



**THE WORK
FOUNDATION**
PART OF LANCASTER UNIVERSITY

Investing in a workforce fit for the future

*challenges for the UK
government*

Health at Work Policy Unit

About the Health at Work Policy Unit

The Health at Work Policy Unit (HWPU) provides evidence-based policy recommendations and commentary on contemporary issues around health, wellbeing and work. Based at The Work Foundation, it draws on The Work Foundation's substantial expertise in workforce health, its reputation in the health and wellbeing arena and its relationships with policy influencers. The HWPU aims to provide an independent, authoritative, evidence-based voice capable of articulating the views of all stakeholders.

Acknowledgements

The Work Foundation transforms people's experience of work and the labour market through high quality applied research that empowers individuals and influences public policies and organisational practices. Through its rigorous research programmes targeting organisations, cities, regions and economies, The Work Foundation is a leading provider of research-based analysis, knowledge exchange and policy advice in the UK and beyond. The Work Foundation is part of Lancaster University – an alliance that enables both organisations to further enhance their impact.

The paper was written and designed by Karen Steadman, Stephen Bevan, Zofia Bajorek, Victoria Shreeve, Stephanie Scott-Davies and David Shoesmith.

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Foreword

We are at an important stage in the evolution of public policy on workforce health in the UK. During the past decade there has been a tangible increase in the quality of research evidence, innovative practice and informed debate on the health of people of working age. Policy-makers are alert to the social and economic consequences posed by poor health among working age people and the challenges these bring.

There are now many good examples of organisations investing in the health and wellbeing of their staff; of clinicians whose practice reflects the importance of working life to their patients; and a new dialogue between them. But the progress we have made needs to be built upon, shared and extended into local economies, embedded in clinical practice and into the practices of all employing organisations – especially smaller businesses.

In 2014 I was especially pleased to support the launch of The Work Foundation's **Health at Work Policy Unit**. This initiative has the explicit aim of offering sound evidence-based advice to those charged with developing policies and services that support health at work. Its work is directed to policy-makers across the UK as they seek to implement, evaluate and promote interventions to improve not only workforce health and wellbeing, but in consequence also productivity, quality of service and social inclusion. This document, *Investing in a workforce fit for the future*, is a summary of the first four 'White Papers' produced by the Policy Unit. These papers are valued by officials and Ministers across government. The issues they raise have resonance with current policy thinking.

I should like to acknowledge the invaluable sponsorship and support given to the Policy Unit by distinguished organisations: Bupa, Napp Pharmaceuticals and, from year two, the British Safety Council.

The case for investing energy and resources in building a healthy workforce and healthy workplaces has been strongly made and is widely accepted. But we are still unsure about the most effective kinds of intervention. What we need now is creative thinking, innovative interventions and solid evidence of effectiveness. This will enable government, and other public sector and private organisations, to focus on supporting actions that deliver real and sustainable change. The Health at Work Policy Unit has established itself as an important contributor to this effort and I am confident that its voice will continue to be heard.

A handwritten signature in black ink that reads "Carol Black". The signature is fluid and cursive, with the first name "Carol" and the last name "Black" clearly distinguishable.

**Professor Dame Carol Black, Principal of Newnham College, Cambridge;
Expert Adviser to DH and PHE on Health and Work.**

Health at work in numbers: UK

Prevalence of long-term health conditions (LTCs)



1 in 3 employees have an LTC

(Steadman, Wood, Silvester 2015)

42% of whom feel their condition affects their work

14%

of the working age population in England have more than one LTC.

(Hind & Steadman, forthcoming)

Those with **both mental and physical health conditions** are more likely to feel their health affects their work



64%

mental & physical conditions



35%

physical conditions only



43%

mental conditions only

(Steadman, Wood, Silvester 2015)

Cost

Ill health amongst the working age population is a major economic burden to society

£100 billion

Estimated annual cost of sickness absence and worklessness associated with working age ill-health

greater than the annual budget for the

NHS



equivalent to the GDP of Portugal.



