Action for healthier working lives

Final report of the Commission for Healthier Working Lives

The Health Foundation

Commission for Healthier Working Lives

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We are an independent, cross-sector group – including policy experts, employers and worker representatives – building a consensus for the action needed by government and employers to meet the UK's work and health challenges.

This report, Health Foundation analysis for the Commission and reports from our research partners are all available at www.health.org.uk/commission-for-healthier-working-lives.

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Foreword

Welcome to our report on healthier working lives.

As the Commission got underway, it became increasingly clear that people are fighting against an unfit system – and that we all need to think very differently about health and work.

There has never been a better time to do that, with an urgency driven by the sheer number of people with work-limiting conditions, an ageing population reliant on sustaining healthy people of working age and whole industries facing the very real challenge of not knowing exactly where their next generation of workers will come from.

Our interim report endeavoured to bring clarity to the scale and dimensions of these challenges – and the opportunities that exist if we can tackle them.

It would be easy to get stuck on how hard it can be to drive large-scale systemic change. However, it is possible to undertake actions right now that can make a real difference, and we found many examples of individuals and organisations doing just that. We also need longer term actions to lay the foundation for a system that works better for everyone.

As you read our findings and recommendations, I encourage you to consider where they challenge your assumptions about work, health and the respective roles of individuals, employers and government.

People who want to be in work have told us time and again the difference that can be made by early, simple actions, such as:

- designing roles and adjusting workloads to enable good health
- creating a culture where colleagues check in on each other – just as we do outside of work, noticing if someone seems distracted or not themselves – and providing access to more specialist support when needed
- structuring roles and work to allow flexibility, enabling people to stay in work, earn a living and maintain the connections so important for mental health.

We know all too well one of the most common reasons people fall into financial distress is a physical or mental health issue that takes them out of the workplace. This can result in steep declines in mental health that place them in further jeopardy. Changes to the welfare system are needed to support people in managing their health and getting back into work without the fear of losing income and security if it does not work out. This type of support needs to extend to the self employed – a large part of our workforce who often fall between the gaps in the system.

For employers, whole industries are facing the challenge of an ageing workforce. The current physical and mental pressures of work are making it increasingly hard for employers to attract and retain people. There are great examples of employers trialling new ways of scheduling to provide employees more control and certainty over their work. It will take collaboration within and across industries to undertake this type of redesign on a more systemic level.

For policymakers and beyond, the way in which we think about work and design the world around it needs to be rethought. Without integrated planning, people managing health conditions can find themselves travelling hours to their place of work, travelling further hours to health appointments in different parts of town and navigating transport systems not equipped for such travel patterns. Inadvertently, a hidden labour is built into how our world is constructed that falls on those least able to bear it.

Above all, our thinking about work and health needs to centre on people and what they are able to do. Then we will be able to design work, systems and policies that enable people to be in work and have all the positives that come from it.

Sacha Romanovitch OBE
Chair of the Commission for Healthier Working Lives

Executive summary

Declining health among working-age people is a growing risk to both livelihoods and economic prosperity. Too many people leave work due to ill health with little support to stay employed. 8.2 million working-age people have work-limiting health conditions, and each year over 300,000 people leave their jobs and end up out of the workforce entirely with health conditions – predominantly musculoskeletal or mental health conditions.

Losing work can have devastating personal consequences. For the country, rising ill health means lower tax revenues, reduced spending power and higher benefit costs – a significant strain on public finances and extra pressure on the NHS. These trends undermine plans to raise the state pension age, with people forced to leave work early, risking poverty and higher welfare costs. The rising number of younger people experiencing mental health conditions and spending time out of the labour market raises serious concerns about their future earnings and financial security.

The cost of inaction is high and only likely to grow.

Government has acknowledged the link between health and economic success. A narrow focus on short-term benefit savings and reducing headline NHS waiting lists risks repeating past policy failures and limiting impact. Current pilot programmes, the forthcoming Green Paper on disability and health-related benefits and the Keep Britain Working review of employer practices present an opportunity to build lasting solutions instead.

This report calls for major changes in government policy and employment practices. It sets out practical steps to shift policy and action towards earlier intervention. Some changes will require investment, while others focus on using existing resources more effectively. Reform will take time – action must start now.

Why this matters

Health-related exits from the workforce are costly for individuals, businesses and the wider economy.

- Each year, around 300,000 people move from being in work to being out of the workforce with a work-limiting health condition.
- Poor workforce health is estimated to cost UK employers up to £150bn a year through lost productivity, sickness absence and recruitment costs.
- Public spending on incapacity benefits is expected to rise in 2024/25 real terms from £20.9 bn a year in 2019/20 to £32.1bn by 2029/30.

The personal impacts can be severe – from falling into poverty and poorer health to losing one's identity and social connections. Once people leave work due to ill health, they often struggle to return. Only 3% of people with work-limiting health conditions return to employment after 12 months out of work, with particular challenges for those in areas with weaker labour markets.

People who have already left the labour market should have the support they need – but preventing health-related job loss must be a priority.

The work and health challenge

8.2 million working-age people now report a long-term health condition that limits their ability to work. Mental health conditions have risen significantly, particularly among younger workers. At the same time, more people are living with multiple health challenges, which can be harder to manage and make working more difficult.*

Much of the burden of ill health could be prevented through wider changes in public health policy. But even if committed to by government, such action will take time to have an effect. Employers need to act and adapt now to enable people with poor health to stay in work for longer.

Employment plays a key role in protecting and improving people's health and wellbeing. Good-quality work provides income, purpose and stability – all of which support good health. However, poor-quality work – stressful conditions, inflexible working arrangements and poor job design – can make health worse, especially in demanding sectors like health and social care and transport and logistics. Today, 1.7 million people in Great Britain have health conditions caused or made worse by work.

Work and health challenges are not the same everywhere in the UK. Some areas have far higher rates of people not in the workforce for health reasons. Differences in population health, education and economic factors shape local employment opportunities for people with health conditions.

Evidence shows that, with the right support at the right time, people with diagnosed illnesses can often continue to work effectively. It is not just the condition itself but a mix of physical, psychological and social factors that determine whether someone can stay in work. While better access to primary and community health care is important, this alone will not solve the problem.

Many people could remain in work with better flexibility, job adjustments and timely support. We heard from a number of leading employers who are taking a comprehensive approach to workforce health by providing support for workers with health issues while considering broader factors like job design and leadership culture. Yet, many employers – already facing other pressures – often lack the knowledge or capacity to create the right conditions to support and retain their workforce when health issues emerge.

* Recognising the limitations of recent survey data, we examined a wide range of available evidence and believe the trends in deteriorating working-age health must be taken seriously.

A system that does too little, too late

The UK's work and health system does not do enough to prevent health-related job loss. A typical journey out of work involves multiple missed opportunities for intervention:

- A failure to create working conditions that consistently protect health from the outset through good job design, reasonable adjustments, effective absence management and flexible working.
- Varying levels of workplace support for people with health conditions. Department for Work and Pensions data suggest 29% of employers offer little or no health-related support, and only 45% of workers have access to occupational health or vocational rehabilitation services.
- Statutory sick pay that is too low to provide financial security, forcing many to work while unwell or leave employment entirely. While some employers offer additional support, many do not, leading to uneven protection for workers and weak incentives to invest in workplace health.
- A welfare system that is slow, rigid and ineffective at supporting a return to work. Many people have a long wait before moving straight onto long-term benefits without access to opportunities for rehabilitation or retraining.

For those who could return to work with the right support, the high-stakes Work Capability Assessment creates a fear of losing financial security, preventing many from trying.

Despite the case for action to address all these missed opportunities, the policy debate is too often focused on reducing the benefits bill – overlooking those at risk of leaving work. As a result, support is more concentrated on getting people who receive benefits to enter work than preventing people from falling out of work.

A different approach is needed that prevents work-related health issues from arising, keeps people in work where possible and supports them to return quickly if they leave.

Learning from other countries

The UK is not alone in facing these challenges, but other countries have taken more effective approaches:

- Employment rates for people with health conditions are higher in many European countries than in the UK.
- Early intervention is standard practice in countries like the Netherlands and Denmark, where structured return-to-work support is available before people move onto long-term out-of-work benefits.

Previous UK reforms have often been short term or underfunded, leading to repeated cycles of policy change without sustained progress. Other countries have succeeded because they have committed to long-term investment in early intervention and practical support.

A better approach

We have reviewed the evidence and consulted employers, worker representatives, sector leaders and people with experience of work-limiting health conditions. This work has informed our case for an ambitious shift in focus from late-stage intervention to early action that prevents job loss and supports retention.

To build a system that enables sustainable employment and good work while reducing health-related job loss, reform should be guided by three key aims:

1. **Prevention through best practice** – Many employers, particularly smaller ones, lack clear guidance or evidence on effective workplace health practices. Strengthening understanding across different settings, keeping guidance up to date and promoting standards and resources on accessible working can help ensure best practice is widely applied and continuously improved.

2. **Capacity for early, joined-up support** – Too many people fall out of work because they lack timely access to health and employment support. Expanding caseworker-led services and vocational rehabilitation capacity can help people manage health conditions and stay connected to work. This requires upfront investment in front-line services and better coordination across sectors.

3. **Incentives to support preventative action** – Statutory sick pay and social security should help people to stay in or return to work where possible while encouraging employers to take early action on workforce health.

Our recommendations provide the key components of an effective system that could help achieve these aims. Together, they provide the foundation for employment practices that support a healthier workforce while aligning financial incentives. Change cannot be delivered overnight, but a government serious about seeking growth and prosperity has little alternative but to commit to these ambitions.

The benefits of reform

Initial modelling suggests that fully implementing more proactive practical support – the focus of recommendations 2 and 4 – could help 100,000 more people stay in work within 5 years. Even after accounting for the costs of support, this could save £1.1bn over 5 years, with significant ongoing savings beyond that point. A more supportive approach could potentially deliver further savings by re-engaging existing incapacity benefit recipients.

To help ensure our recommendations are made a reality, the Health Foundation is committed to further refining, testing and developing proposals and taking forward action for healthier working lives.

Summary of recommendations

1. **Update and apply best practice in accessibility, workforce health and retention, with a focus on at-risk sectors.** The government should work with sector leaders, trade unions and health experts to update evidence and solve shared workforce health challenges. This will ensure best practices are effectively applied, including in sectors under strain like social care and transport and storage.

2. **Embed early intervention through a caseworker-led support model that matches help to individual needs.** The government should roll out a locally based caseworker service to provide independent advice to employers and advocacy for workers. The focus should be on addressing work and health challenges and preventing unnecessary job loss due to health issues, not just diagnosing conditions.

3. **Commit to reviewing statutory sick pay to improve financial security for workers.** The government should review statutory sick pay levels within this parliament to ensure better financial security for workers, targeting a level closer to 60 to 80% of usual earnings. Reforms should incentivise all employers to proactively support workforce health, with targeted help to manage higher costs.

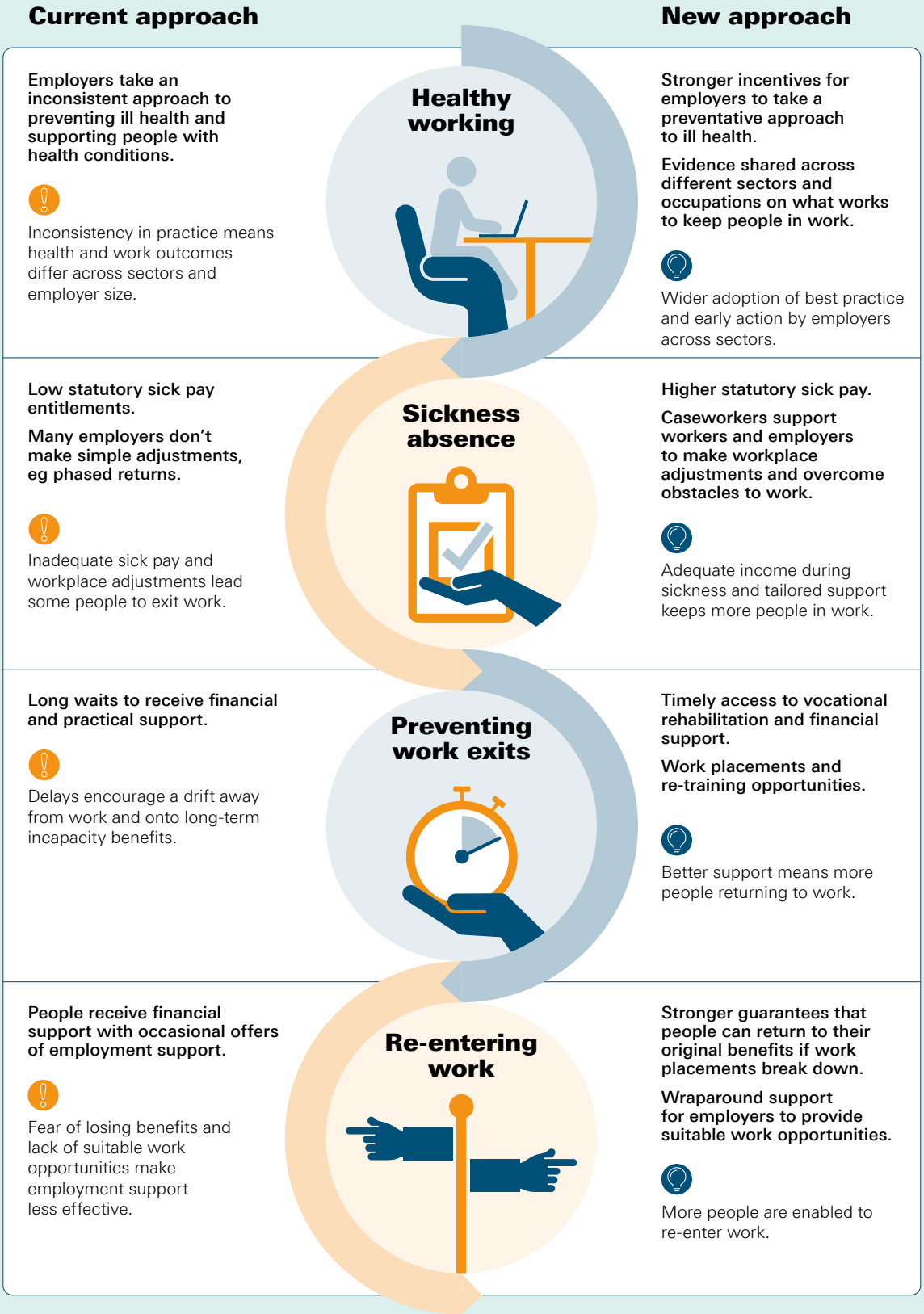
4. **Introduce a vocational rehabilitation benefit to help people stay in work after statutory sick pay ends.** The government should provide up to 12 months of financial support after entitlement to statutory sick pay ends, coupled with practical support to help people remain in the workforce, preventing long-term incapacity.

5. **Develop a stronger 1-year job guarantee for workers on long-term sickness absence.** The government should explore stronger job retention protections to ensure workers on long-term sickness absence are not dismissed too soon and have a clear route back to their employer where possible.

6. **Trial local job-pooling initiatives for workers unable to return to their previous roles due to health challenges.** The government should work with employers and local authorities to trial job-brokerage and pooling initiatives, helping people with health challenges move into suitable alternative roles when returning to their previous employer is not possible.

