An exploration of local variations in health and job outcomes across the UK

A report for the Commission for Healthier Working Lives

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About the Commission for Healthier Working Lives

Learning and Work Institute (L&W), The Institute for Employment Studies (IES) and Royal Society for Public Health (RSPH) have formed a new collaboration as the research partners for the *Commission for Healthier Working Lives*, supported by the Health Foundation.

The *Commission for Healthier Working Lives* aims to build a consensus on the action needed to address the decline in working-age health. It will create a better understanding of health trends and inequalities – and their impact on individuals, employers, and the economy. The Commission will make recommendations for action to improve working-age health, and to help more people with health conditions get the support they need to access, remain, or thrive in the workforce.

This report is one of a series of commissioned reports, all of which are available at www.health.org.uk/commission-for-healthier-working-lives

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Table of Contents

Executive summary

In every part of the UK, disabled people and those with long-term health conditions are less likely to be in work than their peers. However, **there are also significant geographic inequalities in employment outcomes for people with health conditions**.

- Spatial inequalities in health and employment outcomes are wide and persistent. Addressing these would support the government in reaching its target of 80% employment rate.
- Variations in population health explain most of the variation in health-related economic inactivity, but our research also points to the importance of historic and persistent economic factors that are still affecting people today.
- Demand-side interventions, those that create good jobs in local areas, are essential to reduce levels of economic inactivity. However, supply-side interventions, those that support individuals, are also needed if everyone is to benefit from job creation.

This paper takes a more detailed look at these geographical variations and potential solutions, combining analysis of national data and existing research with six local area case studies. The selected case study areas were Belfast, Coventry, Newport, South Ayrshire, Westminster, and Wokingham.

Variations in health and employment outcomes

- Long-term health conditions make finding and remaining in employment more challenging. In 2024, an estimated 2.8 million people were economically inactive due to health-related conditions: more than twice the population of Birmingham (over 6% of the working age population).[1]
- Rises in economic inactivity due to ill health are linked to the ageing population, the design of the benefit system, and growing pressures on the health-care system.
- While every nation and region has seen a rise in economic inactivity due to ill health, there are still large variations in rates across local labour markets. Whereas some local areas have seen improvements, others have seen economic inactivity due to ill health rise sharply. In some local areas, more than one in ten working age people are economically inactive due to ill health.
- In 2020-22, nearly 10% of the total number of people who were economically inactive due to ill health lived in only 20 local authorities (out of 372) representing 4% of the working age population.[2]

[1] There are concerns with the accuracy of Labour Force Survey data due to small sample sizes, however, these trends are also mirrored in administrative and census data
[2] This percentage is consistent across Census and LFS survey data

- There is a relationship at local authority level between higher proportions of economic inactivity due to ill health and lower life expectancy at birth. However, there are a few outliers. For example, Westminster and Camden have a higher proportion of people who are economically inactive than the UK as a whole, but some of the highest life expectancies in the UK. Conversely Hyndburn has lower than average life expectancy and a lower than average proportion of people who are economically inactive.

The impacts of people- and place-based factors

- History matters – the places with the highest level of health-related economic inactivity in 1991 tended to be the areas with the highest levels in 2019.
- Former industrial areas and coastal towns have the highest proportion of people economically inactive due to ill health, while urban and metropolitan areas are relatively less affected.
- People with lower levels of qualifications, older people and people from some ethnic minorities are more likely to be economically inactive due to ill health.
- One reason for the persistence of inequalities between areas is the sorting of people. There is a complex interaction between the characteristics of people and the availability of jobs and housing in local areas. Younger people, and the more highly qualified are more likely to move to areas where there are more high paying jobs. The characteristics of people in different areas seem to explain much of the disparity in overall labour market outcomes.
- Characteristics of place (namely the types of jobs available) matter more for the employment chances of disabled people and people with health conditions. In some places, particularly former industrial areas and coastal towns, there are significant numbers of economically inactive people who could work if the right type of jobs were available.
- This means that in areas where there are fewer jobs available, some people may move from unemployment to economic inactivity and claim incapacity benefits. The impact of this is then compounded by the fact that people in receipt of incapacity benefits do not typically receive employment support.

Insights from the case studies

- Local context matters to health and employment outcomes, whether this is the decades of conflict in Belfast, South Ayrshire's vulnerability to the economic shock of the Covid-19 pandemic, or the process of deindustrialisation in Newport.

- Healthy and wealthy local areas, such as Westminster, still have pockets of deprivation where economic inactivity due to ill health is high, highlighting the need for highly targeted and localised approaches across all parts of the UK.
- There are examples in all the case studies of local responses to the challenges of economic inactivity. However, the effectiveness of this local action is limited due to the lack of long-term strategy and sustained efforts, including funding.

Conclusion and policy discussion

The Get Britain Working White Paper published in November 2024 acknowledges the scale of the challenge in relation to economic inactivity due to ill health in the UK. Reflections on how the Government can effectively address this challenge are set out below.

Providing effective integrated support

The principles of integrated employment support are uncontested, but the question of how to do it well remains. There is a need to:

- build the evidence on how to better integrate work and health services,
- create the conditions for effective employer engagement within employment support programmes and in broader efforts to increase local job opportunities
- improve engagement and reach to people who have been out of the labour market longer term.

Empowering local leaders

The Government should ensure the benefits of a local approach to work, health, and skills as set out in the White Paper are experienced equally across the UK. Local areas, particularly those that our research have identified as the most deprived, should not be excluded from the benefits of integration and investment because they are in new or nascent combined authorities or sit outside them. For example, Blackpool and Hull are two areas with high rates of economic inactivity that sit outside Combined Authorities. More focus is needed on achieving better integration and increasing capacity building in non-devolved areas. Further devolution should also be underpinned by transparent accountability, so that mechanisms are in place to ensure local areas are meeting targets such as moving job seekers into employment.

Supporting the creation of more good jobs

Local government should work in partnership to support the creation of good jobs through the Government's new industrial strategy. Local Growth Plans should be informed by the principles of good work. This could be facilitated through Good Work Partnerships that bring together the key partners in an area, such as key employers, the NHS, higher education institutions, colleges, employment support providers, chambers of commerce and others. These partnerships would agree how the key tools at their disposal could work together to create local jobs, promote, and incentivise good work, and harness the power of anchor institutions. The sector focus of the Government's new strategy may also provide the opportunity for local areas to

build and share evidence of what good work looks like in particular sectors.

Better data and evidence

The Government should prioritise building evidence of what works to improve employment and health outcomes across the UK. High-quality, timely data is needed to understand what works and create good policy. National administrative data sets for education, health, tax, and benefits should be made more widely available and linked more effectively (with appropriate controls for ensuring anonymity).

Evidence and evaluation should be built into the commissioning of services. This should include a commitment to conduct and publish evaluations of all publicly funded programmes.

Charters and accreditation schemes, positive procurement, and inclusive growth strategies are all intended to create the conditions for better and healthier work, but there is no reliable evidence of whether they are effective. A test and learn approach is needed to understand what actually works.

Introduction

Since 2020, long-term sickness has become the main reason people report for being out of work,[3] with nearly 2.8 million working-age people economically inactive primarily due to ill health.[4] The number of people economically inactive due to long-term sickness has increased by a third (671,000) since the pandemic. While low response rates to the Labour Force Survey (LFS) mean these estimates need to be treated with caution, these trends are mirrored in administrative data. The number of people claiming out-of-work disability benefits has increased by almost one million, (946,000, 37%) since the start of the pandemic to 3.2 million.[5] These rises are attributed to several factors including an ageing population, unintended effects of the benefits system, the continuing impact of the Covid-19 pandemic, and the growing pressure on the health-care system.[6]

Evidence from multiple sources, including the LFS, census and benefits data also suggests that economic inactivity due to ill health varies significantly by region.[7] In 2020-22, just under 10% of people economically inactive due to ill health lived in just 20 local authorities.[8] To successfully address economic inactivity, and achieve an 80% employment rate, the Government needs to tackle these longstanding inequalities.

When making policy decisions on how to tackle these inequalities, there is a key question about whether spatial inequalities are due to the kind of people who live within a local area, or whether there are also area characteristics (namely the local labour market) that drive these inequalities. In other words, can inequality in outcomes between local areas be explained by the fact that people who are more at risk of economic inactivity tend to be concentrated in particular areas or are there also structural factors at play? This question is crucial to informing how to balance investment in supply-side solutions through active labour market policies, and demand-side interventions that drive local economic growth.

This paper explores the question by looking at spatial variation in economic inactivity. Our analysis suggests that some places have similar levels of health, but varying rates of economic inactivity due to ill health, and that in some places there have been changes to rates of economic inactivity that cannot be wholly explained by changes in population health. We look at the interplay of local industrial histories and socio-economic characteristics that influence these variations. This includes: a review of relevant literature; statistical analysis to identify spatial variations in health and employment outcomes across local authorities, including ONS area classifications, and

[3] Clayton, N., Evans, S., and Vaid, L. (2023) Missing Workers: Learning and Work Institute. Available at https://learningandwork.org.uk/resources/research-and-reports/missing-workers/

[4] Powell, A. (2024) Economic update: Inactivity due to illness reaches record. Available at https://commonslibrary.parliament.uk/economic-update-inactivity-due-to-illness-reaches-record/

[5] Learning and Work Institute (2024) Get Britain Working: The path to an 80% employment rate. Available at: https://learningandwork.org.uk/resources/research-and-reports/get-britain-working-the-path-to-an-80-employment-rate/

[6] Lane Clark & Peacock (2023) The Great Retirement or the Great Sickness.

[7] Clayton, N., Evans, S., and Vaid, L. (2023) Missing Workers: Learning and Work Institute. Available at https://learningandwork.org.uk/resources/research-and-reports/missing-workers/
A comparison of 2021 Census data with pooled LFS data showed that the average variation between Census and LFS data in local areas was 0.4%, however there were a few areas with much greater variation

[8] These 20 local authorities accounted for just under 16% of the total working age population. This figure has been checked against the Census 2021.

analysis of six case studies.

There are some limitations with the data used in this report. This is due to geographic coverage, the distortionary effects of the Covid-19 pandemic, and growing concerns about the accuracy of LFS data due to overall falling response rates, inaccurate population estimates and small sample sizes at local authority level. Nevertheless, the report provides insight into why health and employment outcomes might vary and identifies how these inequalities can be addressed.

It is encouraging that the Government's recently published White Paper: Get Britain Working recognises and addresses some of the challenges outlined in this report. The wider roll-out of Connect to Work (formerly known as Universal Support) in England and Wales will enable more people to have access to high quality employment support. The announcement of investment in eight trailblazer areas to trial new interventions with a focus on joined up work, health and skills offers that increase engagement with people who are outside the workforce is also promising. However, the challenge of how these reforms will be implemented across the UK and whether they will be delivered at sufficient scale remains. In our conclusions, we set out some of the key considerations that need to be addressed if the Government is to achieve its ambitions.

Geographical inequalities in health and employment outcomes

Summary

- There is significant variation in the proportion of the working-age population economically inactive due to ill health at the local level
- The distribution of health-related economic inactivity is closely related to the distribution of poor health. Places with the lowest life expectancy also tend to have the highest levels of economic inactivity due to ill health, though there are some outliers and variations not fully explained by general health levels.
- Former industrial areas and coastal towns have the highest proportion of people economically inactive due to ill health, while urban and metropolitan areas are relatively less affected.

Measuring health and employment outcomes

Life expectancy at birth is the headline measure of local population health in this report.[9] Life expectancy is a robust indicator of population health that is not subject to reporting biases, allowing for reliable comparisons across the four UK nations. [10] Life expectancy does not directly capture the health of the working-age population or provide information about quality of life but it is closely related to self-reported measures of working-age health, such as those from the LFS, and non-self-reported measures such as working-age mortality rate and healthy life expectancy.

The proportion of the working-age population reporting a long-term health condition limiting either their day-to-day activities or their work is another measure used to explore the local population health.[11] This measure is available across UK local authorities, but it is dependent on people's perception of illness and disability. People are more likely to report a disability when living in a disabling environment rather than an inclusive one,[12] and perceptions can also change over time.

[9] Office of National Statistics (2024) Life Expectancy releases and their different uses. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/articles/lifeexpectancyreleasesandtheirdifferentuses/2018-12-17

[10] Chan SL et al (2020) Frameworks for measuring population health: A scoping review. PLoS One. 2024 Feb 13;19(2):e0278434. doi: 10.1371/journal.pone.0278434. PMID: 38349894; PMCID: PMC10863900

[11] LFS captures whether the respondents have any long-term health conditions, whether this illness is limiting their day-to-day activities (EA core disabled) and whether this is limiting the type or amount of work people do (work-limiting disabled).

