Institute for Public Policy Research

# A HEALTHY LABOUR MARKET

## CREATING A POST-PANDEMIC WORLD OF HEALTHIER WORK

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and **Carsten Jung**

February 2022

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## ACKNOWLEDGEMENTS

The authors would like to acknowledge and thank Dr Adam Coutts, senior research fellow at the University of Cambridge, and Sarah Beale and the Virus Watch Study team at University College London, for their invaluable contributions to this report.



# SUMMARY

That work determines health has been impossible to ignore during a pandemic. People in 'working class jobs' have been around twice as likely to die from Covid-19 than those in 'middle class jobs'. And those in the lowest paid occupations have experienced a mortality rate five times higher than those in the highest paid occupations.

Policy decisions during the pandemic mediated the way in which work shaped health. The coronavirus job retention scheme should, for example, have been a successful public health intervention that reduced viral transmission (and unemployment) and therefore protected population health. On the other hand, the decision not to increase statutory sick pay is an example of how policy has contributed to viral transmission and deepened Covid-19 inequalities. Not only does the UK have the one of the lowest levels of statutory sick pay as a proportion of earnings in the OECD, but new research for this report finds stark age, race and class inequalities in accessing any sick pay whatsoever.

The pandemic illustrated the complicated but critical relationship between work and health in real-time. Not only has it highlighted the importance of work as a determinant of health, but indicates the policy instruments most effective at improving population health.

As the pandemic reshapes labour markets and redefines attitudes to work, this report makes the case for why health should be put at the heart of work. We outline how the government and businesses can create healthier jobs, and consider how structural economic policy and labour institutions shape the health of the working age population.

## HEALTHIER JOBS

Governments and businesses have historically focused on expanding occupational health services to improve the health of workers. For example, in response to rising of mental illness rates among workers, there have been efforts to expand access to occupational mental healthcare services. These are important. But it is an approach that reflects a common assumption that healthcare services are the most effective policy instrument to improve health outcomes. Evidence tells us this is a weak assumption. Policymakers have overlooked how the nature and quality of work, modifiable through labour market regulations and workplace policies, determine health.

The broader range of policy tools to make jobs healthier includes:

- **Raising pay floors**. The relationship between income and health is especially important at the lower end of the income distribution. We propose the national living wage is permanently fixed to the real living wage, and that statutory sick pay is increased to 80 per cent of previous earning with the lower earnings limit abolished.
- **More secure work.** Some types of job insecurity are as bad for health as long-term unemployment. With an estimated 5.5 million people in insecure work in the UK, we advise the government brings forward legislation to give employees more control over their working hours and better contractual stability.

- **Shorter working time.** A growing body of evidence that is revealing long working hours have a detrimental impact on physical and mental health. We suggest the government follows examples in countries such as Spain, Iceland and Scotland to pilot a shorter working week scheme.
- **Worker-in-control flexibility.** While contractual flexibility is associated with poor health, a worker-in-command approach to flexibility – especially relating to working hours and working location – improves the mental health and wellbeing of employees. Where possible, all employees should have a right to flexible working hours, while those who work shift patterns should have access to self-rostering.

## HEALTHIER INSTITUTIONS

Structural economic policy and labour institutions shape the health of working age adults through both the conditions of work and through broader economic- and population-level effects. These include:

- **Healthier macroeconomic policy**. In addition to the economic benefits, a labour market in or near full employment would reduce the number of people in long-term unemployment and help those in insecure work to bargain for better working conditions. This could drive considerable improvements in population health and narrow health inequalities.
- **Trade unions as public health institutions.** Trade unions have played an important role in protecting the health of workers during the pandemic. However, as the vital institutions through which workers achieve better pay and better working conditions, their role in shaping health extends far beyond the pandemic. A World Health Organisation report in 2019 observed that working conditions tend to be healthier, poverty rates lower and sickness absence rates lower in European countries with higher collective bargaining coverage rates. We argue public health practitioners should view trade unions as public health institutions through which better population health outcomes can be achieved
- **Rethinking back-to-work**. Back-to-work policies and programmes can have positive health impacts – for example, active labour market programmes, when designed well, can mitigate the negative health effects of losing employment. However, they can also have detrimental health effects – for example, conditionality and sanctions associated with welfare-to-work policies have detrimental health impacts on people with mental health problems. A radical rethink of back-to-work policies that puts health and wellbeing at its centre is in need.

# 1. INTRODUCTION

It is widely believed, among both rich and poor, that some people deserve to be paid more than others because of the job they do (Friedman et al 2019). But do people also deserve to live longer than others because of the job they do?

The central role of occupation in determining health has been impossible to ignore during a pandemic. People working in public-facing and essential service jobs have been more likely to die from Covid-19 than those able to work from home (ONS 2021). Indeed, occupational differences have been an important explanatory factor of the stark race and class inequalities in Covid-19 mortality (SAGE 2021).

But it would be a mistake to assign this phenomenon as something exceptional to the pandemic; that work is a major determinant health has been understood for decades (Jahoda 1982, Marmot et al 1991). Employment, occupation and job quality all independently shape mental and physical health – but these insights have poorly permeated into policy and practice.

It is time for that to change. The pandemic is reshaping labour markets and redefining attitudes to work. This comes atop structural labour market transformation driven by the climate emergency and energy revolution, technological advancement and geopolitical upheaval. How the pandemic shock combines with these structural forces to define the future of work will be determined by policy and politics in coming years. The moment to put health at the heart of work is now.

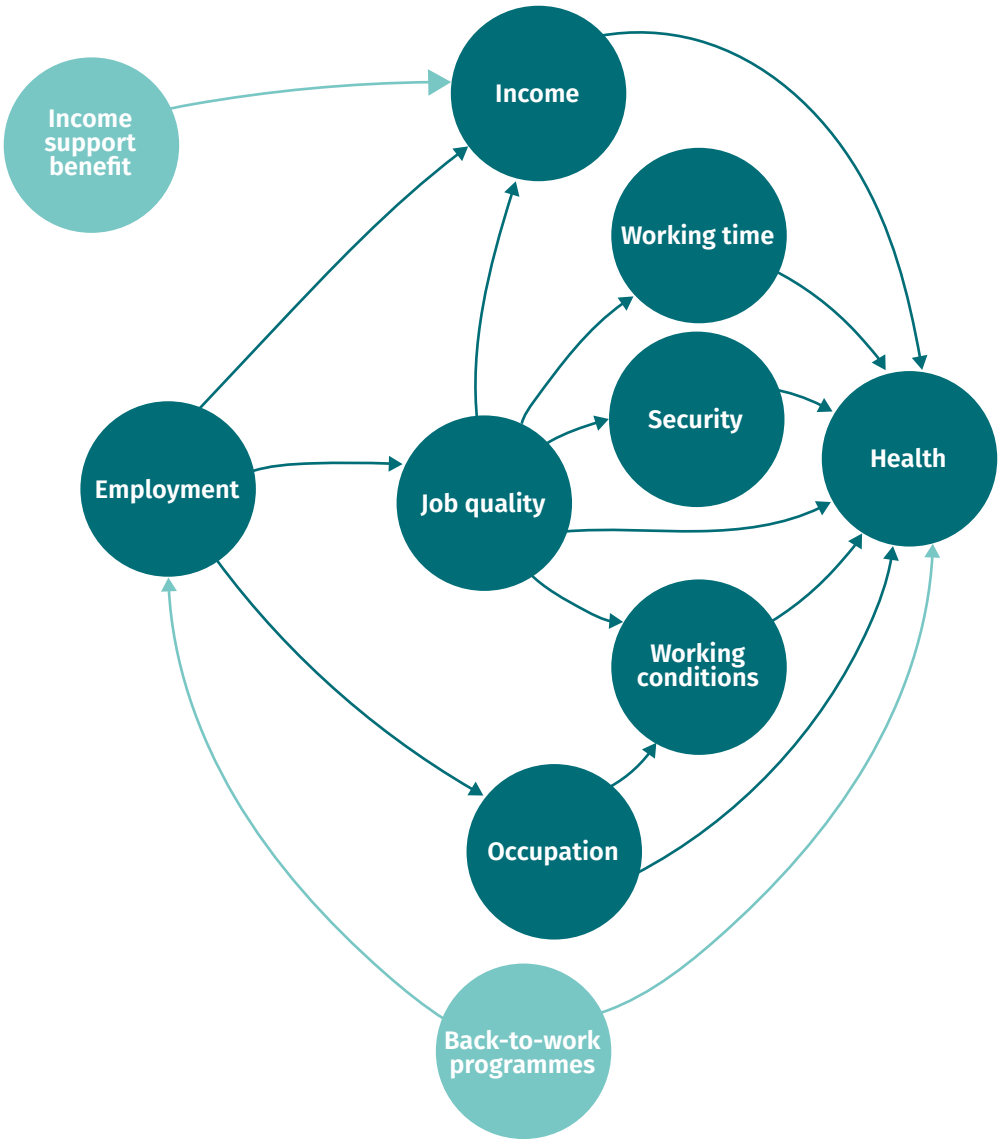
## 1.1 HOW DOES WORK DETERMINE HEALTH?