7. **Deliver a bold new back-to-work offer for people receiving work-related health benefits.** The government should incentivise and reduce the risks of moving into work by allowing people to try working for at least 18 months without losing their health-related entitlements. Voluntary access to employment support should be available. Once employment is sustained, financial support should taper gradually to prevent sharp drops in income.

A new approach to keep people in work



A woman works from her home office.

Credit: CocoSan

1. Introduction

Employment plays a key role in protecting and improving people's health and wellbeing. Good-quality work provides income, purpose and stability – all of which support good health. However, in the UK, health challenges can cause people's links to work to break down too easily.

8.2 million working-age people report having a long-term health condition that limits their ability to work. While employment rates for this group have improved in recent decades, only half are in work today. Each year, over 300,000 people leave their jobs and end up out of the workforce entirely with work-limiting health conditions, predominantly musculoskeletal or mental health conditions such as anxiety and depression.[1]

Leaving work due to poor health is rarely a choice. The personal impacts can be devastating – from falling into poverty and worsening health to loss of identity and social connections.

> Nobody understands the devastation that causes… Nobody chooses to be unwell, not go back to work or annoy their employer.
>
> **Jonny, 54, from Northumberland**

The long-term impact can also be significant. Workers who spend 2 years or more out of employment face a 25% loss in pay if they return, often moving into lower-paid, lower-quality jobs that do not make best use of their skills.[2,*] The longer someone is out of work, the harder it is to get back in, especially for people with work-limiting conditions.[†] This is particularly concerning for the growing number of young people with mental health conditions who are out of the workforce, as they face a higher risk of lower lifetime earnings.

Meanwhile, public spending on incapacity benefits is expected to rise in real terms from £20.9bn in 2019/20 to £32.1bn by 2029/30.[3] With sluggish economic growth and rising business costs, preventing health-related job losses is more urgent than ever.

These dynamics undermine longer term strategies designed to cope with an ageing society that are centred on raising the state pension age[4] and boosting labour force participation to reduce welfare costs. If fewer people can work to older ages because of their health, poverty is likely to increase and spend on incapacity benefits rise.

* A US study found that workers who experienced long-term unemployment (over 6 months) still earned 32% less a decade later compared with those who remained employed, with some never fully recovering their previous earnings.[2]

† Between 2014 and 2023, only 3% of people with work-limiting health conditions who had been out of work for more than 12 months moved into employment each year, compared with 13% of those without health conditions. After a year or more out of work, they were 5.3 times less likely to return than those who left more recently. In contrast, people without long-term health conditions were only 2.9 times less likely to return.[1]

Part of the burden of ill health could be prevented through wider public health policy. However, even with government commitment, it will take time to see the benefits of such action. With an ageing population, employers must also act now to adapt their practices and help people with poor health remain in work, as well as secure their future workforce.

Poor health costs UK employers up to £150bn a year – equivalent to £5,000 per employee – through lost productivity, absenteeism and staff turnover.[5]

For some businesses, the issue is not just the cost of replacing workers but the difficulty of finding new ones. Labour shortages have eased, but sectors such as health, social care and transport still struggle to recruit, partly due to the combined effects of an ageing workforce and rising health needs across the population.

> There is huge pressure on some sectors to reinvent themselves to recruit and retain workers in different ways.
>
> **Sector leader, transport and logistics**

A different approach is needed

Healthier working lives could bring enormous benefits: improving people's quality of life, strengthening businesses and easing pressures on public finances. Too often, health-related challenges lead to long sickness absences, job loss and permanent exits from the workforce. Decades of failure to build the right policy structures and labour market conditions have only reinforced this pattern.

The new government has recognised the importance of working-age health to the UK's prosperity. Since our interim report in autumn 2024, early steps have been taken to improve the integration of health and employment services, and a forthcoming green paper on disability and health-related benefits is expected to explore changes to those parts of the welfare system.

However, it is important that policy efforts focus on preventing job loss in the first place, not just on short-term reductions in benefit spend or the difficult task of getting people who have been out of work long term back into employment. A review led by Sir Charlie Mayfield on how government and businesses can better support employees with health challenges is a promising step. But sustained progress will require deep-rooted changes to both policy and workplace practices.

The work of the Commission for Healthier Working Lives

We examined the UK's work and health challenges, focusing on how to prevent people with health issues from leaving work unnecessarily. While we found some strong existing employer practices and promising initiatives to keep people in work, we also identified serious shortcomings at every stage of people's journey out of work – from gaps in early support to inconsistent employer practices and major weaknesses in the design and delivery of the sickness and welfare systems.

This report sets out a new approach. We propose an ambitious shift in focus from late-stage intervention to early action that prevents job loss and supports retention.

Effective solutions require shared responsibility between employers, employees and government. The focus should be on early, preventative support to help people remain in work rather than reacting after they have already left the workforce – when it is often too late.

We recognise that, for some people, their own health or that of a loved one may make staying in work impossible, whether temporarily or permanently. It is essential that people in this situation receive the right support to meet their needs, and that people who want to work can do so.

While our focus is on the intersection of health and employment, we acknowledge that wider factors – such as housing, education, household income and exposure to known risk factors such as tobacco, alcohol and poor-quality food – also shape people's health and ability to work. If employers and individuals are expected to take on new actions to improve workforce health, all parts of government must also tackle the root causes of poor health and economic insecurity.

We did not set out to review the entire working-age welfare system or health care services in depth, but our work has highlighted challenges in both that need to be addressed. We make recommendations where reforms to these systems are necessary to support our vision of a healthier workforce.

This report

Improving work and health outcomes is a long-standing challenge, deeply entrenched in parts of the UK. This challenge has also evolved and grown over the past decade. The nature of health issues has become more complex, and far more people of working age now live with a health condition (Section 2).

While employers are increasingly taking action in this space, there is a lack of clear evidence on what works, and existing policy structures do not fully support effective action (Section 3). Similarly, the structure of the existing social security system does not support the preventive approach needed (Section 4). There is much to learn from past and present UK labour market policies and international success stories (Section 5). Given the current situation, success will require commitment to a positive long-term vision focused on protecting people's health and employment (Section 6). Long-term change requires a new approach to work and health that supports people to stay in work or return when they can (Section 7).

A man serves a customer at a fast food takeaway in North Yorkshire.

Credit: SolStock

2. A growing working-age health challenge

The health of the working-age population is worsening, with more people developing often preventable long-term conditions across all age groups. In 2023, an estimated 8.2 million people aged 16–64 years had a long-term health condition that limited the type or amount of work they could do – that is 20% of all working-age adults, up from 15% in 2013.

While work-limiting health conditions have increased sharply among younger adults, their prevalence remains much higher among older workers, affecting 28% of people aged 55–64 years.* Health status also varies by sex, ethnic background and qualification level.[6]

More people are leaving the workforce with poor health

People with health conditions that limit the work they can do are three times more likely to leave the workforce than those without long-term health conditions, and the risk is even higher for workers aged 50–64 years.

From 2022 to 2023, **320,000** people moved from employment to being out of the workforce with a work-limiting health condition – up from an average of 260,000 a year between 2014 and 2019.† Most (83%) were employees, with the rest being self-employed or in other types of work.

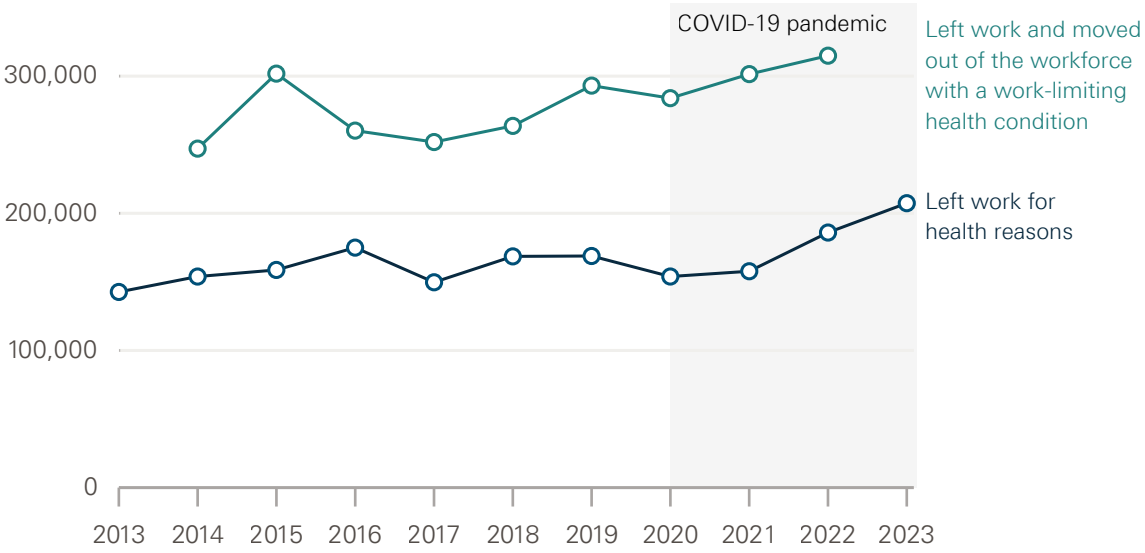
More recent data show that in 2023/24, almost **210,000** people left their last job specifically for health reasons – up from 160,000 a year between 2013/14 and 2019/20 (Figure 1).

* In this report, we use 'work-limiting health condition' as a more work-focused term than 'self-reported disability status'. In practice, there is significant overlap between the two.

† Recent increases in the number of people moving into being out of work with work-limiting conditions are due to the growing prevalence of work-limiting health conditions, not rising exit rates.

Figure 1: More people are leaving work for health-related reasons

Number of people leaving work for health-related reasons across multiple measures, UK, 2013–23



Source: Health Foundation analysis of Office for National Statistics Annual Population Survey and Department for Work and Pensions disabled people in employment data.
Note: 'left for health reasons' is for the period starting 2013/14 to the period 2023/24.

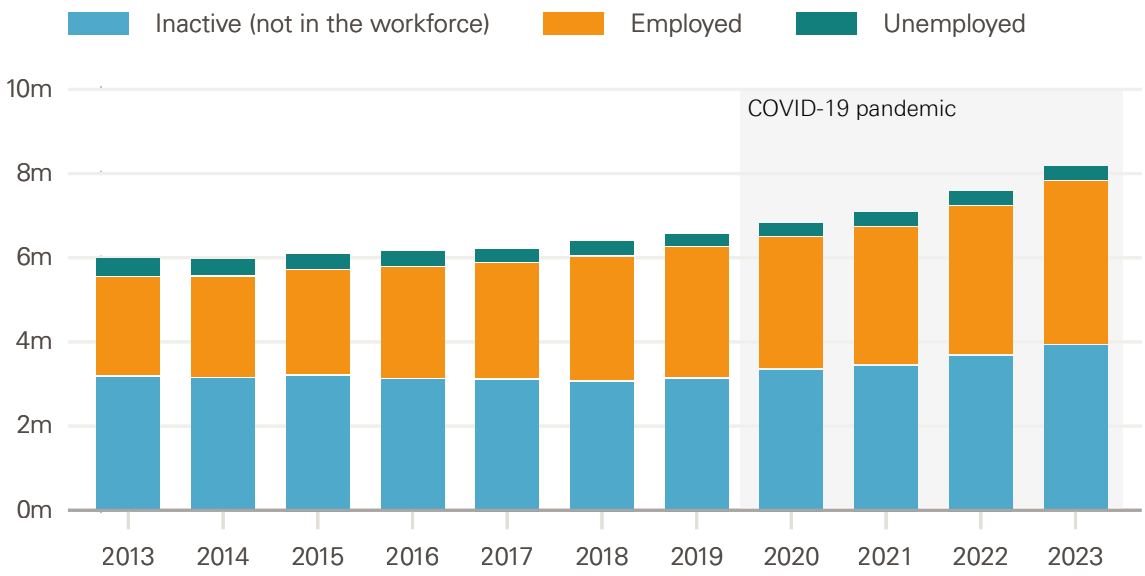
Among the 8.2 million people with work-limiting health conditions in 2023 (Figure 2):

- 4.0 million were out of the workforce entirely – a 24% increase from 2013. Half of this group received work-related health benefits and 2.6 million cited long-term sickness or disability as their main reason for not working.*
- 300,000 were unemployed and actively seeking work.
- 3.9 million were in employment – a 64% increase from 2013.

* We use the term 'work-related health benefits' to refer to out-of-work benefits received due to poor health, primarily the Employment and Support Allowance or the health element of Universal Credit. These are sometimes called 'incapacity benefits'. They do not include other health benefits such as personal independence payments.

Figure 2: Growing numbers of people report a work-limiting health condition

Number of people (aged 16–64 years) with work-limiting health conditions, by labour market status, UK, 2013–23



Source: Health Foundation analysis of Office for National Statistics, Labour Force Survey, 2023.
Note: quarterly figures averaged for each year.

Despite some improvement in employment chances for people with work-limiting health conditions over the past decade, there is still a large employment gap between those with and without such conditions. In 2023, only 48% of people with a work-limiting condition were in work, compared with 82% of those without. This health-related employment gap has not improved since 2019. It is also larger for older age groups, people without degree qualifications and those reporting mental health conditions, and larger still for people with multiple health conditions.*

Is working-age health getting worse?

While the limitations of labour market data from household surveys are well known,† there is strong evidence that health challenges among working-age people have been increasing. A recent Health Foundation study of health records in England found that the number of people aged 20–69 years living with major illnesses increased from 2.4 million to 3.0 million between 2010 and 2019.[7] While there were some improvements linked to major risk factors (such as reduced smoking), these were outweighed by rising obesity, anxiety and depression.

* Among working-age people with one to three additional conditions, their employment rate drops to 46%. For those with four or more additional conditions, it declines further to 27%.

† Much of our knowledge about working-age health relies on people's self-reported data in surveys such as the Labour Force Survey. While these surveys are helpful, we recognise their findings need careful interpretation. Self-reported health status can be subjective, and recent problems with the Labour Force Survey – including lower response rates and sampling issues – could affect the results, especially after the pandemic. People's perceptions of whether their condition is 'work limiting' also depend on their personal experiences and expectations, including the jobs available locally.

At the same time, life expectancy improvements slowed in the decade before the pandemic, even declining for some groups.[8] More recently, the pandemic and the cost-of-living crisis have further strained population health and access to services, with unequal impacts – including on ethnic minority and migrant communities.[9]

People with health challenges can often remain in work with the right support

Ill health alone is not the only reason people leave work – workplace conditions, access to support and wider social and economic factors all play a role. People with the same health condition can also have very different experiences, with employment outcomes varying widely by condition and region.[10] A work-limiting condition does not automatically mean someone cannot work, and staying in employment often supports long-term health and wellbeing.[11]

With the right support, many people can stay in employment, though this is often hardest in the early stages of a condition, when symptoms are less predictable. Without the right support, people who become unwell can find it harder to manage their job and may feel less confident.

