KEEP BRITAIN WORKING REVIEW
DISCOVERY

MARCH 2025

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Contents

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Foreword from Sir Charlie Mayfield

The Secretaries of State for Work and Pensions and Business and Trade asked me in November 2024 to lead this independent review. The aim is to make clear and concrete recommendations to the Government that focus on (i) what more employers can do to tackle economic inactivity due to ill-health and disability, and (ii) what the government would need to do to encourage and support people living with ill-health and disabled people in work. In doing so, we will be looking to support the Prime Minister's long-term ambition for the UK to reach 80% employment.

I agreed to lead the review for three reasons.

First, I have long believed in the importance of work as the place where people have the opportunity to grow and develop. There are today more people of working-age who are economically inactive for reasons of ill-health and disability than ever before. For some that is unavoidable. Many though would like to work, given the opportunity. Missing out on the benefits of good employment is bad for them, it is bad for the employers, and it is bad for the economy and for society at large.

Second, I have seen, over the course of my career, too many instances where business and government talk past each other even when there is a shared desire to achieve better outcomes. Many of our most pressing and difficult problems are better

solved by employers, government and other interested parties working together. This is one of them.

And finally, failing to tackle this issue is not an option. The human and economic cost of economic inactivity is huge. And the nature of it is pernicious. It compounds upon itself - once people become economically inactive there is a very low chance of them moving into work. And the problem, without significant change, is likely to get much larger.

However, while this all affirms the seriousness and urgency of this problem, even at this early stage, I am also confident we can tackle it.

I have already spoken to many businesses, large and small, who are committed to creating opportunities for people with work limiting health conditions and disabled people. There are inspiring examples of businesses doing things that are literally life changing for the people affected. And there are in fact more disabled people and people with health conditions in work today than ever before.

It is already evident that tackling this issue will not be achieved by small changes. It requires system change. Getting to that first requires a shared understanding of the problem. The “discovery” phase, being published today, sets out how we see economic inactivity now, including the issues that we think need to be addressed to improve it.

We are doing this in large part to prompt engagement, the next phase, which will run to the end of May. We want to hear what we have got right and what we may have missed. We want to hear about initiatives that are making a difference, and especially where there is evidence of impact to support. The third phase, recommendations to the Government, will follow in the autumn.

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Executive summary

1. Today there are nearly 800,000 or 40% more people of working-age who are economically inactive for health reasons than there were in 2019. The growth in the number who are becoming economically inactive for health reasons is nearly 10 times the growth of the working age population.

2. In the same period there has been a similar increase in the number of people reporting work limiting health conditions – up by over 2 million, an increase of 31%. One in five of all people of working age report having a work limiting health condition. The challenge of tackling economic inactivity is therefore as much within the workplace as it is in the benefits system.

3. There has been a surge in the number of people with work-limiting health conditions between 2015 and 2024. The largest increases were observed among younger people (aged 16 to 34) with an increase of 1.2 million or 77%, and older people (aged 50 to 64) with an increase of 0.9 million or 32%. Specifically, there were increases of 530,000 younger people whose main health condition was mental

health related, and 140,000 older people whose main health condition was musculoskeletal.[1] Many people also have not just one, but several conditions, which is a key driver of economic inactivity. And, once out of work for more than a year, the chance of someone ever moving into work becomes vanishingly small.

[1] Department for Work and Pensions, “Get Britain Working White Paper,” GOV.UK, November 26, 2024, https://www.gov.uk/government/publications/get-britain-working-white-paper.

4. These numbers are in themselves shocking. They represent a huge loss. A loss of opportunity, life chances, and fulfilment for people who must be a part of our future. A loss of productive capacity for employers and the economy equivalent to £150bn.[2] A loss in terms of public finances on a scale that is equivalent to the entire defence budget.[3]

[2] Robert Catherall, “The Economic Cost of Ill Health among the Working-Age Population,” Oxera, January 17, 2023, https://www.oxera.com/insights/reports/the-economic-cost-of-ill-health-among-the-working-age-population/.
[3] Based on Autumn Budget 2024, defence spending in 2024-25 is expected to be £56.9 billion while Working Age incapacity and disability benefit spend is expected to be £51.9bn

5. All projections suggest this loss is expected to increase. By 2030, 600,000 more people could become economically inactive if recent trends continue, losing out on opportunities in the workplace, making a tight labour market even more so for employers, and the latest forecasts estimate that the growth in working-age health and disability benefits could add £25bn to working age incapacity and disability welfare spending between now and 2029-30.

6. Comparisons to other countries need to be made with care – systems, cultures, data definitions and collection are all different. However, it is likely that economic inactivity has worsened in the UK in comparison to other countries. The costs in welfare benefits are rising in the UK, to a level that is among the highest in the OECD, and the outcomes are getting worse. In countries that perform better, the balance of investment and incentives within their systems is weighted towards prevention, retention and rapid rehabilitation. In the UK, it is not.

7. We cannot afford this deteriorating performance in economic inactivity. Changing it is possible. We have already seen examples of employers achieving radically better outcomes for them and their employees. And the government appears ready to act to tackle the issues within the welfare benefits system.

8. Our strong sense is that prevention, retention, early intervention and rapid rehabilitation in the workplace are likely to be more effective remedies over time. Good work can be protective of health and prevent issues from occurring. We should be striving to achieve that.[4] However, when ill-health does occur, or barriers to work are faced by disabled people, the system needs to act more quickly and effectively. Strenuous efforts are also required to move people towards work, focusing particularly on young people who have never worked, and those who have recently become economically inactive.

[4] “Healthcare Professionals’ Consensus Statement for Action on Health and Work” AOMRC, January 20, 2025,

9. To achieve the degree of change required to power up prevention, retention and rehabilitation demands “system” change rather than making tweaks around the edges. That will take time, but there is potential for significant improvement. We have identified three areas that we expect to focus on as we develop recommendations:

a. **Incentives:** Our view is that employers are generally highly incentivised to retain employees, and many are investing more than ever before in making work more protective of health and in improving health and wellbeing at work. However, at critical moments in managing absence, these incentives are muddled, especially for employees, or misaligned between employers and employees.

b. **Interventions:** When people face ill-health, fluctuating conditions or barriers to work, there is often a lag before they access effective support and treatment, especially related to mental health – leading to deterioration in outcomes and longer periods out of work or early exits.

c. **Case Management:** When people are absent from work because of ill-health or barriers faced by disabled people, there is little in the way of effective case management or leadership, precisely at a time when that support is most needed.

10. Creating and supporting better pathways back into work, or into work for the first time, is also vitally important. Our analysis points towards focusing most on returning people to work as rapidly as possible - those out of work for less than a year are nearly 5 times more likely to return than those out of work for longer.

11. The government, its agencies and local organisations are likely to be the lead actors here, but, with employers playing a key supporting role. As such, in developing recommendations in this area, we will reflect on reform options the government is considering as a part of the Get Britain Working White Paper. We also expect to build on the recent work of the Pathways to Work Commission, published in July 2024.

12. We will bring forward recommendations this autumn and are approaching that in three phases - discovery, engagement, and recommendations. This initial discovery report sets out our current perspective on the challenge we face and our views on where we need to focus in addressing it. The purpose is to prompt engagement - we want to hear what we have got right, what we have not, what we may have missed, and examples, especially those backed by impact evidence, of interventions that have worked.

13. We look forward to continuing the conversation.

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Introduction

14. The Get Britain Working White Paper sets out the Government's plans to kick-start growth by committing to building an inclusive and thriving labour market. These plans aim to improve standards of living and ensure the United Kingdom can fund vital public services by breaking down barriers to opportunity and bettering the health of the nation.[5]

[5] Department for Work and Pensions, "Get Britain Working White Paper," GOV.UK, November 26, 2024. Get Britain Working White Paper - GOV.UK (https://www.gov.uk/government/publications/get-britain-working-white-paper)

15. As part of these plans, the Government has set a long-term ambition to achieve an 80% employment rate, which would rank the UK as one of the highest performing countries in the world. To achieve this ambition, the UK would need the equivalent of over two million more people in work based on today's numbers.[6] Succeeding in this mission is critical to ensuring future growth and prosperity of the UK.

[6] "Get Britain Working White Paper" Analytical Annex. Get Britain Working White Paper - GOV.UK (https://www.gov.uk/government/publications/get-britain-working-white-paper)

16. Reversing the increase in economic inactivity linked to ill-health and reducing the barriers faced by disabled people is, therefore, a national priority. These groups are much more likely to fall into economic inactivity and, once there, find it challenging to return to the labour market. This adversely impacts the people affected, businesses, the economy, and public finances.

17. Successfully tackling this issue is unlikely to be achieved by the Government or employers acting alone. Instead, employers have a key role to play in creating inclusive workplaces that protect mental and physical health and support the retention and rehabilitation of employees, including disabled people and people with health conditions, and the government has a responsibility to encourage, champion and support effective practices.

18. This review focuses primarily on how employers can prevent people from falling out of work due to ill-health and the barriers faced by disabled people and how they can create new pathways for reintegration. More specifically it focuses on working together with relevant stakeholders, including businesses, health and disabled people's representative groups and individuals with lived experience, to understand what employers and government can do to increase support and skill-building to help people with ill-health remain and reintegrate into the workforce.

19. The review complements plans already underway to Make Work Pay and to consider reform options for the health and disability benefit system aimed at helping more people stay in work, improve job security and boost living standards. These are important reforms; they impact people in and out of work and influence the confidence with which individuals enter the labour market and engage with employers.