In general, those in employment have considerably better mental and physical health outcomes than those who are unemployed (Murphy and Athanasou 1999, Marmot 2005). But the relationship between employment and health is not straightforward; it is mediated by factors such as occupation, income and job security (figure 1.1).

Put simply, some jobs are good for your health and others are bad your health. Poor-quality or insecure work can have a similar, or possibly worse, effect on health as unemployment (Kim and von dem Knesebeck 2015, Chandola and Zhang 2018). Those in marginalised or disadvantaged social groups are at greater risk of being unemployed or employed in poor quality work, which in turn puts them at greater risk of poorer mental and physical health (Marmot 2010). Work is therefore an important mechanism, perhaps even the most important mechanism, through which health inequalities operate (Thomas 2021).

The welfare system mediates the relationship between work and health and is able to mitigate health inequalities. Income support benefits can reduce individual deprivation and financial stress, while back-to-work policies have been shown to have both direct and indirect effects on health and wellbeing (Coutts, Stuckler and Cann 2014, Burchell et al 2020).

FIGURE 1.1: LEADING PATHWAYS THAT LINK WORK, WELFARE AND HEALTH




Source: IPPR analysis

The relationship between work and health has been of particular interest to the Department for Work and Pensions (DWP) for many years. In 2006, the department commissioned a major review of the evidence on work, health and wellbeing (Waddell and Burton 2006). Two years later, Dame Carol Black was asked to examine the heath of working age Britons and develop a plan to improve their health and wellbeing (Black 2008). These reviews went on to influence the creation of a joint work and health unit between DWP and the Department for Health and Social Care (DHSC). In 2017, the unit published the *Improving Lives* green paper which set out a plan to get more people (especially those with a disability) into work, on the basis that any employment was better than no employment for their health (DWP and DHSC 2017). It also made several recommendations to improve provision of occupational health and mental health services for working age adults, drawing heavily on another DWP-commissioned independent review of mental health and employers (Stevenson and Farmer 2017).

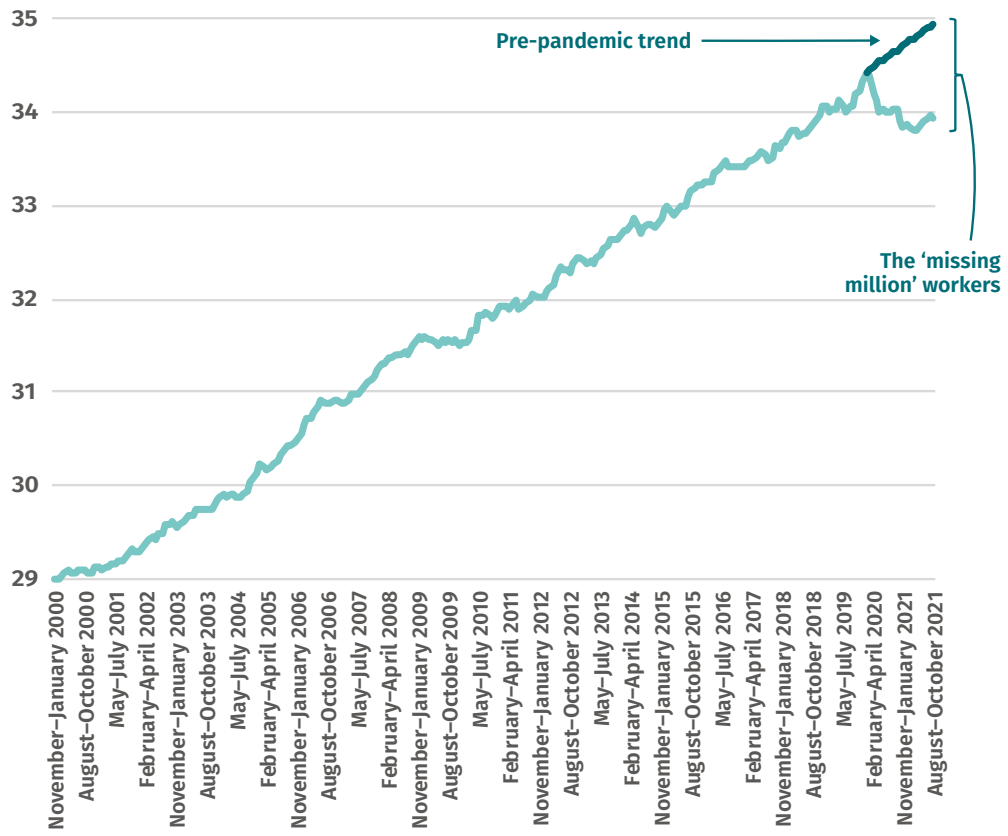
Despite these efforts, the working-age adult mortality gap between the UK and other high-income countries has grown over the past decade (Leon, Jdanov and Shkolnikov 2019). The number of working days lost due to mental health sickness had also steadily been rising, reaching 20 million days in 2019 (ONS 2021c). A better approach to improving the health of working-age people is clearly required.

## 1.2 THE 'GREAT RE-EVALUATION'

As economies and societies reopen, governments and businesses in several high-income countries are asking the same question: where are all the workers? Labour shortages have been reported in the UK, USA, Canada, France, China and Australia (Deloitte 2021). In the UK, there are 1 million fewer people are in the labour market than would be expected has pre-pandemic trends continued (figure 1.2).

**FIGURE 1.2: AROUND 1 MILLION FEWER PEOPLE ARE PARTICIPATING IN THE UK LABOUR MARKET THAN EXPECTED**

**People actively participating in the UK labour market, Jan 2000 – Aug 2021**




**Source: IPPR analysis of ONS (2021)**

Some of these labour shortages can be explained by falls in the number of migrants workers and people leaving the labour market because of ill health or Covid-19 related concerns (Wilson, 2021, US Census Bureau 2021). But there also appears to be a sociological shift underway. Millions have used the pandemic's pause to reflect on what they value in work. A recent survey of employees in the UK, USA, Australia, Canada and Singapore found 40 per cent of employees say they are at least 'somewhat likely' to quit within the next six months, and that nearly two-thirds of those are ready to go with no new job in hand (McKinsey 2021).

Not only has the pandemic led many of us re-evaluate what we want from working life, it has reminded us of the importance of health and wellbeing. Like workers, the government and employers should use this moment to re-examine the relationship between work and wellbeing. It is time to cast new light on an old question: how to create healthier work?

The modern system of occupational health and safety regulation, embodied in the Health and Safety at Work Act 1974, is the result of the Robens report which was commissioned by Harold Wilson's government in 1970. It made the UK a much safer country to work in (Löfstedt 2011). But progress since has been limited and more recent governments have seen little success in attempts to improve the health of workers. Indeed, there has been a notable deterioration in mortality rates of working age adults in the UK compared to trends in other high-income countries since the turn of the century (Leon, Jdanov and Shkolnikov 2019).

Governments over the past 40 years have utilized only a narrow set of policy instruments at their disposal when considering how to improve the health of working age people. The primary focus have been to get unemployed people into work, based on the oversimplified view that simply being in work is better for your health than being out of work. This has neglected the importance of job quality (and labour market regulations that could improve it) in improving the health of working age people. Governments have also overlooked the role of macroeconomic policy in creating healthier jobs and the influence of welfare policy on health outcomes.

There is considerable variation in businesses' approaches to employee health and wellbeing. It is obvious that some have made it a much greater priority than others. But even among the more committed employers, the focus has been on specific healthcare interventions (for example providing access mental health services) and rather less on how the quality of work itself (for example working hours and employee autonomy) determines health.

In this moment of labour shortages and an at least temporary power shift from employers to employees, businesses are thinking about how to attract and retain workers. Better approaches to employee health and wellbeing will be important in the bid for workers. To that end, it is encouraging that Business for Health – a large business-led coalition that includes the Confederation of British Industry (CBI) – has been set up to underline the key role of businesses in determining individual and population health (Business for Health 2021).

