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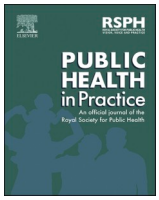

Health inequalities and health-related economic inactivity: Why *good* work needs *good* health

Paul Crawshaw [a,*], Joanne Gray [b], Catherine Haighton [c], Scott Lloyd [d]

[a] *Public Policy, Teesside University, UK*
[b] *Health Economics, Northumbria University, UK*
[c] *Public Health, Northumbria University, UK*
[d] *Public Health South Tees, UK*

A R T I C L E I N F O

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A B S T R A C T

Tackling health inequalities demands whole systems strategies with reach beyond the traditional sphere of influence of health care systems. Practitioners and researchers have long recognised that wider social determinants, where people are born, the communities they live in, their built environment, access to education and resources and, most significantly for this discussion, their relationship to the labour market, profoundly shape health experiences and expectations over the lifecourse. At macro-level, economic structures and systems play a fundamental role in the distribution of good health and incidence of inequalities. Regionally, the health of local labour markets, a phenomenon shaped by macro, national and global economic forces, is a powerful determinant of opportunities to access and remain in work. Simultaneously, health status impacts significantly on ability to participate in paid employment. Absence from the labour market is both a *cause* and *symptom* of health inequalities.

Economic inactivity, where people are both not participating in the labour market, or actively seeking or available for work, is strongly correlated with poor health. In the UK, over one third of the economically inactive experience long-term health problems. The implications for health inequalities, as both cause and symptom are clear. Participation in paid work, where appropriate, can be beneficial both economically and for health and wellbeing. Continued absence from the labour market is directly correlated with ill health. The determinants of health-related economic inactivity are complex and can only be understood using ecological models of public health. This presents significant challenges for politicians and policymakers alike concerned with reducing economic inactivity, delivering economic growth and redressing regional disparities.

1. Introduction - the political economy of health inequalities

As we approach the midpoint of the second decade of the 21st century health inequalities continue to be an urgent policy challenge for the governments of rich nations. One symptom of wider social inequities [1], they manifest in systematic differences in health between social groups [2], often a direct result of economic and political forces that shape everyday environments and determine our opportunities to be healthy. Acknowledging these powerful macro-determinants of health alerts us to the possibility for radical change; change to be achieved through reconfiguration of systems with a renewed focus on promoting wellbeing, prioritising building the social infrastructure that provides opportunities for communities to thrive, and most significantly, ensuring equity of access to the resources that protect and maintain health.

Change begins with understanding that our economic and political environments and the social conditions that follow are a direct outcome of choices made by governments. For example, prioritising investment in early years, a known predictor of wellbeing over the lifecourse [3], ensuring families have minimum income levels that provide access to essential goods and services through minimum wage commitments or provision welfare support for those both with and without employment [4], are all policy choices in the gift of political leaders. Such choices profoundly shape the life chances of communities, particularly those with the highest needs, the economically insecure, who are most vulnerable to societal shocks like the so called, 'cost of living crisis' [5].

* Corresponding author.
E-mail address: p.crawshaw@tees.ac.uk (P. Crawshaw).

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The duty of governments is to provide protection from such shocks, whilst strategically building social infrastructure that ensures communities are the beneficiaries of economic growth and the opportunities it brings.

Our contribution to this Special Issue on *Addressing Health Inequalities* introduces critical debates in health and public policy regarding one vital aspect of social infrastructure: work, employment and relationships to the labour market. Work and employment are potent determinants of health, with occupation and the socio-economic status that follows long understood as powerful predictors of health expectations, both between and within class groups [6]. Specifically, our concern is the relationship between *economic inactivity* and health inequalities.

The international definition of being *economically inactive* describes a person who has not sought work in the past 4 weeks and is not available to start work in the next 2 weeks [7]. Cursory analysis suggests that this very specific relationship between an individual and the labour market is a policy challenge outside the ambit of public health practice. Surely, reducing economic inactivity amongst the working age population (16–64 in the UK) is the remit of those tasked to provide welfare/workfare [8] and support services, alongside professionals delivering education, training and skills as well as employers and those charged with growing regional economies? Relationships to the labour market, however, are shaped by powerful environmental factors such as domicile and proximity to employment opportunities, the strength of local economies, familial and caring responsibilities, and, most significantly for this discussion, our health. The life limiting impacts of ill health on the ability to work outside the home is a key cause of economic inactivity, with mental health and musculoskeletal problems the most common conditions keeping people out of the labour market [9]. Simultaneously, whilst morbidity is a powerful determinant of economic inactivity, inhibited access to paid work has serious consequences for the health of families and individuals who may find themselves facing financial hardship, as well as wider social exclusion and isolation. The implications for organised public health action are profound.