[12] Geiger, B.B. (2020) Has working-age morbidity been declining? Changes over time in survey measures of general health, chronic diseases, symptoms and biomarkers in England 1994–2014. BMJ Open. doi:10.1136/ bmjopen-2019-032378

Employment outcomes for people with long-term health conditions are explored by looking at the **proportion of the working-age population that is economically inactive primarily due to ill health**. This statistic captures people who report health as the main reason they are not seeking work or available for work. In most cases, these individuals are in receipt of incapacity benefits.[13] This measure is also highly correlated with the disability employment rate and the disability employment gap given the high degree of overlap between people who are disabled and people who report long term health conditions.[14]

Health across the four nations

There is significant variation in people's health across UK nations and regions. In 2020-22, people born in England were expected to live on average 2 years and 3 months longer than those born in Scotland (Figure 1). Across England, the northern regions had the lowest life expectancy at birth, while the southern regions had the highest. The recent fall in life expectancy reflects high mortality due to the COVID-19 pandemic but this followed an unprecedented slowdown in improvements in the decade before.[15]

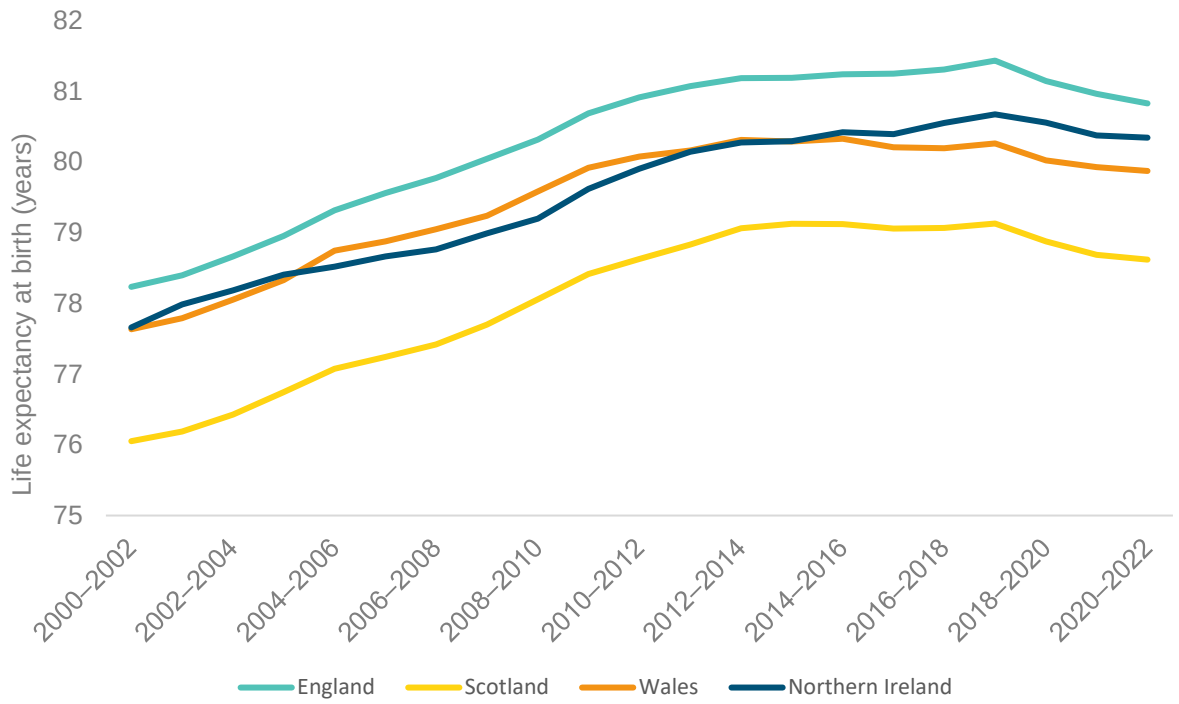
[13] Windett, S et al 2022. The future of work: protected characteristics in a changing workplace' expectancy: Equality and Human Rights Commission https://learningandwork.org.uk/resources/research-and-reports/disability-employment-from-pandemic-to-recovery/

14 Other indicators of employment outcomes were explored, such as the disability employment rate or disability employment gap. However, these depend on whether people identify their health condition as limiting their day-to-day activities. The disability employment rate also varies depending on the survey used to calculate it.

[15] Office of National Statistics (2024) Life Expectancy releases and their different uses. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/articles/lifeexpectancyreleasesandtheirdifferentuses/2018-12-17

Figure 1: Life expectancy at birth has been highest in England and lowest in Scotland over the last decade

Life expectancy at birth in England, Scotland, Northern Ireland and Wales, 2000-2022



Source: Life expectancy estimates, Office for National Statistics

The proportion of the working-age population reporting a long-term health condition that limits their day-to-day activities or work also varies significantly between nations and regions**.** Wales has the highest proportion (29%), followed by Scotland (28%), with England and Northern Ireland both at 24%.

The prevalence of limiting health conditions among people aged 16-64 has increased in all four nations since 2018 (Figure 2)**.** This indicator was relatively stable until 2018 but has risen since, with the largest increases occurring from 2019 onwards. Different factors may have influenced this rise including the health impacts of the Covid-19 pandemic and the cost of living crisis, disruption in health care services, including community and mental health services, as well as wider trends such as population ageing and changes in diagnostic and health-seeking behaviours.[0] Within England, all nine regions have seen an increase in limiting health conditions between 2018 and 2023. Although the North East has seen the smallest increase during this period, it still has the highest rate of the English regions.

Figure 2: All nations and regions have seen a rise in the proportion of working-age people with long-term health conditions that limit daily activities or work
Proportion of the population aged 16-64 with limiting long-term health conditions, by nations and English regions, 2018 and 2023

Source: Annual Population Survey, Office for National Statistics

At a more granular level, health outcomes vary significantly between local authorities. For example, in Torfaen (Wales), nearly two in five people (39%) aged 16-64 report a long-term health condition limiting their day-to-day activities or work, compared to one in ten (11%) in Newham (London).

Geographical variation in economic inactivity due to ill health

These health disparities have significant implications for labour market participation. Across the UK, around one in two disabled people are in employment, compared to more than four in five non-disabled people. In 2024, 2.8 million people were economically inactive due to ill health – more than twice the population of Birmingham (over 6% of the working age population).

There are also large variations in the proportion of the working-age population

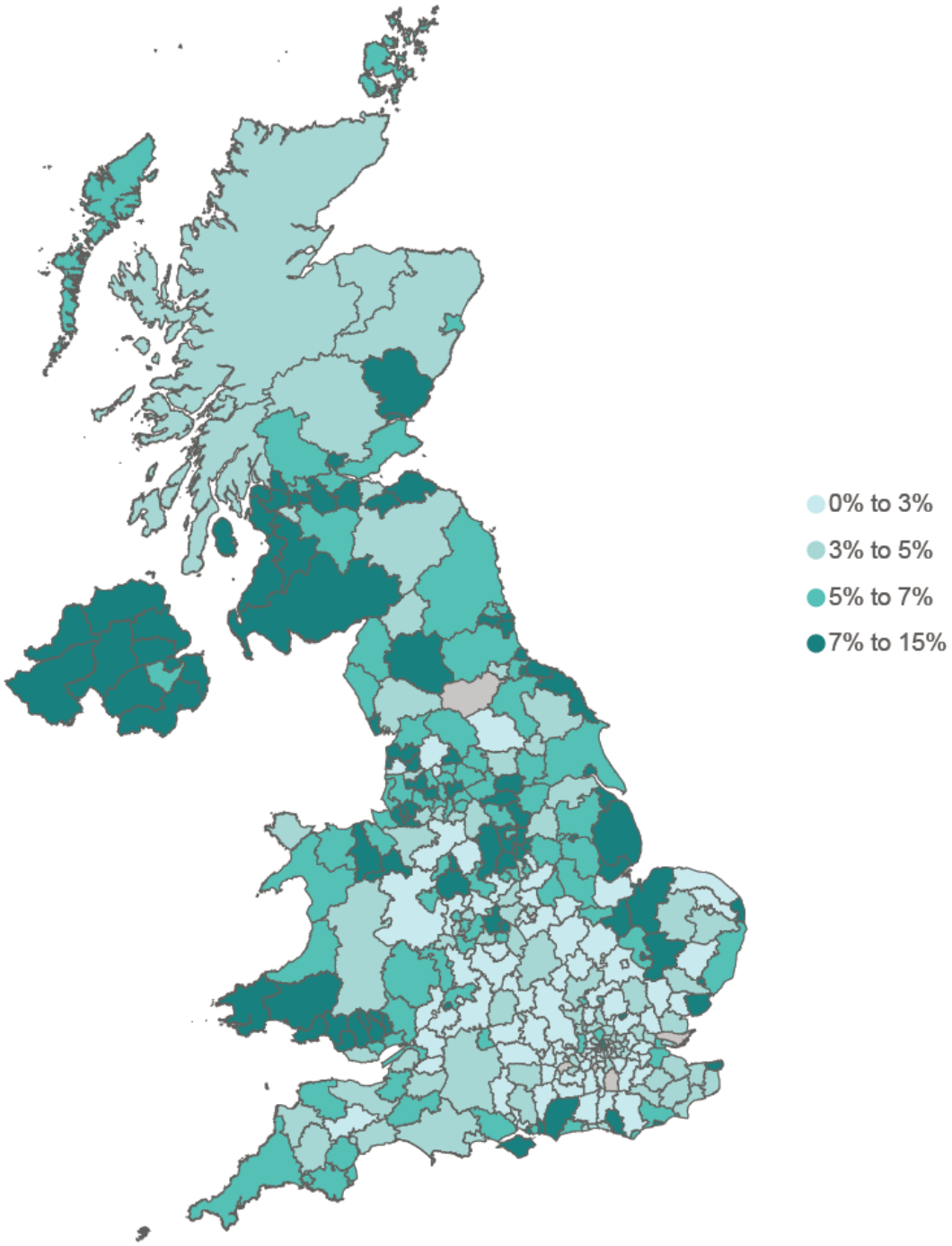
economically inactive due to ill health across local labour markets:

- In some areas, more than one in ten people aged 16 to 64 are economically inactive due to ill-health.
- In 2020-22, nearly 10% of the total number of people who were economically inactive due to ill health lived in only 20 local authorities representing 4% of the working age population (out of 372). [16]
- These areas are concentrated in Northern Ireland, Scotland, Wales, and the North of England, where rates of working-age people economically inactive due to ill health are higher than in the South of England (Figure 3). For example, South Ayrshire in Scotland, Newport in Wales, and Blackpool in the North of England have rates of around 15%, 11% and 15% respectively.
- However, this is not a straightforward north-south divide. For example, Hastings (East Sussex) and Westminster (London) also have relatively high rates of economic inactivity due to ill-health, at 9% and 8% respectively.

[16] This percentage is consistent with census data

Figure 3: There are spatial inequalities in the numbers of people economically inactive due to ill health across the UK

Economic inactivity due to ill health (% aged 16-64) by local authority district/unitary, UK, 2020-22



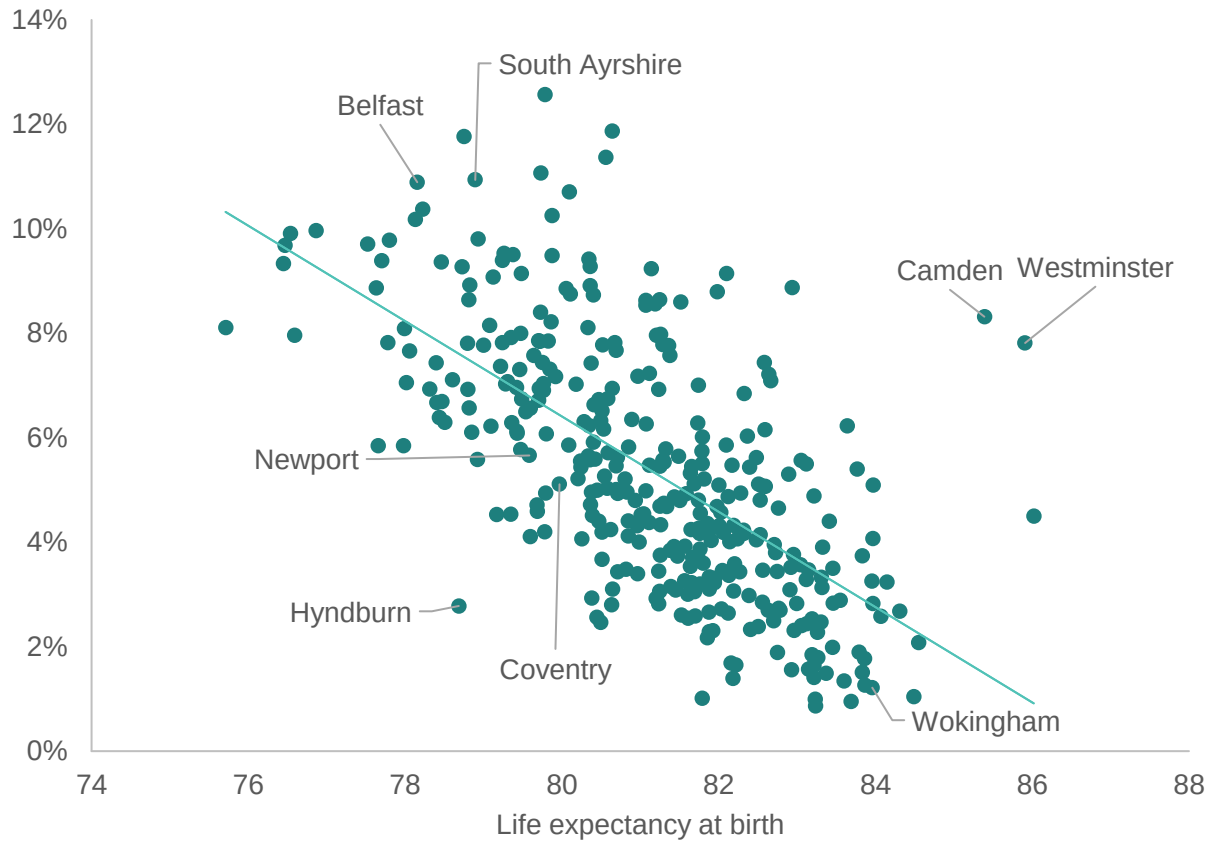
Source: Authors' analysis using data from Office for National Statistics, Annual Population Survey (3 years pooled dataset), 2021 Mid-Year Estimates.

The relationship between health and employment outcomes in local authorities

The share of the working-age population economically inactive due to ill health is strongly correlated with life expectancy. Areas with lower life expectancy generally have higher rates of health-related inactivity, but there are outliers (Figure 4). Westminster and Camden have a higher proportion of people who are economically inactive due to ill health than the UK average, yet they also have some of the highest rates of life expectancy in the country. Hyndburn is another outlier with lower life expectancy (78.7 years old) than the UK average but also lower levels of economic inactivity with less than 3% of its working-age population economically inactive due to ill health. [17]

This suggests that there may be other area characteristics that influence rates of health-related economic inactivity. We explore this further through the ONS' area classifications.

Figure 4: Local authorities with lower life expectancy tend to have high levels of economic inactivity due to ill health, but there are outliers
Proportion (%) of the population aged 16-64 economically inactive due to ill health (vertical axis), 2020-22 vs. life expectancy at birth (horizontal axis), 2018-2020



Source: Life expectancy estimates, Office for National Statistics. Authors' analysis using data from Office for National Statistics, Annual Population Survey, 2021 Mid-Year Estimates.

[17] This analysis uses 2023 data to avoid the distortionary impact of the Covid pandemic

Area characteristics and health-related economic inactivity

Former industrial towns, coastal towns, and places with relatively large manufacturing sectors – or 'Services and industrial legacy' areas as defined in the ONS area classifications (see page 16 for more information) – tend to have higher rates of economic inactivity due to ill health than 'affluent' or 'ethnically diverse metropolitan areas'.[18]

- Nearly all the local authorities in the 'Services and industrial legacy' group (52 out of the 57) had higher than average rates of economic inactivity due to ill health in 2020-22. Local authorities in this group account for 12 out of the top 20 local authorities with the highest rates of health-related economic inactivity, and 11 out of top 20 local authority areas with the lowest life expectancy. Eight areas sit in the top 20 on both measures. These places were historic manufacturing and mining areas, including Wigan or Blaenau Gwent, or areas with a declining service economy, including Blackpool.