The 'great re-evaluation' of attitudes to work has come at a time the climate emergency and the pandemic are transforming labour markets. It is an opportunity for governments and businesses to take a different approach to the health and wellbeing of working age people. In this paper, we examine the link between work and health through the lens of the pandemic and then consider a broad and innovative set of actions to make individual jobs and the government and employers can take to improve the health and wellbeing of working age people in the UK.

# 2. WORKING THROUGH THE PANDEMIC: A MATTER OF LIFE AND DEATH

## 2.1 CLASS AND COVID-19: OCCUPATIONAL PATTERNS OF THE PANDEMIC

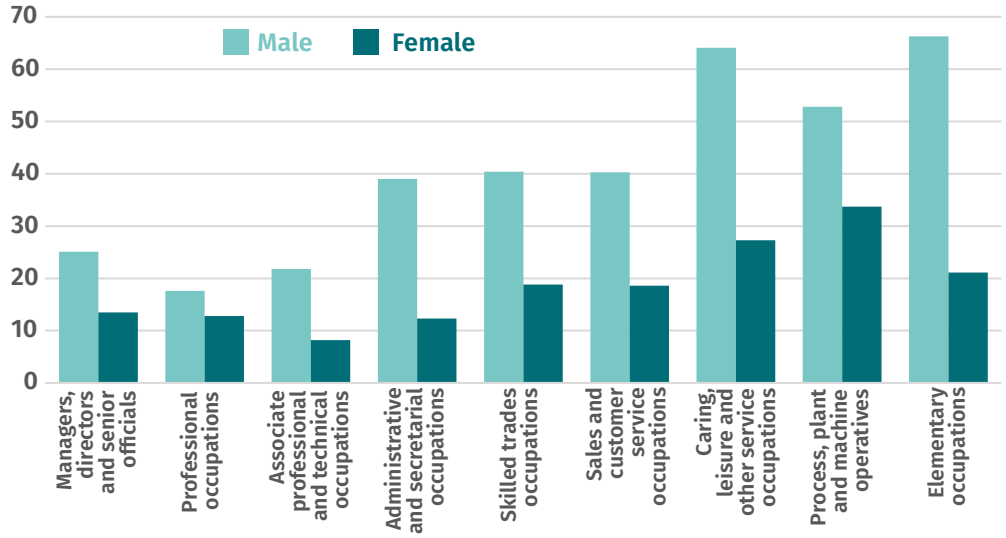
Although there is no simple measure of modern social stratification, the occupational order remains an important manifestation of it. Covid-19, like many other diseases, has run along this occupational hierarchy. Those in 'working class occupations' have been around twice as likely to die from the virus than those in 'middle class occupations (Figure 2.1). This aggregate class inequality is stark, but conceals even starker realities. Those working in the hospitality and food service sector, for example, have been seven times more likely to die from Covid-19 than business professionals.[1]

> ***"Those in 'working class occupations' are around twice as likely to die from the virus than those in 'middle class occupations."***

And the Covid-19 mortality rate among the lowest paid occupations is almost five times higher than the Covid-19 mortality rate among the highest paid occupations (figure 2.2).