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The landscape

Summary

- The **UK's economic inactivity rate has risen since 2019-20**, reversing the downward trend of the previous 25 years. The **UK appears to be an outlier** in this trend compared with G7 and OECD nations.
- The increase in economic inactivity since early 2020 has been driven by an increase in the number of people reporting they are **economically inactive due to ill-health and long-term sickness**. This is now the most common reasons for economic inactivity.
- Over this period there has been **significant growth in people reporting work limiting health condition** (both in and out of work). In 2024, there are more people in-work with a work limiting condition than there are economically inactive because of one.
- The growth in these conditions has been driven by increases in **mental health conditions** particularly amongst the younger cohort (16-34) and **musculoskeletal conditions** in the older population (50-64).
- Multimorbidity, mental health conditions, disability as well as lower educational attainment and longer periods out of work all increase the risk of being economically inactive for health reasons.
- With no changes, **projections estimate this trend to continue**, driving up Welfare spending to one of the highest levels across the OECD.

20. This section sets out the key high-level trends in the UK labour market regarding health-related economic inactivity and the expected future direction of these trends. It also provides the projected impact on UK Government spending on welfare to help frame the wider problem considered by this independent review.

21. We use a range of different terms across the landscape and wider discovery to discuss labour market populations. We have included a set of definitions in the annex to help the reader, along with notes on the data. The underlying data has also been published as official statistics with information on the methodology and data sources, including any limitations.[7]

[7] https://www.gov.uk/government/statistics/keep-britain-working

Labour market trends

22. The UK's economic inactivity rate has grown since early 2020 reversing the long-term downward trend of the last 25 years. This downward trend was mainly due to increased participation in the labour market from older people and women (and particularly older women). A brief rise in economic inactivity followed the 2008 financial crisis, owing to an increase in the number of students. Recently the rise has been driven by more people being economically inactive due to long-term sickness or ill-health.

Exhibit 1

Graph showing the economic inactivity rate. The rate (apart from during the financial crisis of 2009) generally declined between the mid-1990s and the start of the

pandemic. This was driven by more women working and an increase in the state pension age. Since the start of the pandemic the economic inactivity rate has increased from 20.3% to 21.5% at the end of 2024.

23. While international comparisons are notoriously difficult, the UK appears to be an outlier in terms of the recent growth in economic inactivity (Exhibit 2). The UK's level of economic inactivity is middle of the group compared with comparator countries across the OECD, however, when comparing the change in economic inactivity since 2019, the UK is one of the only countries to have seen a growth in their economic inactivity rate. We have provided more details on international comparisons in an annex.

Exhibit 2

Graph showing a comparison of the change in the economic inactivity rate between 2019 and 2024 for a selection of OECD countries. The UK is the only country to have seen an increase in the rate.

24. Within the UK, Exhibit 3 provides a breakdown of the 2024 UK labour market, showing the number of individuals who fall into the different categories of labour market.

Exhibit 3

Graph showing a breakdown of the UK population and for the 43 million people of working-age (16 to 64) by their labour market status. 31.4 million people of working-age in the UK are actively employed; 0.8 million are in employment but off work sick; 1.5 million are unemployed; 3 million are economically inactive due to ill-health and 6.3 million are inactive for other reasons such as being in full time education.

25. Sickness as a reason for economic inactivity has been growing since 2019 and now accounts for around three million people – about a third of those who are economically inactive. It has now become the most common reason for economic inactivity, having overtaken being a student.[8]

[8] Office for National Statistics, "INAC01 SA: Economic Inactivity by Reason (Seasonally Adjusted)," https://www.ons.gov.uk/employmentandlabourmarket/peoplenotinwork/economicinactivity/datasets/economicinactivitybyreasonseasonallyadjustedinac01sa/current.

26. Exhibit 4 shows the changes in these segments of the working age population since 2019. The analysis indicates that while there has been an overall increase in the working age population of around 3.6%, health-related economic inactivity has grown substantially faster over the period, increasing by around 34.6% between 2019-2024. The increase could be due to several factors, including changes in public awareness and attitudes towards health and disability increasing reporting. However, we have seen in other functional-based surveys (which do not rely on people self-reporting), that these are not the only factors.

Exhibit 4

Graph showing a breakdown of the UK working-age population between 2019 and 2024 by their labour market status. The number of people who are economically inactive due to ill-health increased by 34.6% between 2019 and 2024; the number unemployed by 18.6%; the number of people in employment but off work sick by 6.5%; the number who are actively employed by 1.6% with the number of people who are economically inactive for other reasons decreasing by 1.1%.

Health trends

27. These trends in health-based economic inactivity also correspond with a similarly steep rise in the number of individuals in the workforce who report having a work-limiting health condition as set out in Exhibit 5.[9] There has been long term growth in those reporting a work-limiting health condition, however over the last six years this has accelerated, the number of individuals in work reporting these conditions has increased by 30% to 4.1 million. In total, around 20% of the working-age population have a work limiting health condition.

[9] People who report health conditions that impact on the amount or type of work they can or could do. These people could be in or out of work.

Exhibit 5

Graph showing a breakdown of the UK working-age population between 2019 and 2024 by whether they have a work-limiting long-term health condition. In 2024 there were 8.7 million people with a work-limiting long-term health condition. Of which, 33% were economically inactive due to ill-health; 5% were unemployed; 4% were in employment but off work sick; 43% were actively employed and 15% economically inactive for other reasons.

28. There are now around 8.7 million people across the working-age population who report having a work-limiting health condition. There are three key take aways from these trends in the context of this review:

i. More people are in work with a work-limiting health condition than are economically inactive because of one. We have seen a significant growth in the numbers of people managing these conditions in the workforce.

ii. Based on these figures it is likely employers already have members of their workforce who are living and working with a work-limiting health condition. Health and disability are just as much an in-work issue as they are an economic inactivity issue.
iii. Of the 4.2 million economically inactive individuals, only 2.9 million report being economically inactive for sickness reasons. The remaining 1.3 million give their reason for economic inactivity as being carers, students or early retirees living with health conditions. This highlights how improving the way the workplace supports individuals to manage their health, and addresses the barriers faced by disabled people, could help people in other categories of economic inactivity to return to work.

29. Several key health conditions influence the trends in work-limiting health conditions across the working-age population. Exhibit 6 shows the incidence of main health conditions in 2023-24 and the relative growth in different conditions over the last decade, broken down by age and condition. While the largest group with health conditions remains the 50-64 age group, the number of people aged 16-34 is now similar (having grown substantially in the last decade).

30. Nearly 40% of people cite their main condition as either cardiovascular or musculoskeletal. These were more prevalent in individuals within the 50-64 age range, who accounted for nearly 60% of both groups. However, the largest increase in the last decade is due to individuals reporting mental health conditions, particularly those in the younger populations (16-34). The number of individuals reporting mental health conditions as their primary condition has increased by over 70% since 2015, with the younger population contributing over 60% of this rise. Cardiovascular and musculoskeletal conditions have remained relatively stable over the same period, with smaller increases in the 50- 64 age range. It is also worth noting that many of these conditions are linked for example, long term management of Cardiovascular or Musculoskeletal conditions can cause chronic stress and mental health conditions.

Exhibit 6

Graphs showing the number of working-age people in 2024 with a work-limiting long-term health condition and how this has changed since 2015 by main condition and age group. The main health conditions included are autism and learning difficulties; cardiovascular conditions; mental health conditions; musculoskeletal conditions; progressive illnesses and other conditions. The age groups covered are 16 to 34, 35 to 49 and 50 to 64.

31. We have also carried out further analysis to identify the key risk factors (propensities) that make people more likely to experience health-based economic inactivity across the different ages of the working-age population. Exhibit 7 presents some of these key factors, indicating how much more likely individuals with certain characteristics are to be economically inactive than the rest of their age cohort. This analysis highlights that the economically inactive are not a homogenous group: while some key themes emerge, there are different risk factors across various life stages.

Exhibit 7

Table showing the likelihood of being economically inactive due to ill-health by age group (16 to 34, 35 to 49 and 50 to 64) and certain health (whether they have a mental, physical or two or more long-term health conditions or are classed as disabled), education (whether their highest qualification is at GCSE or lower) or employment (whether they left their last job more than two years ago) related characteristics.

32. The results of this analysis are telling.

i. Across all age groups, there is a significantly higher risk of becoming economically inactive due to ill-health if one has a mental health condition, increasing the chance

by 3.2 - 4.7 times. This tends to impact the younger and middle-aged cohorts especially.

ii. Across all age groups, there is a much higher chance of becoming economically inactive due to ill-health if one is living with a disability (2.9 – 4.4 times). Once again, this impacts younger and middle-aged workers more.

iii. Multiple health conditions are among the strongest predictors of becoming economically inactive due to ill-health (2.8 – 5.3 times more likely).

iv. For all workers, extended time out of work significantly increases the likelihood of being economically inactive due to ill-health.

33. The industries with higher rates of former workers who are economically inactive due to long-term sickness, such as retail, hospitality, and health, include jobs which require more interaction with others, and are less adaptable to hybrid and home working. This may mean they are less flexible and harder to carry out while managing a long-term sickness. At occupation level, the lowest paid occupations were more represented among the long-term sick.[10]

[10] Office for National Statistics, “Half a Million More People Are out of the Labour Force because of Long-Term Sickness - Office for National Statistics,” www.ons.gov.uk, November 10, 2022,

34. At a regional level, we observed that regions with a higher incidence of the risk factors highlighted above also have higher economic inactivity. A comparison of these risk factors across regions with high and low economic inactivity is set out in the annex (Annex – Exhibit 3).

35. It is important to point out the intersectionality in this analysis: many people will face multiple risk factors, which compounds the likelihood of them falling into economic inactivity. For example, a younger person could face mental health issues, have lower educational attainment, and be in a region where the outcomes are generally poorer, thus compounding their likelihood of being economically inactive. Based on our discovery work, we have set out in the annex the types of tailored support that could help each age group.