The cost of lost productivity of those who are out of the workforce is in excess of:

£60 billion



(Black, 2008)

Unemployment and welfare



60% of people with LTCs are employed (DWP 2015)

but just



43% for people with common mental health conditions

(DWP 2015)

and



8% for people with schizophrenia (The Schizophrenia Commission 2012)

7% of people with health conditions are on incapacity benefit

The State spends **£13 billion** annually on health-related benefits

The average claimant receiving Employment and Support Allowance (ESA) costs the State **£8,500** a year

Over **300,000** people every year fall out of work onto health-related state benefits

(Black & Frost 2011)

The Future

By **2030** the prevalence of LTCs in the working age population is set to increase to **40%**



(Vaughan-Jones & Barham 2009)



Introduction

Boosting UK productivity and reducing the deficit are two key challenges which the new government has pledged to tackle in this Parliament. Fundamental to both of these goals is the health of UK industry, and the health of those that drive it: the UK workforce. It is with great hope we see the health of the UK working age population increasingly being recognised as a priority issue for policy-makers. There is now a mainstream realisation that as the workforce ages and has to work longer, the prevalence of chronic illness in the workforce threatens to exacerbate existing problems of stagnant labour market productivity, social exclusion and health inequality. The price of inaction is already considerable and in this context is likely to grow. The costs of ill-health are not only borne by the health, social and welfare systems, but also in terms of national productivity, and by individuals and their families.

In practical terms the workforce health challenge has led to an increased policy focus on both interventions which prevent premature job loss for those already in work, and those which support people who are ill and out of work to re-join the labour market. Such initiatives are to be welcomed, but we also need to pay heed to the challenge posed by the variable quality of the jobs which are currently available in the UK. It is equally important that we acknowledge that – as Sir Michael Marmot argues – ‘good work’ is an important social determinant of health. This means that, while evidence indicates that work can be beneficial for an individual’s health, and those with chronic ill-health may identify returning to work as a goal of their recovery, we must be aware that ‘any job’ may not be a good job, and indeed some jobs are damaging to physical and psychological health. Indeed, if work is to truly have therapeutic and productivity benefits then, as far as possible, it needs to be ‘good work’.

In its first year, The Work Foundation’s Health at Work Policy Unit has focussed on translating the evidence about the relationship between workforce health and the UK economy and society into advice on what policy-makers should be doing to meet this challenge. Our work has targeted a number of key pressure points, considering: how we incentivise employers to engage with this agenda; the role of chronic and fluctuating conditions; what is being done at a local level to improve working age population health; and how to support older workers who are living with chronic illness. Our approach has involved bringing together opinion leaders to discuss and debate our recommendations, allowing us to identify the most valued and valuable for a wide range of stakeholders – for employers, government, healthcare professionals, occupational health and vocational rehabilitation experts, academics, charities and individual employees.

This paper brings together the learning from the Health at Work Policy Unit in its first year. Its purpose is to highlight the principal policy challenges faced by the UK government in building a healthy, engaged and productive workforce. Drawing on our repository of evidence we make the case for tackling these

challenges and provide recommendations on what can be done to ensure that poor workforce health does not impede productivity growth, that good work and good health are central to our economy and our society.

Health and employment policy challenges for this Government

The following outlines a programme for change which would enable the government to unleash the potential in the UK labour market by optimising opportunities for improving the health of the working age population, through providing good quality work, and support to stay in and return to work.

The 'next steps' outlined in each chapter are for the attention of key government departments, working together to support this agenda – in particular the Department for Work and Pensions, the Department of Health, Department for Business, Innovation & Skills, Department for Communities and Local Government, and HM Treasury.



Reports from the Health at Work Policy Unit

The Way Forward:

Policy options for improving workforce health in the UK

The Health at Work Policy Unit's first paper makes the case that the government must comprehensively reform its strategy if it's to tackle the barriers that remain for many businesses in implementing health and wellbeing programmes.

<http://www.theworkfoundation.com/Reports/372/The-Way-Forward-Policy-options-for-improving-workforce-health-in-the-UK>

Fluctuating Conditions, Fluctuating Support:

Improving organisational resilience to fluctuating conditions in the workforce

This report looks at the challenges faced by employers in managing a workforce where the prevalence of chronic and fluctuating conditions is set to rise to around 40 per cent of the UK's working age population by 2030.

<http://www.theworkfoundation.com/Reports/378/Fluctuating-Conditions-Fluctuating-Support-Improving-organisational-resilience-to-fluctuating-conditions-in-the-workforce>

Healthy, Working Economies;

Improving the health and wellbeing of the working age population locally

This report highlights good practice examples where policy has been used at a local level to achieve improved workforce. And explore how national and local policymakers can use policy to more effectively encourage joined-up action on workforce health locally.

[health.http://www.theworkfoundation.com/Reports/381/Healthy-Working-Economies](http://www.theworkfoundation.com/Reports/381/Healthy-Working-Economies)

Living long, working well;

Supporting older workers with health conditions to remain active at work

This report considers how, with appropriate support from government and employers, the workplace and labour market will need to change to address one of the key challenges of the 21st Century - an ageing workforce.

