Commission on Health and Prosperity

GETTING BETTER?

HEALTH AND THE LABOUR MARKET

Chris Thomas

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The Commission on Health and Prosperity

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ABOUT THIS PAPER

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SUMMARY

Unlike many other comparable countries, the UK's economic activity and employment rates are yet to recover from the Covid-19 pandemic. Unemployment in the UK is at its lowest rate since the 1970s. However, economic inactivity has hit a seven-year high, at nearly 9 million people, and the UK is the only G7 nation where the employment rate has not recovered to pre-pandemic levels (OECD 2022a).

Improvements in population health have stagnated in the UK – a trend that began before Covid-19 and accelerated during the pandemic. After decades of unbroken progress on population health, both in terms of how many people are dying and how many people experience a negative impact from a health condition, improvement is stalling in the UK – and may be beginning to go backwards (GBD 2020). Long Covid is also becoming increasingly prevalent: 2.1 million reported long Covid in the latest data, more than twice as many as in spring 2021 (ONS 2022f).

Poor health is undermining labour market outcomes and equity. According to the latest data, 2.5 million people are economically inactive because of long-term illness – the highest level since records began (ONS 2022c). Around 700,000 of this 2.5 million say they would like a job – and among all economically inactive people who would like a job, long-term illness is the most common barrier to work (ibid). This indicates much inactivity is often involuntary – and that many could benefit from the wellbeing gains associated with being in a good job.

The health of people in employment is also getting worse. People in employment are also in worse health on average. Compared to 2019, people in employment are 13 per cent more likely to have a health condition and 30 per cent more likely to have multiple health conditions (ibid). This is a larger impact than would be expected from population ageing alone over two years – and, given what is known about health as a barrier to staying in work, could be an indicator of labour market fragility.

People who are economically inactive because of poor health have complicated health needs. Three-quarters of those who are economically inactive because of their health report multiple health conditions. This amounts to six times the risk of having multiple conditions, as compared to people in employment (12 per cent) (ibid). Any policy response will need to be sophisticated, multi-agency and able to account for complexity.

The consequences of long-term illness on the labour market are particularly pronounced in the devolved nations, the Midlands and the north of England. Working-age adults living in Wales, Northern Ireland and the North East are all around twice as likely to be economically inactive because of long-term sickness than people living in the South East. At the same time:

- People in the devolved nations, midlands and north of England have substantially worse healthy life expectancies than both the UK average and London/South East. Healthy life expectancy in the North East is currently around four years lower than the UK average – and around six years lower than the South East average.
- The devolved nations, midlands and north of England have substantially lower productivity than both the UK average and London/South East. Average GVA/head was over £30,000 lower in the North East than in London – which equates to a productivity gap increase of £8,000 since 2012.

This evidence stresses the importance of tackling health disparities in tackling economic disparities – as part of a progressive levelling-up agenda.

When it comes to health, the UK stands at a crossroads. In the future, poor health could be a persistent barrier to a strong and fair labour market. Or good health could be a keystone in prosperity. The latter relies on transforming UK population health – and particularly healthy life expectancy. Data from other countries shows that better health is possible: Switzerland, France, Japan, Singapore and South Korea all have much higher healthy life expectancy than the UK (both at birth, and at age 60). This should be the basis for much greater aspiration and policy action.

Policy needs to improve population health, and limit the harm caused by illness. Policy can either look to improve health overall – by preventing illness entirely, or by providing more access to more effective treatments. Or, where full prevention and treatment aren't possible – and following the logic of the social model of disability – it can aim to reduce the societal barriers faced by people living with health conditions or impairments, whether through: more tailored routes to work; more inclusive employment practices; or more empowering employment and welfare support. We do not make a full and final policy recommendation here – this will follow in the final report of IPPR's Commission on Health and Prosperity. But we do set out a framework to begin informing the policy response.

TABLE S1

A framework for intervening on health and prosperity

Change	Importance	Indicative opportunity
The prevention shift	One of the most effective – and often cost-efficient – approaches to supporting good population health is better prevention of avoidable illness. Many of the conditions impacting on the labour market can be prevented at the population level – by action on direct risk factors, or on the social drivers of poor health. More broadly, prevention should be weaved through the whole patient pathway – for example, secondary prevention can prevent people's conditions becoming worse over time.	Cardiovascular disease was the fifth most common condition among people economically inactive due to poor health. Obesity and diet have been shown to cause cardiovascular disease, by a range of high-quality evidence. Addressing poor diet, increasing access to healthy food, and reducing obesity are indicative opportunities to improve population health through prevention.
The treatment shift	The treatment shift involves ensuring people can get fast access to the best possible treatment. Early intervention helps improve health and can ensure wider impacts on people's wellness and prosperity are mitigated. Faster access to the NHS, early diagnosis and access to innovative treatments that have met cost-effectiveness thresholds can all make a difference.	Mental health was the most common condition among people economically inactive due to poor health. There are opportunities to expand talking therapies further – IAPT[1] is having some success, but waiting lists are still very large and long. There are also opportunities to expand access to medicines, particularly for people with severe mental health problems.
The social shift	The social shift means accounting for the fact that people living with health conditions and impairments experience societal barriers – including in getting and maintaining a good job. Stronger routes to work, better social care services and more inclusive workplace practices can all make a difference.	There is evidence that tailored employment support for people with health conditions or disabilities can increase both general employment and access to good jobs. Well-evidenced interventions include access to (low case load) specialist advisors; supported work placements and internships; positive role models and some employer actions in the workplace. These are interventions that can reduce the economic consequences of a shock health diagnosis, above and beyond what is possible through primary prevention and treatment.

Source: Authors' analysis

1 Improving Access to Psychological Therapies.

1. WHAT'S HAPPENING IN THE LABOUR MARKET?

KEY TAKEAWAYS

At 3.6 per cent, unemployment is at its lowest rate since the 1970s – however, the Bank of England forecasts it will rise to 6.5 per cent by 2025, while the OBR projects it will reach 4.9 per cent by the third quarter of 2024 (ONS 2022k).

Between May–July 2022, UK economic inactivity rose to 9 million – whereas economic inactivity has dropped in the euro area since the onset of the pandemic.

The UK is the only G7 nation with lower employment rates than at the onset of the Covid-19 pandemic.

The rate of population growth and working-age population growth is declining – with net deaths projected to overtake net births from the early 2030s. As a result, policy interventions to support the labour market will be increasingly important in the coming years and decades.

A common hypothesis during the Covid-19 pandemic was that employment rates would get significantly worse (see for example McKinsey 2020). The logic ran that when temporary business and individual support schemes ended – such as VAT deferral, recovery loans, business rate relief and furlough – the number of viable jobs would fall significantly.

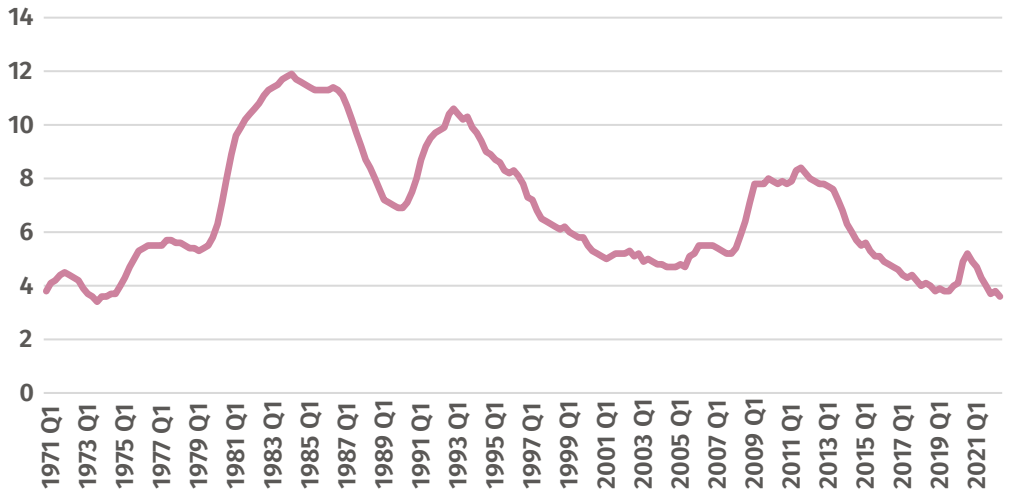
This has not yet come to pass. While there was a rise in unemployment rates in 2020 – a year in which the UK suffered its biggest, one-year fall in GDP in more than 300 years – there has since been a full recovery. The ONS' latest calculation of the UK unemployment rate (at 3.6 per cent) is one of the lowest levels recorded since the mid-1970s.

However, projections suggest more trouble could yet emerge down the line. The UK's economic context remains challenging, and it could yet increase the unemployment rate substantially. In their most recent projections, the Bank of England predicted an unemployment rate of 6.5 per cent by 2025 (BoE 2022); while the Office for Budget Responsibility recently predicted it would reach 4.9 per cent by the third quarter of 2024 (OBR 2022).