Looking ahead

36. Up until now, the analysis has focused on the current situation and historical trends. Now, we want to highlight the importance of looking ahead and considering the future of this problem. The growth in health-based economic inactivity over the next five years could be four times greater than that of the working age population if past trends continue (Exhibit 8).

Exhibit 8

Graph showing the actual (in 2024) and projected (in 2030) distribution of the working-age population by labour market status. The projection assumes trends seen between 2019 and 2024 continue over the next five years. The number of

people who are economically inactive due to ill-health is projected to increase by 20%; those in employment but off work sick by 21%; those actively employed by 8%. The number of people who are unemployed is projected to decrease by 12% and the number who are economically inactive for non-health reasons by 13%. The working-age population as a whole is projected to increase by 5%.

37. These changes are driven mostly by the impact of an ageing population. However, the Health Foundation's *Health in 2040: projected patterns of illness in England*, flags further risk factors in their projections that could increase the likelihood of people becoming economically inactive. Their report highlights the effect of broader lifestyle risks, such as the greater incidence of obesity, the health-related factors discussed above and the increase in multimorbidity across all age groups. The presence of more than one health condition has been one of the strongest risk factors for becoming economically inactive. These long-term trends thus point to a concerning direction of travel.[11]

[11] "Projections of Ill Health: Overall Levels of Ill Health in England over the next 20 Years | Health in 2040: Projected Patterns of Illness in England," Health Foundation. https://reader.health.org.uk/projected-patterns-of-illness-in-england/projections-of-ill-health-overall-levels-of-ill-health-in-england-over-the-next-20-years#key-points.

38. The growth in economic inactivity is coming at a great cost to the economy, most obviously in growing spending on working-age incapacity and disability benefits. Exhibit 9 below shows the forecasted growth in spending on working-age incapacity and disability benefits. This is driven by increases in the benefit caseloads over time as a result of changes to the health of the working-age population, alongside other factors such as operational features of the benefits system with more people claiming and remaining on benefits for longer. These forecasts are broadly consistent with what we are seeing in terms of the incidence of health conditions and propensities across the population.

Exhibit 9

Graph showing actual and forecast expenditure on working-age disability and health-related benefits in £billions. This is forecast to increase from its current value of around £50 billion to around £70 billion in 2029.

39. Over the last four years, expenditure on working-age disability and incapacity benefits has increased from around £28 billion in 2019-20 to £45 billion in 2023-24 (a growth of 59%). This spending is forecasted to increase by a further £25 billion to over £70 billion (57% growth) by 2029-30. The Institute for Fiscal Studies recently observed that, over the same period (2019-20 to 2023-24), across 11 similar countries, all but one have seen stable or falling spends on their nearest equivalent benefits, with only Denmark seeing a significant increase. Even then, it is lower than the UK (13%). The IFS note that with this rate of growth in health-related benefit spending, the UK will likely become one of the highest spenders on health-related benefits amongst comparable countries.[12]

[12] "Health-Related Benefit Claims Post-Pandemic: UK Trends and Global Context | Institute for Fiscal Studies," Institute for Fiscal Studies, September 19, 2024,

https://ifs.org.uk/publications/health-related-benefit-claims-post-pandemic-uk-trends-and-global-context.

40. Exhibit 10 also highlights that the spend on incapacity benefits is not well correlated with the actual impact on economic inactivity. There are many other facets of a country's system that will be important. The international comparisons annex looks at these in more detail.

Exhibit 10

Graph showing a comparison of spend on incapacity benefits (as a % of GDP) in 2019 and the change in the economic inactivity rate between 2019 and 2024 for a selection of OECD countries. The UK ranked one of the lowest in terms of spending on incapacity benefits in 2019 although its share of spending is expected to grow from 1.3% GDP in 2019 to 2.2% by 2029-30. The UK is the only country to have seen an increase in the economic inactivity rate between 2019 and 2024.

41. The IFS have estimated that moving 400,000 people who are out of work due to ill-health back into work could save the Government around £10 billion through higher tax revenues and lower benefit spending.[13] There are big gains to be made in tackling this issue.

[13] Institute for Fiscal Studies, "The government's 80% employment rate target: lessons from history and abroad" (12 December 2024)

42. The Government does not solely bear the cost of economic inactivity and ill-health. An Oxera report in 2023 estimated that the total economic cost of lost output among the working-age population due to ill-health (sickness absence and economic inactivity) was around £150 billion per year (in addition to the cost to the government of around £70 billion).[14] These are costs shouldered by employers.

[14] Robert Catherall, "The Economic Cost of Ill Health among the Working-Age Population," Oxera, January 17, 2023, https://www.oxera.com/insights/reports/the-economic-cost-of-ill-health-among-the-working-age-population/.

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System dynamics

Summary

- The "journey" to economic inactivity is complex and non-linear and may involve multiple transitions between employment, sickness absence, unemployment and economic inactivity.
- Our analysis shows that once someone is out of work, the chances of them re-entering employment erode dramatically. If someone becomes unemployed their chances of moving into or returning within a year is 47%.
- This falls to just 3.8% if they become economically inactive for health reasons.
- Prevention, of both health and disability challenges arising in the first place and of people falling out of work, is very likely to be better than "cure".

- It is therefore a priority for the review to consider measures and initiatives to prevent people from falling out of work, protecting their health and ensuring support is readily available.
- This is where employers can play a lead role, have most influence and deliver the best return.
- If people do fall out, its vital to act fast. We have found people are 5 times more likely to return to work if it is within a year than if they have been out of work for more of than a year.

43. In this section, we seek to explain the dynamics within the “system” to see when and at what stages individuals become economically inactive.

44. We will cover the following:

a. **Pathways and dynamics of economic inactivity in the UK:** The journey into economic inactivity, highlighting the importance of prevention

b. **Addressing existing economic inactivity:** A deeper assessment of who is already economically inactive, with a particular focus on the characteristics that determine the likelihood of returning to work

c. **International comparison overview:** Lessons from other countries, with a particular focus on the balance of effort and effectiveness across prevention and return to work

A: Pathways and dynamics of economic inactivity in the UK

45. Economic inactivity is not a single-step process but a complex journey involving multiple transitions (Exhibit 11). People move between different states - such as sickness absence, unemployment, and economic inactivity - each with distinct challenges and potential intervention points. Our model presents a simplified version of reality: it is useful for understanding broad trends, but individual experiences are obviously far more varied.

Exhibit 11

Graph showing some of the movements between the four groups of people in the labour market. These are the 31.4 million (in 2024) actively employed; the 0.8 million who are in employment but off work sick; the 1.5 million unemployed and the 3 million who are economically inactive due to ill-health.

46. The journey is not linear; individuals may cycle through stages multiple times before becoming economically inactive. Different drivers emerge at each stage, meaning that interventions must be tailored rather than applied as a “one-size” approach.

47. Our analysis confirms that the further someone moves along the pathway towards economic inactivity, the harder it becomes to re-enter employment. For example, once someone becomes unemployed, their propensity to move into or return to active employment within a year is 47%, but, if they become economically

inactive for sickness reasons, this falls to just 3.8% (Exhibit 12).[15] These figures are even lower for those with health conditions, reinforcing the need for early intervention.

[15] https://www.gov.uk/government/statistics/keep-britain-working

Exhibit 12

Graph showing some of the movements between the four groups of people in the labour market. These are the 31.4 million (in 2024) actively employed; the 0.8 million who are in employment but off work sick; the 1.5 million unemployed and the 3 million who are economically inactive due to ill-health. People who are economically inactive due to ill-health are very unlikely (3.8%) to move into active employment.

48. We believe that preventing people from becoming economically inactive is at least as important as – if not more important – than trying to reactivate those who have already left the workforce. There are two key reasons for this:

a. First, our high-level modelling indicates that reducing the number of people leaving work into economic inactivity leads to significantly lower overall economic inactivity than an equivalent increase in reactivation rates (Exhibit 13).

Exhibit 13

Graph showing some of the movements between the four groups of people in the labour market. These are the 31.4 million (in 2024) actively employed; the 0.8 million who are in employment but off work sick; the 1.5 million unemployed and the 3 million who are economically inactive due to ill-health. The graph highlights that increasing the flow of people from economic inactivity due to ill-health to active employment by 50% would reduce the number of people who are economically inactive due to ill-health by around 100,000. Similarly, reducing the flow of people from active employment to ill-health related economic inactivity by 50% would reduce the latter by around 150,000.

b. Second, the effort and investment required to achieve that reduction in the number of people leaving work initially is likely to have a greater return. This is because employers are more likely to be the lead actor: they control more levers and can thus realise benefits faster and in more areas (Exhibit 14).

Exhibit 14

This chart visually represents the various intervention points across an employee's journey, focusing on health-related economic inactivity and return to work.

At the top, six key transition stages are displayed in a linear flow, each marked with a numbered coloured circle:
1. **Health Issues** (orange) – This stage highlights repeated or extended absences due to health problems.
2. **Departure from Job** (brown) – Employees leave voluntarily or due to termination, moving to unemployment or seeking new employment.

3. **Return to Employment** (green) – This stage covers rehabilitation and reintegration into the workforce.
4. **Withdrawal from the Labour Force** (blue) – Employees transition into economic inactivity from unemployment.
5. **Direct Exit into Economic Inactivity** (teal) – Employees leave the workforce directly from an earlier stage.
6. **Return to Labour Force** (grey) – The final stage focuses on re-engaging economically inactive individuals.

Below each transition stage, interventions are outlined. The employer's role is emphasised in early stages, such as preventing health issues, retaining employees, and supporting rehabilitation. In later stages, the government takes the lead in supporting economic re-engagement.