In the 16 years following the financial crisis of 2008, political environments have become systemically less conducive to the reduction of social inequality and the promotion of good health. In the UK, and elsewhere, the imposition of austerity, a strategy intended to stabilise economies by regulating public spending, has had devastating impacts on the poorest, resulting in underfunding of the public realm and an alarming deterioration of social infrastructure. The impact continues to be felt with significant increases in hardship, evidenced by growth in demand for emergency food, spiralling child poverty and an accelerating housing crisis [10]. Simultaneously, the health of the population has declined [11].

Reducing health inequalities requires long term commitment to macro policies that aggressively target the social determinants of health [12]. These determinants interact with wider socio-economic inequalities, themselves a historic and recurrent feature of the UK regions and a stubborn barrier to growth [13]. Despite high profile promises to 'level up the regions' [14], post 2008, local government, who, alongside combined authorities, are the UK's key regional stakeholders empowered to deliver economic development, has experienced persistent disinvestment, with disproportionate impact in regions already experiencing significant levels of deprivation and concomitant low growth [15]. Increasing health inequalities, including elevated mortality rates, are a direct result [16].

The UK Labour government, elected July 2024, is resolute that its strategy for tackling entrenched social decline will be to deliver economic growth. Central to its manifesto [17], growth is presented as a panacea for reinvigorating an impoverished public realm where school buildings are unsafe, prisons are overcrowded and health care waiting lists at an historic high [18]. Economic growth, it is posited, will create surplus for investment, ameliorating these challenges, with benefits felt across the UK. Various levers can be pulled to achieve this growth and ultimately tackle inequalities. One is the focus of our commentary: reducing health-related economic inactivity.

2. Understanding economic inactivity

Brown [19] succinctly describes the impact of government choices on the public's health, stating *'much of today's NHS workload was created by yesterday's economic policy'* (p. 1164). Presenting a powerful case for economic policy makers to take health more seriously, Brown reiterates the need for *'health in all policies'*, embedding health outcomes in the core activities of all government departments.

Public health practitioners and researchers have, of course, long understood the significance of the wider social determinants of health [20] and the need for cross cutting interventions. One feature of these complex systems is the macro-operation of economies and their impact on the lives of communities. A vital component of these eco-systems, the labour market (most simply understood as the supply and demand for labour) is a powerful determinant of health. Interestingly for public health practice, although economic determinants are well understood, for example the relationship between low income, poverty and poor health, the bi-directional relationship between economic activity (participation in the labour market), the wellbeing of individuals and the health of the economy is less well examined. That is, although socio-economic status is widely understood as a strong predictor of health outcomes [21] at a population level, how health status determines people's ability to actively participate in the labour market and the implications of this for regional prosperity has been given less attention.

One outcome of the transition of public health from the NHS to local government (following the Health and Social Care Act of 2012) has been a shift closer to placed based provision, including economic development. This has provided opportunities for shared learning, and most significantly, joined up strategy to address the problems communities face at local level, with opportunities to influence planning, tackle inequalities, improve the health of children and young people and ameliorate some of the negative impacts of emerging challenges such as the cost-of-living crisis [22]. These challenges are recurrent, stubborn and resist simple solutions. Delivering change requires partnership across sectors, services and systems whose core business is to improve local economic environments, whilst supporting individuals into opportunities for skills development and work [23].

Enhancing economic literacy amongst practitioners and researchers can be a powerful tool in the struggle to deliver joined up strategy and reduce health inequalities. A critical appreciation of the distinction between *unemployment* and health-related *economic inactivity*, and significantly, the implications of these status for people's access to welfare and opportunities for work is vital. Those less familiar with research and practice in demography and economic geography can be forgiven for assuming that unemployment data provides a relatively complete picture of those who are 'out of work'. However, a far larger proportion of those outside of the labour market come out with the UK Department of Work and Pensions (DWP) definition of unemployed. Economic inactivity means absence from the labour market, but it is a distinct status from the more commonly heard unemployed. The unemployed are those both actively seeking work in the last 4 weeks *and* available to start work in the next 2 weeks [7]. The economically inactive are neither seeking, nor available for, work.