<http://www.theworkfoundation.com/Reports/386/Living-long-working-well>

Key facts: Incentivising employers to take action



140 million working days are lost to sickness absence every year
(Black & Frost 2011)

Employers spend **£9 billion** in sick pay every year

(Black & Frost 2011)



Almost **HALF (42%)** of all employees take time off sick every year.

(Steadman, Wood, Silvester 2015)



7% of employees take long term sickness absence – lasting 2 or more weeks

(Steadman, Wood, Silvester 2015)



62% of employees who have long-term sickness have one or more long-term health condition(s), as compared to **26%** of the employee population overall.

(DWP 2014a)

Many employees attend work while ill:

lost productivity through presenteeism costs **£30 billion**

(Black & Frost 2011)

costs of mental health related presenteeism are estimated to be **1.5 x** the costs of sickness absence

(Sainsbury Centre for Mental Health 2007)

Employees in good health can be up to **3 x** more productive

(Vaughan-Jones & Barham 2010)

Under half (**48%**) of people with two or more LTCs are in work

(Hind and Steadman 2015)

Only **half** of employees have access to occupational health services, and **2 out of 5** have access to counselling. Access is much lower in smaller organisations.



One-fifth (19 per cent) of new ESA claimants moved straight from work to claiming ESA without any period of sickness absence.

(Adam et al 2015)



One-third of employees with a LTC have not discussed it with their employer



Over a quarter (**26%**) of employees with mental health conditions would not feel comfortable discussing with their employer, compared to **14%** with physical health conditions

(Steadman, Wood, Silvester 2015)



Incentivising employers to take action

Despite the strong case for employers to tackle poor workforce health, those rising to this challenge are the exception rather than the rule.

Optimising the health of the UK workforce is not a challenge that the government can solve on its own. Successful and effective policy is dependent on the engagement of key stakeholders - employers, employees and healthcare professionals must also play their part.

The workplace can provide a vital setting for promoting employee health and wellbeing. Many employers we work with recognise the important role that they can play in enhancing the health, wellbeing, and productivity of their workforce and work hard to have a positive influence. Many more do not, or do not do it effectively.

Workplace health and wellbeing programmes are designed to promote health and prevent illness among the well, and to support employees who are ill to prevent the worsening of their health, which may result in absence, or indeed their loss from the workforce. We are seeing an increasing array of well-evidenced workplace health and wellbeing interventions which have been demonstrated to improve employee health outcomes. Frameworks such as the Workplace Wellbeing Charter provide guidance to support employers to develop effective programmes which meet their employee's needs.

Organisations which implement workplace health and wellbeing programmes often find there are financial benefits in doing so, realised through reduction in days lost through sickness absence and improvements in staff turnover and employee satisfaction. This also has significant implications for the national economy – it is estimated that improving workplace health could generate government cost savings of over £60 billion, the equivalent of nearly two thirds of the NHS budget for England. Thus there is a strong policy case to encourage more employers to invest in their employees.

The policy challenge

Despite the strong case for employers to tackle poor workforce health, those rising to this challenge are the exception rather than the rule. In many cases employers do not recognise the benefits of investing in employee health – they feel the costs are too high, the benefits too low, or they don't know where to start. For smaller employers in particular, everyday pressures of managing the business and meeting regulatory requirements might leave little time or resource for such a programme. The challenge for policy-makers is to find ways to incentivise, encourage, and support more employers to take action on employee health and wellbeing.

Where are the policy gaps?

Providing appropriate incentives, advice and support to encourage employers to take action:

We need to show employers that their engagement in the workforce health and wellbeing agenda is crucial. Their engagement will not be secured until we recognise and address the barriers they face in developing strategies to provide support, and demonstrate the benefits to their organisation.


If the government wishes to see the wider societal benefits of improved workforce health, including improved productivity and lower spending on health and benefits among working age people, then it must be prepared to invest in well-targeted measures and guidance to incentivise employers to act in their own interest, their employees' interests, and in the interests of society at large.

Next steps

To address this challenge, the government must encourage and incentivise employers to take action on workforce health. We recommend that the government:

1. *Assess the feasibility of further fiscal incentives to encourage employers to introduce workplace health and wellbeing interventions.* They should be targeted both to encourage employers already doing something to do more, and to entice those employers not doing anything, to start. In particular, we suggest:

- Review of current taxation of employer sponsored health interventions (currently taxed as benefits in kind).
- Feasibility testing of different fiscal incentives (e.g. tax breaks, matched funding, National Insurance changes, tiered VAT rates, levy systems). This should include piloting of schemes to improve understanding of the challenges of implementation, and their effectiveness in encouraging employers to implement evidence-based workplace health interventions, thereby extending the 'reach' of such



Nearly a third of all working time lost to employee absence is attributable to long-term conditions

[CBI 2013]

schemes to workers in low paid work. This should inform any future decisions by HM Treasury as to the value of introducing such policies and also highlight which incentives would be the most appropriate and cost-effective.