- In contrast, areas categorised as 'Affluent England', such as Wokingham, tended to have lower proportions of health-related economic inactivity. Local authorities in this group account for 12 out of the top 20 local authorities with the lowest rates of economic inactivity due to ill health and 13 out of top 20 local authorities with the highest life expectancy. Five areas sit in the top 20 on both measures. These areas have low rates of unemployment, and the residents are more likely to work in the information or communications sector.

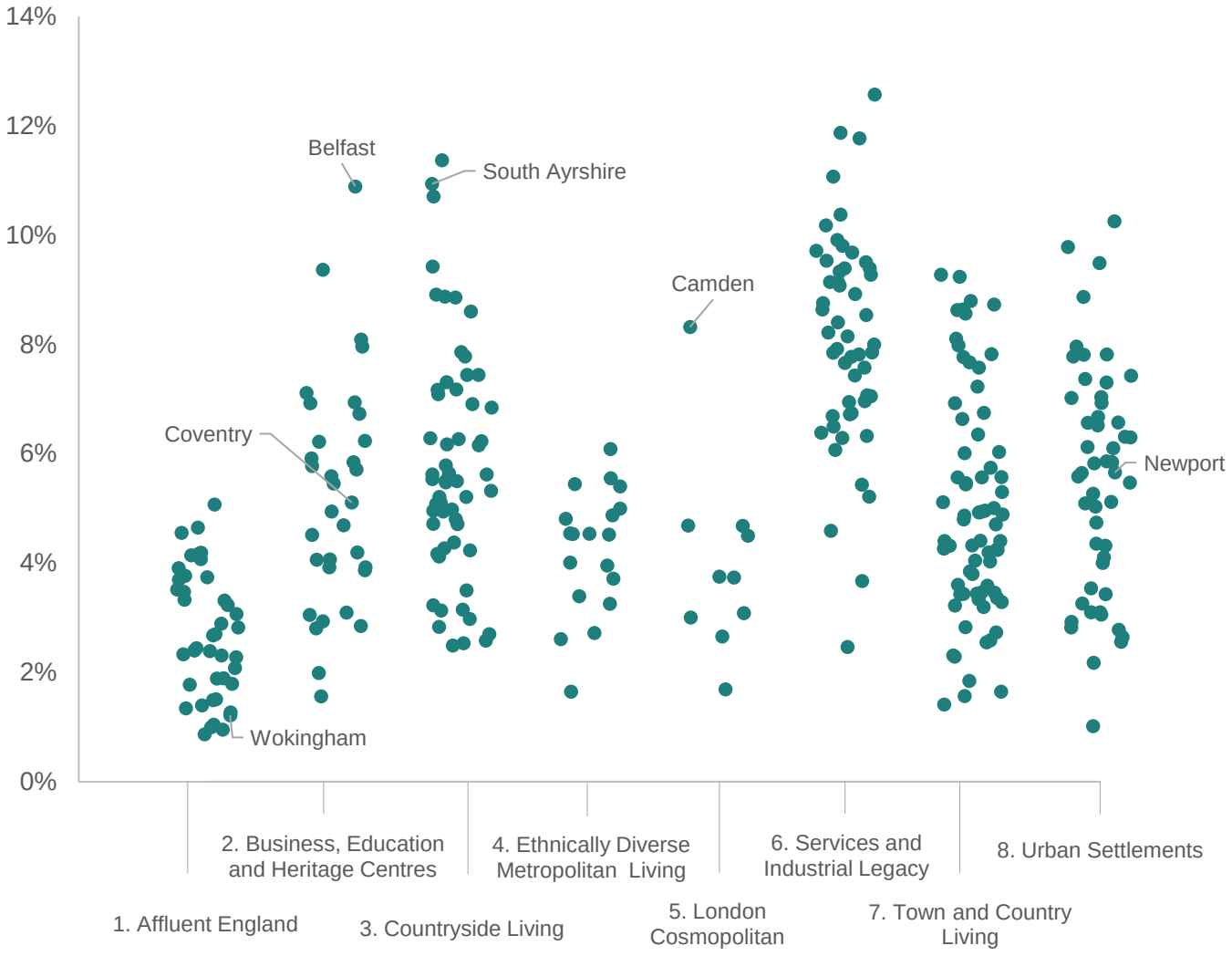
- In other groups, the dispersion between areas is higher (Figure 5). For example, more than 6% of the working-age population in the 'Urban settlements' group on average are economically inactive due to ill health, but there are significant variations between local authorities, ranging from only 1% to 10%.

ONS classifications are defined by a mix of demographic and socio-economic data. Outcomes in 'Services and industrial legacy areas' in particular highlight the complex interplay between people- and place-based factors that influence geographic variation in work and health outcomes. The dispersion in outcomes across areas in other groups highlights the importance of better understanding the factors driving inequality at the local level. In addition, understanding why some areas have better work and health outcomes than other areas with similar characteristics may help to identify effective policy and practice. This is explored further in the following chapters.

[18] New cluster analysis of UK regions using 2021 Census data was published after this work was produced. Due to overlaps between old and updated area classifications, this analysis is not reproduced for the new classifications here.

Figure 5: Affluent England has lower rates of health-related economic inactivity compared to 'Services and Industrial Legacy' areas

Proportion of working-age population (16-64) economically inactive due to ill health by ONS pen portraits, 2020-22



Source: Pen portraits, Office for National Statistics. Authors' analysis using data from Office for National Statistics, Annual Population Survey, 2021 Mid-Year Estimates.

ONS area classifications: Summary of pen portraits

Affluent England

51 local authorities. 10.3% of the UK population with a median age 41 years.
These areas are in England near to and around London – Buckinghamshire, Hampshire, Hertfordshire, Kent, Oxfordshire, and Surrey. Wokingham, one of our case studies, is included in this classification. Residents are more likely to work in the information and communication industries.

Business, education and heritage centres

35 local authorities. 14.4% of the UK population with a median age of 35 years.
The population of this group live within larger cities throughout the UK, with either country and/or regional importance. Belfast and Coventry are included in this classification. Residents are more likely to be working in accommodation or food services and the education sector.

Countryside living

83 local authorities. 15.2% of the UK population with a median age of 46 years.
The population in this group live in rural areas with a low population density. South Ayrshire is included in this classification. Residents are more likely to be employed in the agricultural, forestry and fishing industries.

Ethnically diverse metropolitan living

19 local authorities. 9.4% of the UK population with a median age of 33 years.
The population of this supergroup tends to live in Inner and Outer London Boroughs. Areas outside London covered by this supergroup include Birmingham, Leicester, Luton and Slough. Workers are more likely to work in administrative or support services.

London cosmopolitan

12 local authorities. 4.2% of the UK population with a median age of 32 years.
The population of this group is located within 12 Inner London boroughs. These areas are characterised by a very high population density and a relatively low median age. Westminster is included in this classification. People are more likely to work in information and communication, and financial, insurance or real estate industries.

Services and industrial legacy

57 local authorities. 15.3% of the UK population with a median age of 41 years.
The population of this group is predominately in the Central Belt in Scotland, northern England and south Wales. It includes historic mining and manufacturing areas, as well as coastal areas such as Blackpool. Those in work are more likely to be employed in energy, water, manufacturing or construction.

Town and country living

79 local authorities. 16.1% of the UK population with a median age of 42 years.
This group is represented within all countries of the UK and English regions with the exception of the North East and London regions. People are more likely to work in manufacturing industries.

Urban settlements

55 local authorities. 15.0% of the UK population with a median age of 38 years. These areas are in nine English regions and Wales (Newport) only. People are more likely to work in the wholesale and retail trade, transport and storage, and administrative and support services.

Changes in economic inactivity across the ONS groups

Over the past decade, health-related economic inactivity has increased across all eight groups, though not for every local authority (Figure 6). While these ONS pen portraits are useful to identify some of the shared characteristics of places with similar life expectancy and health-related economic inactivity, these groups are less useful when exploring the pattern of change over the past decade. For example, while most places within the ‘Services and industrial legacy’ group have higher levels of health-related economic inactivity than the UK average, the rate of economic inactivity due to ill health increased for some areas but decreased for others. A similar pattern can be observed for the ‘Town and country living’ and ‘Urban settlement’ groups. Conversely, despite the ‘Affluent England’ group having the lowest rate of health-related inactivity, very few areas within this group saw an improvement in the decade from 2013. Mixed trends across areas with similar characteristics suggest that no single factor has driven recent changes, although results should be treated with caution due to variation in survey estimates.

Figure 6: Across all classifications, local authorities have experienced an increase in the proportion of the working-age population economically inactive due to ill health

Percentage point change in economic inactivity due to ill health by ONS pen portraits, 2013-2023

Source: Pen portraits and Life expectancy estimates, Office for National Statistics. Authors' analysis using data from Office for National Statistics, Annual Population Survey, 2021 Mid-Year Estimates.

Factors influencing the geography of health-related employment outcomes

Summary

- There is a high correlation between historic and current levels of economic inactivity due to ill health.
- People from some groups (particularly those with lower levels of qualifications) are more likely to be economically inactive due to ill health. The availability of jobs and housing means that people with similar characteristics tend to be concentrated in certain local authorities. Evidence suggests that 'sorting' explains much of the disparity in overall labour market outcomes.
- Characteristics of place (particularly the types of jobs available) seem to matter more for disabled people and people with health conditions. In some areas, particularly former industrial areas and coastal towns, there are significant numbers of economically inactive people who may be able to work if the right jobs were available.
- It is important to understand the interactions of people and place when looking at why people are economically inactive due to ill health.

Historical factors

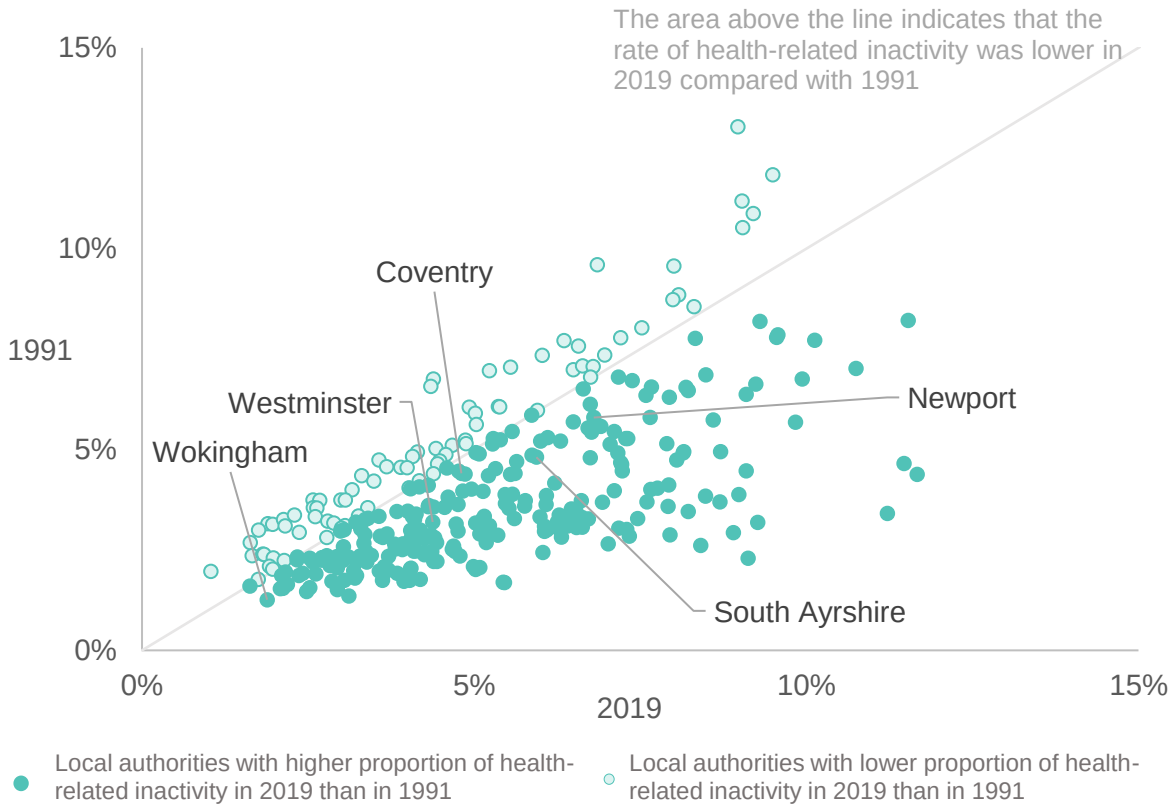
High rates of economic inactivity due to ill health in 'Services and industrial legacy' areas highlight the enduring impact of these areas' socio-economic histories on health-related employment outcomes. Our research shows that while there are increases across most ONS area types, there is a high correlation between historic and current levels of economic inactivity due to ill health.

Figure 7 illustrates that there is a relationship at the local level between rates of health-related economic inactivity in 1991 and rates of health-related economic inactivity in 2019.[19] For example, Blackpool's historic rate of economic inactivity due to ill health was 7%, while the rate in 2019 was 10%. Data from the 1991 census also shows a high disparity between local areas: while nearly 10% of the working-age population in Glasgow was economically inactive due to ill health, this figure was less than 2% in Oxford.

[19] We use 2019 as the comparator here to avoid any potential distortionary effects from the Covid-19 pandemic

Figure 7: Areas with the highest level of health-related economic inactivity in 1991 tend to be the same as in 2019

Proportion of working-age population economically inactive in 1991 and 2019 at local authority level (GB)



Source: Annual Population Survey and Census data, Office for National Statistics.

This relationship highlights the profound role that historical factors play in shaping current health and work outcomes, and the interplay between structural, socio-economic, and health determinants that span decades.

Population factors

It is well-documented that at an individual level, the characteristics of people such as their age, qualifications, or ethnicity, significantly influence their employment prospects.