Put simply, the economically inactive are much further from participation in the labour market than the active, *'job seeking'* unemployed. By definition, they have neither been seeking work in the past 4 weeks, nor are they available to start work in the next 2 weeks [24]. In the quarter up to January 2024 the number of people aged 16–64 that met this definition in the UK was 9.4 million, a rate of nearly 22 % (contrasted with an unemployment rate of 4.4 %). 2.8 million of these are long-term sick. National figures are high, when broken down to a regional level they become more concerning. For the North East of England, the economic inactivity rate is just over 30 % of the working age

population (1.25 million), accounting for over three hundred thousand individuals [25].

3. So what for public health?

What has this got to do with communities of public health practitioners and researchers? Surely economic inactivity is the concern of colleagues in local government or combined authorities tasked with delivering growth for their regions as part of broader devolution agendas. The answer is straightforward. Although the economically inactive are a diverse group, including students, homemakers and carers, close to one third are long term sick. The vast majority of these are suffering with mental health, musculoskeletal or cardiovascular conditions [26].

Understanding this relationship illuminates the intersection between people's employment status and public health. Simultaneously, the health of local labour markets is vital to the health of populations who constitute the labour force, what economists refer to as the human capital available to those markets. For sure, employment is core to economic growth and the constitution of labour forces in terms of population, with skills an essential component. However, the health of these populations is a powerful determinant of both their ability to participate in the labour market and, once within it, to remain as productive workers. In regions experiencing significant health inequalities, it follows that these challenges are exacerbated. Whilst avoidable ill health is obviously bad for individuals, it simultaneously undermines the economy [27]. Health-related economic inactivity, like social inequality more generally it seems [1], is bad for everybody.

These are not new concerns for public health practitioners. The need for a healthy workforce was one of the main drivers of the pioneering movements of the mid 19th century. Though historic concerns with the wellbeing of populations were partially driven by philanthropy in recognition of the immiseration of a working class that had migrated to towns and cities following countryside enclosures, there were other agendas. Newly burgeoning industries required a population fit for work [28]. This imperative has remained a constant in the history of industrial societies that require people able to engage in highly structured forms of labour in exchange for wages. This human capital approach, seeing the individual and workforce as a resource, has remained dominant. Models of homo economicus, a human subject defined primarily by their relationship to the economy, require a disciplined population, motivated to be economically active [29]. Here, public health reflects the normalisation of neo-liberal modes of thinking characterised by an emphasis on productivity. Our economic contribution is identified as the pinnacle of human endeavour, with growth as a primary objective of governments that will benefit all through increased output, resulting in improved living standards. Despite bold policy claims [30], the veracity of these assumptions remains in question [31].

The impacts, cause and effects of economic inactivity are not limited to structural health inequalities. Health *care* inequalities are also part of the puzzle, as foregrounded in recent, highly politicised discussions of the state of the NHS [32]. In April 2024, the number of referrals where a patient was waiting to start treatment (RTT), was 7.6 million, with the number of unique patients estimated to be around 6.3 million. The result is to keep those in need of procedures out of the labour market for extended periods, as well as putting many at risk of longer-term economic inactivity. Health-related economic inactivity is a whole health system challenge, manifesting in inequalities both within and without health care and perhaps a paradigm for wicked social problems that require what the Health Foundation have recently described as a whole government approach to health [33].

Recognition that economic inactivity is overdetermined by wider socio-economic inequalities posits it firmly as a public health problem. Simultaneously, politicians and policy makers view health-related economic inactivity as a significant barrier to economic growth. The latter is strongly correlated with the health of regional labour markets. In the North East of England, an area with a legacy of rapid, unmanaged deindustrialisation, poor transport infrastructure and low small business density, the economic inactivity rate is greater than 30 %. In the South East of England, a locality with robust transport, proximity to the UKs capital and financial services centre and robust traditions of investment and enterprise, the rate is only slightly higher than 10 % [34]. Economic inactivity is clearly correlated with regional inequalities, a stubborn feature of the UK economic landscape. The symbiosis with health inequalities as cause and symptom is clear.

4. Interventions to reduce health related economic inactivity

Recognition of the acuity of health-related economic inactivity as a policy challenge has resulted in a delivery of a range of interventions of varying configurations and efficacy. Many have focused on the supply side, with ambitions to support individuals into work. Interventions have often combined focused methods of working with people, for example employment support, with community-based programmes targeting geographical populations of need. Typically place-based, these interventions have originated in local government and combined authorities, often in partnership with charities, private sector education and training providers as well as DWP. Funded from a range of sources, including UK government, European Social Fund (pre-2021) as well charitable foundations, the result has been a mixed economy of provision across regions.