2. Investigate the current and potential role of Income Protection (IP) Insurance as a means of providing both sick pay and rehabilitation support to employees through employers. In particular we suggest:

- Support for the development of an evidence-base around IP Insurance, particularly in terms of its role in rehabilitation and back to work support for employees who are not usually covered by IP Insurance.
- Incentivising the development of appropriate models which are effective in encouraging more employers, of all sizes, to offer IP Insurance to employees.

3. Offering clearer, more up to date and proactive advice and guidance to employers, for example through reviewing the content and use of the HSE stress management standards, and the active promotion of NICE guidance and other public health guidance from PHE and others. This guidance should emphasise:

- The importance of prevention and early intervention as key to job retention among employees with ill-health or disability. This should include more publicity about the benefits of using the new Fit for Work service for those working in smaller organisations.
- The importance of vocational rehabilitation, job redesign and workplace adjustments as part of 'case managed' return to work.
- Examples of employers who have derived business benefits from adopting such practices.

The challenge for policy-makers is to find ways to incentivise, encourage, and support more employers to take action on employee health and wellbeing.

Key facts: Supporting individuals with LTCs

Mental health conditions & musculoskeletal disorders (MSD) are most common.

About **1 in 6** people of working age have a mental health condition about **1 in 6** have a MSD (6.5 million)

(McManus et al 2007)
(Vaughan-Jones & Barham 2009)

Annual cost to the UK economy

£70 billion on mental ill health or
4.5% of GDP (OECD 2015)

£12.3 billion on back pain alone
(Maniadakis et al 2000)



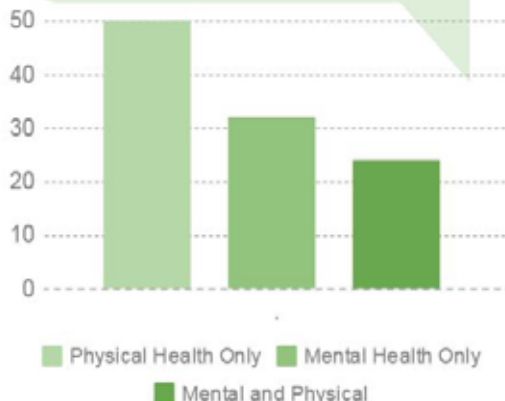
Causes of sickness absence

- **8%** mental ill health
- **19%** MSDs

Long term-sickness absence

- **20%** mental ill health
- **33%** MSDs (DWP 2014a)

Less than a quarter (24%)
of working age people with both
a mental and physical health
condition are in work
(Hind & Steadman, forthcoming)



4 out of 10



of ESA claimants coming directly from work have MSDs (Black & Frost 2011)



of new disability benefit claims are made by people for whom mental ill health is their primary condition (OECD 2015)



of people moving from work onto ESA have a fluctuating, long-term health condition (Black & Frost 2011)

Supporting individuals with long-term conditions

For individuals with long-term conditions (LTCs), finding and staying in employment can be difficult. Compared to the general working age population, they are more likely to be unemployed, to be economically inactive, and to be in receipt of work benefits. The implications can be costly, both for the UK economy and for the individuals themselves who are at greater risk social exclusion and poverty. The reasons for this are often multi-faceted and complex. The reality is that many people with LTCs can work and want to work, but are prevented from doing so by various cultural, attitudinal, and structural barriers. Identifying and addressing these barriers is paramount for both productivity and population wellbeing.

The UK needs a clear, practical, evidence-informed strategy to achieve the twin objectives of helping people with LTCs both to stay in work, and to get back to or enter the labour market.

The policy challenge

Identifying and removing the barriers which are preventing people with LTCs from staying or finding suitable employment. This challenge is unpinned by several contextual facts, including the evidence that:

- Many people with LTCs would like to work and are motivated to work, but are not getting the appropriate, timely support they require to achieve this.
- Good quality work is in most cases good for health, and by providing jobs of good psychosocial quality, work can be a factor in improving the health of people with LTCs. The opposite is also true however, that bad quality jobs can be highly detrimental to health.