> Becoming unwell while working impacts your sense of self. You see yourself in the world differently, and it affects everything in your life. You're trying to work with the health system to get a diagnosis, trying to please your employer, and you feel like you're nowhere in that process.
>
> **Edward, 42, from Northumberland**

There is no single path out of work. While some people leave shortly after a health issue emerges, others exit gradually after long periods of difficulty.* Repeat or long-term sickness absence is often a warning sign – around 120,000 people leave work each year after being off sick for more than 4 weeks, with half exiting within the first 3 months.[12]

A person's ability to stay in work while managing a health condition depends on several factors:

- **The nature and complexity of their condition(s) –** People managing multiple health conditions have lower employment rates, and 38% of people not in the workforce due to sickness or disability report five or more health conditions.[13]
- **Their role and contract type –** Some roles are more physically or mentally demanding than others, and people in higher-paid roles or with degree-level qualifications are generally less likely to experience job loss.[14,15]
- **The support available at work –** Much depends on whether employers can mitigate health risks, provide reasonable adjustments, adapt roles or offer flexible arrangements. Workers without access to flexible working are four times more likely to leave employment.[14]

* Analysis by the Work Foundation indicates that nearly half of employees who leave work due to declining health do so within the first year of experiencing health issues.[14]

- **Wider pressures like financial stress, caring responsibilities or access to health care** – Some people with poor health can rely on savings, personal resilience or a strong support network, but many do not have these resources.[16]
- **Stigma and discrimination** – Fear of judgement or bias can discourage workers from disclosing health conditions or seeking support. Stigma related to age or other characteristics can further compound barriers to staying in work.

Reflecting these complexities, an approach is needed that recognises work and health are shaped by biological, psychological and social factors – and cannot be adequately supported by medical treatment alone. This is the essence of a 'biopsychosocial' model.*

The nature of work-limiting conditions is changing

The most common conditions affecting people's ability to work have changed over time.† Together, musculoskeletal conditions like back pain and arthritis and mental health conditions such as anxiety and depression now account for half of all work-limiting conditions. The other half comprises diabetes, respiratory diseases and cardiovascular disease. These are mostly chronic conditions that can develop gradually, fluctuate and require ongoing management. With timely support, many people can continue working.‡

Notably, people often experience more than one health issue at the same time, with comorbidities becoming more common. In 2023, nearly two-thirds (64%) of those with a work-limiting condition had more than one health condition.

Mental health conditions are rising – and the reasons are complex

The sharp increase in mental health challenges over recent decades is particularly concerning. Over 10% of working-age people now report poor mental health (Figure 3), according to a range of surveys, screening tools and clinical diagnoses.[17] Unlike two decades ago, young adults now report higher rates of poor mental health than older age groups, raising concerns about long-term impacts on their health and employment prospects.

An estimated 500,000 young people (aged 16–24 years) are now out of the workforce and reporting work-limiting health conditions. As seen from the youth unemployment crises of the 1980s and 1990s, long periods out of work at this life stage can have lasting effects.[18] Missing out on early job experience makes it harder to build skills, secure stable work and progress to better-paid roles – without action, this will become a major challenge for the next generation.

* The biopsychosocial model – which considers the physical, mental and social factors that contribute to workforce health – is widely regarded as the gold standard, though it is not consistently applied across workplace health services.

† Since 2008, musculoskeletal conditions have been the most prevalent, affecting 12% of working-age people. However, the prevalence of mental health conditions has risen sharply, with anxiety and depression tripling from 4% to 12% over the same period. Source: The Health Foundation analysis of the Labour Force Survey.

‡ Some health challenges are acute and typically require some time away from work. While minor acute conditions, like the common cold, often resolve on their own, others – such as broken bones or heart attacks – require urgent or short-term medical care.

Figure 3: Across multiple sources, rates of poor mental health have doubled since 2010, especially among young adults

Proportion of population reporting mental health conditions, by data source and age group, UK and England, 2008–23

Source: Health Foundation analysis of Office for National Statistics, Labour Force Survey, 2023; Clinical Practice Research Datalink (CPRD); NHS Digital, Health Survey for England, 2023; University of Essex – Institute for Social and Economic Research, Understanding Society, UK, 2010–22.
Note: Health Survey for England data on mental health conditions are not available for 2019 and 2020. Understanding Society data identify people as having a mental health condition if they have a GHQ score greater than 20 on a scale of 0–36. Health record data are based on the CPRD. Regulatory approvals to use CPRD data for this analysis were granted by the CPRD Independent Scientific Advisory Committee (ISAC protocol number 20-000096).

Several factors appear to be driving the increase in mental health challenges:

- **Financial pressures, job strain and insecurity, and caring responsibilities** – These pressures are more prevalent among people with fewer qualifications or living in more deprived areas (19% of people in the North East of England report a long-term mental health condition versus 10% in London).[17]
- **Evolving identification and reporting of health challenges** – Greater awareness and reduced stigma mean more people are recognising and seeking help for mental health conditions (though stigmas persist).[19] However, this does not fully explain the rise in severe psychological distress recorded in population surveys.
- **Longer term cultural and environmental changes, such as social media, increased loneliness and reduced autonomy for young people** – These trends are harder to quantify but align with rising distress in younger age groups.[20]

While the data do not provide a precise breakdown of contributing factors, the increase in poor mental health likely reflects a mix of evolving definitions and greater recognition of existing challenges, alongside broader economic, social and cultural pressures contributing to a real deterioration in mental health.

We recognise the need for further research to refine our understanding of these drivers, particularly their impact on younger people.* Greater understanding can inform the provision of more effective and appropriate support and service design, which should extend beyond medical treatment – helping people manage their health challenges as well as the wider obstacles they face in both work and daily life.

> [W]e need to step away from the stalemate of defining and categorising 'real' mental illness and take a much more holistic approach to understanding capacity for work.[19]
>
> **Dr Annie Irvine, Lecturer in Social Policy and Public Management**

Many people are struggling to access the right support quickly

While hospital waiting lists often dominate headlines, most of the health conditions that affect working-age people are managed in GP surgeries, community care and mental health services. However, long waits and worker shortages mean many people do not receive timely help, which risks a health need becoming increasingly acute:

- GP shortages and workload pressures are making appointments harder to access, especially in deprived areas.[21]

* Bringing together health, education, work and social data will be critical to building a clearer picture and ensuring that policy responses address the root causes without inadvertently making problems worse.

- As of November 2024, more than 1 million people were waiting for community services, with nearly 360,000 waiting over 12 weeks.[*,22]

Employers and people with health conditions regularly highlight these barriers.

> When I try to get help for my chronic condition, I often face delays that leave me feeling helpless and frustrated. I once waited nearly 3 months for a letter, with no care in between.
>
> **Jim, 45, from Northumberland**

Although the government has announced extra funding, access to services will not improve overnight.[†] There is a strong case for integrating health and employment support to ensure people do not fall out of work while waiting for care and to ensure care is designed to support people to remain in work.[23] Work itself can help to improve health, which is why the quality of work and employer support can make a significant difference.

The world of work is changing – including in ways that harm health

It has long been recognised, and is supported by our research, that good work is generally good for health. Equally, long periods away from work can set off a downward spiral, with reduced income, deteriorating physical and mental health and a loss of social connection.

The quality of work in the UK has improved in many ways over recent decades. The rise in remote and flexible working practices since the pandemic, for example, has created new opportunities to support workers with long-term conditions. However, a third of the workforce is in front-line roles, where flexibility remains more limited.[24,25]

Managers and supervisors continue to play a key role in supporting health and wellbeing at work. The Chartered Institute of Personnel and Development estimates that almost 10 million people in the UK are line managers. How they manage the demands of the role varies widely, and they are often balancing other responsibilities at the same time. Research shows a clear link between how people see their line managers and their own health,[67] and one survey found that managers account for 70% of the differences in employee engagement.[68]

The role of managers has become increasingly important as jobs have become more demanding over recent decades. Tighter deadlines and 'just-in-time' demands have increased pressure – 42% of workers reported having to work very hard at work in 2017, up from 31% in the early 1990s.[26] The UK now has some of the highest job intensity levels in Europe, while fewer workers feel they have control over their jobs.[27]

* The Health Foundation analysis of NHS England, *Community Health Services Waiting Lists*; 2024

† The government's Get Britain Working White Paper includes a focus on 'cutting waiting lists so people can get back to health and back to work'. Funding has been announced for musculoskeletal services and talking therapies.

This rise in intensity reflects long-term labour market changes, including increases in 'atypical' working (for example, forms of self-employment or zero-hours contracts), which people with health challenges are more likely to be employed in.[28,*] As one expert told us:

> Employers expect workers to be fully functional when present and only present when actually needed… The use of workers on light duties and with frequent absences is far less tolerated.[28]
>
> **Professor Paul Gregg, Department for Work and Pensions Labour Market Advisory Board**

People with long-term or fluctuating conditions often find rigid work demands make it harder to enter or stay in employment – especially after a long period away from work. These demands can also limit employers' ability to accommodate workers managing health conditions.[†]

> Going back into the workplace after extended sick leave feels like doing the walk of shame… [the] pressure I felt on top of the existing pain and exhaustion created even more anxiety… Eventually, I felt I had no choice but to severely burn out or leave.
>
> **Tanya, 23, from East Sussex**

Poor-quality jobs are harming health

Most health conditions develop outside work, but for a significant number of people, work itself is the cause. Persistent insecurity, workplace discrimination and extreme demands take a serious toll on health.[27] In some cases, poor-quality work is even worse for health than being unemployed.[29]

Other job features, though sometimes unavoidable, can pose risks if not properly managed. Long or irregular hours and night shifts, while necessary in some jobs, can still increase the risk of anxiety, depression and other serious health issues. Currently:

- 1.7 million workers in Great Britain experience health conditions caused or made worse by their job – higher than before the pandemic
- work-related musculoskeletal disorders have decreased over time, while rates of work-related stress, anxiety and depression have risen since the mid-2010s
- some sectors are more affected than others – workers in health, teaching, construction, transport and customer services report some of the highest rates of work-related health conditions (Figure 4).[30]

* 13% of disabled workers were self-employed in 2023/24, down from 16% in 2013/14. This compares with 11.9% of non-disabled workers. Disabled workers are also more likely to be on a zero-hours contract or in low pay.[28]

† For example, several large employers told us they try to redeploy staff if their health becomes incompatible with their current role. However, fewer roles now offer 'light duties', reducing redeployment options.

Figure 4: Health professionals face the highest rate of work-related health problems

Self-reported illness caused or made worse by current or most recent job (rate per 100,000 workers), top 10 sub-major occupations, Great Britain, 2021/22 to 2023/24

Source: Health Foundation analysis of ONS Labour Force Survey via Health and Safety Executive.

Improving job quality must be part of the solution

Ensuring work supports, rather than harms, health should be a core part of improving working-age health and increasing employment. Some measures in the government's Employment Rights Bill are positive steps, but more action may be needed.

Work-related health issues are not limited to the private sector. By 2021, more than two-fifths of health and education workers reported burnout, partly driven by the pandemic.[27]

> Working in [a] local authority … we have social workers and teachers and so they make a massive impact on people's lives… but they are the most stressed group of staff that we've got.
>
> **Employer focus group participant**

The work and health challenge varies across the UK

Work and health challenges are not the same everywhere in the UK. Some areas have far higher rates of people not in the workforce for health reasons (Figure 5). Across 2022 and 2023, nearly 10% of people out of the workforce because of long-term sickness or disability were living in just 20 local authorities, even though these areas make up only 4% of the total working-age population.[31]

Differences in health, education and economic conditions shape employment opportunities for people with health conditions.[*] The number and types of jobs available vary widely by geographic area:

- In 18 of the 20 local authorities with the highest rates of people not in the workforce due to health reasons, the number of employee jobs relative to the size of the population is below the national average. In half of these areas, there are fewer than 0.6 employee jobs for every resident aged 16–64 years,[†] though some areas have higher labour demand.
- Weaker local economies also tend to rely more on physically demanding or front-line roles such as retail, transport, health and care. These jobs can be harder to sustain for people with long-term health conditions.[‡]
- Education and skill levels further widen these disparities. Around 71% of working-age people with work-limiting health conditions who have degree qualifications are in employment, compared with 40% without degrees. Lower qualification levels make it harder to secure work that accommodates health needs.

Figure 5 highlights areas where a particularly high proportion of residents are out of the workforce for health reasons. Many of the areas with the highest rates also have lower job availability, but this is not the full picture. Cities such as Birmingham, Glasgow and London have large numbers of people out of work due to health reasons despite having more jobs available, highlighting the need to address both job supply and workplace barriers.

Solutions must reflect both local labour markets and sectoral differences, ensuring work is accessible to those with health conditions. This requires a mix of local interventions and broader national policies to improve workforce health and inclusion.

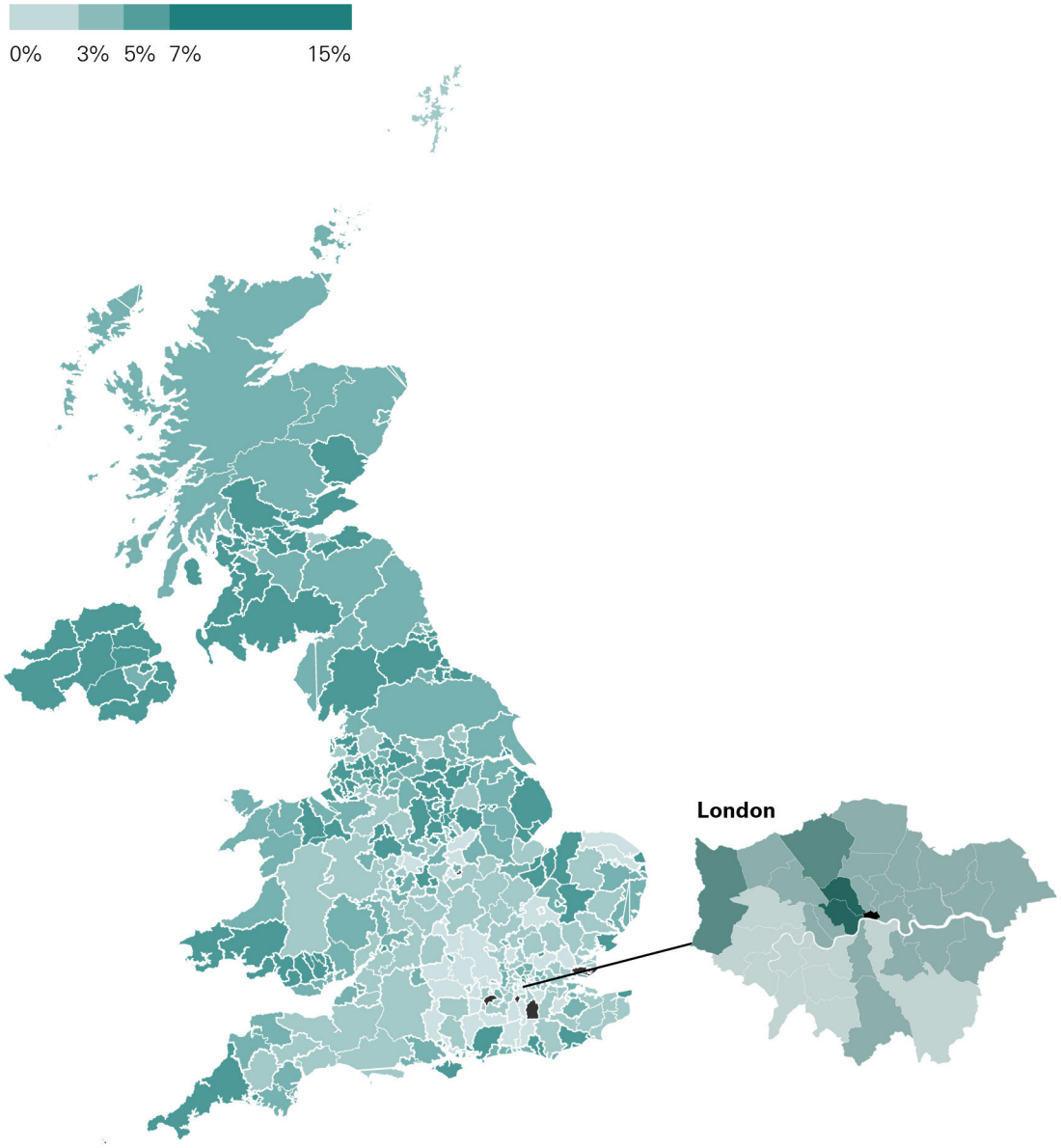
* People in the most deprived areas are far more likely to develop chronic illnesses – such as cardiovascular disease, diabetes and mental health conditions – at an earlier age than those in wealthier areas. This increases their risk of developing work-limiting health conditions.