A gradient-coloured bar at the bottom shows a transition in responsibility from **employers to government**, reinforcing how early interventions fall within the employer's domain, while later-stage re-engagement efforts are government-led.

This structured flow emphasizes the need for proactive measures to prevent workforce exits and facilitate smoother re-entry for those who become inactive.

B: Addressing existing economic inactivity

49. It is also vital to address the question of how we can achieve better return to work pathways for the 3 million people already economically inactive due to ill-health. This group represents a potentially huge loss of human and economic potential, especially given the increasing number of people who are becoming economically inactive at much younger ages – around 25% of those economically inactive for reasons of ill-health are below the age of 35.

50. We conducted a preliminary analysis of the subgroups within the 3 million who are economically inactive. We sought to understand the varying propensity of different subgroups to return to work compared to the mean for the overall group: 3.8%.

Exhibit 15

Graph showing the average movement of people from economic inactivity due to ill-health to active employment on average between 2019 and 2023 by age, when left last job and number of long-term health conditions. 3.8% of people who were economically inactive due to ill-health moved into active employment on average between 2019 and 2023. This varied for those out of work for less than a year (18.4%) and those who were out of work for more than two years or never had a paid job (2.3%) and those with three or more long-term health conditions (2.0%).

51. Our preliminary analysis suggests varying propensities for re-entering employment among different groups (Exhibit 15). Younger workers exhibit twice the propensity to return to work after being economically inactive due to sickness. Those whose last job was within the past year have nearly five times the propensity to re-enter employment. The longer someone is out of work, the chance of moving back

into work fall dramatically. Individuals with only one health condition show a 1.4 times higher propensity to return. These insights indicate that interventions targeting these groups are likely to be the most effective.

C: International comparison overview

52. International comparisons must be made with care. Every country has different (and often complex) systems for addressing ill-health and the barriers faced by disabled people among working-age people, and each of these systems has evolved within sometimes radically different political and business cultures. Tempting though it is, you simply cannot “wish” to be like another country. However, there is value in considering different systems’ approaches and the outcomes they achieve.

53. These comparisons provide a perspective on how different countries balance the incentives and requirements on different “actors” within their systems. There are three main dimensions to this. The first is the levels of sick pay, which vary considerably, as does the responsibility for paying it. Second, there are also large variations in who is supported through sickness absence, and in the way in which that support is provided. And finally, there are many different approaches to coordination of support, case management and leadership across employers, employees, support and healthcare providers and government agencies.

54. These factors shape each system, resulting in a different balance of effort across prevention, retention, rehabilitation, benefits and rates of return to work. Countries that perform best overall in terms of economic participation tend be those where the emphasis within the system is balanced towards prevention with greater clarity and delineation in terms of roles and responsibility between the government and employers.

55. Our analysis suggests five principles that seem to underpin effective labour market design:

a. Strong employer incentives for prevention and retention

b. Early intervention and structured return-to-work support

c. Sufficient support during sickness while maintaining a dynamic labour market

d. Alignment between government and employer roles

e. Minimising structural barriers to re-employment

56. The full international comparison and analysis of these principles can be found in the annex.

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Engagement

57. The main purpose of this discovery phase is to prompt engagement with stakeholders. The introductory chapters set out our current understanding of the landscape of economic inactivity in the UK, and the complex system dynamics. This amounts to a strong case for ensuring people are prevented from falling out of work and into economic inactivity.

58. We see two main areas for this engagement. The first is “prevention” which essentially involves the steps that can be taken within the workplace to prevent people from becoming economically inactive. The second is “pathways back to work”, which involves the steps that can be taken to increase the rate of return to employment for those who are economically inactive.

Prevention

59. From our work so far, both qualitative and quantitative, our current perspective on likely focus areas for improving prevention, retention, rehabilitation and rapid return to work include:

a. **Incentives:** Our view is that employers are generally highly incentivised to retain employees, and many are investing more than ever before in making work more protective of heath and in improving health and wellbeing at work. However, at critical moments in managing absence, these incentives are muddled, especially for employees, or misaligned between employers and employees.

b. **Interventions:** When people face ill-health, fluctuating conditions or barriers to work, there is often a lag before they access effective support and treatment, especially related to mental health – leading to deterioration in outcomes, longer periods out of work or early exits.

c. **Case management:** When people are absent from work because of ill-health or barriers faced by disabled people, there is little in the way of effective case management or leadership, precisely at a time when that support is most needed.

60. To be clear, these are not necessarily the causes of the increase in economic inactivity we have observed, instead, it is our view that addressing these areas is likely to be critical to making improvements needed.

Pathways back to work from economic inactivity

61. So far, we have focused less in this area. This is no reflection of the seriousness we see in the loss of opportunity and life chances for those who are economically inactive and want to work. However, this is an area where the government (and its agencies) are more likely to be the lead actors, whereas the remit of this review is the role of employers. And we are anticipating change as a result of the Government considering reform options for the health and disability benefit system.

62. We have also noted the Get Britain Working White Paper published in November 2024 and the Pathways to Work Commission report, published in July 2024 by Barnsley Council and the South Yorkshire Mayoral Combined Authority. These look

in depth at these issues and includes recommendations and set out programmes of employment reform.

63. Rather than duplicating this work we have decided, at this stage, to focus our engagement mainly on the prevention aspects set out above where employers are most active and can have most influence. Pathways back to work will require a different focus. We will review this as the Get Britain Working programmes and the health and disability reforms become clearer.

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64. In the following sections, we have set out some current perspectives for each of the focus areas concerning “prevention”, along with what we think we will want to explore further with our stakeholders through engagement.

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Incentives

65. For any system to be effective, incentives and outcomes must be consistently aligned. While there is alignment of intent, at critical points the incentives become muddled or misaligned.

Employers

66. From our work to date it seems that many employers are strongly incentivised to retain their staff. They are committed to promoting good health and to creating environments that prevent ill-health from occurring and support disabled people in the workplace. These kinds of conditions are also likely to be protective of good mental and physical health more generally through good relationships, good management, control over work and flexibility. While it is difficult to assess objectively, it seems likely that employers are generally investing more in employee health and well-being today than ever before. In a tight labour market, there are sound financial reasons to do so.

67. However, when analysing closer consider how absence for ill-health or disability manifests in the workplace we have heard about instances where these incentives may be much weaker. For example:

a. Many absences for ill-health or due to barriers faced by disabled people are unplanned and occur suddenly. When an employer, or more likely a line manager, finds they are short of people, the immediate **operational** challenge is often how to complete the work requirement. In that instance, incentives to improve retention may come second to the more immediate imperative reorganise work and then to fill a vacancy.

b. It can sometimes be difficult to support people experiencing ill-health or barriers faced by disabled people. **Individual performance** may deteriorate, and the individual may not feel comfortable or be able to explain the reason. Often, this may be compounded by line managers or supervisors not having the confidence,

capability or even the expectation to be able to discuss this with their staff and make changes to accommodate and support them to stay in or return to work. It can also be hard for a line manager to discern what is going on; we have heard from employers that on occasion, people “just disappear” and submit a fit note a week later.

c. The above can lead to situations where the **financial** incentive to invest in retention is weaker than recruiting a replacement. The costs borne by employers for sickness absence are lower relative to some other European countries and may be worth paying versus the greater time and investment needed to pursue retention, especially where the role in question is relatively easy to recruit.

Employees

68. There is some evidence that changes in benefit policy and assessment methods may have created a greater incentive for some people to pursue benefits as an alternative to work. There has, for example, been an increase in case load for incapacity benefits, a higher conversion rate for applications and lower reassessment rate (refer to Exhibits 16 and 17). However, our strong view is that there is little evidence that those in work or those who have been in work until recently, set out with the aim of being “on benefits”.

69. There are strong incentives to be in work, not just financial, but also for reasons of purpose, personal fulfilment, and progression. Instead, after a series of poor experiences of work and perhaps accompanied by deteriorating health or additional barriers being faced, some people will reach a stage where economic inactivity and the associated benefits appear to be a better or indeed the only alternative to seeking to return to work. For example:

a. An individual who has a series of poor experiences of work may find themselves on a **slippery slope** towards economic inactivity. There is plenty of evidence that “good work” acts as a positive stimulus to health outcomes. The opposite is also true; lack of autonomy, insecure employment, or bad experiences of various kinds will themselves be detrimental, but they are also likely to contribute to ill-health.

b. This can lead to an individual deeming benefits **a more attractive option** than seeking new employment. Both scenarios offer little to no support, but new employment introduces uncertainty and the potential risk of repeating past bad work experiences.

c. Once economically inactive, that state can quickly become **embedded**. The likelihood of returning to work successfully falls steeply once someone has been economically inactive for more than two years. Furthermore, “off-flow” from benefits due to reassessment has fallen to near zero since the pandemic (Exhibit 17), meaning that once a level of benefits has been attained it is rarely reviewed.

70. There is wider Government work that will address potential reforms of the benefits system and therefore these are out of scope for the review. However, there is a need to address the wider incentive issues and other realities in the moments that matter.

Incentives: Engagement focus

- We would welcome evidence from stakeholders which focuses on initiatives that have been successful in better aligning incentives for employers and employees at the critical points discussed above.
- We would like to explore what has worked to increase the incentive to:

- Prevent ill-health from occurring in the workplace
- Retain employees who are experiencing ill-health or disability-related barriers to work
- Focus on rehabilitating employees to return to work more quickly.

Exhibit 16

Graph showing the number of people flowing on and off incapacity benefits between 2009/10 and 2023/24. Since 2018/19 the number of people flowing onto incapacity benefits has been greater than the number flowing off. This has meant an increase in the incapacity benefit caseload.