FIGURE 1.1

Unemployment has reached a 50-year low, but is now expected to rise

Seasonally adjusted unemployment rates (%, aged 16 and over, quarterly), 1971–present, UK



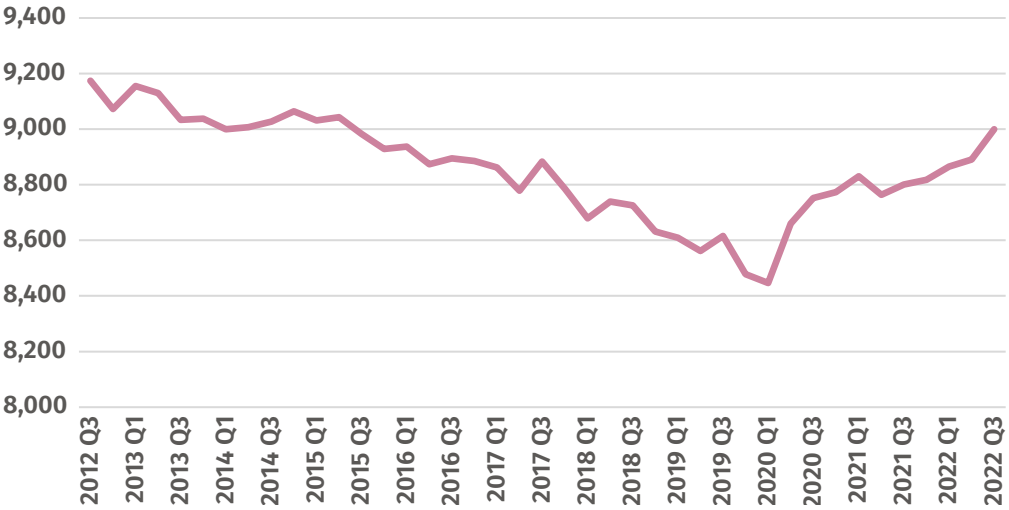
Source: ONS, 'Unemployment' (ONS 2022a)

Elsewhere, there are worrying indications on the current health of the labour market. Economic inactivity[2] has reached a six-year high of 9 million (figure 1.2). This increase is in contrast to the euro area, where economic inactivity has reduced since the onset of the pandemic (Bank of England 2022).

FIGURE 1.2

Economic inactivity has reached a six-year high

Seasonally adjusted economic inactivity, thousands of people, 16–64 years old, April–June 2015 to April–June 2022, UK



Source: ONS, 'Economic inactivity by reason (seasonally adjusted)' (ONS 2022c)

Note: Some of the decline in inactivity before 2019 could be driven by changes to the state pension age for women. The rising state pension age (since 2010) is likely to have meant a shift from inactivity to employment for women in their 60s.

2 Defined as people not in employment, who have not been seeking work within the last four weeks and/or are unable to start work within the next two weeks.

In some ways, this is surprising – the shift to more flexible work patterns, combined with the rise of working from home, might have been expected to make work more inclusive. Instead, more working-age people are out of the labour market.

Table 1.1 compares the UK's and the rest of the G7's employment rates. It demonstrates that the UK remains the only country yet to see its employment rate recover to pre-pandemic levels (despite improvements in the employment rate – in line with rising economic inactivity already shown). Moreover, the UK is the only country with a lower employment rate than in 2019 (across all age groups).[3]

TABLE 1.1

The UK has not yet recovered on employment, particularly among older working-age adults
Employment rate, G7, Q2 2019–Q2 2022, working-age population

	Change employment rate (pp), working age	Change employment rate (pp), 16–24	Change employment rate (pp), 25–54	Change employment rate (pp), 55–64
Canada	1.1	1.46	0.37	0.31
France	1.5	1.2	4.59	2.37
Germany	1.7	1.85	2.28	2.6
Italy	1	1.93	1.3	0.42
Japan	0.7	0.83	-0.35	1.81
United Kingdom	**-0.9**	**-0.06**	**-0.78**	**-1.84**
United States	0.1	0.18	-0.22	0.07

Source: Authors' analysis of OECD, 'Employment rate' (OECD 2022a) and OECD, 'Employment rate by age group' (OECD 2022b)

There are indications that this slower recovery is causing problems for UK businesses. Recent survey data suggests that between half and three-quarters of businesses are finding it hard to recruit (Centre for Economic Performance 2021; British Chambers of Commerce 2022).

At the same time, the theoretical benefits of a tighter labour market are not being realised. In principle, more competition for labour should drive up wages and working conditions. In practice, this isn't happening. Average weekly earnings today are at similar levels to 2007 in real terms, reflecting a long-term stagnation in real terms wage growth (ONS 2022d). Elsewhere, the rise in precarious work continues – the number of young workers on zero-hour contracts, for instance, has increased eightfold since 2004 (from 0.4 per cent to 3.2 per cent (ONS 2022e)).

The challenge facing policymakers is twofold: 1) how to ensure a competitive labour market translates into higher living standards, and 2) while also ensuring that the UK labour market is strong, globally competitive, conducive to a strong economy and more just.

3 As broken down in OECD reporting.

IMMINENT LABOUR MARKET TRENDS

The immediate impact of the pandemic is not the sum of what needs to be considered, however. Longer-term demographic changes, combined with unexpected events such as Brexit, are causing further and potentially longer-term labour market disruption.

The slowing rate of population growth among the working-age population is particularly consequential. The total UK working-age population (16–64) is expected to shrink in most years by the early 2030s – not least, as greater numbers of 'baby boomers' retire (Broome 2022, figure 1.3). At the same time, the total number of deaths is expected to overtake the total number of births in most years from the early 2030s (figure 1.4). Until now, a greater number of deaths than births had been observed in only two years since the end of the second world war (2021 and 1977).

FIGURE 1.3.

The UK's working-age population will decrease in most years from 2030

Population projections, 16–64 years old, annual change (pp), UK

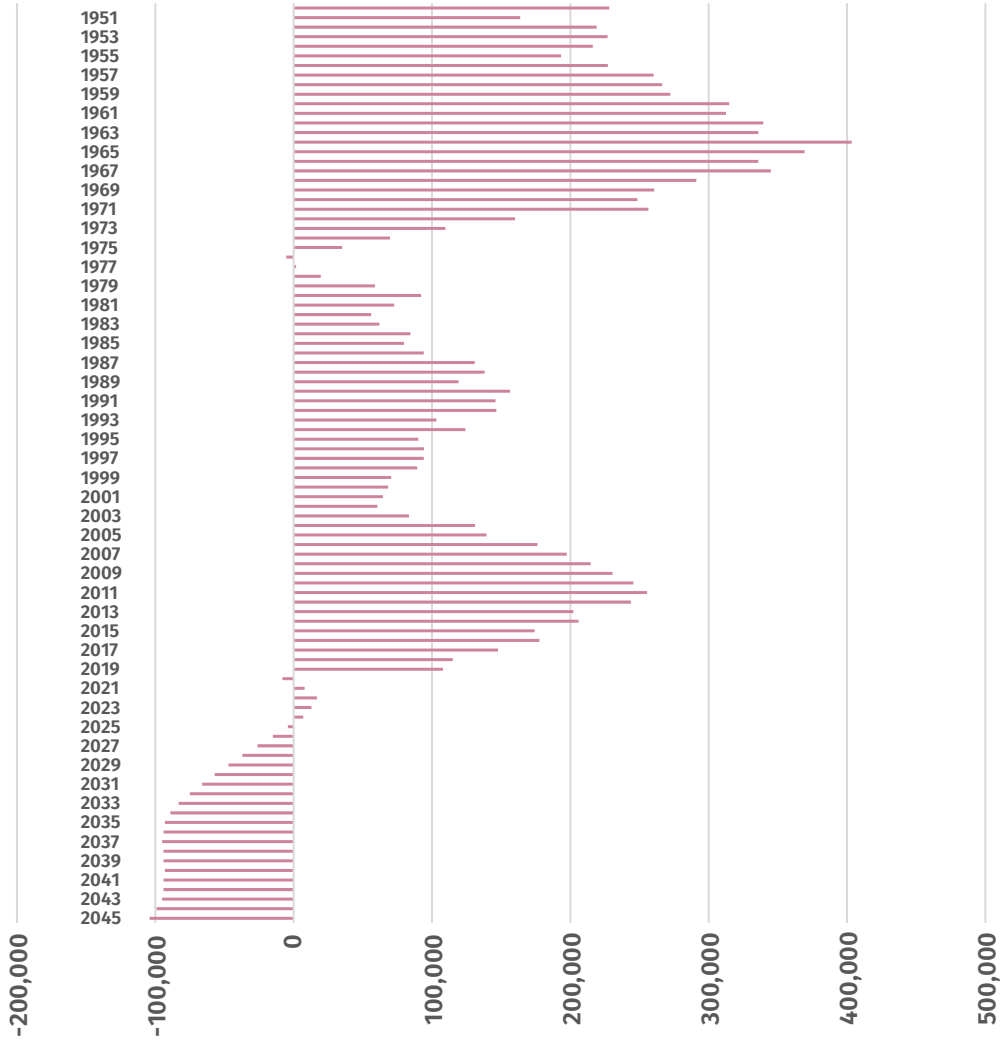
Source: Authors' analysis ONS, 'National population projections: 2020-based interim' (ONS 2022g)

In theory, net migration could help mitigate this change in UK demographics. The ONS projects net migration of 2.2 million people to the UK over the next decade. But in reality, this is far from certain. Indeed, the impact of Brexit is indicative of how quickly policy and perception can change migration preferences and flows. Even before new immigration policies were introduced following Britain's vote to leave the European Union, immigration from the EU decreased substantially after the vote to leave the EU – while emigration increased (The Migration Observatory 2022).

FIGURE 1.4

Deaths are projected to be higher than births by the mid-2020s

Balance of births and deaths, annual, 1951–2045, outrun and mid-year 2020 projections



Source: Authors' analysis of ONS, 'Births, deaths and natural change by UK country' (ONS 2021)

Beyond migration, the scale of demographic trends will almost certainly mean we need to look to new ways to strengthen the UK labour market in the years and decades to come. There are lots of variables that could have a role in the size and rate of growth in the labour market beyond the demographic factors already discussed. The literature also points to the following variables.

- **Earlier retirement:** As the Institute for Fiscal Studies has recently pointed out, early retirement has a bigger role in recent rises in economic inactivity than previously thought (IFS 2022).[4]
- **Population health:** Evidence shows that health is important to the labour market – and that poor health predicts premature labour market exit.

4 Although this should be contextualised by the fact that retirement decisions are not themselves neutral – see chapter 3 for the role of declining health in increasing early retirement rates.

- **Discouragement:** In labour markets where it is hard to get a job, or get a good job, people can become discouraged and so are less likely to seek work (see for example ONS 2022e)
- **Trends in education:** Study is a form of economic inactivity – and one that has risen over the past few decades, as more young people undertake degrees and university education (ibid).[5]

This report looks specifically at health as a major determinant of the labour market, and one that needs to be better understood – particularly in light of the Covid-19 pandemic. Specifically, we cover:

- what the current data tells us about the impact of poor health on the current labour market – both as a primary and contributory factor to inactivity or unemployment
- how complicated health needs (multiple conditions) and inequality (by age and region) inform how we understand the interaction between health and the labour market
- to what extent, in the context of an uncertain future, the UK has the potential to do significantly better on population health – whether through (primary) prevention, better treatment, or by reducing the economic impact associated with illness.