We believe that with appropriate, timely support from the health system, the welfare system, and from employers, and with the development of more good quality jobs, many more people will be able to work and work productively. The UK needs a clear, practical, evidence-informed strategy to achieve the twin objectives of helping people with LTCs both to stay in work, and to get back to or enter the labour market.

Where are the policy gaps?

Improving access to and quality of existing support

We know that having a supportive work environment and making appropriate workplace adjustments, has helped, and continues to help, many people with LTCs to remain in or return to work. Often such adjustments are temporary and inexpensive, but finding the right ones can take time, and many employers

require support to do this. For those that have them, occupational health services can provide valuable help. For those that don't, like many small organisations, options are more limited. Employees may seek support through the DWP Access to Work scheme as is the case for small employers, but there are reportedly many barriers to access, including that it is only accessible through referral by individual employees. We must help employers to provide appropriate support through adjustments.

Recognising employment as a determinant of health and a key aspect of recovery

Returning to or remaining in work is often viewed as a positive outcome by an individual with a LTC. This is not currently well recognised across the health system, with many healthcare professionals reluctant to promote or even discuss work with patients. Work will not be the right outcome for all people with LTCs, but it should be recognised as an option for those who wish to work; even where they are only at the start of a potentially long path. Healthcare professionals often have considerable influence on individuals' decisions about what their health means for their life. We must look at ways to improve understanding and recognition of the positive contribution that work can make to the life of someone with a LTC, and support those patients who see work in their future to achieve it.

Access to specialist back to work support

The Work Programme has found it difficult to support people with LTCs and complex needs back into work. Greater success has been achieved through Work Choices, though access to this is limited to only a specific group of jobseekers. Considerable evidence has been accrued about the value of Individual Placement and Support (IPS) supported employment in helping people with severe mental illness into work, and we are increasingly seeing this as valuable for those with more common mental health conditions too. We must find ways to increase access to effective evidence-based return to work support across the UK.

Next steps

To address these challenges and make a fundamental difference to the ability of the growing proportion of the working age population with LTCs to work, these gaps must be addressed. We recommend that the government:

1. **Improve access to the Access to Work scheme** as outlined in the recent Work & Pensions Select Committee report. Key to this will be improving referral processes, ensuring service providers are equipped with the specialist knowledge required to provide appropriate support and advice for people with complex and fluctuating health needs, including where there are multiple LTCs, and considering how an appropriate offer might be made to employers as well as to individuals.
2. **Align health and social care outcome frameworks to encourage systems to see work as an outcome.** Outcome frameworks, such as those used by public health, by adult and social care services, and by

Clinical Commissioning Groups, provide a useful means of encouraging healthcare professionals to deliver care plans, promote self-management and commission interventions which prioritise work as a clinical outcome of care. Several outcomes frameworks already include employment as a measure, but these are hugely inconsistent across frameworks and there is currently no 'information standard' to help measure employment status at Clinical Commissioning Group (CCG) level. This inconsistency increases the risk that patients for whom work may have therapeutic benefits miss out on opportunities to receive care which has a vocational rehabilitation component. Greater consistency and better data will also allow employment status and work outcomes of patients to be monitored and evaluated.

3. Make the provision of high quality support for people with LTCs a priority of the "Work Programme 2". The recommissioning of the Work Programme must improve the effectiveness of the support provided to people with complex, fluctuating and comorbid LTCs. This should include allowing specialist 'supported employment' NGOs and social enterprises with local labour market knowledge to be commissioned as part of new contracts and enable resources to be focused on 'what works'.