FIGURE 2.1: COVID-19 MORTALITY RATES ARE HIGHER IN 'WORKING CLASS' OCCUPATIONS

**Age-standardised Covid-19 mortality rate stratified by occupation and sex**



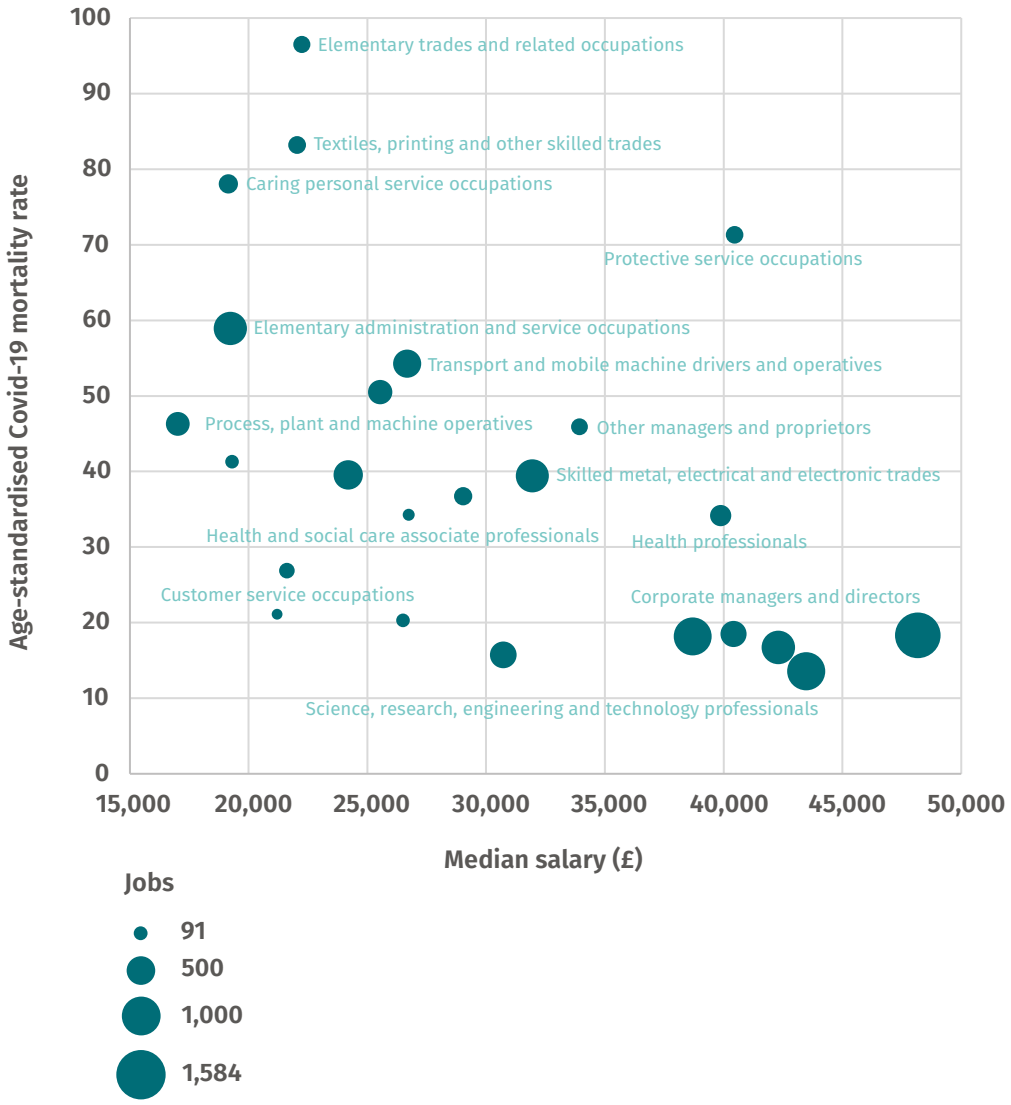

**Source: IPPR analysis of ONS 2021**

**Note: See appendix for list of occupations within each category occupational category.**

1 IPPR analysis of ONS 2021

FIGURE 2.2: LOWER PAID OCCUPATIONS HAVE EXPERIENCED THE HIGHEST COVID-19 MORTALITY RATES

**Covid-19 mortality rate against median salary by occupation**



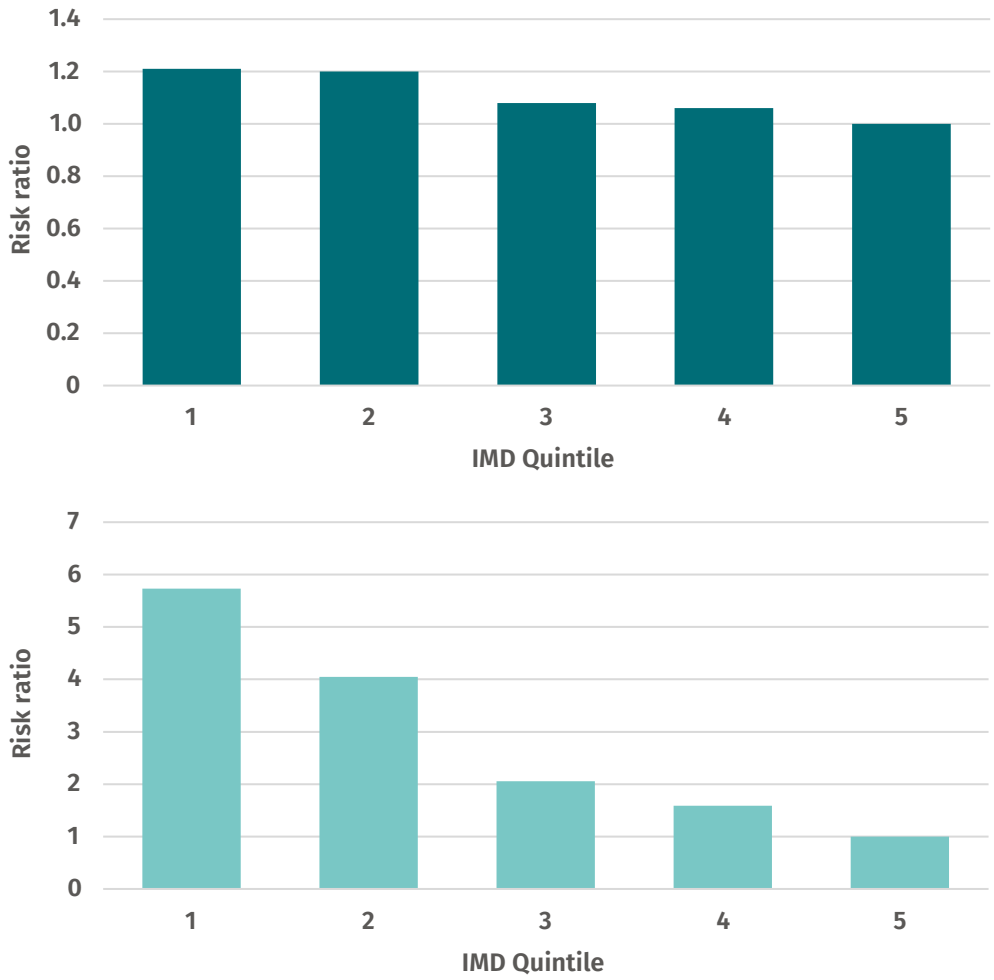

**Source: IPPR analysis of ONS 2021 and ONS 2019**
**Note: Each bubble represents an occupational group by 2 letter ONS SOC code. Size of bubble corresponds to number of jobs within each group.**

People's ability to work from home, practice social distancing, limit contact with potentially infectious individuals and work in well-ventilated conditions are all determined by their occupation (Industrial Injuries Advisory Council 2021). And around one in three working-age adults who contracted Covid-19 believe they caught it in the workplace (Beale, Byrne et al 2021).

The ability to avoid 'risky' activities also cuts clearly along the social deprivation gradient. The poorest fifth of the population were 21 per cent more likely to have to leave their house to attend work during the third national lockdown compared to those who live in the least deprived areas (figure 2.3a). They were also over five times more likely to rely on public transport to travel (figure 2.3b).

**FIGURES 2.3A AND 2.3B: PEOPLE LIVING IN MORE DEPRIVED AREAS HAVE BEEN LESS ABLE TO WORK FROM HOME AND MORE LIKELY TO RELY TO PUBLIC TRANSPORT**

**Relative likelihood of attending work (top) and using public transport (bottom) during third national lockdown by deprivation quintile**




Source: Beale et al 2021
Note: IMD 1 is the least deprived quintile and IMD 5 is a most deprive quintile.
Note: Based on survey of 25,228 people in England and Wales between 9 February and 16 February 2021.

## 2.2 FURLOUGH AS A PUBLIC HEALTH INTERVENTION

For the first 18 months of the pandemic, the coronavirus job retention scheme (CJRS) covered the wages of 11.7 million employments cumulatively and provided 2.3 billion days of furlough (HMRC 2021). It has been praised as a successful economic intervention that prevented catastrophic rises in unemployment during the worst recession in at least a century (ibid).

It should also be praised as a successful public health intervention. First, the furlough scheme is likely to have considerably reduced viral transmission during the pandemic by preventing millions socially mixing in workplaces. Second, the furlough scheme will have prevented large rises in unemployment-related illness. Following the 2008 recession, the suicide rate in England rose sharply from a 20-year low – around two-fifths of which was attributable to rising unemployment (Barr et al 2012). Countries with stronger and more supportive welfare systems

than the UK's were more able to offset the negative health consequences of unemployment following the 2008 recession (Stuckler et al 2009). To that end, for those who were able to access it, the CJRS is likely to have prevented a large number of suicides this time round. Analysis of the UK Household Longitudinal Survey found the mental health of people who were furloughed was similar to those who were able to keep their jobs full-time – both had considerably better mental health levels than people who lost their jobs during the pandemic (Burchell et al 2021).

## 2.3 SICK PAY POLICY: AMPLIFYING COVID-19?

An estimated 2 million employees in the UK do not earn enough to be eligible for statutory sick pay (Brewer and Gustafsson 2020; Trade Union Congress 2021). For those who do, mandatory paid sick leave as a proportion of previous earnings is among the lowest of the countries constituting the OECD (Scarpetta et al 2020).

There has been considerable policy attention on statutory sick pay in the context of the Covid-19 pandemic. From a public health perspective, the risk of income loss encourages presenteeism and drives Covid-19 transmission in the community (DiGiovanni et al 2004; Pichler and Ziebarth 2017). Indeed, it is more than plausible that community Covid-19 rates have been amplified by UK statutory sick pay policy. Furthermore, from a living standards perspective, limited access to paid sick leave risks exacerbating the cost of living crisis for low income households during periods of illness.

Inequalities in access to sick pay among UK workers are very poorly understood. There is little public data or previous literature on sick pay coverage in the UK. A 2014 survey of 2,030 employees by the Department of Work and Pensions is limited to employees eligible to access sick pay (DWP 2015). The characteristics of the estimated 2 million workers without paid sick leave can only be indirectly inferred from workers earning below the income threshold to access statutory sick pay using data from the Office of National Statistics' Labour Force Survey. This is imperfect and assumes all workers earnings above the eligibility threshold will automatically have access to paid sick leave. It is limited in its ability to examine unwarranted labour market inequalities in access to paid sick leave.

In that context, IPPR worked with the Virus Watch study at UCL to better investigate inequalities in access to paid sick leave. By harnessing data already collected by this large taxpayer-funded study of Covid-19 epidemiology, this analysis fills an important evidence gap on inequalities in sick pay access without needing to duplicate efforts to generate research data.

A multivariable logistic regression analysis of 8,874 working people in England and Wales reveals stark age, race and class inequalities in access to paid sick leave (Patel et al 2022).

## TABLE 2.1: THERE ARE STARK AGE, RACE AND CLASS INEQUALITIES IN ACCESS TO SICK PAY

**A multivariable logistic regression of sociodemographic factors associated with lacking access to sick pay**

| | Multivariable logistic regression | | |
|---|---|---|---|
| **Characteristic** | **Odds ratio*** | **95% confidence interval** | **p-value** |
| **Age** | | | |
| 25-44 | — | — | |
| 16-24 | 1.28 | 0.94, 1.74 | 0.11 |
| 45-64 | 1.72 | 1.53, 1.93 | <0.001 |
| 65+ | 5.26 | 4.42, 6.26 | <0.001 |
| **Sex** | | | |
| Female | — | — | |
| Male | 1.08 | 0.97, 1.19 | 0.2 |
| Missing | 1.08 | 0.36, 2.84 | 0.9 |
| **Ethnicity** | | | |
| White British | — | — | |
| White Irish | 1.20 | 0.82, 1.74 | 0.3 |
| White Other | 1.12 | 0.93, 1.35 | 0.2 |
| South Asian | 1.40 | 1.06, 1.83 | 0.017 |
| Other Asian | 1.25 | 0.77, 1.99 | 0.4 |
| Black | 0.99 | 0.53, 1.78 | >0.9 |
| Mixed | 1.04 | 0.69, 1.54 | 0.8 |
| Other minority ethnicity | 2.93 | 1.54, 5.59 | 0.001 |
| Prefer not to say | 1.11 | 0.43, 2.66 | 0.8 |
| **Household income** | | | |
| £75,000+ | — | — | |
| £0-24,999 | 2.53 | 2.15, 2.98 | <0.001 |
| £25,000-£49,999 | 1.43 | 1.25, 1.63 | <0.001 |
| £50,000-£74,999 | 1.09 | 0.94, 1.25 | 0.2 |
| Missing | 1.80 | 1.47, 2.20 | <0.001 |
| **Occupation** | | | |
| Managers, directors and senior officials | — | — | |
| Administrative and secretarial | 0.70 | 0.56, 0.88 | 0.002 |
| Healthcare | 1.13 | 0.88, 1.46 | 0.3 |
| Indoor trades, process and plant | 2.03 | 1.58, 2.61 | <0.001 |
| Leisure and personal service | 2.43 | 1.84, 3.21 | <0.001 |
| Missing | 1.26 | 0.87, 1.80 | 0.2 |
| Other professional and associate | 1.30 | 1.07, 1.59 | 0.009 |
| Outdoor trades | 5.29 | 3.67, 7.72 | <0.001 |
| Sales and customer service | 1.15 | 0.87, 1.52 | 0.3 |
| Social care and community protective services | 0.85 | 0.64, 1.13 | 0.3 |
| Teaching, education and childcare | 0.74 | 0.58, 0.94 | 0.013 |
| Transport and mobile machine | 2.04 | 1.42, 2.94 | <0.001 |

**Source: Patel et al 2022**

**Note: *Odds ratio greater than 1 indicates increased odds of lacking access to sick pay**

It is unsurprising that those in low income households are more likely to lack access to sick pay than those in high income households given statutory sick pay entitlement in the UK is conditional on earning above an income threshold. More concerning are unwarranted inequalities in sick pay access between age and ethnic groups that cannot be explained by differences in income, occupation and employment status. They are suggestive of age and race-based discrimination in the labour market.