We provide an assessment of how health is currently interaction with the labour market, and what potential improvements in population health could contribute to increasing not only wellbeing but prosperity across the UK.

5 Indicative that not all economic inactivity is undesirable.

2. ILL HEALTH AND THE LABOUR MARKET

KEY TAKEAWAYS

After decades of improvement, the rate of progress on population health has stagnated in the UK – including in relation to all-cause mortality, mortality attributable to preventable risk factors, disability adjusted life years and healthy life expectancy.

Between May and July 2022, economic inactivity primarily due to long-term illness reached 2.5 million – the highest since records began.

Of those economically inactive primarily because of their health, more than 6 in 10 are living with a mental health problem. In other words, 1.5 million of the 2.5 million who are out of the labour market due to long-term illness are living with at least one mental health problem.

People who are economically inactive primarily because of their health tend to have complicated health needs. Three-quarters have two or more health conditions, and over half have three or more conditions, and a full quarter have more than six. By contrast, 12 per cent of people in employment have multiple conditions.

It is important to first understand the trajectory of UK population health if we are to understand its role in the labour market. New analysis of Global Burden of Disease data shows that health outcomes are stagnating (figure 2.1). Between 2010 and 2019, progress on a) reducing mortality attributable to risk factors,[6] b) reducing mortality in the under-70s, c) reducing Disability Adjusted Life Years lost from all causes, and d) increasing healthy life expectancy[7] is either static, or actively going backwards – including in all four UK nations (author analysis of GBD 2020).

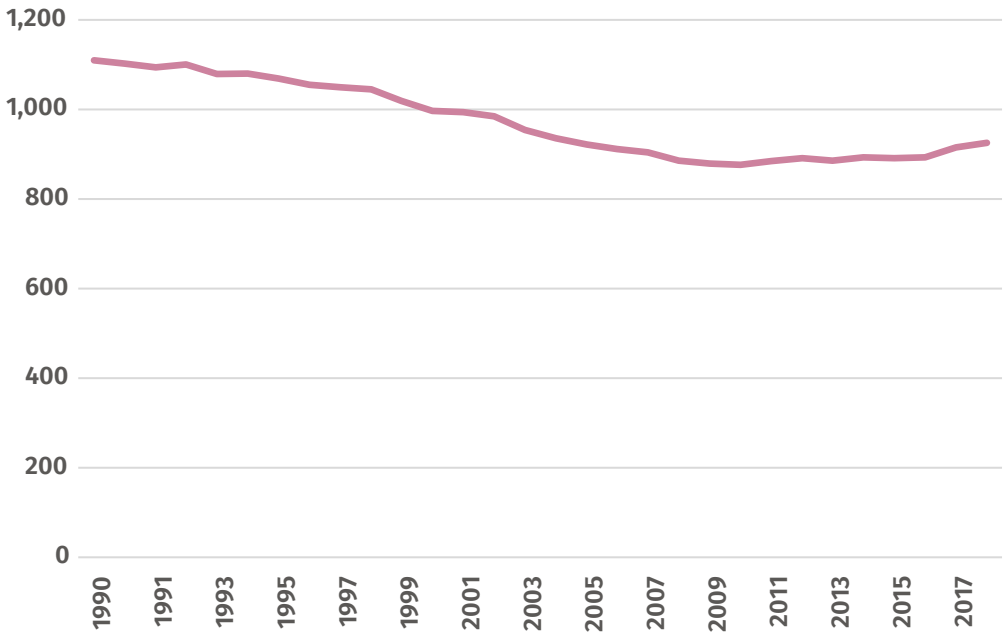
6 That is, deaths from identifiable and preventable risks such as smoking or diet.

7 The number of years we can expect to live in at least a reasonable level of good health.

FIGURE 2.1

After progress in 1990s and 2000s, population health in the UK is stagnating

Mortality rate per 100,000, UK, 1990–2019 (latest data), all causes



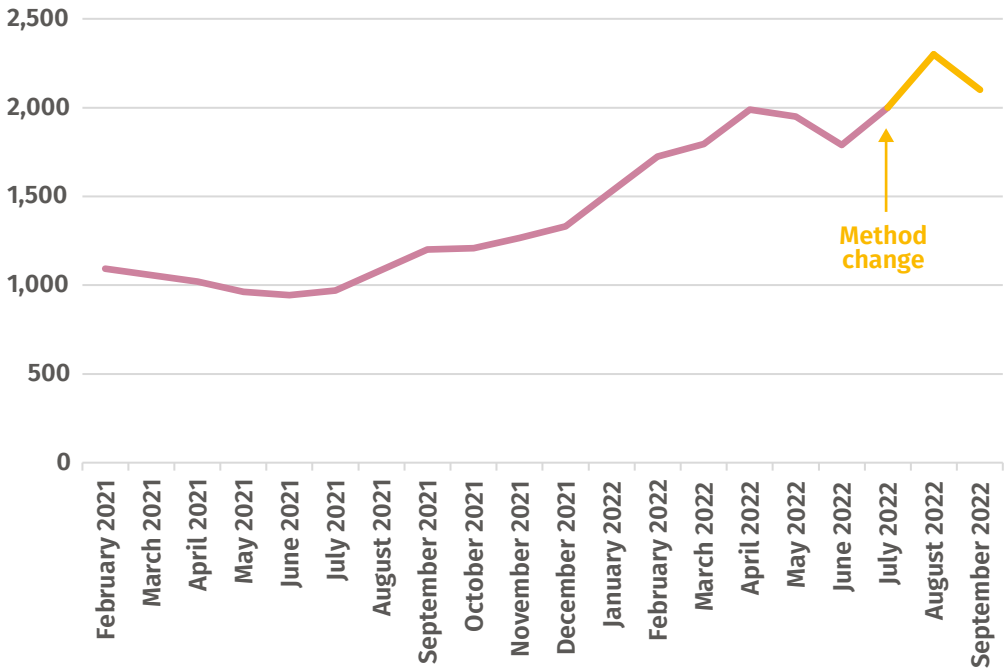
Source: Global Burden of Disease, 'Mortality, UK' (GBD 2020)

Above and beyond this, Covid-19 continues to have a substantial, additional impact on population health. IPPR research has elsewhere documented the health challenges experienced since the onset of the pandemic – including due to interruptions in healthcare provision, from prescriptions of preventative cardiovascular disease drugs (Patel et al 2021); the lower number of care plans delivered for people living with Alzheimer's disease (Thomas et al 2022a); and the increase in incidence of mental health problems among young people (ibid). More directly, an ongoing increase in incidence of long Covid is also having an impact. Self-reported long Covid rates, as measured and reported by the ONS, are now over twice as high as when data collection first began, with 2.3 million now reported to be suffering from it (figure 2.2).

FIGURE 2.2

Long Covid rates continue to rise

Self-reported long Covid cases, thousands of people, UK



Source: Authors' analysis of ONS, 'Long Covid' (ONS 2022f)

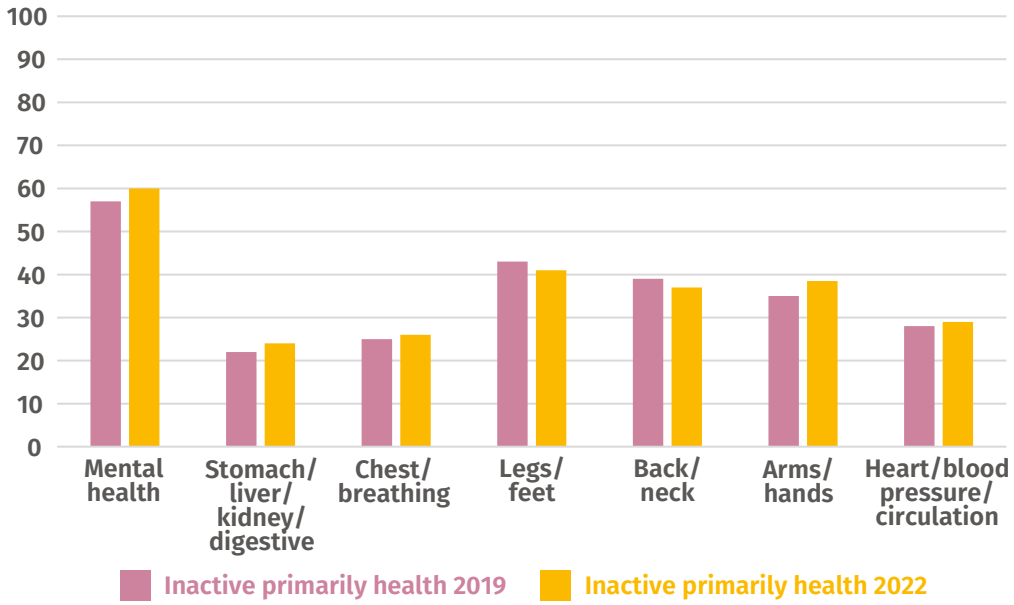
SICKNESS IN THE LABOUR MARKET

This contextualises data showing significant health challenges in the UK labour market. Figure 2.3 shows the sheer incidence of some health conditions among people who are economically inactive primarily because of long-term sickness. Mental health problems are the most common health need in this group – with six in 10 reporting a mental health problem in the latest data (figure 2.3). Conditions impacting the back and neck; conditions impacting the arms and hands; and conditions impacting blood pressure, circulation and the heart are also prominent.