Exhibit 17

Graph showing the number of people flowing off incapacity benefits due to reassessment by benefit type from 2009/10 to 2022/23. The disallowance rate was generally decreasing between 2009/10 and 2020/21 but has increased in the last two years.

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Interventions

71. When people experience ill-health or disabled people face barriers at work, there is often a lag before they can access effective support. Delays in this support can exacerbate and deteriorate conditions, creating absences.

72. Between July 2023 and June 2024, 1.5 million people experienced a period of long-term sickness absence from work. Exhibit 18 implies there is a causal relationship between the length of time that people are off work due to ill-health and the likelihood of them leaving employment. The longer that people are away from the workplace the lower the likelihood of a successful return to work. Generally, when someone is out of work for more than a year, they are more likely to leave employment than return.

73. Additionally, around a quarter of those on long term sickness absence are absent for more than three months, which appears to be an inflection point at which the likelihood of return begins to markedly fall.[16] People whose long-term sickness absence was caused by a mental health condition are less likely to return to work compared to those with musculoskeletal or other conditions.[17]

[16] Department for Work and Pensions, “The Employment of Disabled People 2024,” GOV.UK, November 5, 2024, https://www.gov.uk/government/statistics/the-employment-of-disabled-people-2024/the-employment-of-disabled-people-2024.

[17] Department for Work and Pensions, “The Employment of Disabled People 2024,” GOV.UK, November 5, 2024, https://www.gov.uk/government/statistics/the-employment-of-disabled-people-2024/the-employment-of-disabled-people-2024.

Exhibit 18

Graph showing the duration of sickness for working-age people in employment between July 2023 and June 2024 who are off work sick. This is broken down by the percentage who stay in and the percentage who leave work following their absence. The likelihood of falling out of work increases as the length of sickness absence increases. 6% of people with an absence of four weeks left work compared to 51% of those absent for more than a year.

Delays to Support

74. The first port of call during periods of ill-health, fluctuating conditions or when dealing with additional barriers is most commonly a general practitioner (GP) or other healthcare professional in general practice. While waiting lists are a subject of debate, data from across England shows that waiting times to be seen in general practice are generally not a major issue with 80% of people having an appointment within two weeks (Exhibit 19).

75. However, the ability of general practice to play this first-line role is much more questionable. General practice staff are not generally qualified in occupational health. Additionally, they will not be well versed in a patient’s workplace dynamics and are unlikely to have the time to get to the bottom of the barriers they are facing in the workplace.

76. As a result, 93% of fit notes issued by general practice stated, “not fit for work”.[18] There is also a disparity between the level of detail that many employers might expect from fit notes if the system worked as intended (to support them in helping the employee) and the type of detail that health care professionals offer.[19]

[18] Note that fit notes can be issued by doctors, nurses, physiotherapists, pharmacists and occupational therapists. 90.4% of fit notes are issued by doctors.
[19] “Exploring Perceptions and Attitudes towards the Extension of Fit Note Certification,” GOV.UK, 2020, https://www.gov.uk/government/publications/exploring-perceptions-and-attitudes-towards-the-extension-of-fit-note-certification/exploring-perceptions-and-attitudes-towards-the-extension-of-fit-note-certification#summary.

77. While signing someone off as being unfit for (all) work may be appropriate in some cases, it may be less so in others, especially where retaining a connection with the workplace is beneficial to the individual and makes a return to work more likely.

Exhibit 19

Graph showing the time between booking a GP appointment, and the appointment date, as a percentage of total appointments. The chart shows that, in December 2024, 46% of appointments took place on the same day they were booked, with 7% taking place after one day, and 17% taking place between 2 and 7 days after

booking. 5% of GP appointments were recorded as taking place more than 28 days after they were booked in.

78. Waiting times for specialists are often much longer. Demand for treatment or interventions for musculoskeletal and mental health conditions, the two most common workplace-related health issues, has significantly exceeded supply. In England, waiting lists for MSK Community Services are high, at around 330,000 people in December 2024, the highest of all Community Service waiting lists. The waiting list increased by 29% over the previous 2 years.[20] For mental health, 1 million people are waiting to access services.[21]

[20] NHS England, “Community Health Services Waiting Lists”, February, 2025, Statistics » Community Health Services Waiting Lists
[21] British Medical Association, “Mental Health Pressures Data Analysis,” The British Medical Association, 2024, https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/mental-health-pressures-data-analysis.

Employer schemes

79. Set against this backdrop, we have found that many employers provide forms of occupational health services, vocational rehabilitation and employee assistance programmes (EAPs). Around three in ten employers provide occupational health services or vocational rehabilitation,[22] covering around half of the workforce[23]. These types of schemes are much more common in larger employers (89%) than in smaller companies (28%) and vary across sectors.[24] Around 13% of employers offer EAPs, which often include access to a variety of services including virtual GPs, therapists, and financial advisors. This can be dependent on the programme, however.

[22] Department for Work and Pensions, “DWP Employer Survey 2022”, GOV.UK, September 14, 2023, Department for Work and Pensions Employer Survey 2022 - GOV.UK
[23] Department for Work and Pensions, “Employee Research Phase 1: Sickness Absence, Reasonable Adjustments and Occupational Health,” GOV.UK, March 15, 2023, https://www.gov.uk/government/publications/employee-research-phase-1-and-2/employee-research-phase-1-sickness-absence-reasonable-adjustments-and-occupational-health#access-to-occupational-health-services.
[24] Department for Work and Pensions, “DWP Employer Survey 2022”, GOV.UK, September 14, 2023, Department for Work and Pensions Employer Survey 2022 - GOV.UK

80. These types of schemes are relatively widely available; however, we have not yet seen clear evidence of the levels of uptake by employees or their impact on absence and economic inactivity. These schemes are also more focused on rehabilitation than prevention.

Interventions: Engagement Focus

- We would be interested in hearing about activity and initiatives employers are undertaking to prevent health issues occurring, and to proactively remove barriers for disabled people, including how effective these initiatives have been.

- We are keen to understand initiatives being undertaken to improve access to support and treatment for employees (both in terms of the range of support and speed of access), again including evidence of how effective these initiatives are.
- We want to hear from occupational health and healthcare providers about innovations in interventions that yield better results, along with evidence of the impacts of these initiatives.

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Case management

81. Sickness absences and periods out of work to manage health conditions are highly individualised experiences, but these can often be times of loneliness and vulnerability. A lack of effective case management and support during these periods leaves people isolated and can increase the chances of an individual having to leave work or lengthen the time before successfully returning.

Employee journey

82. Every individual's experience will differ; but we have drawn up the illustrative "journey" below to describe the stages an employee facing a decline in health may pass through.

Exhibit 20

Diagram showing level of employee attitude to employment throughout an illustrative journey of an employee going through an experience of a decline in health leading to economic inactivity. Employee attitude to employment gradually declines through a series of mostly negative experiences.

- Step 1: Employee is struggling at work with their health condition or disability. Negative impact.
- Step 2: Employee approaches their line manager to discuss the issue. Manager identifies some flexibilities and adjustments and implements them that initially help the employee. Positive impact.
- Step 3: The adjustments help but the condition fluctuates and the individual's health continues to decline. Negative impact
- Step 4: Manager suggests a referral to occupational health service. Positive impact
- Step 5: Occupational Health support meets the employee and discusses the condition – makes some recommendations to employee/ manager on further adjustments. Positive impact. Negative impact
- Step 6: Individual continues to struggle with their health and goes off sick so goes to visit the GP who provides a fit note saying individual is "not fit for work". Negative impact
- Step 7: Individual wants to remain in contact with work, so asks if they can work reduced hours but employer is concerned this could cause issues due to the "not fit for work" GP assessment so declines. Negative impact
- Step 8: Individual begins to feel isolated and this worsens their condition/ adds further illness. Fit note extended by GP. Negative impact

- Step 9: Manager does not want to be seen to harass member of staff so leaves them alone – due to length of absence, the process becomes more formal and HR are involved. Negative impact
- Step 10: Individual becomes anxious about job security which adds to existing health troubles. Negative impact
- Step 11: Individual eventually feels unable to return to work and has to leave
- Step 12: At this stage the individual may consider benefits as a better option than seeking new employment. Negative impact

83. We have identified two emerging issues here: a creation of distance between the employee and employer, and a lack of coordinated leadership or case management.

Distance between employer and employee

84. We have heard several times from employers in the early stages of the review that once their employees are absent from work, they “lose them” and communication and dialogue breaks down. Periods of absence are therefore circumstances which can put a strain on or create distance in the key relationship between employers and their employees when they may most benefit from support and strong management to help manage a successful return.

85. As described in the previous section, fit notes aren’t being used as intended. They create a degree of formality within the management of sickness absence; they have been described to us as being “like a firewall” between the employer and the employee. This separation is sometimes necessary and appropriate. However, it can also mean that constructive conversations regarding gradual or flexible returns to work are harder to initiate.

86. Employers also report lacking confidence in managing sickness absence. The fear of doing the wrong thing, harassing or pressuring employees or triggering tribunals acts as a barrier to regular contact or actively managing sickness absence. Employers described not knowing which party was responsible for instigating discussions about absence and return to work, how often they should happen, or even which issues should be discussed[25]. Some employers were also not sure whether they should contact employees at all.[26]

[25] Department for Work and Pensions, “Sickness absence and health in the workplace: understanding employer behaviour and practice,” July 20 2021, Sickness absence and health in the workplace: understanding employer behaviour and practice - GOV.UK (https://www.gov.uk/government/publications/sickness-absence-and-health-in-the-workplace-understanding-employer-behaviour-and-practice/sickness-absence-and-health-in-the-workplace-understanding-employer-behaviour-and-practice-report#employer-behaviours-in-managing-sickness-absence)
[26] Department for Work and Pensions, “Sickness absence and health in the workplace: understanding employer behaviour and practice,” 2021.