Occupations with elevated odds of lacking access to sick pay relative to managerial occupations are classifiable as working class according to the widely used Goldthorpe class schema (Goldthorpe and McKnight 2006). That working class occupations are most likely to lack access to sick pay is further cause for concern with regard to inequalities in the labour market.

Paid sick leave has been judged an effective intervention to reduce transmission of Covid-19, flu and other infectious diseases (Stearns and White 2018; OECD 2020a). The UK government made some changes to sick pay policy when the pandemic began by allowing eligible employees to receive sick pay during periods of self-isolation in addition to confirmed Covid-19 illness, and to receive sick pay from the first day of illness or self-isolation, rather than from the fourth day of illness as is the case for other illnesses. However, unlike around half of other OECD countries, the UK has not altered the replacement rate, nor has it modified the eligibility criteria to expand access to statutory sick pay. Given the inequalities highlighted by this new analysis, improving access to paid sick leave should be a policy priority as we 'learn to live with Covid-19'.

### *RECOMMENDATIONS*

- Abolish the lower earnings limit threshold to access statutory sick pay.
- Increase the statutory sick pay rate to 80 per cent of earnings, up to the full time equivalent of £2500 per month.
    - The government should reimburse small and medium-sized enterprises (under 250 employees) for the costs of providing sick pay, in keeping with the sick pay rebate scheme that was established during the pandemic. We estimate a full rebate would cost £7.5bn and a half rebate would cost £3.8bn per annum (see appendix for further details).
- Ensure access to sick pay from day one of illness, making permanent this pandemic amendment to statutory sick pay entitlement rules.
- Improve enforcement to ensure employers are meeting their legal obligations to provide sick pay.

# 3.
# HEALTHIER JOBS

As much as we should think about better safeguarding workers in the current public health emergency, we should use the experience of the pandemic to move into a world of healthier work. It is a simple but striking injustice that some people are more likely to die than others because of the job they do. But the argument for healthier work goes beyond social justice – an estimated 30 per cent of the productivity gap between the North and the rest of England has been attributed to ill-health (APPG Longevity 2021).

In their attempts to make jobs healthier, governments and businesses have historically focused on expanding occupational health services, especially mental health services. While this is welcome, it reflects a common assumption that health services are the most effective policy instrument to improve health outcomes. It is a weak assumption. The policy focus on expanding access to workplace health services means policymakers neglect to consider how nature and quality of a job itself shapes health.

The widening gap in working-age mortality rates between the UK and other high-income countries (Leon, Jdanov and Shkolnikov 2019), despite years of low unemployment, is reason for policymakers to rethink their approach to making jobs healthier. It is time both the government and employers follow the problem of poor worker health to its cause. That means a focus on job quality.

As a recent report by the think tank Autonomy argues, the government's guiding principle that simply being in work is good for your health has led to ineffective, and sometime harmful, policy (Autonomy 2021). In 2017, the government-commissioned Taylor Review of modern working practices made the case that it is important for government to not simply focus on the quantity of work, as it has been doing, but equally on the quality of work. Many of the recommendations in that report are still waiting to be implemented.

> ***"it is important for government to not simply focus on the quantity of work, as it has been doing, but equally on the quality of work"***

Job quality mediates the relationship between work and health and low-quality work can be as detrimental to health as unemployment (Butterworth et al 2011; Chandola and Zhang 2018). There is no single definition for job quality. The International Labour Organisation definition of 'decent work' considers the following elements:

- employment opportunities
- adequate earnings and productive work
- decent working time
- combining work, family and personal life
- stability and security of work
- equal opportunity and treatment in employment
- safe work environment
- social security (such as pensions)
- social dialogue, employers' and workers' representation.

Many of these factors are in the control of employers. The government, however, has a crucial role in setting standards – and ensuring they are enforced. Modernisation of labour market regulation has the potential to improve the health of millions of people.

In this chapter, we examine how stronger labour market regulations can make jobs healthier. We then outline how employers can take a more innovative and upstream approach to worker wellbeing.

## 3.1 HEALTHIER LABOUR MARKET REGULATION

### 3.1.1 Raising pay floors

The relationship between income and health is complicated but well established (Kessler et al 1994; Osler et al 2002; Marmot 2005). In the middle portion of income distribution (10-90 per cent), the doubling of income is associated with a similar effect on a range of physical health outcomes (Ecob and Davey Smith 1999). The effect relationship is steeper at the lower end of the income distribution, and flatter at the higher end of the income distribution.

Almost 4 million people in the UK earn below the real living wage (Living Wage Foundation 2021), a wage figure derived from the cost of living. Fixing the minimal wage to the real living wage, something IPPR has previously called for, would to have considerable health benefits for working families living in poverty (IPPR 2018). It is often argued that raising the minimum wage could lead to greater unemployment, since without a rise in productivity firms will not be able to afford it. There is now considerable empirical evidence to suggest this is not true and that in fact raising the minimum wage can boost productivity (Card and Krueger 2000; de Linde Leonard, Stanley and Doucouliagos 2014).

In October 2021, the government announced a 6.6 per cent increase to minimum wage for over 23-year-olds (also known as the national living wage) to £9.50 per hour. This is welcome and will support 2 million low-paid workers. However, with inflation at around 3 to 4 per cent, it is likely to fall below the real living wage figure for 2021/22.

Statutory sick pay has not been raised during the pandemic despite the fact that financial consequences are a leading reason for the low levels of adherence to self-isolation guidance in the UK (Reed et al 2021). The government has made available a £500 self-isolation payment, but it covered only one in eight workers and accessing it required navigating a bureaucratic process (ibid). During the pandemic, mandatory sick pay as a proportion of earnings have been lower in the UK than all other OECD countries (OECD 2020b). It is in no-one's interest for someone with an infectious disease – whether it is Covid-19, the flu or even just the common cold – to go into work and risk spreading it to others. The consequences, both health and economic, extend far beyond the individual. The International Longevity Centre has estimated the flu was responsible for £30 billion of lost output across high income countries every year (ILC 2019). Covid-19, of course, is responsible for vastly more lost output – and will continue to dent the economy on annual basis as it become an endemic disease.

#### *RECOMMENDATIONS*

- Permanently fix the national living wage to the real living wage.
- Increase statutory sick pay to 80 per cent of previous earnings and abolish the lower earnings limit.

### 3.1.2 More secure work

Job insecurity has become an increasing problem since the great recession and as labor markets have become more flexible. We estimate there are approximately 5.5 million people in insecure work in the UK today and is concentrated among low-paid workers and minority ethnic workers.[2]

Job insecurity is associated with poor health, although the effect on health varies considerably depending on the nature of insecurity (Thorley and Cooke 2017; Green 2020). Irregular shift work, for example, has been associated with greater risk of several health conditions, including cardiovascular disease, obesity and cancer (Sun et al 2018; Rivera et al 2020; Wang et al 2021). In some studies, job insecurity has been shown to pose a comparable threat to health as unemployment (Kim and von dem Knesebeck 2015).

Employment rights in the UK are very unclear, with both workers and employers frequently confused about how to identify an individual's employment status and rights. The lack of clarity allows unscrupulous employers to avoid the law and makes it harder for individuals to decide whether to challenge their status. In 2019, the government pledged to enshrine workers' rights in law and "make Britain the best place in the world to work". A promised employment bill has not been forthcoming. More recently, the Labour party pledged to make a similar legislative commitment in government, to ensure gig economy workers have access to basic employee rights such as minimum wage and sick pay from day one of employment.