FIGURE 2.3

Mental health problems are particularly common among working-age people who are economically inactive primarily due to their health

Percentage of working-age people reporting conditions, seven highest prevalence conditions, Q2 2016, 2019 and 2022, UK



Source: Authors' analysis of ONS, 'Economic inactivity by reason (seasonally adjusted)' (ONS 2022c)
Note: Analysis is from Q2

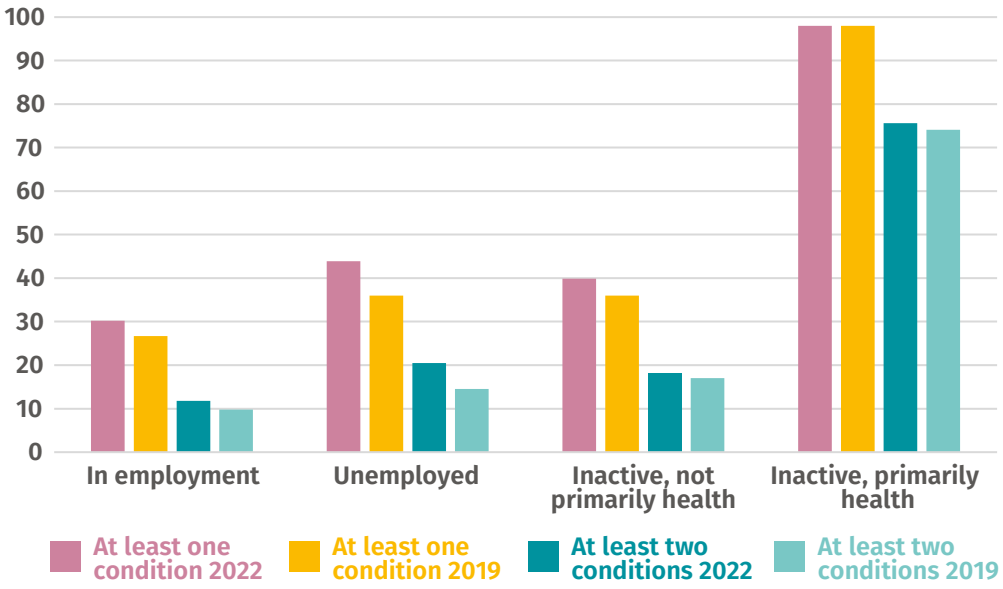
The Labour Force Survey also shows a high prevalence of multiple conditions among people out of the labour market primarily because of long-term sickness. Three-quarters of this group have multiple conditions; half have at least three health conditions; and a full quarter had six or more conditions. Elsewhere, unemployed people are also more likely to have multiple health conditions than people in employment. One in five report they have two or more conditions, compared to one in eight among those in employment. And 6.6 per cent report four or more different health conditions, compared to 2 per cent among those in employment – a more than threefold difference in the number living with the highest complexity of health needs (ONS 2022c)

The health of the UK labour market is also getting worse. Figure 2.4 compares this between 2019 and 2022 across each labour market category.

FIGURE 2.4

Health of people in the labour market has got worse since the pandemic

Percentage of people with at least one or at least two (multiple) health conditions by labour market categories, Q2 2019 and Q2 2022



Source: Authors' analysis of ONS, 'Economic inactivity by reason (seasonally adjusted)' (ONS 2022c)
Note: Data is from Q2 2019 and Q2 2022

The biggest regress is observed among unemployed people: including an 8-percentage point increase in the number with at least one health condition and a 6-percentage point increase in the number of people with multiple health conditions (a 20 per cent and 40 per cent increased risk, respectively). But it is also significant that there has been a rise in poor health among the employed population, including a 3.5-percentage point rise in the number with a health condition and a 2-point rise in the number with multiple conditions – a 13 per cent and 20 per cent increased risk, respectively. This could indicate increased labour market fragility.[8]

As may be expected from this data, the number of people reporting either long-term sickness or 'temporary' sickness as the primary reason for their inactivity is at its highest level since records began, at just under 2.7 million people (see figure 2.5).[9] This is a 500,000 increase since spring 2019. Importantly, the number of people who are inactive, but who would like a job, further indicates that economic inactivity is often involuntary. People who are economically inactive primarily due to long-term illness make up the largest share of economically inactive people who would like a job, at nearly a third (figure 2.6).

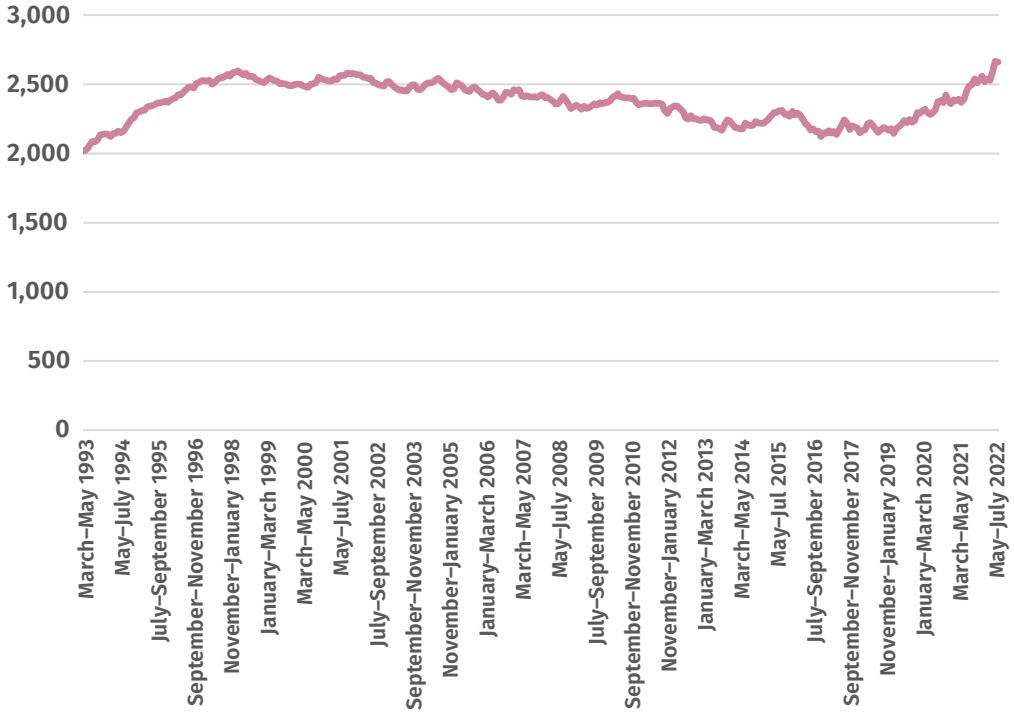
8 That is, an increase in the average risk of an economically active person becoming inactive.

9 Around 2.5 million of whom are long-term sick, and 200,000 of whom have a shorter-term illness; out of a total of 9 million economically inactive people.

FIGURE 2.5

Economic inactivity due primarily to poor health (long term or short term) is at its highest level since records began

The number of people economically inactive primarily due to temporary illness or long-term health conditions, UK, millions of people

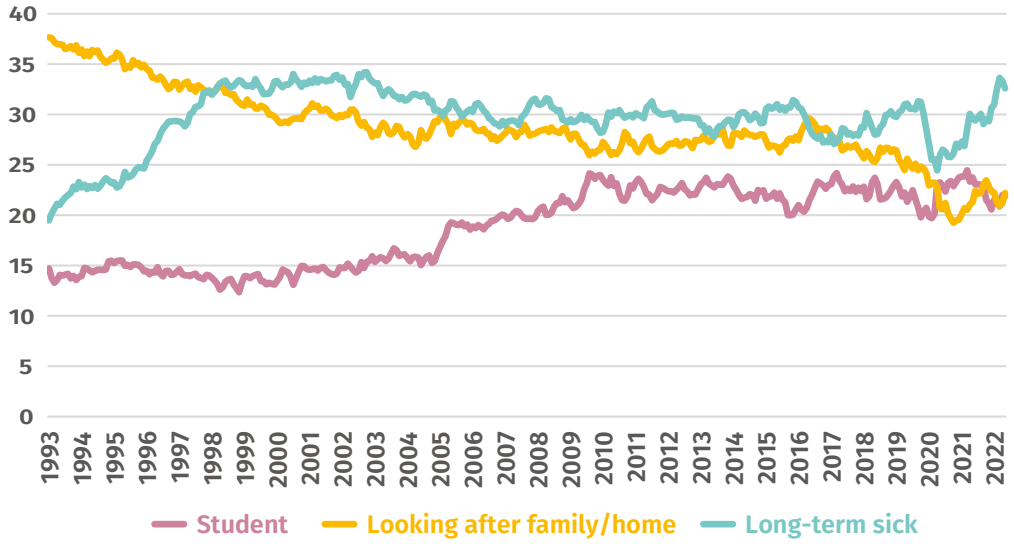


Source: ONS, 'Economic inactivity by reason (seasonally adjusted)' (ONS 2022c)

FIGURE 2.6

Those with long-term health conditions are overrepresented among economically inactive people who would like a job

Proportion by primary cause of economically inactive people who report they would like a job (%), UK



Source: ONS, 'Economic inactivity by reason (seasonally adjusted)' (ONS 2022c)

SICKNESS AS A CONTRIBUTORY FACTOR

Labour Force Survey data gives an individual's 'primary' reason for economic inactivity. However, only focusing on this would exclude the role health can play as a contributory factor in unemployment or inactivity – even where a survey respondent cites a different, primary reason. Put simply, poor health could be both a determinant of inactivity, and of the other causes of inactivity.