† Similarly, in 12 of the 20 local authorities with the highest rates of work-related health benefit claims, there are fewer than 0.6 employee jobs per working-age person, compared with a national average of 0.75. Figures are for Great Britain in 2022. Source: The Health Foundation analysis of Office for National Statistics Business Register and Employment Survey and Mid-Year Population Estimates.

‡ By contrast, areas with more professional and administrative jobs tend to have higher employment rates among people with work-limiting conditions, as these roles are often more adaptable.

Figure 5: There are geographic inequalities in the numbers of people not in the workforce for health reasons

People out of the workforce due to long-term sickness or disability (% aged 16–64 years) by local authority district/unitary, UK, 2020–22



Source: The Health Foundation analysis of Learning and Work Institute data from the Office for National Statistics, Annual Population Survey (3 years pooled dataset), 2021 Mid-Year Estimates.
Note: four local authorities use 2022 data only due to boundary changes.

Inequalities are deeply entrenched

Most areas that had high rates of poor health a decade ago still experience low labour force participation today. Tackling these long-term disparities requires action beyond the scope of this Commission. A coordinated national approach is needed to drive investment in local economies, create good jobs and improve health outcomes across all parts of the country.

The ageing population

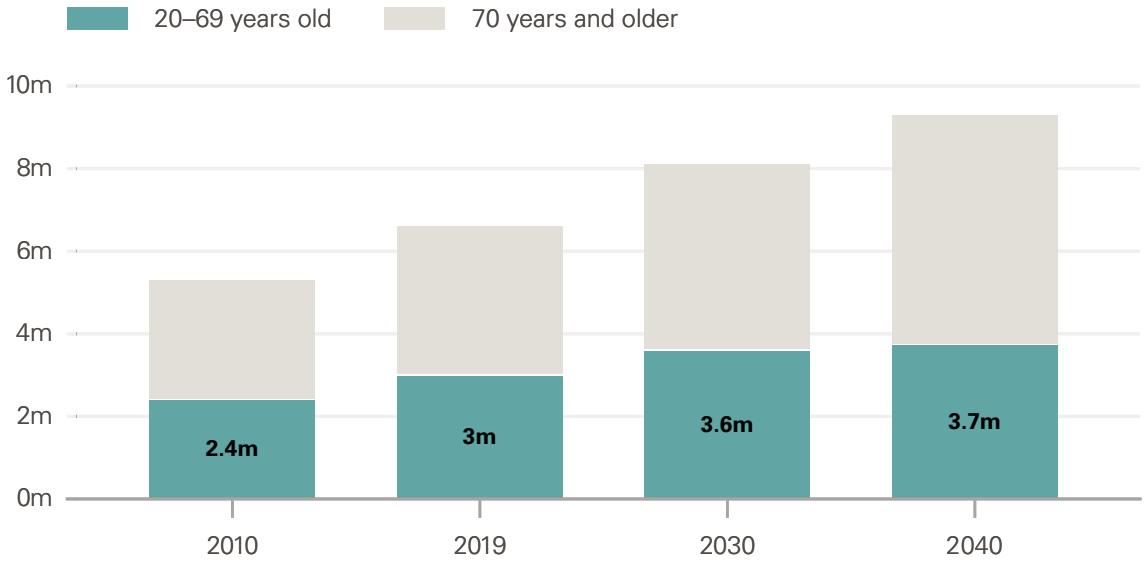
Without action, these health-related headwinds will only worsen as the population continues to age. The UK population is projected to increase from 67 million in 2021 to over 73 million by 2035, with the median age rising from 40.7 years today to 42.3.[32]

Health-related challenges are likely to become more pronounced. By 2040, the Health Foundation projects that the number of working-age adults in England living with major illnesses will rise to 3.7 million, up from 3.0 million in 2019 (Figure 6).[7] Most of this increase is expected in more deprived areas of the country, adding to existing health inequalities.[33]

51% of UK employers expect workforce health challenges to increase over the next 5 years, while only 8% think they will improve.* Supporting people to start and stay in work despite health conditions will be more important than ever for individuals, employers and the wider economy.†

Figure 6: The number of working-age adults living with major illnesses is projected to rise to 3.7 million

The estimated number of people living with major illnesses in England, past and projected



Source: Analysis of linked health care records and mortality data conducted by the REAL Centre and the University of Liverpool.
Note: To better represent the working-age population, we present the estimated and projected number of people living with and without major illness aged 20 years and older. The model is designed to project the population aged 30 years and older. We therefore assume that the proportion of people living with major illness aged 20–29 years will be the same in 2040 as in 2019.

* The Health Foundation analysis of YouGov UK employer survey data. Sample size 1006. Fieldwork conducted 21 January to 7 February 2025. The survey was carried out online, with figures weighted and representative of all UK businesses.

† People in the most disadvantaged parts of England already spend nearly 20 fewer years in good health than those in the least disadvantaged areas.

A young school leaver with Down's syndrome answers a call during her work experience placement.

Credit: sturti

3. Improving workforce health: addressing systemic gaps

Workforce health is not just an employer challenge. As highlighted in our interim report, a typical path from early health concerns to job loss – often culminating in late-stage support from the welfare system – reflects structural gaps in how the UK supports people to stay in work. Three key groups have distinct responsibilities:

- **Employers** have a duty of care to support employee health, including mental health, and prevent avoidable health-related job losses. Line managers play a key role, and early identification of issues is important for effective support.
- **The government** has a role in providing support and resources, ensuring a fair and accessible social security system, setting workplace standards and regulating markets.
- **Employees** are expected to do their job well and attend work in a condition that allows them to perform their role effectively. This includes managing their health and communicating their needs to employers.

While expectations of employers and employees have evolved alongside changes in workforce health, policies and practices have not kept pace with a changing workforce.

Why employer practices vary

We specifically wanted to understand the employer perspective. We gathered insights through focus groups, roundtables and discussions with businesses across the UK, alongside carrying out employer visits, engaging with trade bodies and conducting a bespoke survey to understand employer attitudes and approaches to workplace health.

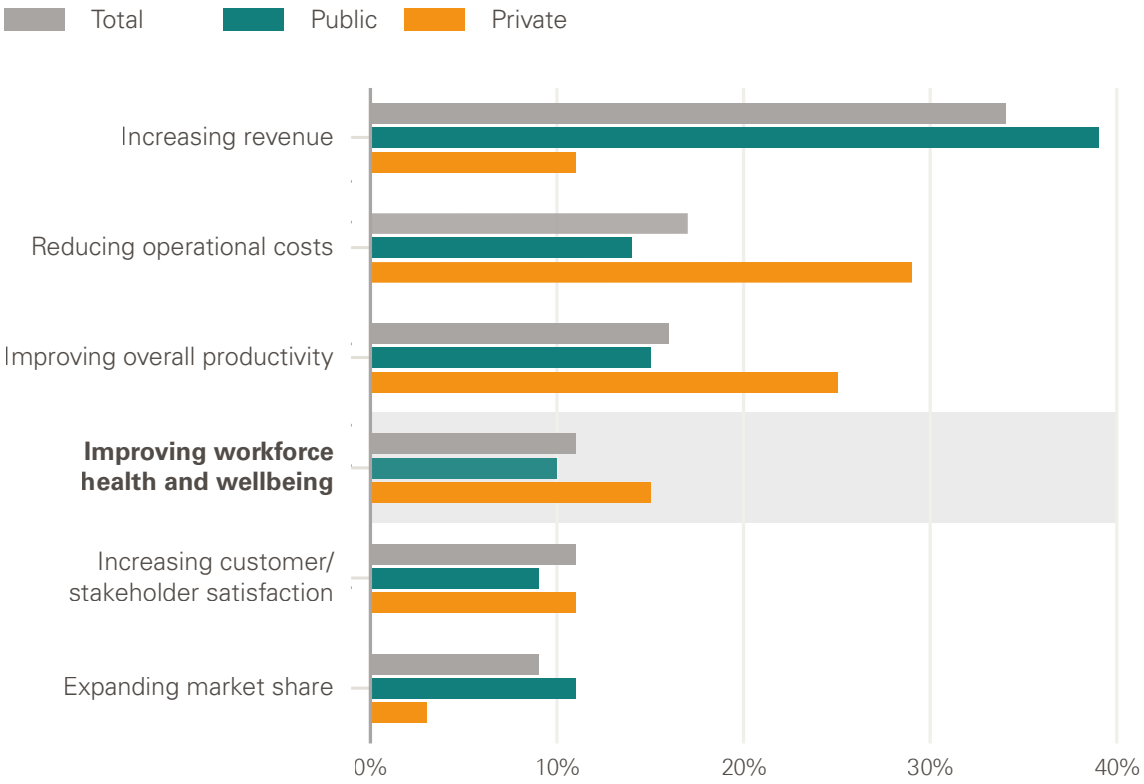
We heard from a number of leading employers who are taking a comprehensive approach to workforce health – providing strong support for workers with health issues while also considering broader factors like job design and leadership culture. However, proactive action often requires employers to go above and beyond what is legally required.

UK legislation leaves most work, health and disability-related support to employer discretion, leading to wide variation in approaches.[34] Cost – whether real or perceived – can be a significant deterrent. Small employers may lack the resources or specialist knowledge to invest in workforce health or stay on top of best practices, while employers in high-turnover sectors may prioritise recruitment over long-term workforce support. Lower-paid workers, particularly those on insecure contracts, often receive little or no support, and self-employed workers are mostly expected to manage their own health needs.

The survey for the Commission found that only 36% of employers rank workforce health among their top three business priorities, and just 11% identify it as their number one priority (Figure 7). Workforce health is a higher priority in the public sector than in the private sector, though it still ranks behind operational costs and overall productivity. This suggests that while many employers recognise the importance of workforce health, other pressures often take precedence.

Figure 7: Relatively few employers say improving workforce health and wellbeing is their top organisational priority

Top organisational priority for the next 12 months, percentage of organisations, UK, 21 January to 7 February 2025



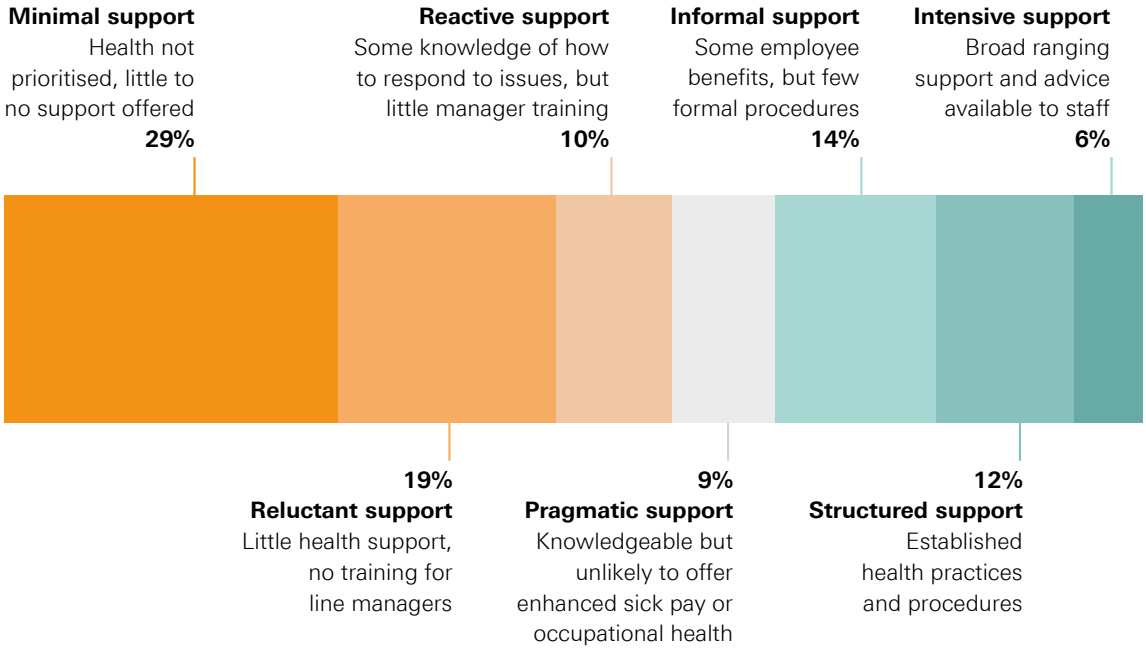
Source: Conducted by YouGov on behalf of the Health Foundation. Question: Please rank the following priorities for your organisation over the next 12 months, where 1 is the most important priority and 6 is the least important (unweighted base 1006).

A recent analysis for the Department for Work and Pensions found that 58% of employers take an approach to workforce health that is categorised as reactive at best.[35] 29% of employers – mainly smaller businesses – offer minimal support, meaning there is little to no prioritisation of employee health. Only 18% of employers, mostly larger firms, offer structured or intensive support with established health practices. The rest fall between these categories, providing either informal benefits or limited support. Figure 8 illustrates this variation.*

* This analysis does not fully capture the informal support employers provide their workforces, particularly in smaller businesses.

Figure 8: Most employers lack structured health and wellbeing support

Segmentation of employers (% of employers), Great Britain, 2018



Source: Ipsos MORI. *Sickness absence and health in the workplace: understanding employer behaviour and practice* 2021. Department for Work and Pensions (research report no. 981. All employers (2,564). A random probability telephone survey was undertaken between June and August 2018.

Some employers are strengthening their support policies – 51% report having expanded or introduced workforce health initiatives in the past year.* Looking ahead, 37% plan to invest more in the next 5 years. However, as noted, over half the employers we surveyed expect workforce health to become more challenging over this period.

Despite these efforts, many businesses continue to face challenges embedding good workforce health practices. These difficulties are often due to limited access to effective solutions or the resources needed to implement them. At the same time, basic line management practices are not always prioritised or implemented consistently.

* The Health Foundation analysis of YouGov UK employer survey data.

Three key barriers to employer action

Our evidence shows that variation in employer approaches to workforce health in the UK is shaped by three key barriers: financial constraints and limited incentives, a lack of clear evidence on effective interventions and wider systemic challenges that make it difficult for employers to act.