87. This uncertainty about how to strike the right balance between concern and not unduly pressuring employees was also a key issue for inexperienced employers. Employers described wanting to show their employees they were concerned about them and to find out when they might be able to return to work (to support with

planning work and cover), but also being concerned about over-contacting them during their sickness absence.[27] More often than not, this may lead to a lack of contact.

[27] Department for Work and Pensions, “Sickness absence and health in the workplace: understanding employer behaviour and practice,” 2021.

Lack of case management

88. Case management of workplace health issues is often performed by over-stretched general practice staff. They are well placed to case manage clinical conditions, however as described previously, they are not occupational medicine professionals and are not funded to perform occupational health case management and support employers. It is not their job.

89. Occupational Health services can provide case management function. However, we have also had feedback from employers and employees that recommendations for adjustments and interventions can be ineffective and are made without a good understanding of the nature of the characteristics of the work. Research by the Business Disability Forum showed that only 22% of disabled employees and 25% of managers said occupational health had helped support the employee in managing barriers at work or understand the adjustment that would help.[28]

[28] Business Disability Forum. “The Great Big Workplace Adjustments Survey 2023 - Business Disability Forum,” June 15, 2023. https://businessdisabilityforum.org.uk/policy-and-research/the-great-big-workplace-adjustments-survey-2023/.

90. There are several key elements of a coordinated employer-led approach that have been found to be effective at reducing sickness absence and supporting return to work. Effective case management and support should focus on interventions that incorporate early and sustained employer contact and support, coordination between employee, employer and the healthcare system, and appropriate adjustments to the role or workplace.[29] [30] [31] [32]

[29] Paul J Nicholson and Lode Godderis, “Occupational Health: Assess Value as ROI,” *Occupational Medicine* 69, no. 3 (April 2019): 158–60, https://doi.org/10.1093/occmed/kqz022.
[30] Gordon Waddell, A Kim Burton, and Nicholas Kendall, *Vocational Rehabilitation : What Works, for Whom, and When?* (London? Tso, 2008).
[31] National institute for health and care excellence, “Overview | Workplace Health: Long-Term Sickness Absence and Capability to Work | Guidance | NICE,” www.nice.org.uk, November 20, 2019, https://www.nice.org.uk/guidance/ng146.
[32] K. L. Cullen et al., “Effectiveness of Workplace Interventions in Return-To-Work for Musculoskeletal, Pain-Related and Mental Health Conditions: An Update of the Evidence and Messages for Practitioners,” *Journal of Occupational Rehabilitation* 28, no. 1 (February 21, 2017): 1–15, https://doi.org/10.1007/s10926-016-9690-x.

91. Several comparable OECD member countries have more active case management approaches than the UK. These bring together the employee,

employer and lead healthcare or occupational health professional to join up complex systems, help the employee access support and provide a forum for dialogue regarding options to facilitate a return to work for the employee or to explore alternative options if a return is not possible.

Case Management: Engagement Focus

- We are interested in hearing about experiences from employers and employees of effective case management and what supported this to work well and what barriers exist.
- A key to prevention is supporting people early. We are keen to explore examples and evidence of where employers have been able to work with employees to identify and manage health conditions and disabilities earlier and more effectively.
- We would like to understand evidence of where closer collaboration and engagement between employers, employees and other parties like Occupational Health or Health Care professionals have been achieved and the impact of that collaboration.

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Pathways back to work

92. As stated previously, rather than duplicate the work of the Barnsley review, the Get Britain Working White Paper and the government's consideration of reform options for the health and disability benefit system, we are proposing to focus our engagement predominantly around the three areas of "Prevention" set out above. We want to understand further how Government action on pathways back into work develops before assessing what role employers could play and how they fit in.

93. However, our analysis suggests there is a large variation in the likelihood of returning to work across the of the 3 million people who are currently economically inactive for reasons of ill-health and the barriers faced by disabled people.

Exhibit 15 (Repeated)

Graph showing the average movement of people from economic inactivity due to ill-health to active employment on average between 2019 and 2023 by age, when left last job and number of long-term health conditions. 3.8% of people who were economically inactive due to ill-health moved into active employment on average between 2019 and 2023. This varied for those out of work for less than a year (18.4%) and those who were out of work for more than two years or never had a paid job (2.3%) and those with three or more long-term health conditions (2.0%).

94. Our inclination would therefore be to focus our engagement on the groups within this population for whom the likelihood of returning to work is greatest, coupled with those characteristics that increase the propensity to become economically inactive (Exhibit 7) and where employers' involvement in those pathways is most likely to increase the chances of success for the individuals and their employers. This is something we may return to later in the review.

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Next steps

95. The challenges set out in this discovery are complex problems and are not going to be solved by one party acting on their own. We want to build and make the case for systemic change to this government and to employers. With that in mind, it will be vitally important that we have robust evidence to build the financial and business case for change.

96. We are therefore most keen to hear from those who can provide robust evidence to support their thinking.

97. With that in mind we are now entering a phase of intensive engagement across April and May. We are structuring the engagement and evidence gathering around three broad strands:

a. **Written feedback from stakeholders:** There will an online portal on Gov.UK setting out the key questions we would like stakeholders to respond to during the engagement phase of the review. We strongly encourage stakeholders to respond via this channel as it will support the review in analysing and gathering information and evidence efficiently.

b. **Face-to-face and virtual engagement:** We will be organising and working with partners to set up events and a series of in-person roundtables as well as virtual events to explore the areas set out in the discovery in more detail and to consider certain aspects of the problems in more detail. We plan to hold these across the UK.

c. **The voice of individuals:** It is vitally important that, as part of our engagement, we hear from people with health conditions and disabled people who have experience of the challenges and barriers described in this discovery. We are therefore planning focus groups and research to gather feedback and understanding from individuals with lived experience.

98. We will also be appointing a small panel to act as an advisory board to the review as we move through the engagement phase and into recommendations. The panel is expected to comprise largely independent people from a variety of relevant backgrounds. Membership of the panel will be announced shortly. We will also work with the DWP's Disability Panel that was announced as part of the Get Britain Working White Paper.

99. The challenges the review is looking to address are wide ranging and complex. This inevitably brings in a broad range of stakeholders, and we want to hear from as many of them as possible. The groups we would be keen to hear from include:

i. Employers (large, medium and small, across sectors and industries, including public sector)

ii. Business representative groups

iii. Trade Unions

iv. Health and disability charities and organisations

v. Disabled people's organisations

vi. People with lived experience

vii. Organisations providing different types of provisions or services, such as GPs and clinicians, occupational health professionals, EAP providers, insurance providers, and vocational rehabilitation providers

viii. Academics and research institutions

100. We are extremely keen to see evidence that provides information on the impact that specific schemes and initiatives have had compared with what would have happened without them. All shared views and evidence will be used in line with the data protection and confidentiality statement set out in the Annex.

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Annex: Labour Market definitions and data

Annex – Exhibit 1

[Included here is a table, the text has been lifted for your reference.]

In work
Employed
People aged 16–64 who did one hour or more of **paid work** per week and those who had a job that they were temporarily away from (for example, because they were on holiday or off sick)

Sickness absence
People in work who are **off work due to sickness or injury**. The period off work can be classed as either short (less than 4 weeks) or long-term (4 weeks or more)

Not in work
Unemployed
People aged 16–64 without a job, who have been **actively seeking work** in the past 4 weeks and are available to start work in the next 2 weeks)

Economically inactive
People aged 16–64 **without a job** who have **not sought work** in the last 4 weeks and/or are **not available to start work** in the next 2 weeks

Economically inactive due to short or long-term sickness
People who are economically inactive and give the main reason as short (less than 4 weeks) or long - term (4 weeks or more) sickness. Most (>95%) of this group will

also report a **long-term health condition** that is **work-limiting** and be classed as **disabled**

Long term health condition
People who report any physical or mental health conditions or illnesses lasting or expecting to last 12 months or more. This includes people both **in and not in work**

Work-limiting long -term health condition
People who report a **long-term health condition** that affects the **amount or type of work than can or could do**. This includes people both in and not in work. Most (>90%) of this group will also be classed as **disabled**

Disabled
People who report a **long-term health condition** that reduces their ability to carry out **day-to-day activities**. Some (~25% or 2.6 million) of this group will report a long -term health condition that is **not work-limiting**

[End of table.]

Data Sources and our approach to analysis

The independent Office for National Statistics (ONS) are responsible for the Labour Force Survey (LFS), which is an important source of labour market information both within and outside of Government. As such, DWP are supporting the ONS to improve the coherence and quality of the data given the increased volatility resulting from smaller achieved sample sizes. Despite these challenges, the LFS continues to be the main source of data for unemployment, economic inactivity, and provides a range of breakdowns that are not available from other sources. The ONS are currently publishing LFS-based labour market statistics as official statistics in development until further review and have advised that estimates of change should be treated with additional caution.

This is in line with the letter from the Office for Statistics Regulation (OSR) (https://osr.statisticsauthority.gov.uk/correspondence/ed-humpherson-to-alex-lambert-and-darren-morgan-labour-market-statistics-derived-from-the-ons-labour-force-survey-lfs/), stating that LFS statistics should not be published as accredited official statistics until the OSR has reviewed them. DWP continue to make more use of statistics based on administrative data (for example, benefit caseloads or HMRC PAYE data) alongside LFS statistics to form the best labour market view. LFS data has been used to inform this review with additional steps taken to ensure the data is robust as possible, such as aggregating or pooling data across several years to increase sample sizes. This data will be published alongside the review in accordance with the Code of Practice for Official Statistics (https://code.statisticsauthority.gov.uk/) and can be found at: https://www.gov.uk/government/statistics/keep-britain-working-2015-to-2024.

