotti et al (2015).

Throughout these analyses we show the predictive margins from the regressions – which estimate the contribution of each variable to the likelihood of exhibiting presenteeism or the number of sick leave days taken. It is important to note that this analysis cannot be interpreted as causal as we are not able to control for all factors that may be driving variation in absence or presenteeism.

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