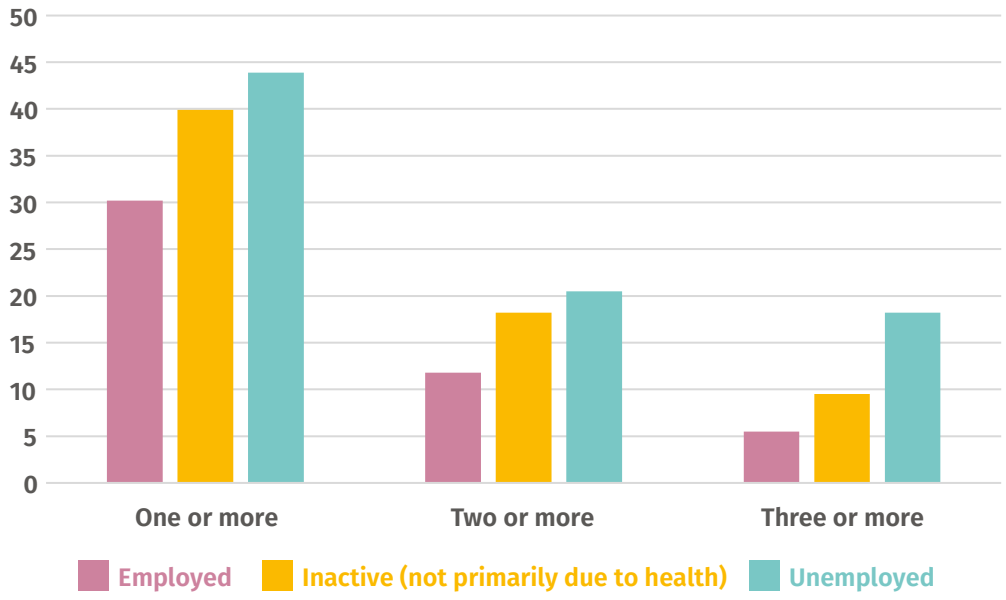
At a headline level this can be seen in the disparity between people who cite long-term illness as the primary reason for their economic inactivity – around 2.5 million – and the number of economically inactive people who are living with at least one health condition: a further 2.35 million (ONS 2022c).[10]

Among those who are economically inactive but did not cite health as the key reason for their inactivity, almost 4 in 10 still reported a health condition of some kind. They were also more likely than people in employment to report multiple health conditions (figure 2.7).

FIGURE 2.7

Poor health can be a secondary factor in unemployment and economic inactivity, even where it is not stated as the primary factor explicitly

Multiple conditions by inactivity (%), 2022 data, UK



Source: Authors' analysis of ONS, 'Economic inactivity by reason (seasonally adjusted)' (ONS 2022c)

10 Once accounting for the small number who are economically inactive due to health, but who do not report a health condition, the total number of economically inactive people with at least one health condition is 4.8 million – or just over 50 per cent.

This is particularly relevant to ongoing debates around what constitutes the biggest driver of the recent increase in economic inactivity – with some citing health, and others citing early retirement. Most notably and recently, an Institute for Fiscal Studies analysis of labour market flows among 50–64-year-olds[11] has shown:

- among this age group there has been a 1.1-percentage point (ppt) rise in the fraction inactive for health-related reasons
- but 0.8 ppt of that rise is observed among people who have been out of work for more than five years; 0.3 ppt is among those who have been in work in the last five years
- this makes early retirement the biggest driver; there has been a 0.7 ppt rise in the proportion of this age group economically inactive due to being retired compared to the end of 2019 (ONS 2022c).

This is an important finding. It does not challenge the idea that health is important to the labour market – whether or not health is getting worse among recent or long-term economic inactivity, it remains a fundamental challenge to recovery in the labour market.[12] Rather, it suggests that labour market policy must not only stop poor health increasing inactivity but should also support people with health conditions, and likely other needs, to regain and sustain employment where appropriate.

However, it also risks missing the fact that early retirement and poor health are difficult to separate in a clear-cut way.[13] While retirement is often categorised as a 'lifestyle' choice, it is often determined by factors beyond an individual's control. This point is indicated by the ONS survey of 55–65-year olds' lifestyles since the pandemic began. This showed that 45 per cent of 60–65-year-olds and 62 per cent of 50–54-year-olds retired despite not having confidence that their retirement provisions would meet their needs (ibid). That is, they retired early for some other reason than financial means/security.

In turn, a large base of literature has shown that poor health is a determinant of early or 'involuntary' retirement, including:

- a 2010 systematic review found that poor health was an important determinant of early retirement – and confirmed the findings through focus group interviews (van den Berg et al 2010)
- a study of 60–64-year-old workers in the Netherlands found health-related work limitations, vitality and subjective life expectancy moderated retirement preferences (Vanajan et al 2020)
- a 2000 study of British civil servants found that ill health increased likelihood of early retirement (Mein et al 2000).

In short, when considering the role of health in the labour market, it is important to recognise that poor health may also be a secondary or contributory determinant of inactivity or unemployment even where it is not cited as the primary reason in survey data.

11 The age group which explains the majority of the most recent rise in economic inactivity.

12 That is, even if other factors are driving inactivity, poor health can still be the biggest barrier in reversing that trend.

13 This is particularly true because the Labour Force Survey records people's primary barrier to work – but not secondary barriers.

3.
AGE, PLACE AND INDUSTRY DISPARITIES

KEY TAKEAWAYS

Poor health is not exclusive to older people. Forty per cent of unemployed people aged 20–29 have a health condition. Sixty per cent of 20–29-year-olds who are economically inactive due to their health have multiple health conditions.

20–29-year-olds are fifty per cent more likely to report a mental health problem than older working-age adults (aged 60–65). Older adults were seven times more likely to report diabetes, and four times more likely or report problems with their heart, blood pressure or circulatory system.

People in Northern Ireland, Wales and the North East were around twice as likely as people in the South East to be involuntarily out of the labour market due to long-term sickness. These nations/regions also have among the biggest productivity gap with London and the South East.

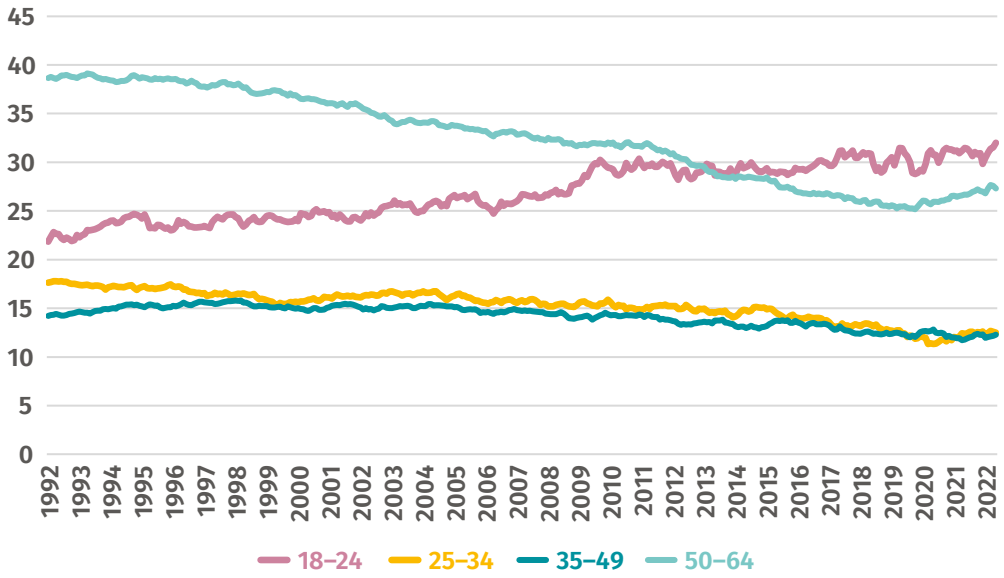
Labour market challenges are not unique to any one age group. Figure 3.1 shows that the youngest adults are the most likely group to be economically inactive,[14] followed by 50–64-year-old adults.

14 We assess that a relatively large part of this rise among 18–24-year-olds is due to increasing numbers in training and further education. However, a substantial number – over 700,000 – are not in any of employment, education or training (ONS 2022g).

FIGURE 3.1

Economic inactivity isn't down to just one age cohort

Economic inactivity, working-age adults, %, 1992–2022, seasonally adjusted, UK



Source: ONS, 'Economic inactivity by reason (seasonally adjusted)' (ONS 2022c)

Health is likely to be a determinant of economic inactivity across different age groups. Indeed, our analysis shows that – in Q2 2022 – there was no age group in which prevalence of a health condition is lower among employed people than among those who are either inactive or unemployed.[15] Moreover, despite the fact that age is among the clearest predictors in prevalence of health and multiple health conditions, both are still highly prevalent among even the youngest employed or inactive people.

- Around 65 per cent of 18–29-year-olds who are economically inactive due to their health already have multiple health conditions (compared to 75 per cent among all working-age adults).
- Nearly forty per cent of unemployed 18–29-year-olds have at least one health condition (compared to around 43.9 per cent among all working-age adults).
- Over 30 per cent of 18–29-year-olds who are economically inactive – but do not report health as the primary reason for that inactivity – still have at least one health condition (compared to 39.9 per cent among all working-age adults).

Also notable is that – despite 50–64-year-olds experiencing the largest rise in economic inactivity overall – the increase in inactivity due to long-term sickness is concentrated on younger people. Between April to June 2019 and 2022, economic inactivity due to sickness rose by 29 per cent among 16–24-year-olds; 42 per cent among 25–34-year-olds; 6 per cent among 35–49-year-olds; and 16 per cent among 50–64-year-olds (ONS 2022l).