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Annex: Tailoring support to different segments of the workforce

Based on our analysis of risk factors for each age range, we have set out some ideas around the types of tailored support that could help these cohorts in the workplace.

Younger workers (16–34)
- Stronger mental health support at work including flexible work arrangements and job security measures.
- Opportunities to build work experience to increase skills.

Middle-aged workers (35–49)
- Greater requirement for adjustments and ergonomic workplaces.
- Phased return to work plans after periods of sickness absence.
- Case management to support management of health conditions.
- Support to manage risks around job strain and burn out.

Older workers (50 – 64)
- Access to flexible working that enable them to remain in the workforce while they manage health conditions, manage other responsibilities e.g., caring, and consider retirement.
- Greater use of reasonable adjustments that effectively target disabilities or health conditions.
- Advice and guidance for longer working lives.

Workers of all ages with Disabilities
- Effective anti-discrimination measures in the workplace.
- Greater focus on workplace inclusivity and design to help manage health conditions.
- Tailored support to ensure long-term employment stability.
- Better and quicker access to adjustments to help manage conditions.

Annex – Exhibit 2

Graph showing a breakdown of the UK working-age population by age (16 to 34, 35 to 49 and 50 to 64) and labour market status. Active employment is the most likely status for all ages but those aged 16 to 34 are more likely to be students and those aged 50 to 64 2.4 times more likely to be economically inactive due to ill-health than those aged 16 to 49.

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Annex: Regional analysis

Annex – Exhibit 3

Table showing the likelihood of being economically inactive due to ill-health by upper tier Local Authority and certain health (whether they have a mental, physical or two or more long-term health conditions or are classed as disabled), education (whether their highest qualification is at GCSE or lower) or employment (whether they left their last job more than two years ago) related characteristics. The Local Authorities with

the highest 6 and lowest 6 rates of economic inactivity due to ill-health are shown in the table.

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Annex: International comparators

101. **Comparing labour market systems across countries must be approached with caution.** National systems differ due to economic, legal, and cultural contexts, making direct comparisons complex. Comparable data is limited, particularly regarding sickness as a cause of economic inactivity, complicating direct assessment. Our approach blends quantitative and qualitative insights, drawing lessons while acknowledging policy differences.

102. **Incapacity benefit spending alone does not explain economic inactivity outcomes. There is little correlation between countries'** spending on incapacity benefits (as a share of GDP) and economic inactivity rates (Exhibit 4). Some countries have achieved significant reductions in economic inactivity or maintain low absolute rates, despite varied spending levels. This highlights the need to examine how funds are allocated, beyond direct financial support. The Institute for Fiscal Studies recently observed that, over the period 2019-20 to 2023-24, across 11 similar countries, all but one have seen stable or falling spends on their nearest equivalent benefits, with only Denmark seeing a significant increase. Even then, the growth rate is lower than in the UK (13%). The IFS note that with this rate of growth in health-related benefit spending in the UK, the UK will likely become one of the highest spenders on health-related benefits amongst comparable countries.[33]

[33] "Health-Related Benefit Claims Post-Pandemic: UK Trends and Global Context | Institute for Fiscal Studies," Institute for Fiscal Studies, September 19, 2024, https://ifs.org.uk/publications/health-related-benefit-claims-post-pandemic-uk-trends-and-global-context.

Annex – Exhibit 4

Graph showing a comparison of spend on incapacity benefits (as a % of GDP) in 2019 and the change in the economic inactivity rate between 2019 and 2024 for a selection of OECD countries. The UK ranked one of the lowest in terms of spending on incapacity benefits in 2019 although its share of spending is expected to grow from 1.3% GDP in 2019 to 2.2% by 2029-30. The UK is the only country to have seen an increase in the economic inactivity rate between 2019 and 2024.

103. **Each country has a distinct system for supporting workers** (Exhibit 5). Sick pay schemes vary, affecting worker security and employer incentives to manage absences. Dismissal regulations influence employer obligations and workforce stability. Infrastructure; return-to-work programs, occupational health services, and reintegration support, play a pivotal role in workforce retention.

Annex – Exhibit 5

[Included here is a table, the text has been lifted for your reference.]

Qualitative comparison of select OECD country workforce support

Country: Norway
Sick pay as % of salary: 100
Sickness pay duration and commentary: Full pay for 16 days from employer, then state covers up to a year
Dismissal regulations: Dismissal requires “just cause”. Redundancies must be made in consultation with unions/redundancy procedures. Strong protection against unfair dismissal
Infrastructure for managing employee journeys: Strong return-to-work programs, employer obligations, collaboration with unions, and public health services

Country: Denmark
Sick pay as % of salary: 100
Sickness pay duration and commentary: Employer covers first 30 days, then state provides benefits
Dismissal regulations: Dismissal requires “reasonable cause”. Redundancies must follow collective agreements and consultation. Weak unfair dismissal protection.
Infrastructure for managing employee journeys: Strong return-to-work programs, employer obligations, collaboration with unions, and public health services

Country: Switzerland
Sick pay as % of salary: 80
Sickness pay duration and commentary: Employer pays salary for a limited period (varies by canton) or provides insurance (typically 80% of salary for up to 720 days)
Dismissal regulations: Dismissal requires “just cause”. Notice based on contract or law. No specific legal redundancy procedure. No social justification needed, but protection from unfair dismissal applies
Infrastructure for managing employee journeys: Employer-provided insurance, disability insurance schemes, and structured return-to-work programs

Country: Sweden
Sick pay as % of salary: 78
Sickness pay duration and commentary: 80% of salary for up to 364 days
Dismissal regulations: Dismissal requires “just cause”. Redundancies must follow collective agreements and consultation
Infrastructure for managing employee journeys: Strong return-to-work programs, employer obligations, collaboration with unions, and public health services

Country: Netherlands
Sick pay as % of salary: 70
Sickness pay duration and commentary: Many employers offer enhanced sick pay at full pay for several months. Employers pay at least 70% of salary for up to 2 years (capped)
Dismissal regulations: Dismissal requires approval from court or Employee Insurance Agency (UWV). Long notice periods and severance pay are common. Strong protection against unfair dismissal
Infrastructure for managing employee journeys: Employers must create a reintegration plan (Wet verbetering poortwachter) with occupational health services

Country: Ireland
Sick pay as % of salary: 70
Sickness pay duration and commentary: Employer covers first 5 days of sick pay followed by statutory sick pay at 70% of salary up to a cap. Many employers offer enhanced sick pay
Dismissal regulations: Dismissal requires acceptable grounds. Redundancies must follow collective agreements and consultation. Only employees with 1 year service can claim unfair dismissal
Infrastructure for managing employee journeys: Unclear where responsibility lies between key actors. Government provides “Intreo” and employee retention grant to support employed disability management

Country: Germany
Sick pay as % of salary: 70
Sickness pay duration and commentary: Full salary for 6 weeks from employer, then 70% of salary (capped) from health insurance for up to 78 weeks
Dismissal regulations: Dismissal requires “socially justified” reasons. Works councils must be consulted. Notice periods increase with tenure. Strong protection against unfair dismissal
Infrastructure for managing employee journeys: Mandatory occupational health services and integration management programs Betriebliches Eingliederungsmanagement (BEM) for returning employees

Country: Japan
Sick pay as % of salary: 66
Sickness pay duration and commentary: No statutory sick pay. Health insurance provides 66% of salary for up to 18 months if the employer does not cover
Dismissal regulations: Dismissal requires “objectively reasonable grounds”. Notice periods set by company policy or contract. Longterm employment norms discourage sudden termination
Infrastructure for managing employee journeys: Employers support return-to-work with medical assessments, job modifications, and health and safety committees

Country: UK
Sick pay as % of salary: 19
Sickness pay duration and commentary: Mandatory Compensation cap per day. Statutory Sick Pay (SSP): £116.75/week (2024) for up to 28weeks. SSP currently starts on the 4th day of sickness
Dismissal regulations: Dismissal requires fair reasons with notice. Redundancy pay based on tenure. Redundancies follow collective consultation.
Infrastructure for managing employee journeys: Fit notes from GPs, phased returns, Occupational Health (OH) services, and access to ACAS for disputes

Country: US
Sick pay as % of salary: 0
Sickness pay duration and commentary: No legal requirement to pay sick leave. Voluntary employer-paid benefits like accrual plans or short-term disability benefits which cover the first 13-52 weeks may be provided

Dismissal regulations: In most states employee can be terminated for any reason unless prohibited by law (e.g. discrimination). Limited protection against unfair dismissal in these states
Infrastructure for managing employee journeys: Job Accommodation Network provides support to employers on provisions for employees with disabilities. Rehabilitation Act prohibits discrimination by specific types of employers

[End of table.]

104. **We selected Denmark, the Netherlands, and the United States for deeper analysis.** Denmark (Exhibit 6) balances labour market flexibility with strong social protections and active labour market policies, ranking first in the EU15 for employment rates among people with health limitations (75% vs 56%). The Netherlands (Exhibit 7) implements stringent employer responsibilities for sick employees, contributing to an eight-percentage point drop in economic inactivity between 2010-2023. The United States (Exhibit 8) relies heavily on employer discretion and private insurance, leading to gaps in worker retention and reintegration.