Estimated long-term conditions in the UK working age population by 2030

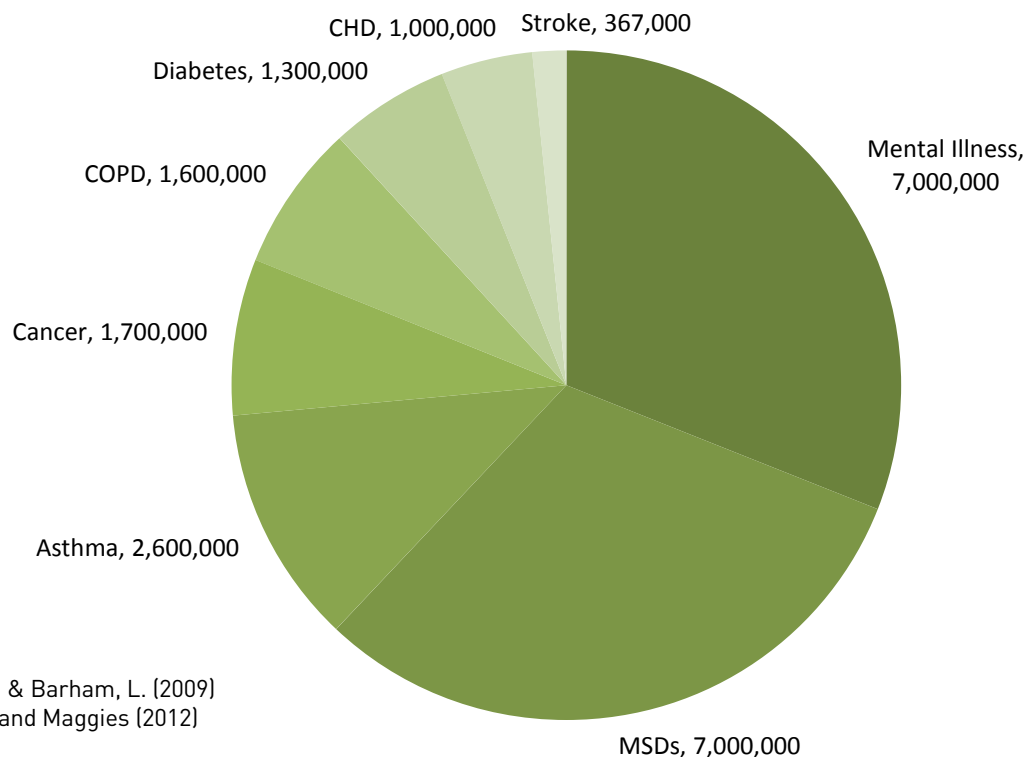


Chart sources:

- Vaughan-Jones, H. & Barham, L. (2009)
- Oxford Economics and Maggies (2012)

Key facts: Driving action at a local level



13.5% of the working age population are out of work
over half of these, **(59%)** are claiming ESA (New Economy, 2014)

The implications for the local economy are considerable



for every ESA claimant moving back into work, the local economy could gain a **boost of £13,100**



the average job outcome performance for the Work Programme in Great Britain is **23%**



for someone on JSA it is **26%**



and only **7%** for someone claiming ESA (CESI, 2015)

There is considerable variation between localities

Unemployment rates

7.7% of the population unemployed in the North East compared to ...

4.5% in the South East and South West
(ONS, 2015)

Sickness absence

0.8% in Derby compared to **4.6%** in Bexley
(PHE, 2015)

Health and work

the gap in the employment rate for individuals with a long-term health condition ranges from

24.2% in Knowsley, to

-2.5% in Kingston-upon-Thames
(PHE, 2015)



Driving action at a local level

Local organisations are well-placed to understand the needs of their local population. Networks of local service providers have considerable potential to provide coordinated, targeted support at a local level. So far we have identified just a handful of good examples of local partners, often led by the local authority, working together to develop innovative activities to address their population's health and employment challenges. In many cases these bodies are doing this despite the national agenda, rather than because of it. We believe central government is failing to give local organisations the clear roles, responsibilities and funds necessary to drive the joined-up local action required to provide support across the health and employment spheres.

The policy challenge

Identifying and implementing strategies which encourage and support effective action at a local level to address local population needs regarding health and employment. Ill health in the working age population presents a significant cost to local economies. This is seen both when individuals fall out of work, particularly where remaining unemployed for long periods of time, as well as through reduced productivity and sickness absence for those in work who are not being well supported. There is considerable variation across localities in both need, and in activity. We need national governance structures which encourage local policy-makers to work to improve the health of the working-age population, encouraging and supporting them to develop solutions tailored to their local population and resources. By making a number of changes to national policy, much more effective local action could be encouraged.