However, our analysis also shows that the experience of poor health is not homogeneous across different age groups. Figure 3.2 shows that the long-term sickness involuntarily keeping younger and older working-age adults out of the

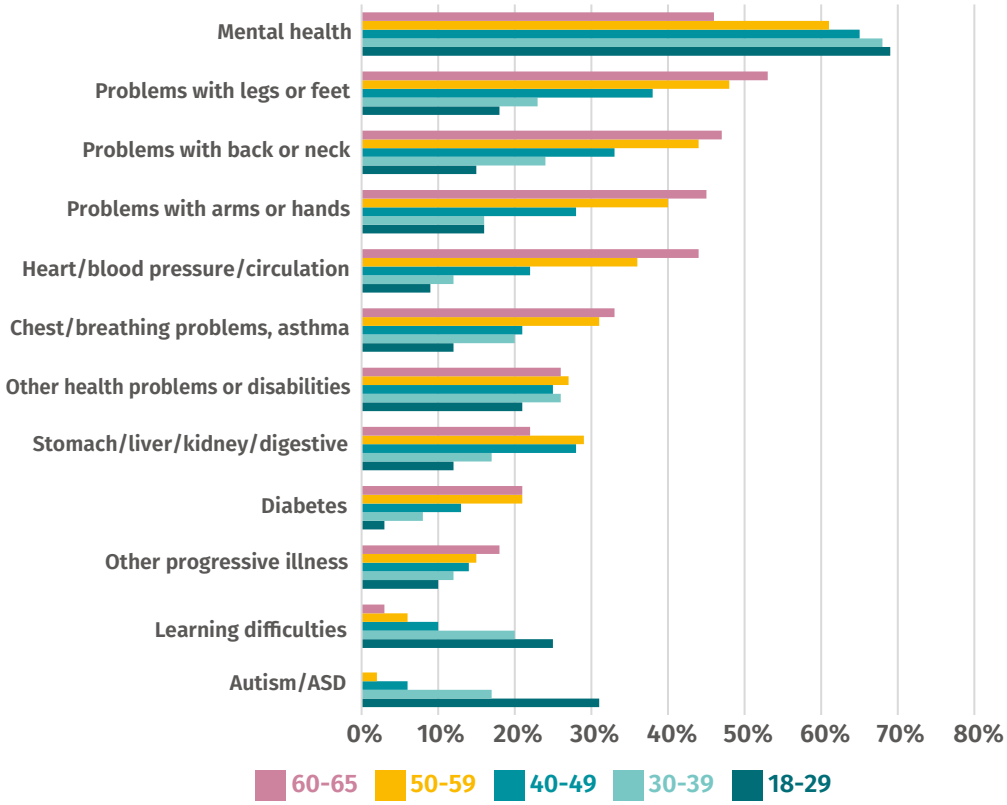
15 This also suggests that worse health among unemployed and inactive people cannot be explained by an older average age than those in employment.

labour market might be very different.[16] For younger adults, autism/ASD and mental health were disproportionately prevalent. By contrast, older working-age people are more likely to experience physical health problems: including with their legs, feet, back, neck, arms or hands; with heart conditions, blood pressure or circulation; and with their chest, breathing and respiratory system. Indeed, 60–65-year-olds are the only group for whom mental health is not the most prevalent health condition.

FIGURE 3.2

Prevalence of health problems varies by age cohort

Proportion of prevalence of health conditions by age cohort, 2022



Source: ONS, 'Economic inactivity by reason (seasonally adjusted)' (ONS 2022c)

HEALTH, WORK AND PLACE

As well as age, analysis of health and labour market trends by place help to explain how health inequalities can drive economic inequalities, and vice versa. It is well understood that the UK has significant, regional health inequalities. Figure 3.3 shows the difference in healthy life expectancy of each region/devolved nation as compared to the UK average for 2018–2020.

16 However, some caution is needed in interpreting the exact scale of the differences here. Mental health and learning difficulties and disabilities have had varying levels of stigma over the past 70 years. It may be that older people are more reluctant to report these conditions in survey data – or have never had a diagnosis.

FIGURE 3.3

The UK has regional inequalities in healthy life expectancy

Average healthy life expectancy, UK nation/region, total years difference to UK average (higher or lower), 2018–20

Source: Authors' analysis of ONS, 'Health state life expectancies, UK: 2018-2020' (ONS 2022i)

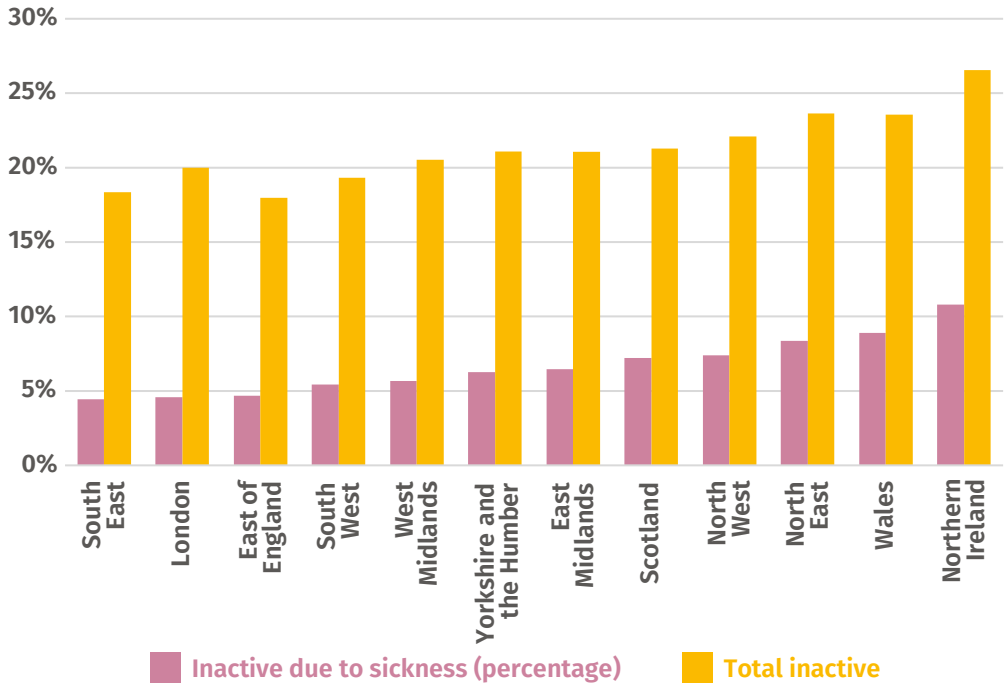
The highest inequality is in the North East – where the average healthy life expectancy is around four years lower than the UK average. Each devolved nation – and all regions in the North and Midlands – have lower healthy life expectancy than the UK average. Moreover, there are indications that Covid-19 may have made this inequality worse. Every region in the North and Midlands has a higher long Covid incidence than the UK average, once accounting for the size of its population – as do Scotland and Wales (authors' analysis of ONS 2022f).

As this might suggest, there are also inequalities by region in economic inactivity – and economic inactivity primarily due to health. Figure 3.4 shows that the south of England tends to have both the lowest rates of economic inactivity and the lowest rates of inactivity primarily due to long-term health conditions.

FIGURE 3.4

There are significant variations in economic inactivity by region

Economic inactivity and economic inactivity due primarily to poor health, regions and devolved nations, Q2 2022



Source: ONS, 'Economic inactivity by reason (seasonally adjusted)' (ONS 2022c)

Levels of economic inactivity due to poor health are a close match to regional disparities in productivity. Figure 3.5. shows the level of inequality in productivity – measured by the difference in (balanced) GVA per head to the UK average. It also shows that in the past 10 years, productivity has increased in London and the South East relative to the UK average – whereas in every other devolved nation and region it has fallen further behind the UK average. The biggest change is in the North East, where GVA/person has fallen £2,604 further behind the UK average since 2012 – and over £8,000 further behind London.

FIGURE 3.5

The UK has vast productivity inequality by region/nation

Output per hour worked by international territorial level 1 region relative to the median region, UK, 2020, balanced GVA/person/year in £

Source: Authors' analysis of ONS, 'Regional gross value added (balanced) per head and income components' (ONS 2022j)

Or in other words, tackling regional health inequality – and with it, economic inactivity due to health – could be important to addressing economic inequalities and spreading opportunity. The English Health Inequalities Strategy provides demonstrable proof that inequalities can be reduced where there are sustained and cross-government efforts to do so (Barr 2017).

The government's levelling-up agenda – integral to commitments made in the 2019 Conservative manifesto – recognises that opportunity is not spread equally across the UK. The Levelling-up white paper recognised the vital role of health in delivering on this pledge, with a commitment to add five years to healthy life expectancy by 2035. Yet, this commitment has already been undermined by the delay of the Health Disparities white paper. This analysis emphasises the need to tackle health inequalities if we hope to achieve a strong and regionally equitable economy.

INDUSTRY

Long-term sickness is not equal between industries. ONS data shows the previous industry of those economically inactive because of their health (where they were in work within the past two years).[17] As table 3.1 shows, wholesale and retail work has the highest long-term sickness rate per 1,000 workers in the economy – with manufacturing, construction, human health and social work, accommodation and food service, and transportation and storage all industries with higher than average long-term sickness.

17 This is true for around a third of the group.

TABLE 3.1.

Inactivity due to sickness was not equal among industries

Workers inactive due to health by former industry, where in work within last two years, rate per 1,000 current workers

Industry	Long-term sickness rate
Wholesale and retail	10.4
Transportation and storage	10.0
Accommodation and food service	9.2
Human health and social work	7.8
Construction	7.6
Manufacturing	6.8
Education	4.7
Professional, scientific and technical	3.3
Public administration and defence	3.1
Information and communication	2.8

Source: ONS, (ONS 2022m)

Table 3.2 shows the long-term sickness rate by previous occupation. It adds that those in managerial or professional occupations – that is, roles associated with offices – had the lowest long-term sickness rate per 1,000 workers. Those in elementary occupations; working in process, plant or machine operation; and within care, leisure and other service roles were far more likely to experience long-term sickness than the average. This also reflects a difference between industries more able to adapt to working from home in the past three years, and those less able.

TABLE 3.2.

Inactivity due to sickness was not equal among occupations

Workers inactive due to health by former occupation, where in work within past two years, rate per 1,000 current workers

Occupation	Long-term sickness rate
Managers, directors, senior officials	4.8
Professionals	2.7
Associate professional	2.7
Administrative and secretarial	5.6
Skilled trades	6.1
Caring, leisure and other services	12.3
Sales and customer service	10.5
Process, plant, machine operatives	14.2
Elementary occupations	13.9

Source: ONS, 'Data on economic inactivity because of long-term sickness' (ONS 2022n)

This analysis provides an important link between the NHS and social care workforce shortages, and the wider challenges being posed by long-term sickness to the UK labour market. As it stands, shortages in the health and social care workforce in England include:

- over 160,000 social care vacancies as of March 2022 (Skills for Care 2022)
- 103,000 FTE workforce supply gap in the NHS (Shembavnekar 2022)

Should policy – which we cover in the next section – bring down levels of long-term illness, it could go a significant way to closing these gaps. The ONS estimates that 4.5 million people work in health and social work activities in the UK. Had the rate of long-term illness in this sector been at levels seen in education – another foundational economy sector – this could mean 15,000 extra qualified staff in work, all of whom have done this kind of work at least at some point in the past two years. Meeting the rates in the best-performing industry (information and communication) could be worth 23,000 staff. And given the split between frontline and managerial professions shown in table 3.2, this would likely be heavily skewed towards frontline professionals.