#### *RECOMMENDATIONS*

The government should introduce new labour market regulations that could have a positive impact on health in the postponed employment bill. This should include:

- a right for employees who work variable hours (including both those on zero-hours contracts and agency workers) to request a more predictable and stable contract
- people working irregular hours or shifts should have the right to a two-week notice period of their shifts, and the right to compensation if this is not followed.

### 3.1.3 Shorter working time

There is a growing body of evidence that is revealing long working hours have a detrimental impact on health.

The Employment Dosage Project at the University of Cambridge recently found that eight hours' work a week could be sufficient to gain the mental health benefits that paid work is known to provide (Kamerāde et al 2019). Their analysis found little difference in the mental health levels of people who worked eight hours a week compared to those who worked more. A separate study of over 600,000 individuals across 24 high-income countries found long working hours, defined as over 55 hours per week, are associated with a 33 per cent greater risk of stroke than those who work 35 to 40 hours per week (Kivimäki et al 2015).

At the eve of the pandemic, 35 per cent of employees work longer than 40 hours per week – that is about 12 million people. And 4 per per cent of workers work more than 55 hours a week – about 1.5 million individuals.[3]

2 Insecure work defined as defined a job as insecure if it is temporary, agency work, a zero-hours contract; or if a worker is looking for another job because of lack of security or sufficient hours; looking for a job on top of their current job; if a worker would work more hours at the job's basic pay rate; or if a worker is classed as self-employed but paid by agency.

3 IPPR analysis of ONS Labour Force Survey, Q1 2020.

The idea of a shorter working week in has been gaining momentum in liberal democracies for some years, on the grounds of giving worker's more free time and potentially even boosting their productivity. It is likely to also have beneficial health effects for workers. Governments in Spain, New Zealand, Iceland, Japan and Scotland are all now piloting shorter working week schemes. In Spain, the government is offering businesses funding to mitigate any potential financial risks of piloting a four-day working week. A trial of 2,500 public sector workers in Iceland found a reduction of four to five hours a week had no adverse effects on output and services delivered (Haraldsson and Kellam 2021).

***RECOMMENDATION***

- The UK government should trial a shorter working week scheme for businesses to apply to without bearing any financial risk themselves. This trial should evaluate the impacts on worker's health and wellbeing, productivity at work, and business output.

## 3.2 HEALTHIER EMPLOYERS

There are a range of estimates of the economic costs of illness in the working age population. Analysis by Vitality, RAND Europe and the University of Cambridge estimates the UK economy lost £92 billion in 2019 as a result of sickness absence and presenteeism in the workplace (Vitality 2020). The CBI has estimates poor health in the working age population costs the UK around £300 billion in lost economic output annually, excluding health costs (CBI 2021). And McKinsey has estimated that ill health in the working age population costs the UK $6,800 per capita (McKinsey 2020). The health of its workers is clearly imperative to the productivity of any company.

Both physical and psychosocial work environments affect health. Despite leaps and bounds of progress made in improving physical work environments, in large part due to the HWA Act 1974, there remains room for improvement – especially in the context of the pandemic. Differing levels of ventilation in the workplace, for example, explains some of the differences in Covid-19 infection rates between occupations (Beale, Patel, et al 2021). Making workplaces safer in the time of a pandemic is imperative. Many companies have taken appropriate steps to make sure employees are safe at work and should be commended. But some have continued to put workers health at risk – despite thousands of workplace outbreaks, not a single employer has been fined and prosecuted for putting their staff in danger. The enforcement of workplace health and safety regulations must improve as we learn to live with Covid-19.

For the remainder of this section, we focus on the psychosocial work environment and look at health outcomes beyond Covid-19.

### 3.2.1 Workplace wellbeing: time for a different approach?

The landmark Thriving at Work review of mental health and employers found 15 per cent of people at work have symptoms of an existing mental health condition and that 300,000 people who have a long-term mental health problem lose their jobs every year (Stevenson and Farmer 2017). Recent analysis by Deloitte estimated that poor mental health costs employers £42-45 billion per year (Deloitte 2020).

In response, many employers have begun implementing workplace mental health support. There is great diversity in interventions companies have implemented to try and improve the mental health of staff. Mindfulness-based interventions, resilience training, physical activity and cognitive behavioural therapy are some of the most popular. A recent review of reviews conducted by The Policy Institute at Kings College London concluded "there is some evidence that workplace

interventions can improve mental health and wellbeing outcomes, though the size of the effect is often small" (Hesketh et al 2020).

What is notable is the focus on interventions addressing individual behaviour change. Much fewer look at the quality of work itself, such as autonomy and flexibility, when considering how to improve the health and wellbeing of employees.

A 2014 report by the Institute of Health Equity and Public Health England identified the following as key features for improving health and wellbeing in the workplace (PHE and IHE 2014).

1. Greater employee control over their work.
2. Greater employee participation in decision-making.
3. Line management training.
4. Effective leadership and good relationships between leaders and their employees.
5. Engaging employees, ensuring employees are committed to the organisations' goals and motivated to contribute to its success.
6. Providing employees with the in-work training and development they need to develop job satisfaction.
7. Providing greater flexibility within a role to increase an employee's sense of control and allow them to improve their work-life balance.
8. Reducing stress and improving mental health at work as these are leading causes of sickness absence.
9. Addressing the effort-reward imbalance.

It is striking how similar these are to the International Labour Organisation's characteristics of 'decent work' (see above). There is also clear similarity with Frederick Herzberg's famous motivation-hygiene theory of factors that lead to employee satisfaction and dissatisfaction. The implication is this: effective policies to improve the health of employees are the same policy prescriptions needed to improve job satisfaction and labour productivity. Employers who want to want to improve the mental health of their workers should focus more on factors such as autonomy at work, opportunities for development and greater flexibility.

In October 2021, the Business for Health network launched an initiative to support employers in their role to improve health. Their survey of over 100 businesses and employers found that more than nine in 10 participants agreed business should "have a more prominent role as a stakeholder in, and contributor to, the health of the nations of the UK, both in terms of individual and population health" (Business for Health 2021). One arm of their three-pronged strategy is focused on workforce health. The Business for Health and CBI are right to emphasise the value of business-led health interventions, such as access to mental health treatment for workers, and to call for better data collection, data analysis and the need to identify of best practice interventions. But they risk overlooking the most direct determinants of worker health: the nature and quality of the job itself.

### 3.2.2 Worker-in-control flexibility

Flexible working can be defined in terms of working time (temporal), working location (spatial), and pattern of work (contractual). Contractual flexibility – such as part-time, temporary or 'gig' work – is often associated with poor mental and physical health (Thorley and Cooke 2017, Chandola and Zhang 2018). But temporal and spatial flexibility has positive effects on health (Joyce et al 2010; Thorley and Cooke 2017; Autonomy 2021). This is, at least in part, because it leads to greater sense of control for the employee and allows them to improve their work-life balance. The infamous Whitehall II study, led by Michael Marmot, showed long ago that locus of control at work is a driver of health outcomes (Marmot et al 1991).

All forms of flexibility at work lead to increased control for either the employer or the worker with respect to where, when or how work is undertaken. It is possible for flexible working arrangements to be instigated by either the worker or the employer, and so be the result of either choice or coercion. This problem of 'one-sided flexibility' was highlighted by Matthew Taylor's government-commissioned review of modern working practices (Taylor 2017). Many of the recommendations in the Taylor Review, which repeatedly emphasised the government ought to focus not just on the quantity but the quality of work, are still yet to be implemented.

It is encouraging that the government has opened a consultation on making flexible working the default. We recommend a worker-in-command approach to flexible working. That is, everyone should have a right to flexible working, where the terms of flexibility are determined by workers. It will particularly benefit those with caring responsibilities and long-term health conditions. And is likely to have significant positive effects on the mental health of many workers.

### *RECOMMENDATIONS*

- All employees should have a day one right to flexible working hours, enshrined in law.
- Where possible, all jobs advertised should include a flexible and/or job-share option.
- Employees who work on a shift-basis should have access to a self-rostering system to schedule shifts, rather than being mandated when to work.

# 4. HEALTHIER INSTITUTIONS

Beyond improving conditions of individual jobs, labour institutions need to change too. This includes different macreconomic policy, more prominent consideration of trade unions as public health institutions and rethinking back-to-work welfare policies. Such institutional changes are needed to deliver healthier work, not just at the level of individual jobs, but at the economy wide and population health level.