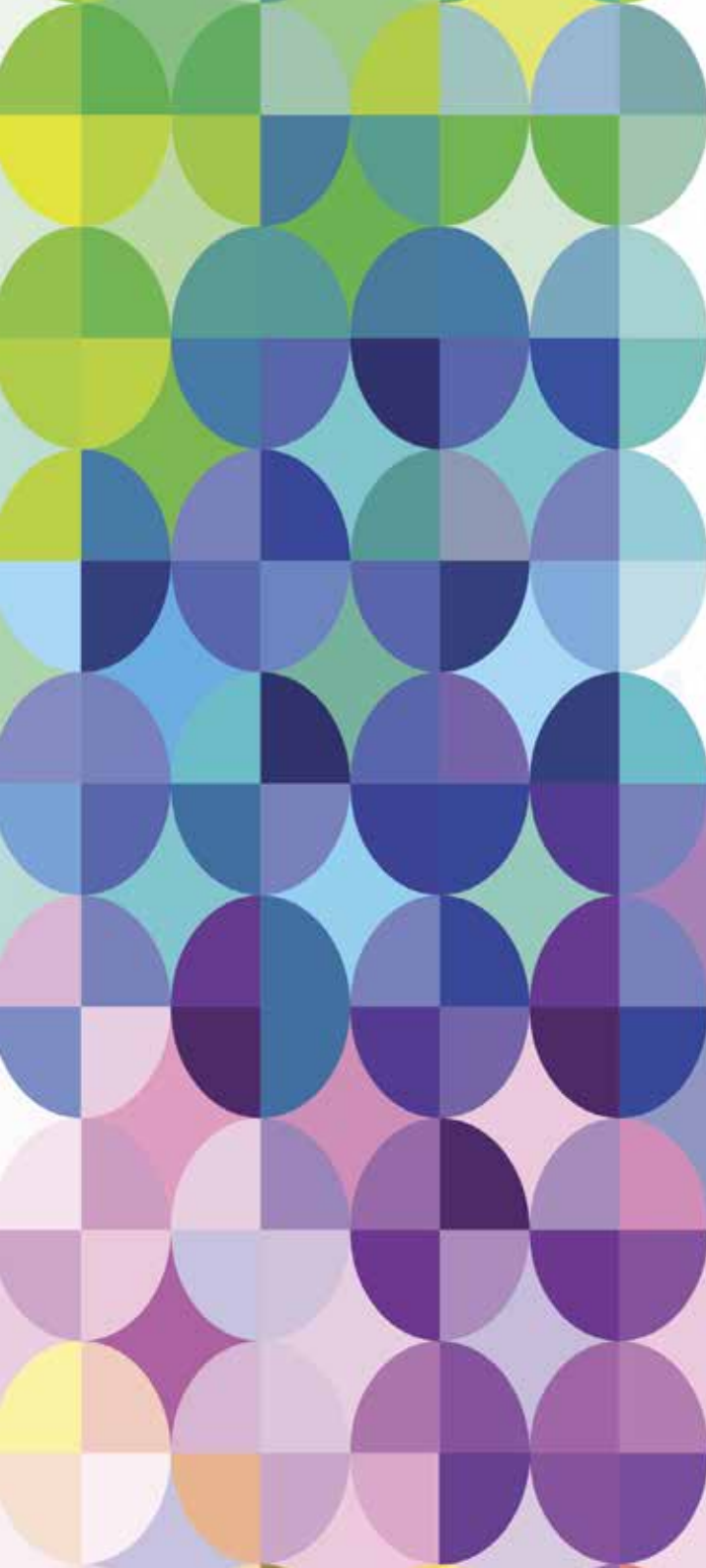
What are the policy gaps?

Enabling local, specialist providers to provide tailored back to work support

National commissioning of Work Programme services on a large scale means that smaller, more specialist local providers are less able to win contracts and are likely to miss out. This is often despite having excellent outcomes for their client base, and good relationships with local employers and the community. Locally commissioned IPS services provide good examples of how local providers can take an evidence-based approach to providing support to people with LTCs who have been failed by the Work Programme. We need to allow local areas to make decisions about what evidence-based support is of most value in their locality. In addition, through evaluating these local programmes, we increase the opportunity for others to learn from local innovation, informing both local and national programmes.

Getting health and employment on the local agenda

There are relevant national policy levers which are not currently being used to their full potential to



At present the government is spending over £13 billion a year on 28 different national employment and skills schemes, creating a fragmented system designed within a national bureaucracy. Local government is often left to fill the gaps where these national schemes fail
(Rolfe et al., 2015)

influence local bodies to improve working age health. Through the localism agenda of recent years we have seen integration of health and social care through Health and Wellbeing Boards, and the devolution of control for local economic growth to Local Enterprise Partnerships (LEPs). What we have not seen is a substantive link between these two areas – Health and Wellbeing Boards have no statutory requirement to address the health of the working age population, while the overwhelming focus of LEPs is on private sector job creation. Both have the potential to do far more than they are currently doing to contribute to the health and employment agenda.