- **Age** – Older people are more likely to have one or more health conditions or disabilities [20] and more likely to be economically inactive due to ill health. However, this relationship has weakened over time with the sharp rise in young people with mental health conditions. The number of young people economically inactive due to ill health has more than doubled between 2012 and 2022, and people in their early twenties are now more likely to be economically inactive due to ill-health than those in their forties.[21]

[20] Disability by age, sex and deprivation, England and Wales - Office for National Statistics (ons.gov.uk)
[21] Murphy, L., (2023) Left behind: Exploring the prevalence of youth worklessness due to ill health in different parts of the UK. Available at: https://www.resolutionfoundation.org/publications/left-behind/

- **Qualification levels** – People with lower qualification levels are more likely to be economically inactive than people with higher qualifications. Nearly one in three (31%) people who had a qualification below level 2 were economically inactive (and not in education) compared to one in ten people (11%) qualified to degree level and above.[22] For disabled individuals, qualifications appear to play an even more significant role. Disabled people without qualifications are far less likely to be employed than their counterparts with higher educational attainment. More highly qualified people are also less likely to leave work if they have a long-term health condition, compared to people with lower-level qualifications. [23] One explanation for this is that people with higher levels of qualifications are more likely to be able to work in sectors and roles that can offer greater flexibilities and accommodations.[24]

- **Ethnicity** – People from some ethnic groups are more likely to experience labour market disadvantages This is driven by a range of factors including discrimination from employers.[25] Disabled people from some ethnic minority groups also experience lower employment rates. The disabled employment gap is smaller for White British people than for other ethnic groups. People from some ethnic groups, in particular Arab ethnic groups, some Black backgrounds and White Gypsy or Irish Traveller backgrounds are also more likely to be economically inactive due to ill health than people from White British backgrounds.[26] People from some ethnic minority backgrounds who also have health conditions or disabilities are therefore likely to experience a double disadvantage.

The impact of these factors means that two people with similar disabilities or health conditions could have different employment outcomes based on non-health related factors. This also plays out geographically, as people 'are sorted' into different areas based on their characteristics and preferences, which are health and non-health related. The movement of people between areas then also affects the prosperity of areas, and in turn the availability of jobs.

The role of 'sorting' by jobs and housing

The availability of jobs and housing drives where people live. Highly qualified people typically move to areas where there are more jobs, while those with lower qualifications are less likely to move to find work. Skilled workers therefore tend to concentrate in the same areas, which reinforces inequalities across the UK, with coastal and northern areas lagging behind other places in terms of skills level. [27]For example, in Newport,

[22] Gov.uk, 2023. Economic inactivity by qualification level Available at : https://www.ethnicity-facts-figures.service.gov.uk/work-pay-and-benefits/unemployment-and-economic-inactivity/economic-inactivity-by-qualification-level/latest/#main-facts-and-figures
[23] https://www.gov.uk/government/statistics/the-employment-of-disabled-people-2024/the-employment-of-disabled-people-2024
[24] Baumberg, B., 2015. From impairment to incapacity–educational inequalities in disabled people's ability to work. *New Perspectives on Health, Disability, Welfare and the Labour Market*, pp.47-64.
[25] Lippens, L., Vermeiren, S. and Baert, S., 2023. The state of hiring discrimination: A meta-analysis of (almost) all recent correspondence experiments. *European Economic Review*, *151*, p.104315.
[26] https://www.gov.uk/government/statistics/the-employment-of-disabled-people-2024/the-employment-of-disabled-people-2024
[27] Britton, J. 2021 London calling? Higher education, geographical mobility and early-career earnings

56% of people are qualified to level 3 (the equivalent of A level), while this rises to 71% in Wokingham. Young people are more likely to move to areas where jobs are available than older people, meaning that rural areas will typically have older populations than cities. In rural South Ayrshire the median age of residents is 50, compared to 36 in the central London borough of Westminster.

The availability and the affordability of housing also increasingly influences where people live. The availability of different tenures of housing varies significantly between different local areas as can be seen in our case studies of Westminster and Wokingham. While only 8% of households were reported as living in social housing in Wokingham,[28] this rises to nearly 30% in Westminster.[29] There are also distinct variations in employment and health outcomes by housing tenure. The households of private renters are most likely to be in work and people in social housing are most likely to be disabled.[30]

Sorting largely explains spatial disparities

Spatial disparities in labour market outcomes have been largely explained by the way that people are sorted between local areas. Overman and Zu (2022) found that spatial disparities in wage outcomes largely reflected the concentration of high-skilled workers.[31] They found that at least two thirds (and up to 90%) of the differences in average wages across areas can be attributed to differences in the types of people (particularly their skill levels) who work in different places. These patterns then become self-reinforcing, as people with higher qualifications move to where more highly paid jobs are available.[32] Recent research from the Centre for Progressive Policy demonstrates how these spatial inequalities create doubly disadvantaged areas with high material deprivation and low community assets.[33]

Spatial variation in ethnic minority populations

People from different ethnic minorities are often regionally concentrated. This means that cities are more ethnically diverse than rural areas. From the 2011 census, 35% of people in Coventry reported being from an ethnic minority background compared to 1% in South Ayrshire. It also means that different ethnic groups tend to live in particular areas. For example, 60% of the UK's Pakistani community live in three northern regions (including the West Midlands)[34] while one of our case studies, Westminster, has the highest proportion of people who identify as Arab (13.5% compared to 2.2%

available at https://ifs.org.uk/news/higher-education-enables-graduates-move-places-better-career-prospects-leads-brain-drain-north

[28] https://www.ons.gov.uk/visualisations/censusareachanges/E06000041/

[29] https://www.ons.gov.uk/visualisations/censusareachanges/E09000033/

[30] https://www.gov.uk/government/statistics/chapters-for-english-housing-survey-2022-to-2023-headline-report/chapter-1-profile-of-households-and-dwellings#economic-status-and-income

[31] Overman, H.G. and Xu, X., 2024. Spatial disparities across labour markets. Available from: https://ifs.org.uk/inequality/wp-content/uploads/2022/02/Spatial-disparities-across-labourmarkets-IFS-Deaton-Review-Inequality-FINAL.pdf

[32] Bryan, M., Bryce, A., Roberts, J. and Sechel, C., 2024. The geography of the disability employment gap: Exploring spatial variation in the relative employment rates of disabled people. The Sheffield Economic Research Paper Series (SERPS), 2024002(2024002). Available at https://eprints.whiterose.ac.uk/213616/

[33] Turner et al (2024) Breaking the cycle: Delivering good jobs for 'doubly disadvantaged' neighbourhoodshttps://www.progressive-policy.net/publications/breaking-the-cycle[33] Centre for Progressive Policy

[34] The latest census data shows that 20.1% of people in the Pakistani ethnic group lived in the West Midlands, 19.1% in the North West, and 18.7% in Yorkshire and the Humber

across England).[35] Because different ethnic groups experience different employment and health outcomes, this spatial variation could therefore affect areas' labour market profiles. Analysis of data from the 2021 Census shows that while Westminster as a whole is ranked 135 out of 330 local authorities for rates of economic inactivity due to ill health, it has some of the highest rates of economic inactivity for people from ethnic minority backgrounds.[36]

The importance of place for health-related employment outcomes

Research suggests that the characteristics of place are more significant when considering health-related employment outcomes as opposed to employment outcomes for the wider population. Little (2009) found that variation in rates of employment-related ill health between areas could not be wholly explained by demographic characteristics. This suggests that there is a structural component in under-performing areas that is driving rates of employment-related ill health.[37] This is supported by researchers from the University of Sheffield who estimate that the disability employment gap would only be reduced by four percentage points if average qualification levels of disabled people could be raised to those of non-disabled people. In contrast if the structural barriers that prevent a disabled person with a given level of education were removed, the gap could be reduced by over 28 percentage points.[38]

Availability of jobs

Evidence suggests that local labour market conditions affect rates of economic inactivity due to ill health. The concept of 'hidden unemployment' refers to individuals who are economically inactive due to ill health who might reasonably be expected to have been in work in an economy with full employment.[39] This means that in areas where there are fewer jobs available, some people may move from unemployment-related benefits to incapacity benefits. This theory does not contest the legitimacy of people's health conditions and disabilities but instead highlights how labour market dynamics can exacerbate barriers to employment.

This is seen most clearly in 'services and industrial legacy' areas as defined by the ONS. Beatty and Fothergill (1996) identified that job losses in the UK coalfields led to significant rises in economic inactivity due to ill health. In these areas, the proportion of

35 13.5% of Westminster's residents identified as Arab in the 2021 census compared to 2.2% in England as a whole https://www.ons.gov.uk/visualisations/censusareachanges/E09000033

36 L&W's own analysis of census data

37 Little, A. (2009) 'Spatial Pattern of Economic Activity and Inactivity in Britain: People or Place Effects?', Regional Studies, 43(7), pp. 877–897. doi: 10.1080/00343400801968395.

38 Bryan, M., Bryce, A., Roberts, J. and Sechel, C., 2024. The geography of the disability employment gap: Exploring spatial variation in the relative employment rates of disabled people. The Sheffield Economic Research Paper Series (SERPS), 2024002(2024002). Available at https://eprints.whiterose.ac.uk/213616/

39 Beatty, C. and Fothergill, S. (1999) Incapacity Benefit and Unemployment. Discussion Paper. Sheffield Hallam University - Centre for Regional Economic and Social Research. Available from: https://core.ac.uk/download/pdf/323305164.pdf

people economically inactive due to ill health has remained stubbornly high.[40] For example, in 2018 over 10% of the working-age population in South Wales former coalfield areas claimed incapacity benefits compared to 6% in the rest of Great Britain.[41] This is partly explained by the fact that the population of these areas have relatively worse health than the rest of the UK. However, the persistence of deprivation and the impact of sustained periods of worklessness, with fewer job opportunities than in the rest of the UK, are also potential factors in the high levels of economic inactivity due to ill health.

In areas with a slack labour market, people with long-term health conditions are potentially doubly disadvantaged by the geographical lack of jobs in combination with the disadvantage they experience in recruitment processes across the UK. A survey from Scope shows how disabled people face disadvantages in job search; they make 60% more job applications, and are less likely to be invited for interview than non-disabled peers.[42] This can be explained by research that suggests that while many employers display positive attitudes to employing disabled people, this is not reflected in their behaviours, and they are less likely to employ disabled people than similar candidates who do not have disabilities.[43]

Types of job available

The types of jobs available within local economies may also impact on the likelihood that people with health conditions are in work. Researchers from the University of Sheffield found that when controlling for the economic prosperity of a local area, the prevalence of jobs in elementary occupations, such as cleaners, reduced the gap between disabled and non-disabled employment rate.[44] This can be explained by the fact that disabled people are more likely to have lower levels of qualifications than their non-disabled peers[45] meaning that elementary jobs are easier for disabled people to access on the open job market.

The research also found that a higher proportion of knowledge-based jobs and jobs where remote working was possible were associated with a lower disability employment gap. This can potentially be explained by the fact that remote working jobs provide more accommodations for disabled people.

Jobs in Information and Communication, and managerial or supervisory roles, are

[40] Beatty, C., & Fothergill, S. (1996). Labour market adjustment in areas of chronic industrial decline: the case of the UK coalfields. *Regional studies*, *30*(7), 627-640.
[41] Beatty, C., Fothergill, S. and Gore, A., 2019. *The state of the coalfields 2019: Economic and social conditions in the former coalfields of England, Scotland and Wales*. Sheffield Hallam University. https://www.coalfields-regen.org.uk/wp-content/uploads/2019/10/The-State-of-the-Coalfields- 2019.pdf

[42] Scope (2023) Understanding the challenges of disabled jobseekers. Available from: https://business.scope.org.uk/understanding-the-challenges-of-disabled-jobseekers
[43] Bredgaard, T. and Salado-Rasmussen, J., (2021) Attitudes and behaviour of employers to recruiting persons with disabilities. *Alter*, *15*(1), pp.61-70.
[44] Bryan, M., Bryce, A., Roberts, J. and Sechel, C., (2024) The geography of the disability employment gap: Exploring spatial variation in the relative employment rates of disabled people. The Sheffield Economic Research Paper Series (SERPS), 2024002 Available at https://eprints.whiterose.ac.uk/213616/
[45] This can be explained by a range of factors including ill health limiting educational opportunities and exclusionary experiences of education https://www.gov.uk/government/statistics/the-employment-of-disabled-people-2023/employment-of-disabled-people-2023

more likely to provide opportunities for home and hybrid working. [46] The evidence is relatively limited but suggests that disabled people and people with health conditions are likely to experience benefits from working from home, including higher self-reported levels of work ability, job control, flexibility and wellbeing.[47] Research also suggests disabled people and people with health conditions are more likely to report improved health and well-being from hybrid working than the population as a whole.[48] However, in general, disabled people are not more likely to work from home than other workers.[49] This is likely to reflect that not all disabled people are able to access more flexible kinds of work.[50]

Areas with jobs that can offer more flexibilities such as our case study Wokingham (which has a large proportion of people working as managers, directors, or senior officials) and areas with higher levels of elementary jobs such as Coventry may therefore offer better employment opportunities for people with health conditions for different reasons.

Interaction of people and place

It is important to recognise the interaction of people and place in determining employment outcomes for people who are economically inactive due to ill health. For areas that have high levels of economic inactivity and low levels of suitable employment, this then becomes self-reinforcing. This is most clearly seen in former mining and industrial areas and coastal towns.