1. Financial constraints and limited incentives

The high cost of external services (43%) and a lack of internal resources or capacity (36%) are cited by employers as the main barriers to implementing workforce health initiatives, with budgetary constraints playing a significant role in decision making.*

Many employers are operating in a challenging business environment. However, the level of support provided to employees varies widely across businesses, with some going much further than others to support workplace health. This is partly due to the financial and regulatory environment in the UK, which offers limited incentives for employers to invest in proactive health support. There are three key issues:

- The low rate of statutory sick pay – just £116.75 per week, or 27% of a full-time minimum wage salary – means businesses, particularly in lower-paid sectors with high staff turnover, may not feel compelled to prioritise absence management or workforce health. The rate of income replacement during sickness absence is far lower in the UK than in most other countries.[36]
- Sick pay provision varies widely, with larger employers far more likely to offer enhanced sick pay. While 77% of large employers provide coverage above statutory sick pay, smaller businesses are more likely to rely on the statutory minimum, with 55% offering no additional support and 13% providing no sick pay at all (see Table 1 in the Appendix).
- Low-paid and insecure workers are left most at risk. Inadequate sick pay forces some to return to work before they are fully recovered, increasing the risk of repeated absences and eventual job loss.[37] For others, the low rate of support can act as an incentive to leave employment and claim benefits.

Legislation plays an important role in setting minimum workplace standards, particularly around workplace adjustments. However, these standards are largely enforced through individual cases, which can lead some employers to adopt a compliance-driven approach focused on avoiding legal risk rather than actively improving employee wellbeing and retention.

2. Lack of evidence on what works and low awareness of best practice

Many industries lack a shared understanding of what good practice looks like for them. While general guidance exists from bodies like the National Institute for Health and Care Excellence and the Health and Safety Executive, employers can struggle to apply it to their specific business models or navigate operational constraints such as shift work,

* The Health Foundation analysis of YouGov UK employer survey data.

lean staffing or sedentary and isolated roles. 30% of employers told us that difficulty demonstrating return on investment is a barrier to implementing workforce health initiatives in their organisations.

Employer discussions highlighted several key challenges, including:

- a lack of real-world examples and evidence on business outcomes to guide effective action
- competitive pressures and limited sector-wide coordination, making it harder to share and scale successful approaches
- difficulty sustaining buy-in from senior leadership or front-line managers on changes in workplace practices.

The market for workforce health support and workplace adjustments is also fragmented, with few recognised quality standards.* This lack of transparency – combined with limited feedback from service users – makes it difficult for employers to identify cost-effective, high-quality support.† The challenge is particularly significant given the scale of the sector: the UK's occupational health market is valued at around £1.6bn a year, while the employee assistance programme market is worth £118m.‡,38,39

While employers are generally positive about the impacts of various workforce health initiatives, a significant portion still feel investments are not effective – particularly when it comes to health apps and technology (31% say they are ineffective), and to a lesser extent, occupational health services (23%) or employee assistance programmes (20%) (see Tables 2 and 3 in the Appendix).§

3. Wider systemic problems

Workforce health is not just an employer issue – it requires coordination across government, health services and employment support. However, limited integration between these systems leads to missed opportunities for early intervention.

- **Fit notes** can help employers identify work-related health barriers but are not being used to their full potential. GPs – who are the first point of contact for most workers and still issue the vast majority of fit notes – often lack the time, training or information to provide tailored work and health advice.40
- For absences lasting 4 weeks or more, there is no structured return-to-work pathway provided by the public sector, leaving many employees and employers without clear next steps. **WorkWell pilots** are currently exploring ways to provide

* The Faculty of Occupational Medicine have developed 'Safe Effective Quality Occupational Health Service' (SEQOHS) standards for occupational health providers. As of February 2025, 190 providers had achieved SEQOHS accreditation.

† Occupational health buyer's guides have been published by the Society for Occupational Medicine and the Health and Safety Executive.

‡ Employee assistance programmes are employer-funded services offering confidential support to employees. They typically provide counselling, advice and referral services to help employees manage both personal and work-related difficulties.

§ The Health Foundation analysis of YouGov UK employer survey.

more integrated health and employment support, with wider evidence suggesting intervention at an early stage can improve work and health outcomes (see case study on tiered vocational support).

- The **Access to Work** scheme, which funds workplace adjustments for disabled employees and people with long-term conditions, is highly valued by those who receive it. However, its potential is undermined by low awareness, long wait times, administrative barriers and funding pressures. Anecdotal evidence suggests that the process of securing or renewing awards is increasingly difficult and inconsistent, putting an undue burden on individuals – especially when changing employer or employment status.
- The **Disability Confident** scheme has good awareness but lacks accountability, allowing employers to sign up with little meaningful change.[41] There is little evidence that light-touch or voluntary approaches have worked to improve standards. A stronger, outcome-focused approach is needed to help ensure accreditation reflects real commitments to disability inclusion.

There are also significant barriers to accessing health services. The NHS is under increasing pressure, particularly due to an ageing population. Alongside issues with the fit note system, long waiting lists and difficulties accessing primary care can worsen employment outcomes, especially for those with multiple health conditions.

Case study: developing a tiered vocational support offer

A pilot across 21 primary care sites in England, Scotland and Wales tested co-locating vocational support within health care settings to help people with work-related health challenges stay in or return to employment.*

Using a tiered model, where the support provided meets identified needs, eligible patients – those who were disabled, out of the workforce, at risk of leaving work or self-employed – were referred by their GP to a Jobcentre Plus health and work coordinator for an initial conversation. Patients with more complex needs were referred to an occupational health physician. Non-clinical staff were trained in the biopsychosocial model to help make the right referrals for clinical support.

Between October 2022 and July 2024, over 6,800 conversations took place, with support focused on goal setting, confidence building, job searching and navigating benefits. Data from one pilot site indicated that only 5% of cases required input from an occupational health physician, underscoring the resource efficiency of the tiered pathway. Among those who saw an occupational health physician, 90% successfully returned to work.[42]

An early evaluation highlighted improved patient access, timelier intervention and reduced pressure on GPs and work coaches.[43]

* This service model was designed by Dr Shriti Pattani, OBE, National Clinical Expert in Occupational Health and Wellbeing at NHS England.

Case study: vocational support through GP practices

The Black Country NHS Foundation Trust has piloted a new initiative through its Thrive into Work programme to support people at risk of leaving work due to health conditions.

The pilot across six GP practices introduced an automatic referral system. Fit note requests for absences of 4 weeks or more triggered a text offering support from a vocational specialist. GPs conducting long-term condition reviews also flagged patients who might benefit. Those expressing interest were contacted and offered tailored assistance, including discussions on work capability, CV help and employer connections.

Of the 373 patients contacted, 23 received ongoing support through Thrive into Work, with additional referrals made to local services as needed.

Challenges included space constraints for co-locating services, but the pilot showed that trusted health care relationships improved engagement. Automated referrals linking into clinical systems were key to success.

The role of insurers

In countries where preventative approaches are more developed, insurers play a significant role in supporting workforce health, often providing rehabilitation services to help businesses manage sickness absences. In the UK, however, uptake of these products remains relatively low, limiting their impact on workforce health. Only 3.3 million workers were covered by group income protection policies in 2023, too few to create meaningful change across the labour market.[44]

We heard examples of employers having positive experiences with insurers. Expanding the use of income protection insurance could encourage the provision of insurance-backed rehabilitation services, helping fill gaps in employer support. Stronger incentives for employers to manage sickness absences could encourage investment.

More widely, the government could do more to stimulate employer investment in return-to-work support. For example, employers highlighted that medical treatment to help an employee return to work is currently exempt from tax, but only up to £500, which can fall short of covering the full cost of rehabilitation services.

What can employers do to support workforce health?

Despite the challenges, many employers are taking steps to improve workforce health. Employers who integrate workforce health into job design, management and workplace culture – rather than relying on isolated individual measures like mindfulness training – see better retention, productivity and wellbeing.[34]

Our research highlights several key areas where employer action can make a real difference.

People management

The way employees are managed directly affects wellbeing, performance and retention. Research shows that a good relationship with a manager is the biggest driver of job satisfaction and closely linked to productivity.[45] Lived experience research also highlights management as a turning point – positive or negative – in a person's work and health journey.

> Having a boss who checks in on my wellbeing and allows flexible hours means I don't have to choose between my health and my job.
>
> **Louise, 33, from Newport**

Effective managers set clear goals, build trust and create an environment where employees feel safe sharing concerns. There is strong evidence across different employment settings that good workplace relationships and psychological safety significantly improve performance. These qualities reduce workplace stress and help people with health conditions stay in work. However, managers can struggle with their own wellbeing.*

> I often feel torn between supporting my team and looking after myself.
>
> **Scott, 37, from Northumberland**

Creating a culture where line managers have regular check-ins and people have a clear route to ask for support is something any employer – of any size – can do. Employers can also provide specific training and support. Professional bodies such as the Chartered Management Institute and the Chartered Institute of Personnel and Development provide clear frameworks and resources to embed good management practices and awareness of accessibility and disability inclusion practices across organisations.

Job design and flexibility

A well-designed job supports health, retention and productivity. Ensuring tasks are manageable, roles are meaningful and employees have autonomy can help prevent excessive pressure and improve job satisfaction. Employers can use staff feedback to identify areas for improvement, such as workloads, control over work and skills development.[27]

* 39% of employers report increased stress or burnout among managers due to the pressures of supporting workforce health. Nearly half of employers expect line managers to handle sickness absences for their direct reports, yet many lack the relevant training and guidance to do so effectively. Source: The Health Foundation analysis of YouGov UK employer survey data.

Flexible working is a key tool in job design, particularly for people with health conditions. Employees without flexibility after developing a condition are four times more likely to leave work.[14] Key forms of flexibility include:

- **Working time flexibility** – Allowing employees to adjust their working hours across the week, or over multiple weeks, to accommodate fluctuations in symptoms.
- **Reduced/flexible working hours** – Adjusting hours to manage energy limitations, fatigue or time off for medical treatment.
- **Working from home** – Reducing the need for travel and avoiding overstimulating work environments, helping employees manage limited energy and fluctuating symptoms.[46]

Until recently, these types of workplace flexibility were often offered as part of 'reasonable adjustments' or phased returns. Now, they are increasingly seen as a way to prevent health issues before they occur, helping to recruit and retain a broader workforce – including carers and parents, as well as workers with health conditions. Among organisations that have adopted hybrid working, 53% report it has made supporting employees with health challenges easier, compared with 20% that say it has made it harder.*

> Breaking those archaic office structures down not only helps people who may otherwise face barriers to be their best selves and reach their potential, but it also increases collective productivity. It's a win–win situation.
>
> **Bobbie, 41, from Chester**

However, access to flexible working remains unequal. It is more common in office-based jobs and less available in lower-paid jobs and front-line roles like nursing. Individual employees can also be reluctant to ask for flexibility, fearing it will be seen as disruptive or expose them to scrutiny. Pilots by Timewise have shown that team-based approaches – rather than individual case-by-case arrangements – can make flexibility possible even in hard to flex sectors, helping to retain key workers while maintaining service delivery.

* The Health Foundation analysis of YouGov UK employer survey data.

Case study: extending flexibility to front-line roles

Flexible working is linked to better wellbeing, retention and business outcomes, particularly for employees at risk of leaving due to ill health. However, in front-line health care, where 24-hour staffing is essential, flexible working has been hard to implement, contributing to job strain and burnout.

To address this, **Timewise** partnered with Guy's and St Thomas' NHS Foundation Trust to trial a new rostering approach for nurses on an acute medical ward. Initial staff feedback highlighted a key issue: the system for individual flexible working requests often clashed with overall staffing needs, leaving some nurses feeling they had little control over their shifts.

In response, Timewise worked with HR, senior leaders and ward teams to test a new scheduling model, increasing the number of shift preferences from five to ten (5 days off and 5 nights on). This allowed nurses greater input and control over their working patterns without disrupting overall workforce planning.

While the pilot was small, it showed that greater team-wide scheduling flexibility can be achieved within shift-based roles, reducing the need for individual flexible working requests, which can be difficult to manage fairly. Follow-up evaluations found:

- improved work–life balance and wellbeing[47]
- greater control over sleep routines, particularly important for night workers, for whom poor sleep is linked to physical and mental health risks.

Access to timely support

When people begin to face health-related barriers to work, early action from an employer can make a major difference in preventing long-term sickness absence. There are several basic steps all employers should take as part of business as usual:

- Offering a decent minimum level of sick pay to prevent financial pressure from forcing employees back to work before they are fully recovered.
- Holding return-to-work conversations with employees after sickness absence to identify support needs.
- Implementing return-to-work or workability plans with employees facing longer term challenges – and outlining the key obstacles to working and practical solutions – without waiting for extended absences.

Return-to-work plans should be personalised and created in partnership between employees and their line manager.

Where additional support is needed, external services – such as occupational health providers or vocational rehabilitation – can help. However, these services are not always accessible to all employers, particularly smaller employers, which may lack the capacity and resources to implement structured return-to-work processes. Moreover, some occupational health providers still take a more medicalised approach that does not address the wider social and workplace factors that also affect job retention.

Case study: supporting early returns to work with guided return-to-work plans

Prolonged sickness absence is costly for employers, insurers and society. Yet many workplaces lack simple, effective return-to-work tools, and 30% of employers conduct no return-to-work planning at all.[35]

To address this, **Swiss Re** and the **University of Huddersfield** developed Re>Work, a low-cost, evidence-based digital tool that helps enable individuals to identify work-related obstacles and create guided return-to-work plans, improving communication with line managers. Using a biopsychosocial approach, it supports physical, mental and social challenges and can be used proactively, even before absence occurs.

Inspired by the Netherlands, where active sickness management is estimated to have reduced flows onto long-term incapacity benefits by 25%,[48] Re>Work was co-produced with over 150 stakeholders to ensure it meets employer and employee needs.

Case study: Centrica – early absence management and tailored support

Centrica, which employs 19,000 people, has introduced integrated health and wellbeing support through a health care trust model, with employees making a small contribution to access support. This opt-in system aims to reduce sickness absences and help absent employees return to work sooner through rapid, structured interventions.

Developed in partnership with HCML, the programme combines HR, sickness absence and occupational health services. Employees log absences through an automated platform, which triggers early intervention for issues such as mental health concerns or musculoskeletal conditions. The system prioritises job-specific support, for example, ensuring engineers receive specialist musculoskeletal care. Case managers oversee initial responses, escalating cases to clinical occupational health specialists where necessary.

The approach is holistic, addressing physical, psychological and social factors together. Employees complete lifestyle questionnaires, helping to identify underlying health issues such as stress or weight management, rather than focusing only on immediate symptoms. Additional support includes nutritionists, sleep interventions and access to online mental health tools like SilverCloud.

By providing targeted, timely interventions, Centrica's approach has had positive results. Over 12 months, nearly 4 in 5 employees who accessed health services avoided absence altogether. Early intervention for musculoskeletal conditions alone prevented thousands of absences. The programme has delivered annual cost savings of around **£2.5m**, demonstrating its financial value in addition to its capacity to improve employee health.

Importantly, engagement with the programme has been high, with 95% of employees participating – a sign that staff see real value in the support offered. The health care trust model also helps manage benefits costs effectively, making them accessible to lower-paid staff who might otherwise struggle to afford such services.