## 4.1 GREEN AND HEALTHY PUBLIC INVESTMENT

Fiscal policy is rarely considered as a tool to create 'healthier' labour markets. That is in both economic and public health terms. But greater public investment, directed at green and social infrastructure, has the potential to:

- accelerate the path to net zero
- create jobs and boost medium-term economic growth
- help 'level up' local and regional economies.

These could have considerable beneficial public health consequences.

IPPR have previously set out the case for a £47 billion public investment until at least 2030 (Jung and Murphy 2020; Murphy, Massey-Chase and Frost 2021; Dibb et al 2021). There is a strong economic case: interest rates are at a historically low level, which means the cost of borrowing for the government is small. Investing in highly productive sectors – such as green infrastructure and care services – will more than pay off the cost of servicing government debt. Indeed, there is a macroeconomic consensus that increasing public spending in these sectors is, in the current moment, key to ensuring sustainable economic growth in the medium term (Jung, Dibb and Patel 2021). In addition to the paradigm shift in macroeconomics, the climate and nature emergency demands a different economy. The government's net zero strategy is an important and ambitious step forward, but public investment is insufficient to redirect the economy toward green growth and crowd in further private investment to accelerate the green transition. The government risks falling short of what is required to meet its key target of net zero emissions by 2050. In contrast, the twin challenges of recapturing equitable economic growth and meeting the climate challenge have led President Biden's administration to attempt to pass $4 trillion of government spending, focused on combatting climate change and improving care services.

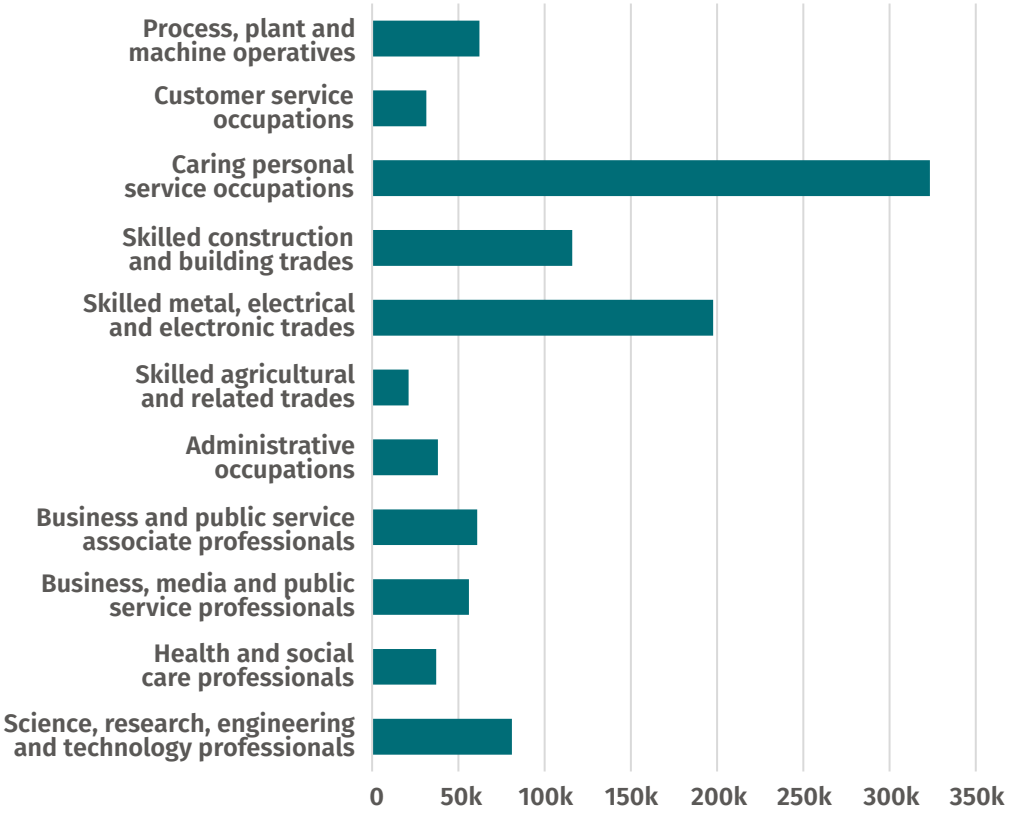
Beyond the economic and environmental rationale is the public health case. A greener and fairer economy will improve population health and reduce health inequalities through several pathways, from reducing air pollution to lower rates of childhood obesity (Romanello et al 2021). One major pathway is through the future labour market – a jobs-rich green economy could improve public health. In new analysis, we have estimated the occupation-related public health consequences of IPPR's £47 billion public investment into green and social infrastructure would save approximate 9,600 years of life every year by 2030 (see appendix for methodology).

This headline figure, however, obscures a more complicated picture. Growth of certain green infrastructure sectors that are associated with higher occupational mortality rates – for example those in metalworks and construction – will pose a growing health risk (figure 3.1). We estimate that by 2030, without improvements

in occupation-specific mortality rates, 990 additional years of life will be lost in metal, electrical and electronic trades and 420 additional years of life will be lost in construction and building trades. Jobs in the green economy will not be healthy jobs by default – more robust occupational health and labour market regulations will be required.

FIGURE 3.1: PUBLIC INVESTMENT THAT DRIVES GREEN ECONOMIC GROWTH WILL CREATE JOBS IN A RANGE OF OCCUPATIONS

**Estimated number of additional jobs created by 2030 under IPPR £47 billion public investment scenario**




Source: IPPR analysis (see appendix for methodology)

## *RECOMMENDATIONS*

- The government should invest £47 billion every year in green infrastructure and care services in order to: drive greater and fairer economic growth, accelerate the path to net zero, and save 9,600 years of life every year by 2030.
- The Health and Safety Executive should identify occupations that are set to grow over the next decade and better scrutinise health and safety regulations in these occupations to reduce avoidable workplace accidents and fatalities.
- The government should subsidise occupational health services should subsidise occupational health services for SMEs and those self-employed. Self-employed people and small employers (under 50 employees) should be able to purchase occupational health services for free and medium-sized employers (50-249 employees) should be offered a discounted rate to commercial or NHS occupational health services.

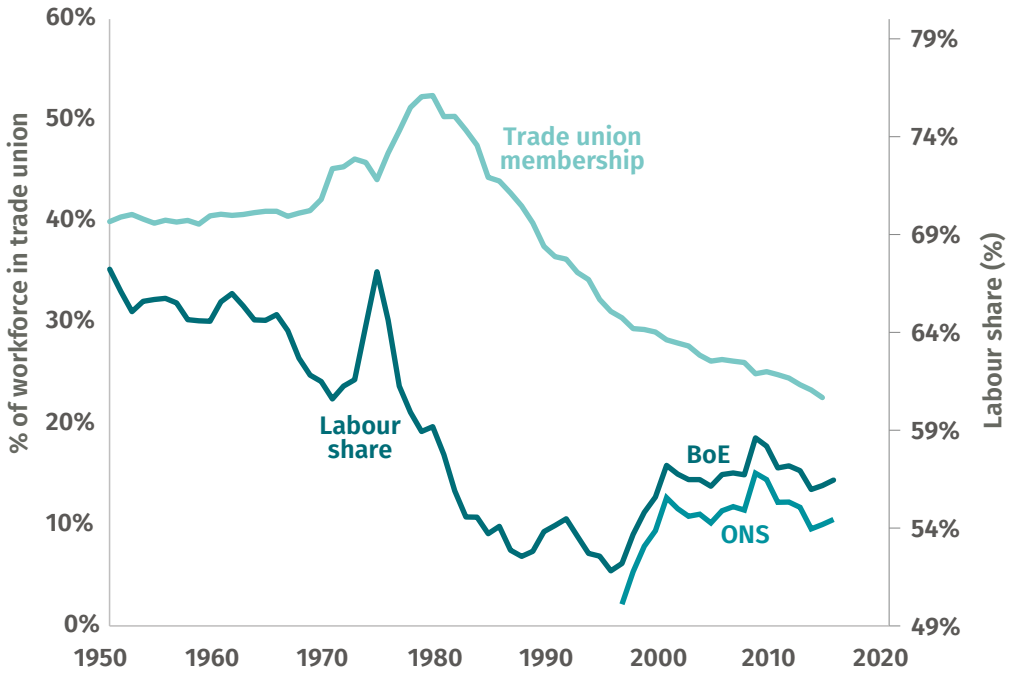
## 4.2 TRADE UNIONS: OVERLOOKED PUBLIC HEALTH INSTITUTIONS?