Highly qualified, and younger people move away from areas where there are fewer jobs or fewer well-paid jobs. For those who remain in deprived areas, disadvantages are compounded. Extended periods of worklessness can contribute to people's ill health meaning they become sicker.[51] The operation of the benefit system can often mean that many economically inactive people do not receive support to find work. Notably, only 1% of people economically inactive due to ill health are in work six months later.[52] Equally, people who are eligible to receive employment support, can be limited by the mechanisms of the system with an emphasis on any job rather than the right job[53] and by limitations in the kinds of employers who typically engage with

[46] Mutebi, N. and A. Hobbs. (2022)"The impact of remote and hybrid working on workers and organisations." *UK Parliament: London, UK* https://doi.org/10.58248/PB49
[47] Beckel and Fisher (2022) Telework and worker health and well-being: a review and recommendations for research and practice; Lyzwinski (2024) Organisational and occupational health issues with working remotely during the pandemic: a scoping review of remote work and health.
[48] Elmore, J, Avanzo-Windett, S. and Klenk, H. (2024) What is healthy home and hybrid working? Available at https://learningandwork.org.uk/resources/research-and-reports/what-is-healthy-home-and-hybrid-working/
[49] Murphy, L. (2023) Reassessing the Work Capability Assessment. Available at https://www.resolutionfoundation.org/publications/reassessing-the-work-capability-assessment/
[50] Baumberg, B. (2015) From impairment to incapacity–educational inequalities in disabled people's ability to work. *New Perspectives on Health, Disability, Welfare and the Labour Market*, pp.47-64.
[51] Kim, T.J. and von Dem Knesebeck, O. (2015) Is an insecure job better for health than having no job at all? A systematic review of studies investigating the health-related risks of both job insecurity and unemployment. *BMC public health*, *15*, pp.1-9.
[52] Evans, S. and Vaid, L. (2023) Understanding benefits: Learning and Work Institute. Available at https://learningandwork.org.uk/resources/research-and-reports/understanding-benefits/
[53] Elmore, J. et al (2024) What support helps disabled people and people with health conditions move into sustainable work? Learning and Work Institute

employment support services.[54]

The interaction between people and place can also be seen in relation to health conditions. The specific health condition and/or disability someone experiences, as well as whether they have multiple health conditions and/or disabilities, will impact on whether they are able to work and the kind of job they can do. People are more likely to develop some health conditions in some areas. Evidence suggests that people who live in deprived areas are at risk of developing multiple conditions 10-15 years earlier than those who live in the most affluent.[55] Inequalities in health across different areas are predicted to increase further between now and 2040.[56] People's health conditions and disabilities can also determine where they live, leading to more sorting by local area. Research from the Health Foundation found that younger healthier people were more likely to move to areas where there are other younger, healthier people.[57] The movement of people then contributes to variations of health inequalities, whether this is migrant populations moving between areas [58] or people moving between rural and urban areas.[59]

[54] Elmore, J et al (2024) The Evaluation of the Restart Scheme. Department for Work & Pensions.
[55] Barnett, K. et al (2012) Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study. The Lancet, 380(9836), pp.37-43
[56] https://www.health.org.uk/publications/health-inequalities-in-2040
[57] Cavallero, F. et al (2022) How does residential mobility shape the health of local areas? https://www.health.org.uk/publications/long-reads/how-does-residential-mobility-shape-the-health-of-local-areas
[58] Norman, P., Boyle, P. and Rees, P. (2005) Selective migration, health and deprivation: a longitudinal analysis. *Social science & medicine*, *60*(12), pp.2755-2771
[59] Riva, M., Curtis, S. and Norman, P. (2011) Residential mobility within England and urban–rural inequalities in mortality. Social science & medicine, 73(12), pp.1698-1706.

Case study insights

Chapter summary

- Local context matters to health and employment outcomes, whether this is the years of conflict in Belfast, Newport's ongoing de-industrialisation or South Ayrshire's vulnerability to the economic shock of the Covid-19 pandemic.
- Health and wealthy areas still have pockets of deprivation suggesting highly targeted/localised approaches are needed in some cases.
- Areas where there is high labour demand, and a higher share of entry level roles appear to be beneficial for the employment of people with health conditions.
- There are examples in all the case studies of local responses to the challenges their areas face through the delivery of employment support provision, the development and implementation of local plans and strategies, and engaging local communities.
- However, the effectiveness of this local action is limited due to failure from central government to provide the sustained, stable long-term funding that is needed to secure change.
- There is also limited published evidence available, so it is difficult to understand the impact of interventions and identify what works.

We selected six local authorities – Belfast, Coventry, South Ayrshire, Newport, Westminster, and Wokingham – to explore how characteristics of people and place interact in an area to impact on the rates of economic inactivity due to ill health. The geographically dispersed case study areas have varying levels of life expectancy, socio-economic and industrial profiles. The case studies also enable us to explore how local responses vary in relation to local context. Further details of the case studies are included as an appendix.

Westminster and Wokingham: two areas with similar life expectancy

Westminster and Wokingham have similar levels of life expectancy; the two boroughs are among the healthiest in the UK. The local economies of these two areas are also similar in that there are high levels of job density, 'banking, finance, and insurance' is one of the largest sectors, and a large proportion of people work as managers, directors, or senior officials. While both local authorities share some characteristics, the socio-demographic characteristics of their population are different, with Wokingham

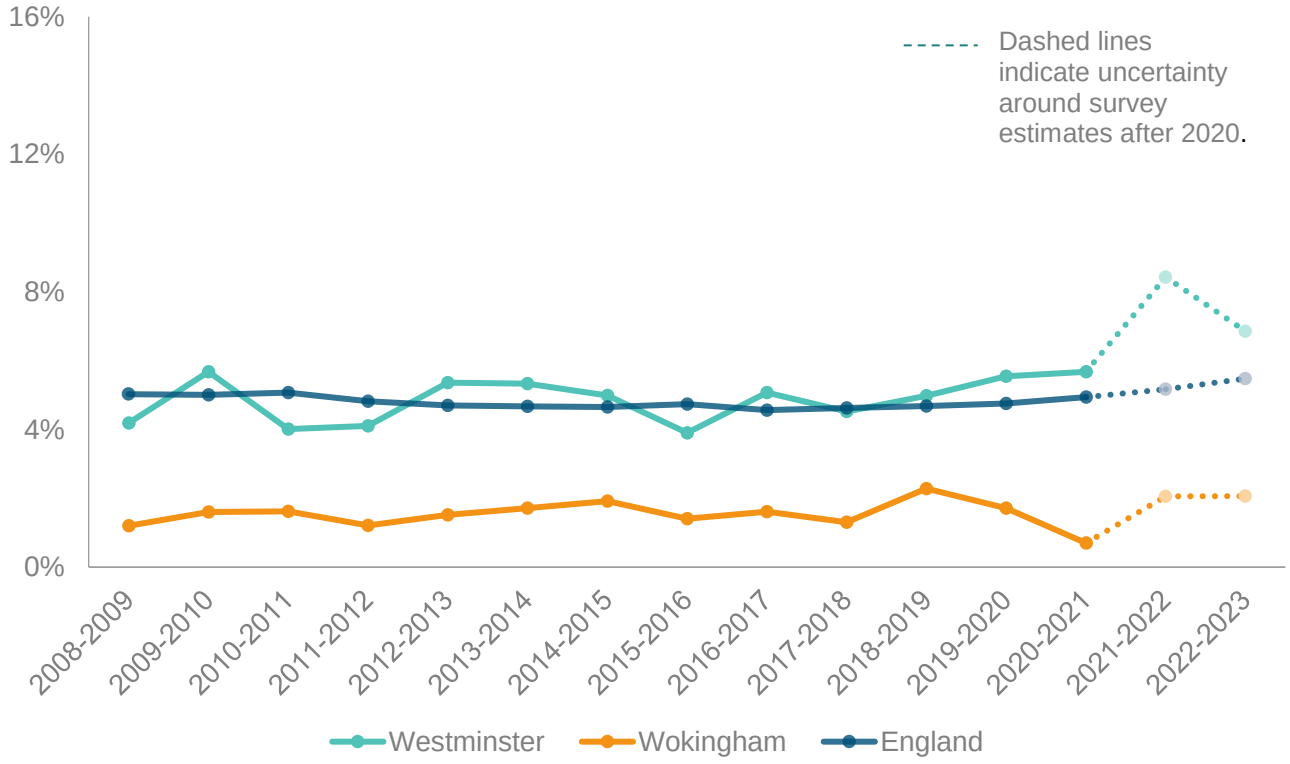
having an older population than Westminster.

While Wokingham has the lowest rate of economic inactivity due to ill health in England, Westminster has a higher-than-average rate (Figure 8). As highlighted previously, Westminster is an outlier for areas with comparable levels of life expectancy, except for Camden (the adjacent London borough which also has high rates of economic inactivity). Wokingham is similar to other areas in the Affluent England group.

There are concerns about the reliability of LFS data, particularly at local authority level. However, 2021 census data for Westminster and Wokingham suggests a similar pattern. Wokingham has one of the lowest rates of economic inactivity due to ill health (1.9%), ranked 329 out of 330 regions, while Westminster's rate is 4.8%, ranked 135th.

Figure 8: Westminster has a higher proportion of working age population economically inactive due to ill-health than Wokingham

Proportion of the working age population economically inactive due to ill health in Westminster, Wokingham, and England, 2008-2023



Source: Annual Population Survey, Office for National Statistics

One explanation for the differences in rates of economic inactivity is that, while Wokingham is more homogenous, Westminster has high levels of inequality. The overall high levels of health and wealth in Westminster therefore mask pockets of deprivation.

These disparities may be partly driven by the availability of social housing in Westminster. More than 30% of households in Westminster are social tenants compared to 8% in Wokingham.[60] Research suggests that social housing tenants face poorer employment outcomes and are less likely to be in work compared to people

[60] Office for National Statistics (2023) Census 2021 How life has changed in Wokingham https://www.ons.gov.uk/visualisations/censusareachanges/E06000041/

who either own or rent privately. In addition, they are more likely to work in lower paid sectors and occupations, more likely to have lower-level qualifications, and more likely to be economically inactive due to ill health.[61] These outcomes reflect the role that social housing plays in supporting people who may have faced disadvantage and cannot access housing on the open market.[62]

The job market for entry-level and lower skilled jobs has been identified as being highly competitive, making it harder for disadvantaged groups to move into employment. This may mean that, despite the overall buoyancy of the labour market, people with long-term health conditions who typically have lower levels of qualifications, are less able to benefit from the available jobs.

There has been a significant rise in the number of young people in Westminster who are economically inactive due to ill health. Westminster has a young population and young people (aged 16 to 24) were less likely to be in work than their counterparts in the rest of London, with 29% in work in Westminster compared to 45% in London on average in 2020-22. [63] The high prevalence of mental health conditions among young people in Westminster may be one reason for these high levels of economic inactivity. Research from 2018 suggested that there were more young people with mental health problems in Westminster than adjacent London boroughs.[64] The council has highlighted the need to address this challenge which has become a more acute national issue in the aftermath of the Covid-19 pandemic and cost of living crisis.

Westminster City Council has recognised the challenges faced by those living in its most deprived neighbourhoods. Increasing the number of entry level jobs within the borough has been identified as a priority. The council has also developed place-based interventions to address these inequalities, including the North Paddington Programme. This programme includes employment support for people with health conditions. It is being developed with the community and local stakeholders in Westminster to improve health and employment outcomes for local people. The programme started in 2023. [65]

There are also initiatives delivered across London. The Greater London's Authority's (GLA) Good Work Standard is a free accreditation programme for employers designed to improve working conditions across the capital.[66] The GLA also leads the No Wrong Door agenda which aims to integrate skills, employment, and health. As part of this, Central London Forward manages an integration hub for the central London boroughs.[67] There is as yet no published information about the outcome and impact of

[61] https://learningandwork.org.uk/resources/research-and-reports/building-opportunity-how-social-housing-can-support-skills-talent-and-workforce-development/
[62] While Westminster has much higher levels of social housing than Wokingham, it is comparable with other London boroughs https://www.ons.gov.uk/peoplepopulationandcommunity/housing/bulletins/housingenglandandwales/census2021#measuring-the-data
[63] This difference is not due to the number of students living in Westminster (8.5% of its working-age population), as this proportion was not significantly different from the other central London boroughs, and lower than some of them, such as Camden or Hackney (10%)
[64] Young Westminster Foundation (2018) A city within a city https://www.youngwestminster.com/wp-content/uploads/2018/02/YWF-Needs_Analysis_Report.pdf
[65] https://www.westminster.gov.uk/north-paddington-programme
[66] https://www.london.gov.uk/programmes-strategies/business-and-economy/support-your-business/good-work-standard-gws
[67] https://centrallondonforward.gov.uk/programmes/central-london-integration-hub/

these initiatives.

Belfast: the ongoing impact of decades of conflict

While Belfast is classified as a 'Business, Education and Heritage Centre,' the unique history of Northern Ireland means that this classification is less useful in understanding Belfast than other cities such as Coventry. It highlights the importance of local context in determining health and employment outcomes.

Health-related economic inactivity is higher in Belfast than the UK average, and disabled people face worse employment outcomes. In 2020-22, more than one in ten (11%) working-age people in Belfast and Northern Ireland were economically inactive due to ill health – this is significantly higher than in the rest of the UK. Economic inactivity due to ill health has been a longstanding issue in Belfast, with similar rates of economic inactivity since 1951. [68]

This is partly explained by the health of the population – Belfast is among the 20 local authorities with the lowest life expectancy life expectancy at birth. The poorer health outcomes seen in Northern Ireland can be attributed to the years of conflict with many people still suffering from the long-lasting traumatic impacts.[69] The decades of conflict have also had a lasting impact on the economic growth of Belfast and Northern Ireland. This was especially the case in some parts of the city, such as the centre and the north. Other parts, such as Antrim, Down, and suburban Belfast were not as economically disadvantaged by the conflict.[70] Today, the areas which were particularly affected by the conflict are among the most deprived in Northern Ireland.

The disparity in economic outcomes for disabled people and/or those with long-term health conditions may also be explained by the specific interactions between the labour market and the population's characteristics. A high proportion of those who are economically inactive in Belfast lack the qualifications they need to move into employment. Analysis shows that 53% of the economically inactive population have less than 5 GCSEs at grades A*-C, compared to only 15% of the employed population.[71] While employment rates in Belfast are relatively high, there are few jobs available for those with no or very low qualifications. This leads to people having to either travel further to find a job or rely on income replacement, mainly through benefits.[72]

Belfast's local development plan aims to bolster the private sector to diversify the economy.[73] Belfast council has also set up an action plan for 2024 to 2025 to support Belfast residents participate in the labour market and help employers fill vacant jobs. This is coordinated by the Belfast Labour Market Partnership. Increasing the percentage of disabled people in employment is one of the four aims of this action

[68] Ulster University (2024) Economic inactivity. Who, what, where, why? https://www.ulster.ac.uk/epc/pdf/2024/economic-inactivity-who,-what,-where,-why/Economic-Inactivity-FINAL.pdf
[69] Ulster University 2024 Economic inactivity. Who, what, where, why? Available at https://www.ulster.ac.uk/epc/pdf/2024/economic-inactivity-who,-what,-where,-why/Economic-Inactivity-FINAL.pdf
[70] Ibid.
[71] French, D. 2021 Work disability and the Northern Irish Troubles. Retrieved from: https://onlinelibrary.wiley.com/doi/full/10.1111/obes.12435
[72] Ibid.
[73] https://www.belfastcity.gov.uk/getmedia/bba4bd89-157d-4209-8d5e-8a6eb58dd760/PS001-Plan-Strategy-Final-Web-May2023.pdf

plan. This also includes an employer accreditation scheme to improve the quality of the jobs available in the city: the Belfast Business Promise. Employers pledge to create pathways into work by providing development opportunities and removing barriers to employment as well as recruiting inclusively. An interim evaluation of the scheme is planned for 2024/25 but is not yet available.