Employers play a key role in workforce health, but they cannot solve these challenges alone. Even with better job design, flexibility and early intervention, many workers still struggle to stay in or return to work. Too often, they fall through the gaps between employer support and a welfare system that treats work and health as a binary issue.

Two mechanics repair a cherry picker.

Credit: SolStock

4. A welfare system that offers too little, too late

Rising health issues are a major driver of worklessness, but the way social security operates is also making the challenge worse. Instead of helping people stay in employment, the welfare system often pushes them out of the workforce altogether.

The number of working-age recipients of work-related health benefits has risen from 2.5 million a decade ago to nearly **3.3 million** in 2023/24. Most (83%) have been out of work for at least 2 years,[49] and very few return to employment – only 1–2% of Universal Credit recipients with health conditions move into work each month.[50]

Since 2019/20, the total number of people receiving work-related health benefits has grown by around 160,000 a year, with more people starting benefits than leaving them.* While demographic and policy changes (such as an ageing workforce, a rising state pension age and Universal Credit rollout) account for around 30% of this increase, key drivers also include worsening population health, incentives within the social security system that can discourage people from taking the risk of returning to work and changes to policy and eligibility.[51]

At the core of this challenge is a rigid, binary approach to health and work. People are effectively categorised as either 'fit for work' or 'not fit for work', with limited recognition of the complexity of health conditions (for example, they can be fluctuating or episodic) or the varying levels of practical support that might help people stay employed. People deemed 'unfit' are placed on a higher rate of benefit with little or no employment support, while the majority of those found 'fit' must often meet strict work-search requirements, without enough consideration of their actual ability to work.

For many, this system creates impossible choices. People who are struggling are pushed towards proving they are unable to work rather than helped to stay in work where possible or return at the right pace.

> When dealing with the welfare system, the only real option people are given to explain why it is difficult for them to work is ill health.[19]
>
> **Dr Annie Irvine, Lecturer in Social Policy and Public Management**

* In 2023/24 alone, nearly 470,000 people started receiving these benefits, while only 280,000 stopped.

The journey onto benefits

People's circumstances often fluctuate – and someone's employment status, household situation and health status all affect their benefit entitlement. However, a typical journey from employment onto the health-related element of Universal Credit might follow these stages:

- **Onset of sickness absence** – The individual starts receiving statutory sick pay.
- **Loss of employment or the need to top up sick pay** – They claim Universal Credit.
- **Fit note submission** – An additional claim is made for the health element of Universal Credit.
- **Work Capability Assessment** – The person undergoes an assessment to determine their ability to work.
- **Outcome** – If assessed as having 'limited capability for work or work-related activity', they qualify for the health element of Universal Credit.

This process is often a lengthy one. Despite widespread recognition of the importance of early intervention, it takes more than 130 days on average to assess a claim for the health element of Universal Credit.[50] During this time, people receive little or no practical support and only a reduced level of financial assistance, which can worsen health – making a return to work even harder.

A system that does not step in early

For people at risk of leaving work due to health issues, support often comes too late – or not at all. Some employment advisers working in health settings* have had positive impacts, but these services remain limited. Most people must claim benefits before they can access any meaningful help.

This problem is exacerbated by two key issues:

- inadequate sick pay for people who rely on the statutory minimum, leading some to return to work before they have fully recovered or, in some cases, making leaving the workforce and claiming benefits a more attractive option
- long waits for health-related benefits assessments, which leave many without financial security or practical support during the critical early period after job loss.[50]

> If sick pay had been enough, I think I would've been able to return to work, but instead, my condition worsened drastically… and I ended up in the worst state, mental health-wise, that I have ever been in, forcing me to claim PIP [personal independence payment] and be unemployed for the past year and a half.
>
> **Asher, 26, from Sedgefield**

* For example, in musculoskeletal pathways or talking therapies.

A system that discourages work rather than enabling it

The risk of losing access to financial support, combined with the possibility of facing strict requirements to undertake intensive activity looking or preparing for work, discourages many people from even testing what work might be possible.[34,*] The Work Capability Assessment plays a central role in this. Instead of assessing what people could do with the right support, it focuses narrowly on what they cannot do.[52]

Fear of losing financial support if health is perceived to improve can also act as another barrier to work. For example, a single person could receive up to £810 per month through the standard and health elements of Universal Credit – more than twice the amount they would receive without the health element (£393 per month). There is a financial incentive to move into work if they remain assessed as having 'limited work capability' – their income could increase to £1,390 per month for 16 hours of work at minimum wage. However, if they are later deemed 'fit for work', their income would fall to £751 per month – lower than if they had not moved into work.

The result is a system that can trap people rather than help them:

- Those who do not 'pass' the Work Capability Assessment must meet strict work-search conditions, even if their health limits what jobs they can take. Without health-related top-ups, out-of-work benefits are now so low many struggle to avoid deep poverty.
- Meanwhile, people assessed as having 'limited capability' for work-related activity receive better financial support but little structured help to return to work. Many are rarely contacted or proactively engaged with. People can also fear a loss of income if they return to work and are reassessed, leaving them stuck on benefits with no clear path back to employment.[53]

This is not just about work disincentives for people receiving work-related health benefits – it is about the broader adequacy of benefits, particularly for those who fall just outside the health category. The gap in financial support between 'fit for work' and 'not fit for work' groups is too wide, and the requirements placed on people who want to try work or are assessed as fit for work can be too rigid. Without addressing this, some people with health challenges will continue to face strict conditionality and financial barriers. These can make returning to work – including part-time work – less attractive and significantly harder, and may lead to further deterioration in health.[†]

* In one recent survey, almost three-quarters of work-related disability benefits recipients said fear of losing benefits was a significant or very significant barrier to work.[53]

† We have not reviewed benefit levels in detail, but financial hardship is clearly a major issue for many people who rely on benefits for financial support. Research suggests that over half of families in poverty include a disabled person, and two-thirds of people in destitution have a long-term health condition.[53]

Illustrative example: monthly income for a single person

Employment and health status	Monthly income
Out-of-work with no health element	£393
Out-of-work with receipt of health element	£810
16 hours at minimum wage with health element	£1,390
16 hours at minimum wage without health element	£751

Source: The Health Foundation analysis.

Since the pandemic, there are signs that the Department for Work and Pensions' engagement with people already receiving work-related health benefits has reduced significantly. Limited effort is made to connect people in this group with meaningful support. People who do look for employment support often find the help available is fragmented and underfunded, offering little real assistance.[53,*]

> Once you're in the benefit system, it is really hard to get out of it. It is a vicious circle. It feels like a huge risk to explore or try work, health-wise and financially… There is no safety net or 'step down' as I see it.
>
> **Zoe, 34, from Kent**

A system that does not deliver results

The impacts of this binary system are clear. Only 1–2% of Universal Credit recipients with health conditions move into work each month.[50] Employment support schemes often struggle to achieve better employment outcomes because they intervene too late, when people have already been out of work for long periods.

Better approaches exist. Individual Placement and Support models[†] have been successful for those with more complex health conditions,[34] while voluntary engagement with support services has improved wellbeing even when it does not immediately lead to employment. But these approaches are not embedded in the current system, which prioritises gatekeeping entitlement over addressing the real obstacles people face.

* Reassessments for Universal Credit and the Employment and Support Allowance have fallen significantly, and recent research by the Joseph Rowntree Foundation found that two-thirds of people who were contacted since starting to receive their work-related disability benefits said they had not received any offers of employment-related support.[53]

† Individual Placement and Support is an intensive employment support model for people with severe mental health conditions, integrating job services within mental health care. Developed in the US, it follows four key principles: personal job preference, rapid job search, interview preparation and in-work support. It focuses on immediate job placement ('place then train') and has been shown to improve employment and recovery outcomes.[34]

Lessons from past policies

Efforts to reduce spending on health and disability benefits have historically focused on tightening eligibility rules rather than fixing the underlying drivers of higher claims – such as reductions in wider public service provision, worsening health or job loss. This has often resulted in rising costs rather than savings, all the while contributing to an increasingly binary, high-stakes system that adds stress and pressure on individuals.

It is important to look at the system as a whole. Despite higher health-related benefit spending, the share of GDP spent on all working-age benefits has barely changed over the past 15 years.[54] This suggests that cutting levels of support in other areas – such as through the benefit cap and out-of-work benefits – has simply shifted pressures elsewhere rather than solving the root problems.

The result is a system that pushes too many people away from work, adding costs for individuals, businesses and public services. Early support is almost entirely absent. By looking at international examples, we can learn from other approaches that better support workers with health conditions.

A disabled decorator paints a door frame.

Credit: Raylipscombe

5. Learning from other countries

The UK is not alone in facing growing work and health challenges – but it does appear to be falling behind other countries when it comes to employment for people with health conditions. While overall employment rates remain high, the UK ranks among the worst in Europe for enabling those with health conditions to participate in work. Closing this gap is one the biggest opportunities to improve UK employment outcomes in the decades ahead.

International comparisons are not straightforward – differences in cultures, labour markets and social security systems all play a role in work and health outcomes.* But the evidence highlights an important point: other countries face similar challenges yet achieve better outcomes. Some have found more effective ways to support workers with health conditions, helping them stay in employment and reducing long-term reliance on benefits.

These international examples prove there are real alternatives. By learning from these approaches, but ensuring they are adapted to the UK context, the UK can take practical steps to improve outcomes and help more people with health conditions stay in work where possible.

The UK lags behind other countries in work and health outcomes

The available evidence suggests the UK is underperforming compared with many European countries when it comes to work and health outcomes.

Research for the Commission shows that the employment gap between people with and without health conditions in the UK is one of the largest in Europe.[55] In 2022, the UK's employment rate for people without health challenges was among the highest in the EU15.† But for those with health conditions, the UK ranked near the bottom (Figure 9) – only Ireland and Belgium had wider gaps in employment rates. A similar pattern holds even when adjusting for the overall prevalence of health conditions.‡

* Experts have highlighted several limitations to the Commission, but international comparisons still offer important insights into how other countries address similar challenges and improve outcomes.

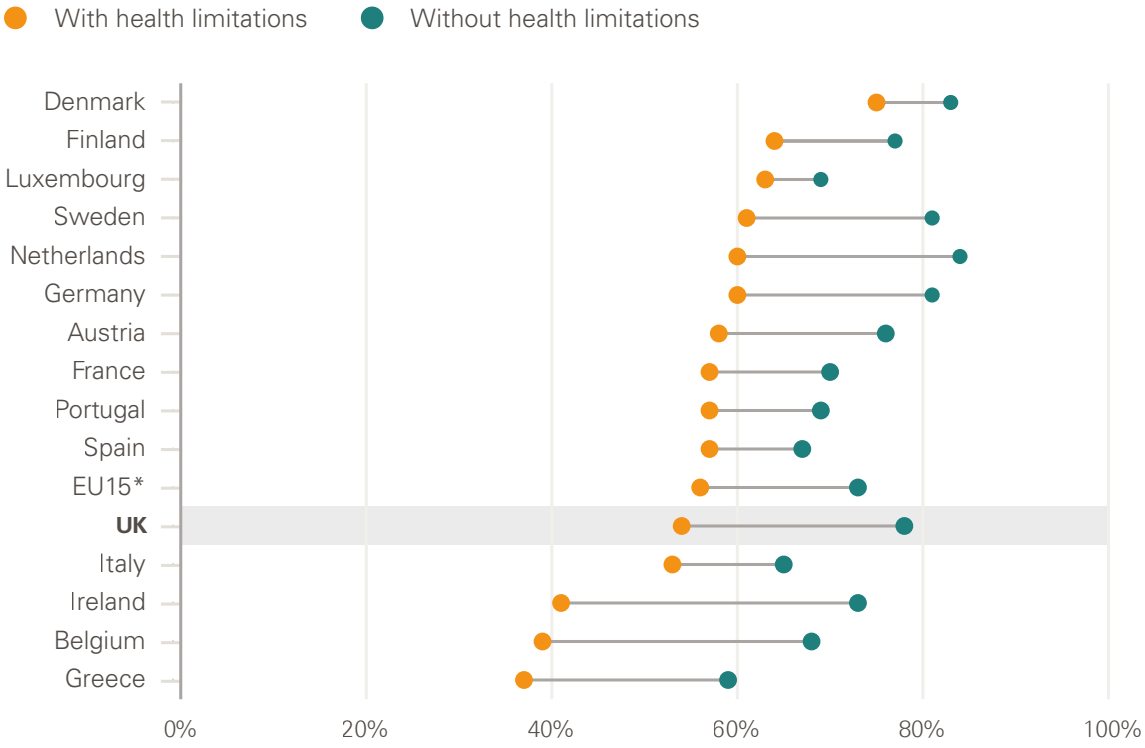
† We use this to refer to the 15 European Union countries from 1995 to 2004, including the UK. See Figure 9 for a list of countries.

‡ The prevalence-adjusted disability employment gap is a measure that takes into account the impact of disability prevalence on the employment gap. It can make comparisons over time more robust and is a useful complement to the conventional reporting of disability employment gaps.

The situation in the UK is particularly concerning for younger adults. Between 2018 and 2022, the likelihood of 16–24-year-olds with health conditions being out of work more than doubled, a sharper increase than in most European countries. This trend poses long-term risks, as early detachment from the labour market often leads to poorer employment and health prospects throughout life.

Figure 9: While the UK has a comparatively high employment rate for people without health limitations, it has a lower rate for people with health limitations

Employment rate (% aged 16–64 years) for people with and without health limitations in EU15 countries, 2022



Source: Institute for Employment Studies analysis of EU-SILC and Understanding Society.

*EU15 average covers the original EU15 countries post-Brexit, ie including the UK.

The UK is falling behind on early intervention

Many European countries intervene earlier to prevent people from falling out of work due to poor health. They ensure better coordination between employers, health services and social security to keep people in work where possible.

The UK has no equivalent system. Support is patchy, often relying on employer discretion rather than structured policies. We have identified three key areas where the UK should aim to improve based on international evidence and expert discussions.

1. Early intervention in work

Acting early is critical to preventing job loss. We repeatedly heard that without timely support – ideally within the first 4 weeks of absence – workers with health challenges face a much higher risk of long-term absence and permanent detachment from the workforce. Early intervention helps to reduce these risks and, in some cases, the progression to a chronic condition.

The UK's reliance on employer discretion and individual responsibility may allow for flexibility and less regulation, but it leads to inconsistent and potentially inadequate support. In contrast, successful countries tend to have formal systems that require or encourage employers to act early when health issues arise. For example:

- **The Netherlands** uses the **'gatekeeper protocol'**, which requires employers to take specific steps during sickness absences, including developing tailored return-to-work plans with input from occupational health professionals. A system of quality standards and certified private providers supports this, helping to reduce long-term absences and improve job retention.
- **Norway's Agreement for a More Inclusive Working Life** is a negotiated framework between the government, employers and trade unions. Employers commit to staying in close contact with absent workers and adapting tasks or schedules to prevent long-term absence. In return, they receive support and guidance from the Norwegian Welfare and Labour Administration. Evaluations show this has shortened sickness absence durations and increased the likelihood of work returns.[56]

2. Adequate and timely support in the welfare system

If people do fall out of work with poor health, the UK's employment support and welfare system does little to help them return. Two major weaknesses stand out:

- **A rigid, all-or-nothing approach** – The UK has developed an unusually binary welfare system, where standard unemployment benefits are low and heavily conditional, while health-related benefits offer more financial support but often push people out of work entirely.[57,*]

* OECD estimates suggest that after 6 months of unemployment in 2022, the UK system would have provided just 17% of previous in-work income, more than three times lower than the OECD average of 57%. These estimates relate to a single person without children whose previous in-work earnings were 67% of the average wage.[57]

- **A lack of early, work-related support** – Unlike many European countries, the UK does not provide structured vocational support before individuals move onto long-term incapacity benefits. Many workers with health challenges receive little help to stay in work or transition back before they become permanently detached from the labour market.