Evidence of success is limited. The authors are part of a regional team delivering collaborative research on health-related economic inactivity that aims to understand what works and how interventions can be up scaled to deliver national impact. It includes a scoping review [35] of extant literature on what works. Published evidence of effectiveness is limited. Individual placement support, whereby beneficiaries receive additional training, and assistance has been shown to both marginally increase work participation and improve clinical outcomes, for example in terms of reducing depression [36]. In the UK, the ONE Advisory offered an integrated service, whereby beneficiaries were allocated a personal adviser who deals with their benefit claim and discusses options for work, job readiness and any additional barriers that they may face, such as childcare responsibilities or disability. Although minor increases in number of hours worked per week were an outcome, differences between intervention and control were not statistically significant and there was no evidence of moving sick and disabled clients onto more active benefits or job seeking [37]. These are just two examples from our initial scoping review of evidence conducted as part of a study of what works for improving economic inactivity in the North of England [38].

Our recently completed review (35 *pending peer review*) has highlighted types of interventions that might be effective in reducing economic inactivity for people with long-term health conditions. The process has simultaneously illuminated the paucity of robust evidence, whilst reiterating the importance of other social, environmental and political factors, including NHS waiting times, impacts of macro political changes (e.g. Brexit) and medicine shortages, declining living standards affecting mental health and the ongoing consequences of the COVID-19 pandemic. The latter has had lasting physical and mental health impacts for many, whether directly, through infection, or indirectly due to behavioural (physical inactivity, smoking, obesity) and socioeconomic effects (reduced income, job loss, increased caring responsibilities). The case for increased investment in prevention capable of reducing inequalities that in turn limit access to work is clear. Long term commitment to funding is vital.

5. Conclusions - what next for public health practice?

Early findings from our ongoing research [38] have flagged the importance of understanding the complex contexts in which people's capacity to work are both enabled and limited and the contribution of

both macro and micro economic determinants. As documented throughout this special issue on *Addressing Health Inequalities*, public health practitioners have long understood the devastating impact of structural problems that disproportionately impact the most vulnerable, entrenching ill health through limiting opportunity, increasing exposure to poor environments and restricting access to resources. Health-related economic inactivity is one part of this picture. The outcome of familial, personal and social determinants, as well as structural and macro-economic factors, in many respects it is a paradigm for understanding how health is shaped by complex interactions that resist single solutions. Rather, solving such wicked issues [39] requires a whole government approach to health, an approach serious about preventative, upstream solutions. Politically this will always be a challenge. The state of the NHS rightly continues to exercise public concern and is a high priority for the newly elected government, evidenced by rapid commissioning of the Darzi report, a review expected to highlight significant challenges when delivered in early September 2024 [40]. In this climate, redirecting resources, or, more ambitiously, reorienting systems to focus on prevention, remains a difficult political choice to make.

For practitioners, understanding the complex, bi-directional relationship between work and health is vital. As outlined, not only is people's ability to participate in the labour market directly determined by health inequalities, themselves the outcome of macro-economic, structural determinants with hugely differential regional impacts, lack of participation is also a significant causal factor in entrenching poor health amongst already vulnerable populations. Public health practitioners are accustomed to working in partnership, driven as they are by ecological models, recognising that people's ability to be healthy is profoundly shaped by where they are born, their family circumstances, their work, or lack of it, and their opportunities to thrive.

In July 2024 the UK government announced a forthcoming *Back to Work Plan* [29] prioritising regional growth through reducing economic inactivity. Simultaneously, changes in the political landscape of the UK herald significant opportunities to enhance public health practitioner's roles beyond locality-based partnerships [41], becoming key stakeholders in regional economies by supporting those with long-term sickness back to work and maintaining a healthy workforce. Increased devolution, where combined authorities are not only tasked with delivering investment and growth but also skills, education and training, is key to the policy puzzle of addressing health related economic inactivity. Similarly, the creation of Integrated Care Systems (ICS) with a specific remit to operate as anchor institutions, supporting economic growth and delivering on the promise of systems [42], is an explicit commitment to health services embedding themselves in regional economies. With enhanced devolution a real prospect, the opportunities are vast for public health practitioners to collaborate beyond local government, integrating regional labour markets as an integral part of health systems, building supportive environments for those with greater needs and delivering enhanced opportunities for *good work* that supports *good health*.

Declaration of competing interest

As discussed, please find enclosed our submission for a commissioned commentary. This is for consideration for inclusion in the forthcoming issue on Health Inequalities. Thank you for your discussions regarding this commentary.

The authors (Gray, Haighton, Lloyd) and I would like to declare that we have no conflicts of interest. We reflect on our ongoing funded Development Award with National Institute for Health and Care Research (NIHR206295) and this is noted as part of the submission process. Integrated Care System (ICS), United Kingdom

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