105. **No single approach works universally.** With this in mind, we have distilled five key design principles that underpin an effective labour market ecosystem:

i. **Employer incentives for prevention and retention:** Encourage businesses to invest in workforce health and retention, like the Netherlands.

ii. **Early intervention and structured return-to-work support:** Improve workforce participation with proactive occupational health policies, like Denmark.

iii. **Balanced flexibility with security:** Ensure worker support during sickness while maintaining a dynamic labour market, akin to Denmark's flexicurity model.

iv. **Strong alignment between government and employer roles:** Coordination of employer-led and public-sector initiatives to enhance workforce resilience.

v. **Removal of structural barriers to reemployment:** Ensure access to training, childcare support, and reintegration programs to prevent long-term economic inactivity.

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Annex – Exhibit 6

Denmark case study
Flexible labour market with comprehensive social security, prioritising job mobility and rapid reintegration. Employers play an active role in preventing long-term sickness absence, while municipal job centres provide structured support for reintegration

Context

- **Underwent extensive structural reform to correct high levels of unemployment**
- **Labour market experiences high turnover**, where approximately 20% of jobs are created or destroyed annually
- **Spends ~1.2% of GDP on Active Labor Market Policies**, including job counselling, training programs, and strict job-seeking requirements
- **Extensive social security system**
- **High degree of income equality**
- **Equal access to education** and **healthcare** for all Danish citizens and **high quality of services**

Approach

- **Employers are expected to prevent** sickness absence, but there are no strong additional incentives. **Employer's** have obligations that include

– Summoning sick employee for a **personal interview** within 4 weeks of illness onset
– Contacting **job centres** from the municipality where the employee lives
– Inviting the sick person to a meeting and creating a **reintegration plan**

- **Employee** can request **employment plan** after 8 weeks of illness
- **Municipal job centres** follow up with sick-listed employees

– Job centre requires **medical statement after 8 weeks**, regardless of previous submissions
– **Sickness benefits** require **work-related activities** as proposed by the job centre

- **Flexicurity model**

– Employers can hire and fire at will, without excessive costs for dismissing employees. Litigation surrounding dismissals is uncommon
– Employees who join and pay subscription fees to an A-kasse (unemployment insurance fund) receive up to two years' unemployment benefit after losing their jobs
– Government runs education and retraining programs and provides counselling services to get unemployed people back to work as quickly as possible

Key outcomes

- Denmark maintains a **relatively low long-term unemployment rate** of 25% compared to the OECD average of 35%
- **75% of displaced workers** find **new employment** within one year
- **High rate of employment of people with work limiting health conditions** (75% compared to EU15 average of 56% and UK 47%)
- **Low sickness absence rates** (4.34% in 2023)

Lessons for UK

- **Flexicurity model balances a flexible labour market with a strong social safety net**, supporting high job mobility and worker security and has proven resilient to shocks such as COVID-19
- **Labour market activation policies** support rapid reintegration into work
- **Comprehensive support for various demographics**, though challenges remain in addressing disparities between different worker groups
- **Ongoing investment in education and vocational training** keeps the workforce adaptable to market changes, with work-based training and apprenticeships aiding transitions

- **Offers unemployment benefits for up to two years at high compensation rates**, reducing inequality and supporting labour force participation
- **Close collaboration between job centres and employers** enhances job matching and worker reintegration
- **Government handles many responsibilities** through job centres, reducing the burden on employers

Source: OECD, Back to Work Denmark, Improving the re-employment prospects of displaced workers 2016; Follow-up regimes for sick-listed employees: A comparison of nine north-western European countries. Health Policy, 2022; IZA World of Labor Danish labour market 2000-2022, 2023; ESFP+ Decentralisation of Active Labour Market Policy, 2022; Press search. Danish website

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Annex – Exhibit 7

Netherlands case study
Employment law centred on strong employee protection and social security system. Employers are obligated to cooperate on return-to-work plans and provide generous financial support during sickness absence

Context
- **Privatisation of sickness insurance** was introduced in the 1990s when sickness absence rates were high at 8%
- Following a series of reforms, the Netherlands now has one of the **highest employment rates and workforce participation** rates in the EU at over 80%
- **Highest rate of part-time** workers in the OECD at nearly 40%
- **Labour market supply** is not rising to meet demands. Shortages in manual labour, digital and tech jobs, and health and social care are expected to increase
- **Health and welfare sector** has 17% of total jobs

Approach
- **Reforms to disability benefits in 2006** included reassessment of entitlements for those under 45 years old, an increase in the minimum work capacity reduction required for entitlement and stronger employee incentives
- **Employers are legally obligated to pay at least 70%** of salary for up to 2 years, in instances of sickness absence
- **Return-to-work plans** are jointly created by the employer and employer with collaboration from the occupational health services (“bedrijfsarts”) or the occupational health and safety service (“arbodienst)”
- **Protection against dismissal** during illness, employees cannot be dismissed during the first two years of sickness unless they refuse to cooperate on reintegration efforts.
- **Dismissal needs approval** from court or Employee Insurance Agency (UWV)

Key outcomes
- **Highly structured and supportive system**, increased collaboration focusing on healthy and sustainable reintegration to work

- **Proactive Occupational Health Involvement**: Dutch employers involve Arboarts (OH physicians) early in the sickness absence process to assess and advise. Plays a proactive role in identifying health risks
- **Incentivised early intervention** and reintegration return-to-work plan ("re-integratietraject) has led to low long-term sickness absence rates
- **Trend towards hiring workers as freelancers** who are not entitled to same protections. The Dutch government is trying to counter this through regulation

Lessons for UK
- **Employer incentives can be powerful drivers of behaviour**
- **Working conditions** as a common interest for employers and employees
- **Joint development** of a reintegration plan can encourage trust and cooperation
- **Extended Sick Pay Responsibility** has the potential to reduce stress and anxiety amongst those on sickness absence and enable engagement on rehabilitation
- **Reintegration Obligations:** Shared obligations to work towards reintegration could encourage the adoption of reasonable adjustments, including to working conditions, alternative roles and to hours
- **Earlier Occupational Health Interventions** could prevent longer absences and improve health outcomes

Source: OECD, Back to Work Denmark, Improving the re-employment prospects of displaced workers 2016; Follow-up regimes for sick-listed employees: A comparison of nine north-western European countries. Health Policy, 2022; IZA World of Labor Danish labour market 2000-2022, 2023; ESFP+ Decentralisation of Active Labour Market Policy, 2022; Press search. Danish website

Source: The return-to-work plan | UWV: Labour market information (https://www.werk.nl/arbeidsmarktinformatie)

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Annex – Exhibit 8

United States case study
Underinvestment in worker conditions and overreliance on market mechanisms exacerbate inactivity during crises, while failing to build the health support or wage floors needed for sustained labour force participation

Context
- **Deep-seated problems for low-wage** workers before COVID-19, with 44% earning low wages in vulnerable sectors
- **Decades of prioritising labour market efficiency** over resilience led to vulnerabilities such as underinvestment in worker protections
- **US saw a decline in middle-wage jobs** and a rise in low-wage roles, making the workforce highly susceptible to economic shocks
- **Labour market lacked resilience during economic shocks**, with 22% of workers lacking employer-sponsored healthcare and facing high risks of sudden income loss which fostered more economic inactivity

Approach

- **Focus on reactive measures:** relied on measures like Unemployment Insurance (UI), neglecting proactive investments and rejecting proactive models like Germany's Kurzarbeit scheme, opting for mass layoffs that severed employer-worker relations
- **Root causes unaddressed:** drivers of disengagement such as stagnant wages, minimal paid leave and employer underinvestment in training remain unaddressed
- **Lack of employer led occupational health** which is instead driven by healthcare system, usually through private insurance (either self-funded or offered as employer benefit)
- **"Low-Skill Equilibrium":** Businesses avoid upskilling workers they expected to leave, while workers lacked incentives to invest in training for low-paying, "dead-end" jobs
- **Inadequate Unemployment Insurance system:** Despite temporary pandemic expansions, the UI system remained fragmented and often inaccessible to vulnerable workers like gig workers and part-time employees

Key outcomes

- **Rapid job losses and slow recovery** compared to peer nations
- **Disproportionate impact** on sectors that employ **low-wage** workers without health insurance (e.g., hospitality and retail)
- **Surge in economic inactivity due to high childcare costs** and **inadequate reskilling programs**, hindering displaced workers' re-entry
- **Limited employer-sponsored training** and pre-existing skills gaps prolonged inactivity in the US compared to the EU
- **Means-tested benefits deepened inequalities**, with Black and Hispanic workers facing higher inactivity rates post-COVID

Lessons for UK

- **Proactive vs. reactive policies:** Reducing economic inactivity demands proactive policies that address job quality and worker security, not just reactive measures like UI
- **Employer accountability:** Alongside supply-side reforms (e.g., job centers), there must be greater employer accountability for wages, working conditions, and worker training
- **Integrated support systems:** Integrating services like healthcare with employment support is essential for addressing the complex needs of individuals facing inactivity
- **Living wages and job quality:** Policies promoting living wages and improved job quality are crucial for encouraging labour force participation. This includes investments in training, aligned with labour market demands
- **Universal social safety net:** Strengthening the social safety net with universal safeguards, rather than relying solely on means-tested benefits, can reduce inequality and provide crucial support during economic transitions

Source: Brookings, Our employment system has failed low-wage workers. How can we rebuild?, 2020; NIH, The U.S. Labor Market During and After the Great Recession: Continuities and Transformations, 2018; Bangpan M, Mendizabal-Espinosa R, Li Z, Lin D, Kneale D, Vigurs C (2024) Understanding the impact of

economic inactivity interventions for people with poor health and disability and the nature of interventions for older workers: a rapid evidence review London: EPPI Centre, UCL Social Research Institute, UCL Institute of Education, University College London; ECB The US labour market after the Covid-19 recession, 2022

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Annex: Data protection and Confidentiality

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