Other countries take a different approach. For example:

- **Denmark** operates a **caseworker model**, providing early intervention for those struggling with health and work. A dedicated caseworker coordinates vocational and medical support to help people stay in employment. Assessments focus on real labour market experiences, only classifying individuals as having severe work-capacity limitations when rehabilitation has failed or is unlikely to succeed. This process is widely seen as fair and is closely tied to rehabilitation efforts.
- **Sweden** assigns **individual case officers** to all workers on long-term sick leave. These officers coordinate between the worker, employer and relevant health and support services, ensuring a structured return-to-work plan. Progress is monitored through a 'rehabilitation chain' of regular checkpoints. Individuals only move onto long-term out-of-work benefits if, after a year, there is little progress and all rehabilitation options have been explored.

These approaches help people stay connected to the labour market before health problems force them into long-term incapacity. However, implementing such models in the UK would require significant changes to the welfare system, along with upfront investment in infrastructure and vocational rehabilitation services.

3. Long-term commitment, not short-term fixes

A final issue is policy instability. Experts have highlighted a lack of consistency and continuity in the UK's work and health policies. While there have been strong research efforts and promising interventions, these initiatives are often cut short by shifting political priorities.*

By contrast, other countries have taken a stable, long-term approach, allowing reforms to embed and improve over time. In the Netherlands, gradual improvements to different parts of the work and health system – such as the gatekeeper protocol and extension of employer responsibility for statutory sick pay to 2 years – have strengthened their overall impact. Successful strategies tend to involve coordinated action across multiple fronts rather than isolated initiatives that come and go with political cycles.

If the UK is to improve work and health outcomes, it must move beyond short-term fixes and commit to a more consistent approach that brings together employers, health services and the welfare system to deliver real and lasting change.

* One expert noted that the Fit for Work Service (2014–18), which was introduced and later discontinued in the UK, served as a model for a successful Fit2Work programme in Austria.

A visually impaired man uses a screen reader at work.

Credit: SolStock

6. A new approach to work and health

The UK's work and health system is not working well enough for employers, workers or individuals who have fallen out of the workforce. The need for reform is urgent. While the principles for change are clear, implementation will be more complex.

A preventative approach – intervening early before problems escalate – is key to improving outcomes. This will require coordinated action across workplaces, public services and the welfare system, with employers, government and health care providers working together to prevent avoidable job loss and improve support for those already out of work.

Laying the foundation for a new system

The UK has some effective policies, but they are fragmented and underfunded. Successive governments have identified problems but failed to act decisively. A focus on reducing benefit spend without addressing wider incentives for employers and individuals or prioritising early intervention has pushed more people to rely on incapacity benefits and driven up costs.

All this has undermined progress, eroded trust and left major gaps in support. Breaking this cycle requires:

1. **Prevention through best practice** – Many employers, particularly smaller ones, lack clear guidance or evidence on effective workplace health practices. Strengthening understanding across different settings, keeping guidance up to date and promoting standards and resources on accessible working can help ensure best practice is widely applied and continuously improved.
2. **Capacity for early, joined-up support** – Too many people fall out of work because they lack timely access to health and employment support. Expanding caseworker-led services and vocational rehabilitation capacity can help people manage health conditions and stay connected to work. This will require upfront investment in front-line services and better coordination across sectors.
3. **Incentives to support preventative action** – Statutory sick pay and social security should help people to stay in or return to work where possible, while encouraging employers to take early action on workforce health.

Our recommendations signal a shift from late-stage interventions, when problems are more complex and expensive to fix, towards early, targeted preventative action. Reform should not be driven by cutting entitlements for people with long-term health conditions, many of whom have already been profoundly let down. Instead, the focus should be on reducing the number of people leaving work and becoming reliant on social security – benefiting individuals, the public finances, businesses and the wider economy.

Principles for change

In developing our recommendations, we have been guided by the following core principles:

- **Employers must lead action with a preventative approach**. Workforce health and retention depend not just on government action but on decisions made by individual businesses and line managers. Reforms should support a shift in employer practices – not through rigid mandates, but by ensuring businesses have the right incentives, information and tools to adapt roles, improve job design and strengthen workforce management and awareness of best practice. Approaches must be flexible to reflect different industries and workplace settings.
- **Support should be person-centred and focused on what people can do**. Too often, decisions about work and health prioritise risk management and compliance over genuinely listening to and supporting people to break down the barriers they are facing. A more person-centred approach is needed that provides meaningful support to help individuals manage work and health.
- **Incentives should encourage connection to work and balance responsibilities**. Changes to statutory sick pay and the welfare system should help keep individuals connected to work where possible. Without this, other measures will not deliver their full potential. Changes should also ensure greater responsibilities for businesses and individuals come with clear opportunities and rewards.
- **Changes must be phased and sequenced**. Reforms should be introduced gradually and in a logical order, ensuring each stage builds on the last. Time for trialling and learning is essential to refine approaches and ensure they are workable and effective. Rebuilding trust with disabled people and people with health conditions is particularly important – reforms must be shaped with their direct input.
- **Sustained action is needed – and stronger measures if progress is too slow**. Lasting change will require sustained investment to build on these proposals over time. Other countries, such as the Netherlands, have used legislation to establish clear employer responsibilities and structured return-to-work processes. If progress is too slow, the UK may need to take further steps to secure meaningful and lasting improvements in workforce health and job retention.

Enacting these principles will provide the foundation for a stronger work and health system. Change will take time, but by applying these principles, meaningful progress can be made. With an ageing workforce, rising health challenges and a growing mental health crisis for young people, the UK cannot afford to persist with a system that intervenes too late – nor bear the economic and social costs that come with it.

Two men take a break during a house renovation.

Credit: SolStock

7. Recommendations

Our recommendations set out a **bold long-term vision** for an approach to work and health that supports people to stay in work or return when they can. The UK's current approach is fragmented, often reactive and in too many instances fails both workers and employers. A different path is not only possible but necessary.

The UK must shift towards a system **where incentives and rewards are aligned** – one that makes it easier for employers to protect the health of their workforce and ensures individuals have the right financial and practical support to remain in or return to work. This is not about short-term fixes – it is about creating a long-term approach that works for businesses, workers and the country.

Our proposals have been **tested with both employers and the public**.* There is strong support for reforms that balance responsibilities between individuals, employers and the government. Focus group participants highlighted the value of good work for health and wellbeing, recognising the important role employers play in supporting workforce health. However, they also emphasised the need for additional support for employers, particularly smaller businesses, in helping people stay in work for longer.

We have identified **seven key changes** necessary to build a more coordinated and effective system. These recommendations prioritise early intervention – helping people stay in work where possible and creating clearer pathways back into employment for people who are temporarily absent. They also outline some ways to better support people who have left the workforce entirely.

Our proposals show what needs to change to build healthier working lives in the UK. The Health Foundation will work with others to develop them further, focusing on how they can be implemented.

* This was through various discussions, workshops and surveys. Ipsos also held a series of focus groups with members of the public and employers in England in December 2024. Participants were recruited to cover a range of ages, working statuses, social grades, ethnicities and regions. Groups 1, 2 and 3 also included participants with a long-term health condition. Group 4 was with employers – defined as senior managers or business owners.

Summary of recommendations

1. **Update and apply best practice in accessibility, workforce health and retention, with a focus on at-risk sectors.** The government should work with sector leaders, trade unions and health experts to update evidence and solve shared workforce health challenges. This will ensure best practices are effectively applied, including in sectors under strain like social care and transport and storage.

2. **Embed early intervention through a caseworker-led support model that matches help to individual needs.** The government should roll out a locally based caseworker service to provide independent advice to employers and advocacy for workers. The focus should be on addressing work and health challenges and preventing unnecessary job loss due to health issues, not just diagnosing conditions.

3. **Commit to reviewing statutory sick pay to improve financial security for workers.** The government should review statutory sick pay levels within this parliament to ensure better financial security for workers, targeting a level closer to 60 to 80% of usual earnings. Reforms should incentivise all employers to proactively support workforce health, with targeted help to manage higher costs.

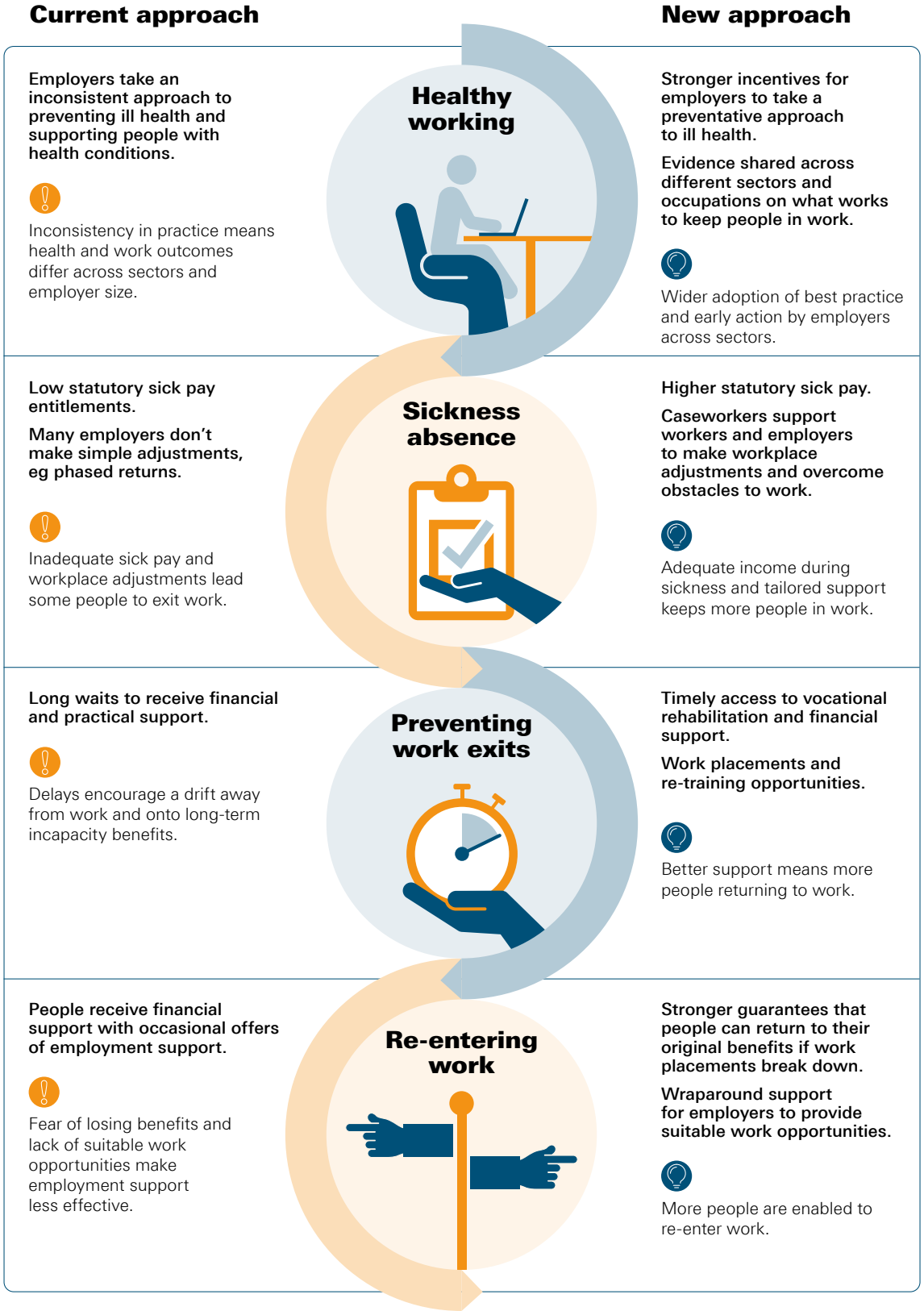
4. **Introduce a vocational rehabilitation benefit to help people stay in work after statutory sick pay ends.** The government should provide up to 12 months of financial support after entitlement to statutory sick pay ends, coupled with practical support to help people remain in the workforce, preventing long-term incapacity.

5. **Develop a stronger 1-year job guarantee for workers on long-term sickness absence.** The government should explore stronger job retention protections to ensure workers on long-term sickness absence are not dismissed too soon and have a clear route back to their employer where possible.

6. **Trial local job-pooling initiatives for workers unable to return to their previous roles due to health challenges.** The government should work with employers and local authorities to trial job-brokerage and pooling initiatives, helping people with health challenges move into suitable alternative roles when returning to their previous employer is not possible.

7. **Deliver a bold new back-to-work offer for people receiving work-related health benefits.** The government should incentivise and reduce the risks of moving into work by allowing people to try working for at least 18 months without losing their health-related entitlements. Voluntary access to employment support should be available. Once employment is sustained, financial support should taper gradually to prevent sharp drops in income.

A new approach to keep people in work



1 Update and apply best practice in accessibility, workforce health and retention, with a focus on at-risk sectors

Why change is needed

Workforce health challenges vary widely by sector and are shaped by factors such as an ageing workforce, shift work, long hours, high turnover and physically demanding roles. Many small businesses and employers in front-line sectors lack the capacity to develop and implement effective workforce health practices. Different sectors face different challenges – from burnout in education and health and care to physical strain and challenging working conditions in transport and logistics.[27] Without sector-wide coordination and increased awareness of best practices, businesses struggle to adopt them consistently.

Our proposal

The government should use its convening powers to work with employers in different sectors to build a stronger, evidence-based understanding of what works in workforce health. This should be tailored to different sectors and informed by real-world and lived experiences. A starting point should be building on the Fair Pay Agreement in social care and extending this approach to another sector facing significant challenges, such as transport and storage.

We recommend the government:

- **Convenes sector leaders and key partners** to tackle sector-wide challenges and develop sector-specific workforce health codes of practice, starting with social care and another sector facing significant strain. These sector panels should focus on:
    1. **improving job design to support long-term workability**, addressing issues like shift length, rostering, workload and job flexibility. For example, consider:
        - A bus driver working long, back-to-back shifts versus one with staggered hours and planned recovery time.
        - A paramedic handling constant emergency calls versus one with structured recovery periods during shifts.
    2. **adapting work to be accessible for people with long-term health conditions**, covering issues like disability inclusion, workplace accommodations, absence management and greater flexibility in how and where work is done.
- **Commits funding to build and share evidence on what works**, ensuring best practice is rigorously tested,* practical for different business settings and adaptable to a changing world of work.

* Lessons from areas like equality, diversity and inclusion show that rigorous evaluation is essential to identifying workplace practices that are genuinely effective.