A range of employment support programmes have also been introduced to help disabled people and/or those with LTHC to upskill and find a job, such as SkillSET: (SET – Support, Employment, Training). This UK Shared Prosperity Fund (UKSPF) funded project aims to provide specialist employment preparation and training for those with disabilities and or health conditions across Northern Ireland. There is limited information about the scale of these programmes; one of the programmes Empower commits to supporting 2000 people over a two-year period.

South Ayrshire: the impact of Covid-19 pandemic

South Ayrshire, on the western coast of Scotland to the south of Glasgow, is categorised as ‘Country Living’ in the ONS area classifications, which are typically rural areas with an older population.

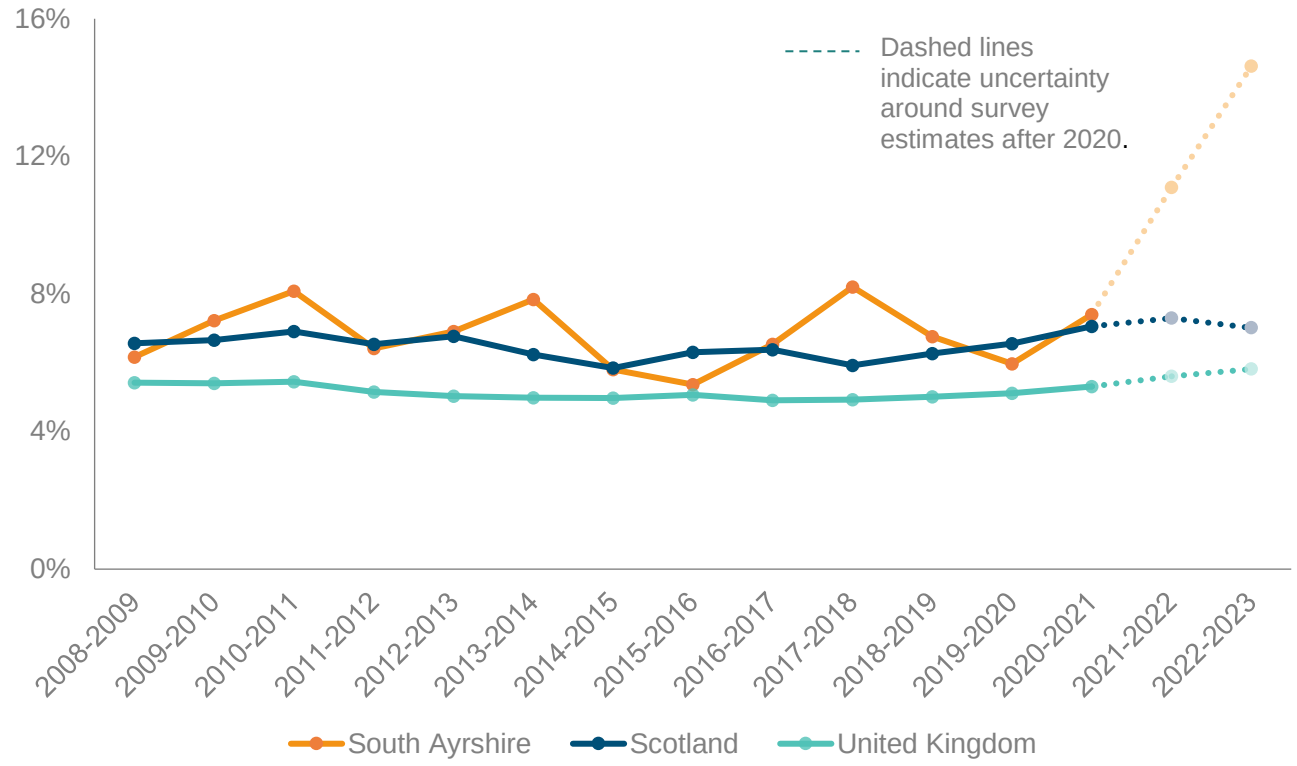
In South Ayrshire, employment outcomes for people with long-term ill health have worsened significantly over time. Only 6% of its population was economically inactive due to ill health in 2019-20, but this had risen to nearly 15% by 2022-23.

This proportion increased considerably in 2020 during the Covid-19 pandemic and has continued to grow in the aftermath of the pandemic. In 2019-20, there were approximately 4,000 people economically inactive with work-limiting conditions in South Ayrshire by 2022-23 this had reached nearly 10,000 (Figure 9).

There are concerns with the reliability of LFS data, particularly at local authority level. However, analysis of benefits data provides potential additional evidence that economic inactivity due to ill health has risen unexpectedly in South Ayrshire. An analysis of Employment Support Allowance caseloads showed that South Ayrshire’s increased in ranking across GB local authorities from 46th highest in 2019 to 38th highest in 2024. A similar analysis of Incapacity Out of Work Benefits caseloads shows that in 2019 South Ayrshire was ranked the 46th highest in GB in 2019 compared to the 37th highest in 2024. [74]

[74] L&W’s analysis of ESA caseload data

Figure *9*: In South Ayrshire, the proportion of the working-age people who are economically inactive due to ill health has increased significantly since 2019
Proportion of the working age population economically inactive due to ill health in South Ayrshire, 2008-2023



Source: Annual Population Survey, Office for National Statistics.

Prior to the Covid-19 pandemic South Ayrshire had similar employment rates to Scotland's average.[75] However, its reliance on sectors particularly impacted by the pandemic – aerospace, manufacturing, and tourism – meant that the impacts of the Covid-19 pandemic were worse in South Ayrshire than other areas.[76] The shock to South Ayrshire's economy may also be compounded by its relatively old population. As well as being more vulnerable to the impacts of the Covid-19 pandemic, older workers are often more likely to find it difficult to secure new work following job loss. [77]This suggests that a lack of suitable employment is moving people into economic inactivity due to ill health, in a similar process to how people in former coalfields became economically inactive as the mines closed. These previous job losses were also more likely to impact on older people.[78]

The council's Strategic Economic Plan sets out the response to the high rates of unemployment and economic inactivity in the area as part of the Ayrshire Growth Deal (published in September 2020). Details are set out below, but it is not yet possible to

[75] https://fraserofallander.org/wp-content/uploads/2021/02/2018-12-11-North-Ayrshire-Economic-Review.pdf
[76] https://www.south-ayrshire.gov.uk/article/26786/Strategic-Economic-Plan-Vision-2030
[77] Bui, T. T. M., Button, P., & Picciotti, E. G. (2020) Early Evidence on the Impact of COVID-19 and the Recession on Older Workers (Working Paper No. 27448; Working Paper Series)
[78] Gregg, P.(2024) Employment, economic inactivity and incapacity: past lessons and implications for future policy. Health Foundation

evaluate the impact of this strategy.

This includes over £200 million of investment from the UK and Scottish governments over a 10-year time frame.[79] The Plan places importance on rebuilding the economy post the Covid-19 pandemic with a focus on fortifying existing industries (e.g., the visitor economy and food and drink manufacturing industries) while prioritising the growth sectors of Advanced Manufacturing, Engineering and Aerospace. It also includes interventions focused on economic growth, such as the Ambition Programme which offers expert advice and support for businesses looking to set up or grow in South Ayrshire. Intended impacts include attracting £300 million of private investment and creating 700 jobs. [80]

The plan also includes an NHS-commissioned health and wellbeing service for employers and employees to improve workforce health. The service is designed to provide person-centered and criteria free access to work focused health support across Ayrshire. It builds on previous successful models that were limited by funding constraints.

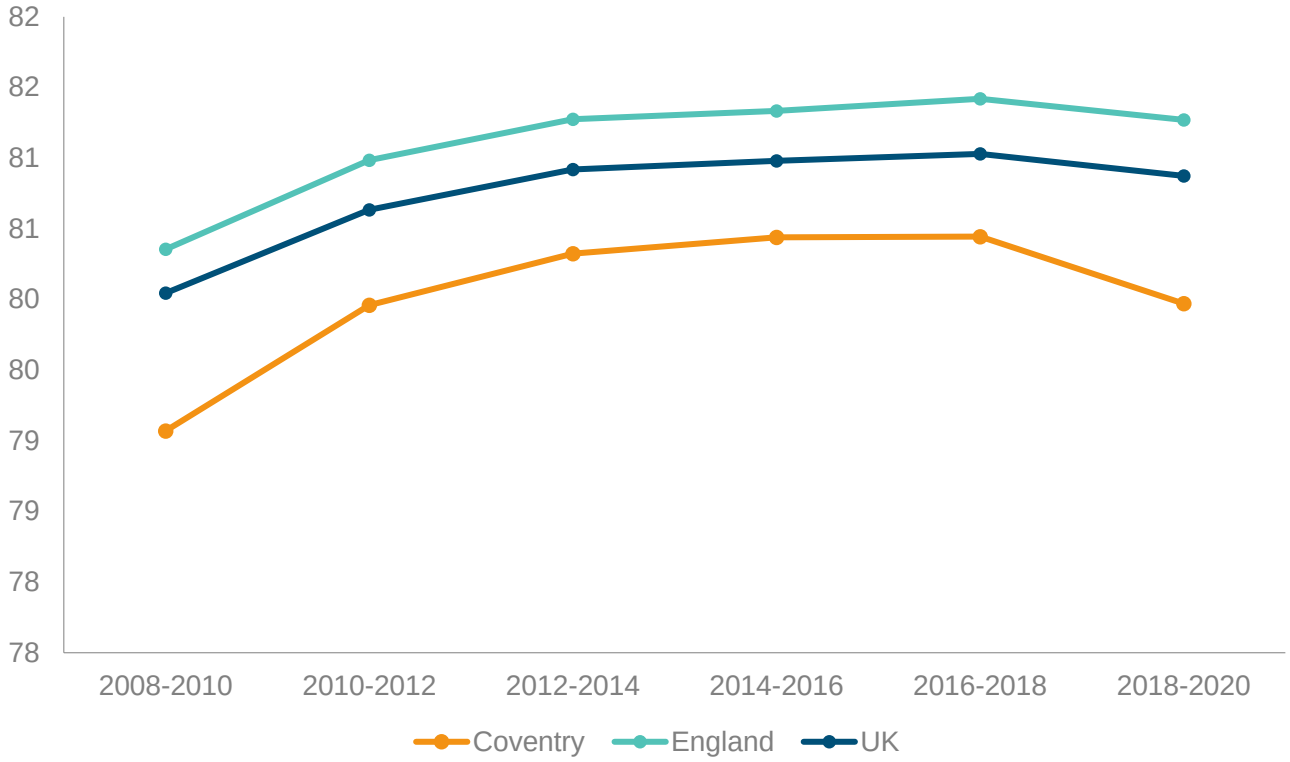
[79] For context South Ayrshire's GDP in 2024 was £2.71 million https://www.statista.com/statistics/1243834/scotland-gdp-by-local-area/
[80] https://www.south-ayrshire.gov.uk/article/26786/Strategic-Economic-Plan-Vision-2030

Coventry: declining life expectancy but improving employment outcomes

Coventry is a city in the West Midlands, classified as a 'Business, Education and Heritage Centre' with similarities to other university cities such as Derby and Leicester.

Life expectancy in Coventry increased between 2008 and 2014 but has declined since 2018 – suggesting the overall health level of the population has worsened in the same period (Figure 10). This is also reflected in other indicators of health, such as healthy life expectancy and the percentage of people reporting work-limiting health conditions.[81]

Figure 10: Life expectancy in Coventry has been consistently worse than in England and the UK since 2008 and has declined sharply since 2016
Life expectancy at birth in Coventry, England and the UK, 2008-2020



Source: Life expectancy estimates, Office for National Statistics .

While the general health of the population has declined since 2018, the proportion of the working-age population economically inactive due to ill health has remained relatively stable over the past decade at around 5% and is now in line with the English average (5%). Coventry has also made more progress than the rest of England in closing the gap between the employment rate of disabled people and non-disabled people. The disability employment gap has narrowed considerably since 2008-09, from more than 40 percentage points to less than 20 percentage points. It further decreased to just over 15 percentage points in 2022-23, well below the gap in the rest of the UK or

[81] Department of Health and Social Care (2024) Public Health Outcomes Framework -Coventry https://fingertips.phe.org.uk/profile/public-health-outcomes-framework/data#page/13/ati/302/are/E08000026

England. However, it is not clear whether this is due to improvements to the employment rate of disabled people or the worsening health of the working-age population.

There are a range of interventions in Coventry focused on health generally and health and work in particular. However, it is difficult to attribute population level change to these interventions. Coventry was the first Marmot city in 2013, which led the city to develop a range of interventions to address the social determinants of health (the non-medical factors that influence people's health). An evaluation of the effectiveness of the programme of work found that there had been some progress in addressing health inequalities, for example, life expectancy between the most and least deprived areas. However, the impact of austerity was described as lessening the effectiveness of the approach.[82]

Coventry is also part of the devolved West Midland's Combined Authority (WMCA) where there has been a consistent focus on health and work through various programmes, for example Thrive at Work and Thrive into Work. An evaluation of the trial of Thrive into Work, an Individual Placement and Support programme (IPS), found that the programme had supported 3,675 people across the West Midlands. Participants were statistically more likely to be in work than non-participants, however, the programme did not have a statistically significant impact on participants' health and wellbeing. This programme has been evaluated as being cost effective at delivering improved outcomes for people with health conditions. However, it has been delivered through a series of funded pilots since 2016 which limits the capacity of providers to plan and deliver for the long-term, build effective partnerships, and employ staff on long-term contracts.[83]

Coventry as the first Marmot city

Coventry became the first Marmot City in 2013, and over the next decade has set up a number of projects and initiatives as part of its Marmot programme of work. Coventry council's new strategy has emphasised the need to build on these innovative approaches to provide more opportunities for young people. A large part of this is the Coventry Job Shop, which is a service aiming to support job seekers by tailoring support to people's personal ambitions, offering training and development opportunities, and supporting people to apply for positions. It has various programmes that target different groups of people who have recognised barriers to employment including those with disabilities. The Pod is a secondary mental health service that works with individuals in the neighbourhoods they live in and includes an employment support service for those with mental health problems and disabilities.