4. COULD OUR HEALTH BE BETTER?

In the coming years and decades, poor health could be a perennial barrier to a strong, fair labour market – undermining people's capacity to access and benefit from work, even if they would like to. Alternatively, good health could be the foundation on which a fairer, stronger and more productive labour market rests. Achieving the latter depends on our capacity to improve population health in the long run.

As it stands, the UK's health is worse than many comparable countries (see Thomas et al 2022b). International data shows that the UK ranks poorly compared to other countries on both healthy life expectancy at birth, and healthy life expectancy at age 60 (ibid). This indicates that there is much work to do. However, it also highlights an opportunity: other countries have achieved better health outcomes; so in all likelihood, the UK can do better too.

To help inform the policy response, we explore three shifts that should be a focus for future government policy:

1. **The prevention shift:** Much morbidity or mortality before retirement age is avoidable. The UK has significant scope to prevent poor health more effectively – by addressing either the social drivers of health, or direct risk factors for poor health.
2. **The treatment shift:** Better, faster and more effective treatment has an obvious role in supporting better health and a stronger labour market. Research shows that delays in access to diagnosis, care and treatment can lead to worse outcomes for an individual's health and wellbeing.
3. **The social shift:** The social model of disability says that people are disabled by barriers in society, not by their impairment. This model can help us understand barriers to work, too. Even where we do not have recourse to prevention or treatment, there are ways to reduce the wider impact of health conditions and impairments – through supported employment interventions, inclusive employer practices, and more personalised employment and welfare services.

1. THE PREVENTION SHIFT

To establish the scope for the UK to improve population health through prevention, we compared UK performance on demonstrable risk factors for disease – including occupational risks (such as workplace carcinogens), personal risks (diet, tobacco use), and environmental risks (air pollution, temperature)[18] – with that of other G7 nations. To ensure our analysis captured the potential to improve health among the working-age population – and to control for different life and healthy life expectancy across different nations – we limited our analysis to those aged 15–69.

Table 4.1 indicates that the UK is lagging behind other countries – on disability adjusted life years, years lost to disease and mortality. To further indicate the scale for improvement possible, table 4.2 compares the UK to the best-performing G7 nation on each indicator.[19]

18 In turn, the literature shows these risks are linked to socioeconomic drivers of health: social security, education, poverty, housing and built environment (see Marmot 2017).

19 It can be challenging to quantify indicators such as years lost to disease or disability adjusted life years. Indicatively, a 2010 paper quantified the economic cost of a disability adjusted life year lost to cancer (globally) at just under $11,000 USD (2008 prices) (see John and Ross 2010).

TABLE 4.1

The UK is behind comparable countries on prevention

Ranking of G7 nations on deaths, YLDs and DALYs (rate per 100,000) attributable to risk factors, 2019, 15–49 and 50–69-year-olds [working-age population]

	Canada	France	Germany	Italy	Japan	UK	US
Deaths (15-49)	5th	4th	3rd	2nd	1st	6th	7th
Years lost to disease (15-49)	5th	3rd	4th	2nd	1st	6th	7th
Disability adjusted life years (15-49)	5th	3rd	4th	2nd	1st	6th	7th
Deaths (50 – 69)	4th	3rd	6th	2nd	1st	5th	7th
Years lost to disease (50 – 59)	3rd	1st	5th	4th	2nd	6th	7th
Disability adjusted life years (50 – 59)	4th	3rd	6th	2nd	1st	5th	7th
Rank of ranks	4th	3rd	5th	2nd	1st	6th	7th

Source: Authors' analysis of Global Burden of Disease, 'Mortality, UK' (GBD 2020)
Note: 1st and 2nd = green; 3rd–5th = amber; 6th and 7th = red.

TABLE 4.2

The UK would make significant health gains if it was as good as the best G7 nation at preventing ill health

Comparison of UK and best-performing nation, preventable risk factors, working-age population, YLDs, DALYs and deaths per 100,000

	UK	Best performing G7	Difference	UK population in age range (2019)	Gains if matching best nation (annual)
Deaths (15–49)	42	29 (Japan)	13 preventable deaths per 100,000 people aged 15–49 years old	29.6 million	3,850 less deaths
Years lost to disease (15–49)	3,272	2016 (Japan)	1,256 preventable years lost to disease p per 100,00 people aged 15–49 years old		371,965 less years lost to disease
Disability adjusted life years (15–49)	5,313	3406 (Japan)	1,907 preventable disability adjusted life years per 100,00 people aged 15–49 years old		564,759 less Disability Adjusted Life Years lost
Deaths (50–69)	402	269 (Japan)	132 preventable deaths per 100,000 people aged 50–69 years old	16.3 million	21,566 less deaths
Years lost to disease (50–69)	5,697	4,291 (France)	1,406 preventable years lost to disease per 100,000 people aged 50–69 years old		701,066 less years lost to disease
Disability adjusted life years (50–69)	17,038	11770	5,268 preventable disability adjusted life years per 100,000 people aged 50–69 years old		860,689 less Disability Adjusted Life Years lost

Source: Authors' analysis of Global Burden of Disease, 'Mortality, UK' (GBD 2020)

Secondary prevention is also an opportunity – and describes action that stops people's conditions getting worse. There has been disruption to secondary prevention efforts in the past two years. Indicatively, IPPR research showed 470,000 fewer prescriptions of preventative cardiovascular medications were given during the pandemic (Patel et al 2021).

INDICATIVE OPPORTUNITY: ACTION ON DIET AND OBESITY

As already shown, cardiovascular disease and high blood pressure were the fifth most prevalent condition among people who were economically inactive primarily due to their health – and had risen in prevalence between 2019 and 2022.

High quality evidence implicates weight and diet in cardiovascular disease. A meta-analysis of 19 different cohort samples over 13 studies showed high salt intake caused significantly increased risk of stroke and total cardiovascular disease (Strazzullo et al 2009). Meta-analysis has also shown that obesity or high body mass index is associated with an increased risk of cardiovascular disease events (Dwivedi et al 2020).

Despite this, UK salt consumption is higher than recommended, with most of that salt added to food before purchase (BHF 2022). The UK is also one of Europe's heaviest nations (see for example OECD 2017). This is indicative of the opportunity for government intervention to support access to healthy diets, physical activity and a healthy weight. A range of interventions have been shown to be effective in reducing obesity, including:

- Levies: The sugary drinks levy succeeded in promoting reformulation of sugary drinks, an innovation that has been shown to have been positive for businesses and consumers (Law et al 2020, Pell et al 2021).
- Subsidies: Studies have shown the subsidising healthy, sustainable diets can support healthier eating and weight – particularly in a context of increasing rates of food poverty (Hawkes et al 2015). The Rose Voucher scheme is a practical, well evaluated example (Food Matters 2017).
- Advertising: Restricting advertising to children can help reduce unhealthy eating (Thomas et al 2018).
- Place based protections: Active transport schemes, and restrictions on fast food density and proximity to schools, also have strong evidence bases respectively (Hawkes et al 2015).

2. THE TREATMENT SHIFT

We can prevent much illness among the working-age population and beyond. But there are some conditions that are not amenable to prevention – and even with best efforts, people will still get sick. Treatment and prevention are not an either/or – they are both vitally important.

The UK faces two related challenges when it comes to treatment. The first is in early diagnosis – at a point they are still either manageable or curable, and when intervention is likely quicker. Cancer provides one of the most tangible indications of the importance and benefits of early diagnosis. A comprehensive study by the Office for National Statistics and Public Health England – using data from Cancer National Statistics – showed:

- for uterine cancer, five-year net survival was over 90 per cent among those diagnosed at stage 1, but under 20 per cent for those diagnosed at stage 4

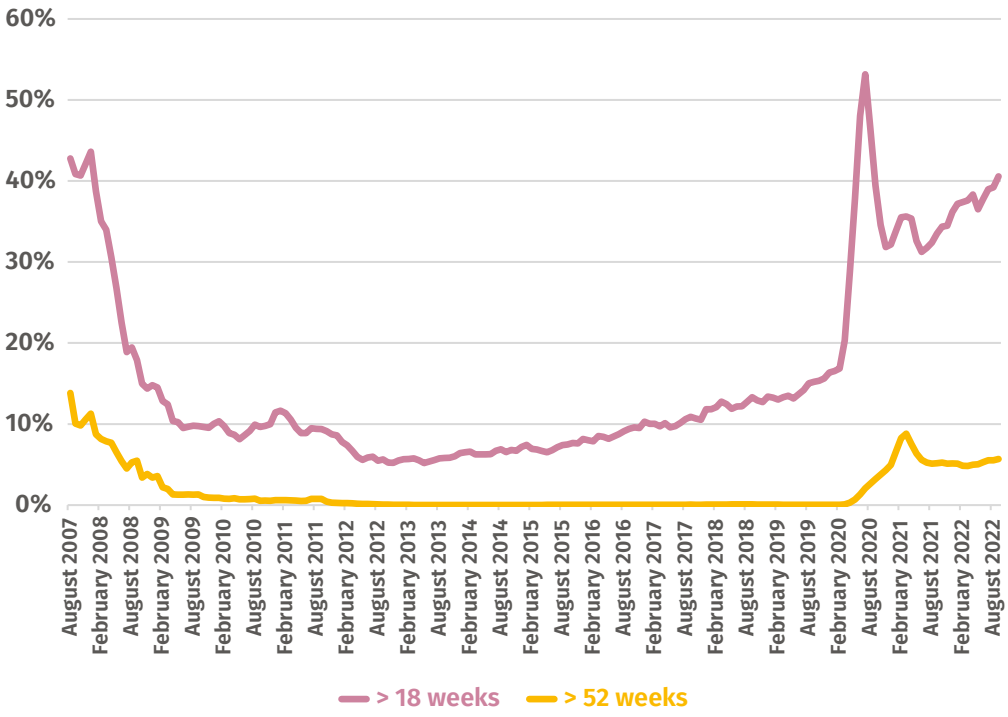
- for kidney cancer, five-year net survival was nearly 90 per cent if diagnosed at stage 1, and around 10 per cent for those diagnosed at stage 4
- for lung cancer, five-year net survival was almost 90 per cent for those diagnosed at stage 1, but under 20 per cent for those diagnosed at stage 4 (ONS and PHE 2019).