Organising around workplace safety during the pandemic has led to renewed recognition of the importance of trade unions to public health in the UK. A report by think tank CLASS found several examples of the health protection offered by unions during the pandemic (CLASS 2021). In their survey, employees that were members of trade unions were more likely to report that their employers had "done everything they could" to ensure employee safety during the pandemic. And workplaces that are heavily unionised were better safeguarded against the pandemic's economic impacts than those with low rates of unionisation.

But the role trade unions play in determining health extend far beyond the pandemic. Trade unions are the key institutions through which workers achieve better pay and better working conditions. A 2020 paper by Anna Stansbury and Larry Summers argued that a secular decline in bargaining power is the "major structural change" explaining sluggish wage growth and low inflation (Stansbury and Summers 2020). Indeed, the erosion of trade unions since the 1980s was mirrored by declining labour share of national income (figure 3.2).

**FIGURE 3.2: DECLINING UNION MEMBERSHIP OVER THE LAST CENTURY HAS COINCIDED WITH A FALLING LABOUR SHARE OF NATIONAL INCOME**

**Trade union membership as a proportion of the total workforce (left axis) and labour share of GDP (right axis)**




**Source: Dibb et al 2021**

Public health academics and practitioners often focus on government spending and taxation but overlook the importance of industrial organisation and unions in determining health (Greer 2018). That income and quality of work are the two most important determinants of health means trade unions should be recognised as critical public health institutions.

As Geoffrey Rose first outlined in his *Strategy of Preventative Medicine*, population-level interventions are more effective at improving health than individual-level

or targeted interventions (Rose 2001). Unions, by bringing individuals in to a collective, have the same theoretical underpinning as public health medicine. In the age of personalised medicine and 'predictive prevention', which are promising innovations but risk widening health inequalities, those working in public health should look more often to unions as the medium through which bigger-than-the-individual interventions to improve population health can be achieved. Indeed, a 2019 World Health Organisation analysis of European countries noted that where collective bargaining arrangements are in place, working conditions tend to be healthier, poverty rates lower and sickness absence rates lower (WHO Europe 2019). The UK has lower collective bargaining coverage rates than any other western-European country (Fulton 2015), partly because firm-level bargaining predominates over a sector-level system.

#### *RECOMMENDATIONS*

- The government should introduce a 'right to join' to encourage workers to join a union. As part of a statement of rights for workers, this would set out the right to join a union and the benefits of joining, and allow workers to 'opt in' to membership on starting employment, with subs deducted from payroll.
- Government should trial trade union auto-enrolment in the gig economy, building on the success of pensions auto-enrolment.
- The Office for Health Improvement and Disparities and local government public health practitioners should work directly with trade unions to identify workplace changes that improve employee health and wellbeing.

### 4.3 RETHINKING BACK-TO-WORK POLICIES

Back-to-work policies refer to helping people who have dropped out the labour market or are unemployed into work. It has been a central tenet of the approach to work and health over the past two decades.

One popular policy approach are active labour market programmes (ALMPs), which are delivered in the form of various types of employability provision (for example job search assistance and basic skills training), subsidised employment and welfare-to-work programmes. They gained popularity in the UK since the 'new deal', a large-scale welfare-to-work programme introduced by the New Labour government in 1998. People out-of-work were increasingly compelled to undertake work or participate in ALMPs in order to receive state benefits. The 'new deal' became the dominant labour market policy for tackling unemployment from 1998 to 2010, targeting a range of population groups such as young people, single parents and disabled people. In 2010, the 'new deal' was replaced by the 'work programme' under the Coalition government and later the Conservative party. Compared with ALMPs in continental Europe and Scandinavian countries, which tend to include more 'human capital development', ALMPs in the UK have tended to focus more on providing job search skills and career counselling with the aim to get people into work as quickly as possible. Few programmes provide adequate support to overcome personal barriers to work such as mental health issues (Coutts, Stuckler and Cann 2014).

Whereas the economic evidence on the effectiveness of ALMPs is mixed in terms of generating employment outcomes (Card, Kluve and Weber 2018), such programmes – if designed in the right way – have been found to mitigate the health-damaging effects of unemployment (Stuckler et al 2009; Coutts, Stuckler and Cann 2014; Wang et al 2020). A recent large-scale randomised controlled trial in the UK of the JOBS II intervention – a 20 hour ALMP aimed at enhancing the job search skills, psychological resilience, and mental health and wellbeing of individuals not in employment – found it improved participants mental health and wellbeing (at

least in the short term – six months after the programme), although it did not have significant impacts on their employment outcomes (DWP 2021).

Welfare-to-work policies aim to increase unemployed welfare claimants motivation to find employment through a combination of support and sanctions. A review of randomised controlled trials assessing the impact of welfare-to-work on the health of single parents found that overall the effects on health are of a magnitude unlikely to have tangible impacts – the negative health effects of welfare-to-work policies are balanced by the marginally positive health effects of finding employment (Gibson et al 2018). For those with mental health problems, however, not only have such policies been ineffective at helping them find employment but have triggered deteriorations in mental illness and made future employment counterintuitively less likely (Dwyer et al 2020).

### *RECOMMENDATIONS*

- The DWP should terminate welfare conditionality and sanctions for people with mental health problems and for those awaiting a work capability assessment.
- The DWP should provide clear guidance documentation and training for work coaches to better identify claimants with potential mental health issues and on easing conditionality requirements for people with mental health problems.
- DWP and DHSC should commission an independent review of back-to-work policies in the UK. Informed by this, the government should develop a green paper on reimagining job centres and the role of work coaches to improve the health and wellbeing of people not in employment.

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# APPENDIX

## COSTING SICK PAY POLICY REFORM

In this report, we propose reforms to statutory sick pay that would incur greater costs:

- Increasing the statutory sick pay rate to 80 per cent of earnings, with a government rebate for small and medium size enterprises (fewer than 250 employees)
- Providing sick pay from day one of illness
- Abolishing the lower earnings limits

The table below estimates the additional government expenditure associated with these reforms, under two different scenarios of government rebate.

### TABLE A.1: ADDITIONAL GOVERNMENT COSTS RELATED TO REFORMS

| Policy proposal | Total annual cost for chancellor |
|---|---|
| Proposal A: 80% of pay covered, up to the full-time equivalent of £2500 per month (£100 on average per day missed due to sickness for a full-time employee and £68 on average per day missed due to sickness for a part-time employee). Paid by the chancellor. | £7.5 bn |
| Proposal B: Same as scenario A, but chancellor covers only 40% of pay, up to the equivalent of £1250 per month (£50 on average per day missed due to sickness for a full-time employee and £34 on average per day missed due to sickness for a part-time employee). | £3.8 bn |

**Source: IPPR analysis of ONS ASHE (2021), ONS sickness absence (2020), BEIS annual business population data (2021).**

**Note: We calculate the average sick pay rebate across pay deciles for full- and part-time work, then assuming that total sick days are equally distributed across the pay distribution and between full- and part-time workers. The rebate cap bites from the 7th decile for full time workers and from the 9th decile for part-time workers. ONS sick pay do not have a cut-off for fewer then 250 employees, so we impute this cut-off based on BEIS data.**

## ESTIMATING THE OCCUPATION-RELATED HEALTH IMPACTS OF IPPR'S GREEN TRANSITION PLAN

IPPR have previously set out a £47 billion annual public investment plan to (Dibb et al 2021):

- accelerate the path to net zero
- create jobs and boost medium-term economic growth
- help 'level up' local and regional economies.

The £47 billion annual investment stimulus consist of £30 billion investment in environmental and climate related investments and £17 billion investment in care related investments including adult social care and child care. Please see Murphy et al 2021 for details on the £30 billion green investment plan and Roberts and Jung (2020) for details on the £17 billion care investment plan.

Based on these public investment plans, we estimated occupation-level compositional changes to the UK labour market for every year until 2030 using the UK Labour Force Survey and the ONET database. See Williams et al (2021) for further details on how these estimates were derived.

Comparing the occupational (three-digit SOC code level) and employment differences in our estimates for the composition of the labour market in 2030 under the £47 billion public investment scenario and the estimated composition of the labour market in 2030 without public investment, we estimated age-standardised and sex-specific mortality pattern differences between the two scenarios using mortality rates by occupation in the UK from Katikireddi et al (2017).

There are several limitations to our analysis and it should not be treated as a forecast. Estimating the composition of a future labour market is highly uncertain and patterns of mortality by occupation may change over time. Our analysis does however illustrate the potential health benefits of a public investment led green transitions, while also highlighting particular occupational groups that will need greater protection.

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