An evaluation of the impact of the national Marmot programme of work found that while individual initiatives delivered by Marmot places have made positive steps in reducing health inequalities, large funding cuts and policy changes at the national level have undermined the ability of local councils to address social determinants of health. For example, active labour market programmes that the 2010 report found to

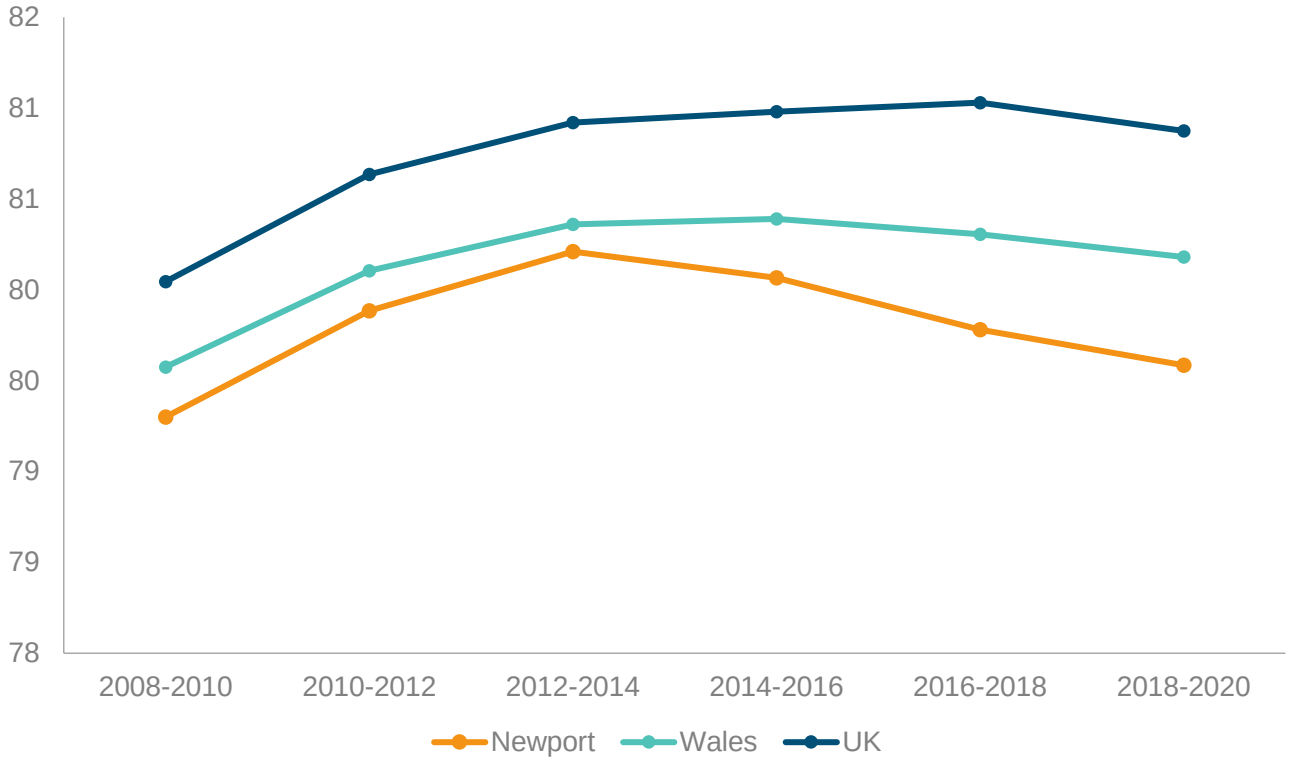
[82] Munro, A (2020) Coventry: A Marmot City https://www.instituteofhealthequity.org/resources-reports/coventry-marmot-city-evaluation-2020/coventry-marmot-city-evaluation-2020.pdf
[83] Edney, C. et al (2023) Health-led Employment Trial Evaluation: 12-month outcome. Work and Health Unit

be effective in supporting unemployed people into work have been scaled back and national policy has instead extended conditionalities and tougher sanctions for those who are unemployed or underemployed.[84]

Newport: the process of ongoing deindustrialisation

Life expectancy in Newport has declined since 2015, following trends in other parts of the Gwent region and Wales; however, Newport's life expectancy has decreased more sharply than elsewhere (Figure 11).

Figure 11: Life expectancy worsened in Newport between 2012 and 2020
Life expectancy at birth in Newport, Wales and the UK, 2008-2020



Source: Life expectancy estimates, Office for National Statistics

Newport also has higher levels of economic inactivity and relatively low productivity in comparison to the rest of the UK with previous research suggesting that Newport has a high level of involuntary economic inactivity.[85] Levels of economic inactivity do not appear to have worsened in line with declining levels of health. However, it is important to note that levels of economic inactivity due to ill health in Newport have varied significantly since 2008, with a high degree in volatility in the data.

There is a significant difference between Newport and other boroughs in Gwent such as Blaenau Gwent. From the ONS area classifications, Newport is classified as an

[84] https://www.instituteofhealthequity.org/resources-reports/marmot-review-10-years-on
[85] Centre for Cities (2023) Cities Outlook 2023. Available at https://www.centreforcities.org/publication/cities-outlook-2023/

Urban Settlement, the only Welsh local authority in this grouping. This illustrates the difference between Newport and areas such as Blaenau Gwent, which are classified as Services and Industrial legacy, and have the highest levels of economic inactivity due to ill health. Newport has a younger, more ethnically diverse population, as well as a different labour market profile.

Since the 1980s, Newport has experienced a more gradual closure of the coal and steel industries rather than the sudden mass redundancies of other areas. The employment rate in Newport (73%) is comparable to Wales as a whole (74%) rather than Blaenau Gwent where the rate is 69%. Newport is also a city with a more diverse economy than Welsh former industrial towns. More people in Newport work in elementary occupations than the Welsh and the UK averages. Newport has also successfully managed to attract large employers in public service administration – namely the Office for National Statistics and the Intellectual Property Office. The city is also focused on increasing jobs within the advanced manufacturing sector, particularly semiconductors. This means that Newport has similar proportions of people working in professional occupations as the rest of Wales.

There are national, regional and local interventions in Newport to support those with health conditions to find or stay in work, however there is no evidence whether these were designed based on local need or on their effectiveness. For example, the Gwent Out of Work Service supports people who are out of work due to challenges with their mental health, or who have struggled with substance use, to engage in training and volunteering to build confidence and help them into employment.[86] Newport City Council also offers support for disabled people to help them find appropriate employment, including job training and assistance from an employment support specialist.[87]

Across Wales, the Communities for Work Plus scheme offers employment support for under-represented groups in the labour market. This programme was originally funded by European Social Funding and ran from 2018 to 2023. Across Wales it engaged 42,390 people and supported two fifths of them into work exceeding its expected outcomes.[88] The future of this programme is uncertain under current plans for the UK Shared Prosperity Fund, highlighting the challenges of delivering consistent high quality employment support without sustained long-term funding.

The Welsh Government also runs a national programme, Healthy Working Wales, to encourage employers to support their staff with their health and wellbeing and improve the health of the working-age population. This includes support for individual employees and for small and medium-sized enterprises to promote workplace wellbeing. An evaluation found that it was effective in improving individual's wellbeing and supporting return to work, with some evidence of positive outcomes for employers. However, recruitment of employees was challenging due to difficulties engaging with healthcare professionals, and more time needed to be invested in building employer relationships.[89]

In 2022, Gwent became Wales' first Marmot region with the aim of addressing the social determinants of health, including a commitment to reducing unemployment and

[86] Gwent Out of Work Service (platform)
[87] Access Supported Employment | Newport City Council
[88] Holtom, D. et al. (2023). Evaluation of Communities for Work and Communities for Work Plus: Stage 1 (process evaluation and theory of change).]
[89] https://phw.nhswales/services-and-teams/healthy-working-wales/

poor-quality work. The approach is being developed and delivered through the five-year Gwent Wellbeing Plan 2023-2028.[90]

[90] The former county of Gwent maintains some administrative functions such as the Public Services Board https://www.gwentpsb.org/en/

Conclusion and policy discussion

Our analysis shows a close relationship between levels of economic inactivity due to ill health and levels of health as measured by life expectancy. It also points to the importance of historic and persistent economic factors that are still affecting people today. Areas where there has been sustained economic inactivity due to ill health in the past are generally those areas where high rates persist. Economic inactivity due to ill health is highest in areas such as Blackpool, Wigan or Blaenau Gwent, places which have been scarred by the decline of industry or services from the 1970's to the present.

Local context matters, whether this is the legacy of decades of conflict in Belfast or South Ayrshire's more recent vulnerability to the economic shock of the Covid-19 pandemic. It is also important to recognise that in every local area, even the healthiest and wealthiest, there are people with long-term health conditions who would be able to work with the right support and the right labour market conditions. Action is therefore needed at the local level to address local challenges.

People are more likely to be economically inactive due to ill health in areas where there are no suitable jobs. This suggests that creating the conditions for inclusive growth is essential to reduce levels of economic inactivity. However, supply-side interventions, those that support individuals, are also needed if everyone is to benefit from job creation. Belfast and Westminster are examples of areas where there is a mismatch between the qualifications of people with health conditions, and the kinds of jobs that are available.

In the long-term, improving the health and employment outcomes of people who live in areas of inequality requires a UK government strategy with social inclusion, local leadership, and institutional capacity building at the heart of it. This must include a sustained commitment to regeneration and long-lasting, transformational change. The constant reinvention of policy across local government, skills, employment, and health have created instability and fragmentation. There needs to be significant investment in social infrastructure, such as education and healthcare, as well as the physical infrastructure, such as transport and housing.

The Get Britain Working White Paper published in November 2024 is welcome in so far as it acknowledges the challenges in relation to economic inactivity due to ill health and the need to address it. Below are reflections on its strengths, considerations for effective implementation, and ideas for what else needs to be done.

Providing effective integrated support

Government should provide support and capacity building to local areas so they can adopt a test and learn approach to delivering effective support

Integrating work and health

The White Paper recognises the importance of integrating work and health and proposes further roll out of Individual Placement and Support (IPS). The interactions between people's health, work, and skills identified in this research demonstrate the importance of a joined-up approach to employment support. However, while the principles of joining up work, health, and skills are uncontested, the question of how to do it well remains.

Better integration of work, health, and skills is not a new idea, but has gained increasing policy saliency. In Scotland, the government has recently introduced No One Left Behind, an integrated programme of employment support modelled on IPS. This focuses on those most disadvantaged in the labour market, including disabled people and those with health conditions. There is also some evidence of successful joining up within the case studies, most notably in Coventry as an established Marmot place but also in, for example, South Ayrshire's employment and skills strategy.

There is, however, limited evidence on how to better integrate health and employment support. This means it is critical that lessons are learned and applied from current programme delivery in this area. Previous evaluations suggest there needs to be strategic consideration of how to engage different partners, and that significant time is needed to build partnerships and agree shared ways of working.[91] However, capacity issues within the NHS represent a continued challenge to service integration. The time pressures experienced by healthcare professionals, particularly General Practitioners, means that appointment times are short so conversations about work and health are not always feasible, and that there is insufficient time to build partnerships across services.[92]

Effective engagement with employers

Our research highlights the importance of the availability of suitable jobs for people to move into. One way to achieve this is through effective employer engagement within employment support programmes. Employer engagement in the UK tends to resemble "instrumental engagement" where the relationship is restricted to information provision rather than "relational engagement" where a collaborative relationship means providers can develop routes into work beyond existing vacancies. Relational engagement means that providers are able to create jobs that meet the needs of their clients as well as meeting employer needs.[93] This could include the agreement of adjustments for

[91] Elmore, J., et al. (2023) Health-led Employment Trials: Theory based evaluation. Work and Health Unit,
[92] Learning and Work Institute (2023) Evaluation of Welsh Government in work support service Welsh Government.
[93] Mansour J, at al (2022) Shared employer engagement model Institute for Employment Studies

health needs such as changes to working patterns, or changes to job design. However, relational employer engagement requires employment support programmes to employ suitably experienced employment support advisors who are embedded in their local communities on secure contracts, so they have time to build networks.[94]

Reaching economically inactive people

The Government's recent plan to extend employment support to economically inactive people through the expansion of Connect to Work (formerly Universal Support) is welcome. Estimates suggest that one in five economically inactive people want to work, including 600,000 disabled people, and that only one in ten out-of-work older and disabled people get help to find work each year.[95] This can be clearly seen across the case studies in areas such as Newport and Belfast where there are high numbers of people economically inactive due to ill health, some of whom could potentially work if they had the right support or the right jobs available. However, Connect to Work even at full roll out will only reach 100,000 people a year meaning that without further intervention, many will not receive support. There is also a wider question of how these people will be reached.

In addition to investing in employment support for economically inactive people, consideration could be given to inviting people on incapacity benefits to annual or six-month work and health appointments with JCP or local employment support services. These would explore readiness to work and potential support needed but with no obligation to commit to work readiness.

The involvement of trusted local actors is also crucial to reaching those furthest from the labour market. There is an urgent need to restore trust in JCP as identified in the Commission on the Future for Employment Support, [96] however, this should not distract from the wider question of who is best placed to reach underserved communities. Organisations such as housing associations, as demonstrated in Westminster, but also community, civil, and faith organisations have an important role to play in delivering effective employment support.[97]

Subsiding jobs for young people

Improving the effectiveness of employment support and ensure that it reaches the right people, should reduce the number of people who are economically inactive due to ill health. However, there may still be some people who need different forms of support such as the provision of subsidised and sheltered jobs. The evidence for this is relatively weak for the UK and internationally. Indeed, Individual Placement Support emphasises the importance of moving people rapidly into competitive employment.

However, this approach may be needed to address the rising number of young people who are out of work due to ill health and who have not had the opportunity to develop the skills needed for competitive employment. Previous initiatives that have supported young people through subsidised jobs in times of economic crisis, most notably the

[94] Elmore, J., et al. (2023) Health-led Employment Trials: Theory based evaluation. Work and Health Unit,
[95] Evans, S. and Vaid, L., (2023) Understanding benefits: Learning and Work Institute https://learningandwork.org.uk/resources/research-and-reports/understanding-benefits/
[96] Institute for Employment Studies (2024) Working for the Future: Final report of the Commission on the Future of Employment Support
[97] Community focused models of employment support such as Jobs Plus, currently being piloted in the UK offer one alternative model of delivery https://learningandwork.org.uk/news-and-policy/piloting-jobsplus-in-the-uk-creating-more-pathways-to-sustainable-employment/

Future Jobs Fund, have resulted in benefits for participants.[98] With the introduction of the Youth Guarantee, it may therefore worth be considering job subsidies for the most vulnerable of young people including those with health conditions. However, this should only be considered alongside a wider programme of support and for those young people who have experienced substantial periods of unemployment or economic inactivity.