Survival is not the only benefit of earlier diagnosis – it can also reduce the morbidity and invasiveness of treatment associated with a condition (see for example Langer and Hirsh 2010). This is a core logic to the recent Richards review, which has led to the rollout of community diagnostic centres to facilitate swifter cancer diagnosis in England.

The second related challenge is swift access to care. In the first instance, rapid and early access to health and social care services are key – both in ensuring treatment and management is possible, but also in limiting the wider social and economic damage done by a health shock (Richmond Group 2019). However, data shows that Covid-19 accelerated a pre-existing trend of significantly more people waiting longer to access the NHS care they need (figure 4.1).[20]

FIGURE 4.1

A trend towards longer waits has been accelerated during the pandemic
Proportion waiting longer than 18 weeks and 52 weeks, 2007 – latest data



Source: Authors' analysis of NHS Digital, Consultant-led referral to treatment waiting times data 2021-22 (NHS Digital 2022a)
Note: This does not take account of double counting, which could reduce waiting list estimates – or 'hidden' need, which could increase waiting list estimates

20 This builds on our finding in chapter 3 that many people aged 50–64 who have become economically inactive during the pandemic are on an NHS waiting list.

Beyond swift access to care, the UK also has difficulty in ensuring nationwide and equal access to the most innovative treatments to patients across the country. Office for Life Sciences data shows that the UK struggles both with adoption and spread of innovative treatments. Latest analysis shows that UK uptake of NICE-approved medicines in the first year after launch was around half of that in comparable countries. By year five, it was 70 per cent of that in comparable countries. This reflects a significant gap in access to medicines that have been assessed, formally, as both effective and cost-efficient (OLS 2021).

INDICATIVE OPPORTUNITY: MENTAL HEALTH

Mental health problems were reported by more people who are economically inactive due to health, than not. There are significant treatment opportunities, many of which are not easily accessible within the NHS.

Psychological therapies are one evidence-based approach. The Improving Access to Psychological Therapies (IAPT) programme has had some success in increasing access, from very low levels – with official data showing the number of people accessing talking therapy through the NHS for conditions such as anxiety and depression increased by around 22 per cent in 2021–22 (NHS Digital 2022c). However, this comes against a backdrop of more than a million people waiting to access mental health support.

3. THE SOCIAL SHIFT

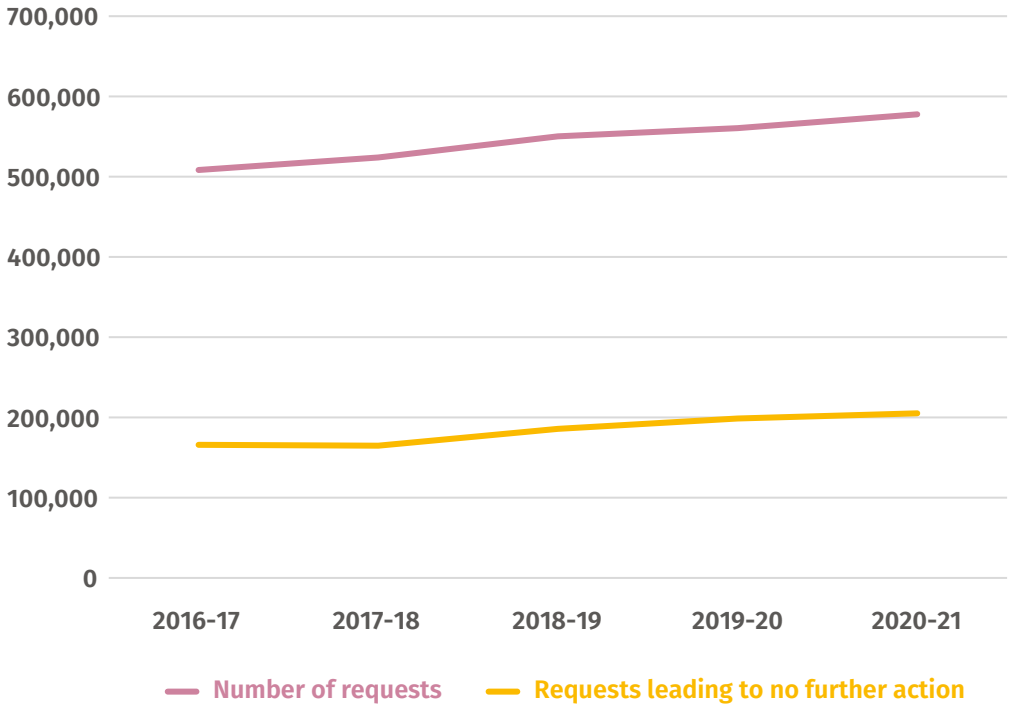
The social model of disability contends that people are disabled by barriers in society, not by their impairment. This perspective suggests that, even where we do not have recourse to prevention or treatment, there are ways the impact of health conditions and impairments can be reduced – including through supported employment interventions, inclusive employer practices, and more personalised employment and welfare services.

Social care is particularly important here. Yet, as with the NHS, access to social care – particularly access to early intervention, which can prevent or slow the development of more severe needs – is difficult for many. Figure 4.2 shows an absolute increase in both the number of people seeking local authority social care, and in the number who do not go on to receive any support.

FIGURE 4.2

An increasing number of working-age people are being turned down for social care by local authorities

Number of requests for care and number of requests for care leading to no further action, 2016–17 to 2020–21



Source: Authors' analysis NHS Digital, 'Adult social care activity and finance report' (NHS Digital 2022b)

As well as an absolute increase in the number of people not getting the support they want and need, these figures amount to a 4-percentage point increase in the proportion of working people requesting support, but receiving none, over the past five years.

But interventions are not limited to health and care services. Evidence shows that more inclusive job design can help people with long-term conditions or impairments to access work. Other evidence shows that well-designed employment services can help more people with long-term conditions into work. While these interventions do not necessarily and immediately improve health, they reduce the consequences of an individual's health diagnosis on their economic lives.

INDICATIVE OPPORTUNITY: TAILORED SUPPORT

There is increasing evidence, including evidence from RCTs, on tailored support as a mechanism to better support people with disabilities and health conditions into work (Learning and Work Institute 2019) In particular, evidence reviews have found that supported employment and internships can lead to large employment gains for those with learning disabilities. This paper has already shown a large prevalence of learning disabilities and difficulties among economically inactive people – particularly younger people.

Evidence has also shown efficacy in:

- integrated support across public services for people with complex needs (Modini et al 2016)
- the use of specialist advisors, with lower caseloads, to provide more personalised employment services (Asquith et al 2013)
- the impact of role models, particularly on young people (Smith et al 2019)
- one to one support (in preference to no support or group support) (Valizade et al 2022)
- individual placement support – with the strongest evidence on those with severe mental health conditions (Suijkerbuijik et al 2017).

These are likely to be cost-effective analyses and should help policymakers expand their ideas of what works in reducing the impact of poor health on work.

CONCLUSION

The experience of Covid-19 – including the period beyond lockdowns – is indicative of the reliance of the UK labour market on population health. The disruption to health and care services, wider population health and nature of employment has seen economic inactivity rise, and employment rates struggle to recover in the UK. At the same time, those inactive primarily because of their health has increased – particularly in 2022 – and could yet continue to rise.

This is worrying immediately and is already impacting people's wellbeing and business outcomes. But it could yet be a bigger issue in the future. With many in the 'baby boomer' generation now retiring, with deaths set to outnumber births, and with net-migration limited by the impact of Brexit and wider policy, the health of the population will only be more important in the future. The time to get ahead of this trend, and do better, is now.

In this context, an ongoing debate about whether worse health is driving new inactivity – or predominantly occurring among people already inactive for some time – may be somewhere beyond the point. Either way, a policy focused on optimising labour market outcomes and equity for the future must find a means of improving population health.

There is much that policymakers can do to better align health and prosperity. This paper has explored three potential shifts: towards better preventing illness; towards providing better faster treatment; and towards ensuring supported employment opportunities exist for people living with long-term conditions or impairments. Other countries are doing better on these domains – the UK could and should show more aspiration.

It is important, however, to finish with a note on the complexity of long-term conditions. As this paper has shown, health needs themselves are often complicated - with a majority of those people who are inactive primarily due to their health suffering from at least three conditions simultaneously. And the fact that many economically inactive people who do not cite ill health as the primary reason for their economic inactivity nevertheless have a health condition, indicates that ill health can be a factor in causing economic inactivity even in complex cases where other factors are also significant.

This suggests that there is unlikely to be an easy silver bullet in improving the labour market. Rather, success will rest on our capacity to deliver a multi-agency approach – tailored to individual's health, social, economic and employment needs. The IPPR Commission on Health and Prosperity is exploring this complexity and will report on each of:

- how industrial strategy can better support health
- how health and care services can be more personalised, based on a shift from a sickness to a wellness service
- how government policy, beyond the Department of Health and Social Care, can take better account of the value of good health
- how health can be created in and by places, in support of levelling-up
- how public services can be better integrated and coordinated, around complex needs.

As such, while the shifts described in this paper indicate a route forward for policymakers, they do not yet give our final blueprint for a healthier, more prosperous future. This will follow by the end of 2023, when the commission releases its final report. That will provide a rigorous assessment of health, and a route to the healthier, more prosperous future that this paper indicates is both possible, and necessary.

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