Next steps

To address this challenge we call upon the government to make the following changes to drive local action to improve working age health:

1. **Increase local engagement in the planning, development and delivery of “Work Programme 2”.** This can take many forms, depending on local circumstances and capacity, and could range from an advisory role, to a full co-commissioning model. More local input would allow for the development of more bespoke services, tailored to the local need and context. This might also better incentivise local areas to put resources into this agenda, as often the benefits of such activity are felt at a national (e.g. health system, welfare spend) rather than local level.
2. **Make statutory the requirement for at least one local business leader to sit on every Health and Wellbeing Board.** This will promote better collaboration between the worlds of health and business at a local level – encouraging health professionals to improve the role of employment in care, and employers to consider how the health of the working age population affects their employees and business.
3. **Renew the statutory guidance for Joint Strategic Needs Assessments (JSNAs) to include a more standardised set of measures, including health and employment measures.** This will send a clear signal to local areas about the need to consider working age health, by incorporating employment related measures in the JSNAs, cementing its importance as a wider determinant of health. This would ensure systematic consideration of health and employment in needs assessments, influencing strategies and commissioning across England.

We need national governance structures which encourage local policy-makers to work to improve the health of the working age population, encouraging and supporting them to develop solutions tailored to their local population and resources.

Key facts: Supporting older workers with health problems

Approximately **one third of the labour force will be over 50** by 2020



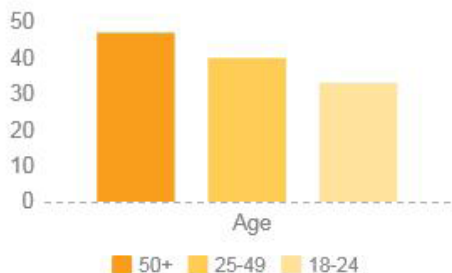
Of the 7.2 million people aged 50-64 who are employed **42% are living with an LTC** (ONS, 2013)

Almost half (47%) of unemployed older people have been out of work for a year or more, compared to:

40% of 25 - 49 year olds

33% of 18 - 24 year olds

(DWP, 2014b)



For those aged 50+, even a short period of unemployment increases the risk of mortality and heart attacks more than smoking

(Dupre et al., 2012; Meneton et al., 2014)



Almost **half** (46%) of people aged 45-64 no longer in the workforce retired because of a chronic health condition.

The most common are back problems (10.4%) and arthritis and related problems (8.6%).

Of those no longer in the labour force, **58%** reported having depression, and **57%** respiratory disease.



Having **multiple LTCs** is more common amongst older workers.

Among older workers, the odds of being outside the labour market **increase with the number of LTCs.**

(Schofield et al., 2008)

Supporting Older Workers with Health Problems

As the number of working age adults has begun to decline and pension provision remains inadequate for many, people need to carry on working longer. The numbers leaving work before state pension age are significant – on average, men leave the labour market earlier now than they did in the 1950s and 1960s. Many older workers have reported instances where they have been forced out of the workplace earlier than planned due to circumstances beyond their control, such as declining health, and not receiving the right support to cope with remaining at work.

Finding effective ways to extend working lives and prevent early retirement among those older workers living with chronic health conditions.

The policy challenge

Finding effective ways to extend working lives and prevent early retirement among those older workers living with chronic health conditions. Many such conditions are manageable, but a combination of poor knowledge about how to support health needs, a lack of flexibility in the workplace, and negative attitudes about ageing workers present a considerable barrier to work retention. We need address both regressive attitudes about the role of older workers and the contribution they can make, and poor understanding about what interventions and support can help to retain older workers with health conditions.

What are the policy gaps?

Employers and healthcare professionals are often not equipped to manage this dual challenge of ageing and poor health. Identifying and promoting interventions which support both job retention and return to work among these workers remains an important gap. We need to promote a forward view about the ageing workforce, and develop strategies to support organisations to adapt to this new reality.

Next Steps

As part of its wider strategy towards extending working lives and promoting ‘age friendly’ employment practices, the government needs to focus specifically on the job retention and work participation of older workers with health needs.

1. **Integrating specialist support for older workers into occupational health and back to work services:** The Fit for Work service should be developed with specialist awareness of, and provision for the needs of older workers with health conditions. Access to Work’s provision for older workers should be enhanced, and the re-commissioning of the Work Programme should include smaller more specialist support for older jobseekers.

2. **Encouraging individuals and employers to plan early on for the health challenges of working in later life:** More employers should be encouraged to offer mid-life career reviews which include discussions about health as a matter of course and access to training and re-skilling for older workers with a health condition should be expanded. Support for employers who wish to assess the physical and psychological demands of work being carried out by older workers should also be offered.

3. **Changing attitudes and creating an age friendly working environment:** Opportunities for flexible working through the removal of the 26 week rule from right to request flexible working should be extended. The government should issue guidance about the types of gradual retirement opportunities employers should be providing, and should introduce an “Age Confident” campaign in order to raise understanding and awareness of the benefits of employing older workers.

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