Empowering local leaders

The Government should ensure the benefits of a local approach to work, health and skills as set out in the White Paper are experienced equally across the UK.

There is a welcome focus in the White Paper on empowering areas to address local challenges. Local interventions to address employment, health and skills have historically been damaged by multiple programmes that have not been sustained. This has resulted in fragmentation, inconsistency, sub-optimal delivery in short timescales, and a lack of opportunity to embed good practice and improve delivery from lessons learned. [99] Rounds of resource-intensive competitive bidding for essential provision also make planning around local priorities more difficult. This can be seen in Coventry with Thrive into Work and in Newport with Communities that Work Plus, both successful programmes that have not received consistent and sustained funding. Further devolution or decentralisation of services could therefore enable greater flexibility and coordination at a local level to provide support where it is most needed.

The Government's recognition of the need to work in partnership with the Welsh and Scottish Governments over their shared interests and responsibilities for employment issues is also welcome. The integrated settlements for West Midlands and Greater Manchester Combined Authorities (GMCA) also empower these areas to take the local action they need to address their work and health challenges.

However, there is a significant concern that those local areas which have a very new or nascent combined authority, or sit outside one, will not receive the same benefits. Our analysis showed that Blackpool and Wigan were two areas where historically high levels of economic inactivity continue to the present day. Under the current plans Wigan will benefit from the GMCA's share of the Trailblazer deal, while Blackpool as part of the proposed Lancashire Combined Authority will have more limited access to support. Further sustained funding and support with integration is needed from central Government in these areas.[100]

Further devolution should be underpinned by transparent accountability.

The Devolution White Paper published in 2024 identifies the importance of further strengthening accountability through linking financial settlements to outcomes frameworks. [101] However, within the UK, there has so far been limited devolution in

[98] DWP (2012) Impacts and Costs and Benefits of the Future Jobs Fund Available at https://assets.publishing.service.gov.uk/media/5a7c00bde5274a7318b906f1/impacts_costs_benefits_fjf.pdf

[99] Institute for Employment Studies (2024) Working for the Future: Final report of the Commission on the Future of Employment Support

[100] The economic inactivity trailblazers will be in West Yorkshire, the North East, South Yorkshire, York and North Yorkshire, Greater Manchester, with a further two in London

[101] https://www.gov.uk/government/publications/english-devolution-white-paper-power-and-partnership-foundations-for-growth/english-devolution-white-paper

employment and there are useful international examples of how this could work effectively. In Denmark, most aspects of labour market and welfare policies have been devolved to its municipalities since 2009. These municipalities develop employment and welfare policies while also delivering active labour market interventions. Denmark's employment support service is characterised by strong partnerships with employers. There are also strong accountability mechanisms, with municipalities accountable to the Ministry of Employment for the supply of labour to employers, and the re-integration of jobseekers into the labour market.[102]

Devolution on its own is unlikely to make a significant difference, and economies of scale mean that some activities will always need to be delivered by central government. But greater devolution with outcome agreements and sharing of evidence around what works, has the potential to secure change, or at least enable us to know what does and does not work.

Supporting the creation of more good jobs

Local government should work in partnership to create more good jobs in their communities

Ensuring there are more good jobs in underperforming areas is critical to address inequalities in health and employment outcomes. The Government's proposals for Local Growth Plans as part of their new industrial strategy recognises the importance of a place-based approach.[103] It makes sense to give Combined Authorities the power to drive growth in their local areas. However, it is critical that local strategies consider how to address inequalities and create good jobs rather than just any jobs. This could be achieved by Good Work Partnerships which bring together the key partners in an area, such as key employers, higher education institutions, colleges, employment support providers, chambers of commerce and others. The partnerships could then agree how the key tools at their disposal could work together to create local jobs, promote, and incentivise good work and harness the power of anchor institutions. The sector focus of the Government's new industrial strategy may also provide the opportunity for local areas to build and share evidence of what good work looks like in particular sectors.

Promoting and incentivising good work

Local and combined authorities have several levers for improving the quality of jobs. This includes positive procurement by stipulating conditions such as paying the living wage, enforcement through the functions of public health teams, charters and accreditation schemes such as Belfast City Council's Business Promise as well as general advice, guidance and awareness raising.

Local government also has an important role to play in creating inclusive growth in their local communities, including investing in infrastructure and connectivity, to support

[102] OECD (2021) Institutional and regulatory set-up of active labour market policy provision in Denmark https://www.oecd.org/content/dam/oecd/en/topics/policy-issues/employment-services/denmark_almp_institutional_set-up.pdf

[103] Department for Business and Trade Invest 2035: the UK's modern industrial strategy https://www.gov.uk/government/consultations/invest-2035-the-uks-modern-industrial-strategy/invest-2035-the-uks-modern-industrial-strategy

economic development and attract investment. For example, South Ayrshire's strategic economic plan outlines a comprehensive approach to boosting local growth, while Newport's success in attracting civil service jobs demonstrates the potential impact of targeted efforts to bring employers into the area. However, it is also important to recognise the limitations of local government in job creation and regeneration. Effective action is also needed by central government to create the conditions for inclusive growth across the UK.

Direct employment and procurement

Public administration, education, and healthcare employ significant numbers of people across the UK. Less prosperous areas also typically have a higher proportion of the workforce employed by these sectors. For example, in Belfast four in ten people work in public administration, education, or health. Local authorities and other anchor organisations such as the NHS and universities are therefore important employers in their local areas, as well as involved in the significant procurement of services. Initiatives that improve the quality of work in anchor institutions and in commissioned services therefore have the potential to create healthier lives across a significant proportion of the working-age population.

Better data and evidence

The government should prioritise building evidence of what works to improve employment and health outcomes across the UK. This should be facilitated by learning from international examples, sharing what works, commissioning robust evaluations, and ensuring availability of key administrative data sets.

The process of data collection and analysis was a key challenge for this research. This is a concern for good policy making across the UK, as an evidence-based approach is dependent on the availability of reliable and consistent data and the commissioning and publication of high-quality evaluations.

Availability and comparability of data

High-quality, timely data is needed to understand what works and create good policy. However, there are significant challenges in the availability of data across the UK. National administrative data sets for education, health, tax, and benefits should be made more widely available, with appropriate controls for ensuring anonymity. This should include better linking of data sets to show what works. Consideration should be given to extending the Justice and Employment Data Lab approaches to other policy areas such as skills.

Supply-side

Effective employment support should be grounded in evidence and tailored to local labour market conditions and building the evidence of what works to help people find jobs. Policy makers and providers need to know what practices are most effective in helping people find and progress in work, as well as the relative costs of different models of provision.

Evidence and evaluation should be built into the commissioning of services. This should include a commitment to conduct and publish evaluations of all employment support programmes including key learnings, job outcomes, and value for money data. Equally providers should be required to have casework management systems that

collect information about people's backgrounds and their employment and skills outcomes.

Demand-side

There is even less evidence on demand-side interventions. In the case studies and more widely across the UK, charters and accreditation schemes, positive procurement and inclusive growth strategies are all intended to create the conditions for better and healthier work. However, these initiatives are not consistently evaluated, tend to proliferate rather than coordinate, and there is no reliable evidence of whether they are effective.

A test and learn approach is needed to understand what actually works at the local level to create better work. This should include collecting systematic evidence, and commissioning and publishing robust evaluations. Consideration should also be given as to whether there are consistent principles, for example, the dimensions of job quality that could be used to ensure consistency across different local areas. [104]

[104] Irvine, G., White, D. and Diffley, M., 2018. Measuring good work: the final report of the measuring job quality working group.

Appendices

Appendix 1: Definitions

Economic inactivity refers to people who are not currently working and have not been looking for a job in the past four weeks or who are not able to start working in the next two weeks. This could be because they are unwell or disabled, retired, studying, or looking after their family or home, among other reasons.[105]

Someone who is **unemployed** is currently not working but is able and available to start a job, is actively seeking work, or has found a job and is waiting for it to start. A person does not have to be claiming unemployment-related benefits to be defined as unemployed.[106]

In the UK, **disability** is defined under the Equality Act 2010 as a physical or mental impairment that has a substantial and long-term negative effect on a person's ability to live their day-to-day life.[107]

EA core disabled or disabled people refers to people who report a health condition that lasts more than 12 months and that limits their day-to-day activity. We also use the term 'limiting-health conditions' to refer to EA core disabled or disabled people.

A **work-limiting condition** is a long-term health condition that someone reports limits either the type or the amount of work they can do. Some people with work-limiting conditions are employed, and others are not.[108]

An employee is defined as having a **long-term sickness** when they are off work for more than four weeks due to illness. In some instances, someone who is long-term sick can be considered to have a disability.[109]

[105] Office for National Statistics. Consulted on 4th April 204. Retrieved from: Economic inactivity - Office for National Statistics (ons.gov.uk)
[106] Office for National Statistics (2020) A guide to labour market statistics, Retrieved from: A guide to labour market statistics - Office for National Statistics (ons.gov.uk)
[107] Definition of disability under the Equality Act 2010 - GOV.UK (www.gov.uk)
[108] What we know about the UK's working-age health challenge - The Health Foundation, Health, demographic and labour market influences on economic inactivity, UK - Office for National Statistics (ons.gov.uk)
[109] Taking sick leave - GOV.UK (www.gov.uk)

Appendix 2: Case study selection

There are 372 local authorities in England, Scotland, and Wales, including district councils in England and 11 local government districts in Northern Ireland. We selected three pairs of local authorities with similar health levels, using local authority life expectancy as a proxy for general health.

Other considerations for the case study selection include:

- Sample size – a few local authorities are too small to have reliant data.
- Geographic spread across the UK with one case study each from Northern Ireland, Scotland, and Wales and three from England.
- Areas with different balances of industries and occupations, and geographies (large city/district in large city, town, largely rural)
- Areas which:
    - have experienced deindustrialisation,
    - are part of a mayoral combined authority,
    - have high inequality within the local authority's boundaries.
- Availability of interesting qualitative data, including relevant interventions that focus on improving health and employment outcomes
- Existing narratives and stereotypes about nations and cities that are renowned for their ill-health.

With these factors in mind, we identified the following six case study areas.

Life expectancy	Local authority 1	Local authority 2
Lowest (78 years old)	South Ayrshire (Scotland)	Belfast (Northern Ireland)
Below average (79.5 years old)	Coventry (North West England)	Newport (Wales)
Highest (84/86 years old)	Wokingham (South East England)	Westminster (London)

Appendix 3: Data explored in the research

In this research, unless specified otherwise, we have used the data at the local authorities lower-tier level to explore variation with the highest granularity. In some cases, we have used data at the upper-tier level to reduce the confidence intervals which remain wide. Whenever possible, data for the four nations were used.

The table below provides more information on the data used throughout the research, including data sources and time period. Not all the data analysis performed on these variables were included in the report, but please do get in touch with L&W if you are interested in knowing more about specific data variables.

Domains	Sub-domains	Variables	Time period	Data sources
Health	General health	Life expectancy, at age under 1	2018-2020	Deaths registered and mid-year population estimates, Office for National Statistics
		General health – bad or very bad aged 15 to 64	2021	Census 2021
	Wellbeing	Life satisfaction Worthwhile Happiness, Anxiety	April 2022 to March 2023	Annual Population Survey, Office for National Statistics Mean score out of 10
	Health conditions	Prevalence of common mental disorders		England GP data, Welsh Health survey, Scottish Health survey, Northern Ireland Census 2021 % of those aged 16 and over
		Coronary Heart Disease Register Stroke/TIA Register Hypertension Register Heart Failure Register Atrial Fibrillation Register BHF Heart & Circulatory Diseases (CVD) Estimate % of population	2023	GP patient registers, British Heart Foundation
	Smoking	Current smokers Ex-smokers	2022	Annual Population Survey and Opinions and Lifestyle Survey, Office for National Statistics
Labour market	Employment rate	Disability employment rate Non-disabled employment rate	Jan 2020-Dec 2022,	Annual population survey, Office for National Statistics
		Employment rate of 16-24 Employment rate of 25-49 Employment rate 50-64 Employment rate working age population	Jan 2022 – Dec 2022	Annual population survey, Office for National Statistics

Domains	Sub-domains	Variables	Time period	Data sources
	Unemployment rate	Unemployment rate working age population	Jan 2022 – Dec 2022	Annual population survey, Office for National Statistics
	Labour market tightness	Vacancy to unemployment ratio	2022	Total job adverts by local authority, UK, units, average over the month of January, 2022/Modelled unemployment 16+, ONS
Skills	Skills	Percentage of NVQ2+ Percentage of NVQ3+	Jan 2022 – Dec 2022	Annual population survey, Office for National Statistics
Employment sectors	Industry SIC 2007	A:agriculture and fishing (SIC 2007) B,D,E:energy and water (SIC 2007) C:manufacturing F:construction G,I:distribution, hotels, and restaurants H,J:transport and communications K-N:banking, finance, and insurance O-Q:public admin. education and health R-U:other services	Jan 2022 – Dec 2022	Annual Population Survey, Three-year Pooled dataset, Office for National Statistics
	Occupation Soc 2020	1: managers, directors, and senior officials 2: professional occupations 3: associate professional occupations 4: administrative and secretarial occupations 5: skilled trades occupations 6: caring, leisure and other service occupations 7: sales and customer service occupations 8: process, plant, and machine operatives 9: elementary occupations	Jan 2022 – Dec 2022	Annual Population Survey, Three-year Pooled dataset, Office for National Statistics
Population	Demographic	Population changes between 2011 and 2021	2011-2021	Census 2021 and 2011
		% of total population aged 16-24 Aged 25-49 Aged 50-49 Aged 16-64	2021	Mid-year estimates, Office for National Statistics

Domains	Sub-domains	Variables	Time period	Data sources
	Ethnicity	% of minority ethnic groups	2011	Census
	Annual Pay	Annual pay £ - Gross Median Pay (workplace 2021)	2021	Annual Survey of Households and Earnings, Office for National Statistics
Social infrastructure	Unions	Trade union membership	2000-2021	Davies R., Bryson A., and Jones S. (2022) Geographical Variations in Trade Union Membership – 2000-2021, Cardiff: Wales Institute of Social & Economic Research, Data & Methods (WISERD), Cardiff University
	Volunteering	Volunteering % of 16+	2019/2020	Taking part survey, DCMS (England), Department of Communities, Northern Ireland, Scottish Household Survey
	Housing	Share of home ownership	2021	Annual Population Survey, 2011 Census - Office for National Statistics, Live tables of dwelling stock, English Housing Survey - Department for Levelling Up, Housing and Communities

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