- **Ensures small and medium enterprises receive tailored support** through wider business groups and a new independent advisory service, helping them implement best practices without facing undue financial or administrative burdens.
- **Takes a lead by reviewing practices and developing solutions** within the education and health care workforces, key parts of the public sector with high risks to worker health.

Visible leadership and shared ownership are essential for success. While government has an important convening role, this initiative should be led by employers with input from trade unions and health and disability experts to ensure solutions are practical, credible and tailored to sector-specific challenges.

Wider actions to support progress

To ensure long-term progress on workforce health and retention across sectors, the government should also update and review the Disability Confident scheme, making it more transparent, outcome focused and effective at improving job retention and career progression for people with long-term health conditions.

As part of this, large employers should be required to report on both disability employment rates and the disability pay gap, alongside broader measures to track workforce health outcomes. Transparent reporting would give a clearer picture of employer action and sector-wide progress, highlight areas for improvement in supporting workers with long-term health conditions and encourage businesses to adopt effective health, accessibility and job-retention measures.

2 Embed early intervention through a caseworker-led support model that matches help to individual needs

Why change is needed

Workplace health support is fragmented and often reactive, leaving many workers – especially those in lower-paid roles or smaller businesses – without timely in-work support. While some employers make significant investments in workplace health, provision remains inconsistent. Fit notes present a key opportunity for intervention, yet health professionals often lack the capacity or specialist knowledge to provide effective work and health advice.

This is not just about expanding traditional occupational health services. Pilot evidence shows that only a small proportion of cases require clinical referrals, while many people benefit from early, non-clinical interventions focused on practical problem-solving and workplace issues.[42] Currently, workers and employers can struggle to find the right help when they need it. A tiered, structured service could help address this gap by providing clear pathways to help.

Our proposal

Over time, a national service should be rolled out to provide timely support proportionate to each person's situation and needs, helping them to stay in work or return when health issues arise. This tiered service should start with self-help resources and employer guidance, escalating to caseworker-led support and referrals to other help as needed. The support should be practical and focused on problem-solving, not just clinical diagnosis.

To achieve this, the government should build on existing services and pilots – including elements of WorkWell, Inactivity Trailblazers, Health and Growth Accelerators and Connect to Work – to:

- **Create a national information and advice service for work and health support**, giving workers and employers access to self-help tools, adjustment support, structured return-to-work plans and practical guidance.
- **Develop a locally based caseworker support offer,** with links to local services and partners. Caseworkers should provide ongoing psychosocial and problem-solving support, refer individuals to employer-provided or external services such as Access to Work and assist with health management, confidence and wider obstacles to work.*

* A locally linked caseworker model should take a biopsychosocial approach, recognising that a person's ability to work is shaped not just by their health condition(s) but by factors like workplace design and culture, financial security, caring responsibilities and job flexibility.

- **Ensure fit notes trigger early intervention,** automatically referring workers with longer term absences – or those at risk of leaving work – to support. Individuals and employers should also have the option to refer those who have been absent beyond a set threshold, particularly where employer-provided occupational health support is lacking.
- **Develop clear referral pathways** to specialist multi-agency support, including rehabilitation services and Individual Placement and Support employment models, to help those facing more complex work and health barriers. Where returning to a previous role is unlikely, caseworkers should actively support skills assessments, retraining and career transitions, ensuring individuals have a clear path to good work.

Key elements of this support – such as vocational rehabilitation and occupational health services – are currently underdeveloped or undersupplied, partly due to strained public services. The right capacity must be built over time, testing and embedding best practices to ensure high-quality, cost-effective provision.

For this to be effective across the UK, the government should work with devolved administrations to scale up support nationally, adapting delivery to regional health and employment systems while building on existing services and local expertise.

Wider actions to support progress

The government needs to get the basics of Access to Work right to make it more effective. This means tackling the backlog, making it easier to transfer awards between employers and offering longer term awards for those with stable support needs. A standardised approach for decision makers, with clear qualifying criteria, is also essential to prevent inconsistent support offers.

Embedding Access to Work in the proposed tiered caseworker support model would improve access, reduce bureaucracy and ensure more consistent support for disabled people and those with long-term conditions. Caseworkers can direct workers and employers to effective workplace health and accessibility services, helping to build employer awareness of, and confidence using, available support.

The government should also improve feedback mechanisms in Access to Work and wider workplace health services – such as occupational health markets – by gathering and sharing data from employers and workers. This would help raise service standards and ensure providers meet clear quality benchmarks.

Features of a new tiered approach for supporting workforce health and improving retention

1

Tools and guidance provided for employers and workers

For workers on short-term absence and/or where health concerns have been raised during workplace conversations.

Help to identify health and other obstacles affecting the worker's ability to work.

Support for the worker and employer to create return to work plans.

2

Specialist support

For workers on longer term absence (2–4 weeks) and/or who face overlapping obstacles to work (eg housing problems, caring responsibilities).

Independent caseworker assesses ability to work and coordinates support.

Caseworker liaises with employer and advises on effective workplace adjustments.

Caseworker triages and refers to appropriate support services if needed.

3

Intensive support

For workers on long-term absence (4+ weeks) and/or at risk of leaving the workforce.

Worker provided with access to work-focused health services, such as counselling or physiotherapy.

More intensive workplace accommodations considered, including amending tasks and workload.

Worker supported to complete transferable skills assessment and consider alternative roles.

Caseworker or local service to support with job search, training and work trial opportunities.

3 Commit to reviewing statutory sick pay to improve financial security for workers

Why change is needed

The expansion of statutory sick pay eligibility under the Employment Rights Bill does not address a fundamental issue: statutory sick pay remains too low to provide meaningful financial security during illness. This forces some people to continue working while sick, and others to rely on benefits without a clear route back into work.

However, businesses – particularly smaller employers – already face a series of cost pressures. The challenge is to raise statutory sick pay to a fairer level while giving businesses the time and support they need to adapt.

Our proposal

Recognising wider pressures, we recommend the government undertake a full statutory sick pay review within this parliament, with a focus on:

- **Enabling employers to pay a higher rate of statutory sick pay**, moving towards a system where statutory sick pay covers a greater proportion of earnings (targeting 60 to 80%, capped at median wages, with a guaranteed minimum amount). A phased implementation would allow businesses time to adjust and government time to assess the impact and take steps to ensure income security for low-paid workers.*
- **Introducing a phased return-to-work option**, allowing statutory sick pay to be paid alongside regular wages for a set period while employees gradually return to work on reduced hours. This would help prevent long-term absence and improve retention, and could be implemented immediately through regulatory change.
- **Providing employer incentives and safeguards**, exploring a targeted rebate system that offsets statutory sick pay costs, particularly for smaller businesses, and actively supports workers back into employment. This would encourage better absence management without placing excessive burdens on businesses.
- **Ensuring clear rules and effective enforcement**, strengthening awareness and compliance through the Single Enforcement Body and making sure all eligible workers receive the statutory sick pay they are entitled to.

* Moving away from a flat-rate system would generally improve income security, but for the lowest-paid workers, 60% of earnings may still be too low to prevent hardship. The review should consider measures to protect those most at risk of financial strain.

4 Introduce a vocational rehabilitation benefit to help people stay in work after statutory sick pay ends

Why change is needed

Returning to work after the onset of a health condition can take longer than 6 months. The UK's welfare system does not currently do enough to help people with health issues to stay in work or return quickly. Support is often delayed or limited, leaving many without adequate financial or practical help after sickness absence. In contrast, many European countries provide early rehabilitation, improving return-to-work rates. A lack of timely practical and financial support risks people becoming permanently detached from the labour market – even when their conditions improve over time.

Our proposal

With the right capacity and infrastructure in place, the government should introduce a vocational rehabilitation benefit that offers timely practical support for up to 12 months after someone leaves employment. Given the link to recent work history, a contributory entitlement could be based on workers' past earnings, with income support provided through Universal Credit for individuals with limited work experience. Key features of the proposal should include:

- **Continued financial support** for people who remain absent from work after at least 6 months of statutory sick pay.
- **Engagement with a caseworker-led model** to provide practical and health support, ensuring individuals participate in activities that help them return to work.
- **Ongoing assessment of work capability**, led by a caseworker, with entitlement based on a fit note, past receipt of statutory sick pay and engagement with support. Input from independent health professionals and employers should be used where needed, ensuring the process is built around the individual's needs.
- **Stronger financial incentives to return to work** through an in-work guarantee, where vocational rehabilitation payments continue when people start working, alongside a higher work allowance. There should also be guidance for employers to help with onboarding and providing workplace adjustments, ensuring a smooth transition into work.
- **A skills and training offer for younger people** with limited work history and lower qualifications, helping to boost future earnings potential.

The focus must be on support, not an extension of strict conditionality. Fast-tracking those with severe health conditions to the health element of Universal Credit should ensure they receive the right support without unnecessary hurdles.* For others, a

* Based on recognised assessments such as personal independence payment scores or inability to engage with practical support due to health.

rehabilitation stage should be an opportunity to access tailored help that could reduce their chances of having to move onto long-term incapacity benefits. This approach should be designed to enable engagement with the right support at the right time based on an individual's health needs.

Note on benefits levels and design

The wider adequacy of benefits is beyond this Commission's scope. However, it is clear that current income replacement is often insufficient and too binary, though increasing rates would have significant fiscal implications.

Given these limitations, we propose the vocational rehabilitation benefit initially match the health element of Universal Credit. The rate of a contributory element could be linked to a percentage of past earnings, capped at the median – similar to the furlough scheme. Over time, there could be scope to align an income-related component more closely with higher statutory sick pay rates for minimum wage earners. This would help to supplement incomes during periods of ill health and prevent sudden financial hardship.

A vocational rehabilitation benefit would not operate in isolation. The wider design of Universal Credit must also recognise that health conditions affect people in different ways, with varying impacts on their ability to work. Some people may not qualify for work-related health benefits but still face health-related barriers to entering work or be limited in the number of hours they can work.* To better reflect people's different circumstances and work capacities, and to address incentives that may encourage people to move towards long-term incapacity, fairer conditionality rules and appropriate financial incentives are needed, particularly in relation to better supporting part-time work.

* Only 50% of working-age people who are out of the workforce with work-limiting health conditions receive incapacity benefits.

5 Develop a stronger 1-year job guarantee for workers on long-term sickness absence

Why change is needed

For many workers with chronic health conditions, returning to work as soon as they are well enough, or as part of their recovery, is beneficial. However, some people need longer recovery periods – especially when access to health services has been delayed. Losing a job during this period can make returning to work significantly harder.

Legal protections exist under the Equality Act and current Employment Rights Act, but these are inconsistently applied, and employers and workers can struggle with unclear expectations. A more structured approach could provide greater clarity and ensure dismissal is a last resort rather than a premature response to long-term sickness absence. Provisions in the government's Employment Rights Bill could also support this.

While maternity protections provide a strong model for job retention protections, health-related absences can be less predictable in duration and impact, requiring a more flexible and tailored approach.

Our proposal

We recommend the government consider options to boost job retention during the first year of a long-term sickness absence. Recognising both existing legal protections and opportunities for better enforcement and improved practices, options could include:

- **Strengthening existing protections**, including reviewing the content and application of current codes of practice to identify where legal safeguards around ill-health dismissals could be improved.
- **Mandating employer engagement with an independent caseworker before dismissing a worker** within the first year of a long-term sickness absence. This would ensure:
  - reasonable adjustments and job redesign options have been fully considered
  - workers and employers receive independent guidance to reduce disputes and lower the risk of costly tribunal claims.
- **Exploring additional measures** to support retention, such as introducing new flexibilities for phased returns within the first year of long-term absence or targeted Access to Work funding to help smaller employers manage extended absences.*
- **Ensuring the provision of suitable alternative employment options** if a caseworker advises a return to the original employer is not workable.

* This must be separate from existing Access to Work funding to avoid adding pressure to an already stretched system.

6 Trial local job-pooling initiatives for workers unable to return to their previous roles due to health challenges

Why change is needed

Many workers who develop health conditions could continue working in alternative roles but lack the support to make that transition. Without structured assistance, these workers risk falling out of the workforce long term, despite having valuable skills and experience.

At the same time, there are many employers struggling to recruit, particularly in sectors facing high demand. While large organisations may have internal redeployment options, smaller businesses and employers in physically demanding industries have limited capacity to offer alternative roles, leaving displaced workers with few viable options.

There is no coordinated system to match displaced workers with new job opportunities suited to their skills and health needs. A more structured approach is needed to help workers and employers, ensuring talent is not lost due to a lack of transition pathways. Bridging the gap between demand for alternative roles and the limited supply of viable options requires clear incentives, support and expectations for employers to create suitable opportunities.

Our proposal

We recommend the government partners with employers, local authorities and recruitment networks to trial job-pooling schemes that link workers unable to return to their previous roles with businesses struggling to recruit. This would involve:

- **Developing structured redeployment pathways**, ensuring workers have access to alternative employment options, retraining and career transitions based on their skills, experience and health capacity. This would require an understanding of suitable employment opportunities and career paths in local areas.
- **Establishing local job-pooling networks**, linking employers in key sectors to create shared opportunities for redeployment, ensuring job vacancies are matched with available local workers.
- **Expanding career transition services** to provide tailored support, including vocational rehabilitation, skills and retraining, and job-matching assistance through Jobcentre Plus and local and national employment initiatives.

Support to improve career transitions should be available at different stages – from when someone first realises they may need to leave their current role through to when they are already out of work and need help returning.

7 Deliver a bold new back-to-work offer for people receiving work-related health benefits

Why change is needed

The current system discourages work by forcing people into a binary choice: they are either fit for work or too sick to work, with little flexibility in between. Evidence shows that many people on health-related benefits want to explore employment but fear reassessment, income loss or being pushed into unsuitable jobs. Concerns about financial insecurity – particularly for those with fluctuating health – often prevent people from even trying work.

While past reforms have attempted to address this, they have not built sufficient trust or provided the safeguards needed to support meaningful engagement in work-related support. A bold new back-to-work offer is needed to create real change – one that feels different from past approaches. In the Netherlands, people can try working for up to 5 years with the guarantee they can return to their previous benefits income if unable to continue.[58]

Our proposal

As part of a reformed system, the Department for Work and Pensions should:

- **Guarantee benefit security for at least 18 months** for those trying work, ensuring they do not lose entitlement to Employment and Support Allowance, Universal Credit health elements or other relevant health benefits – or face reassessment – if employment does not work out.
- **Increase work allowances** so people can work around 15 hours per week (rather than the current 8 hours) before their benefits are reduced, allowing a meaningful transition into employment.
- **Voluntarily re-engage people on health-related benefits** by proactively reaching out, offering clear information and providing support for those interested in work.
- **Ensure return-to-work support remains voluntary and flexible**, giving individuals control over the process; advisers should help identify suitable opportunities and provide access to skills development where needed.

These reforms should form part of wider changes to ensure a fair and gradual transition beyond the proposed 18-month period, limiting sudden drops in income.

The benefits of reform

Our proposals focus on reducing the number of people who leave the workforce each year and report work-limiting health conditions – currently around 300,000. They also recognise the need to better support those who are already out of the workforce but want to return.

Beyond the health-enhancing effects of employment for individuals, there are clear benefits for employers. These primarily stem from a reduction in days lost to sickness absence and presenteeism. Lower health-related exits from work can also help reduce staff turnover, leading to cost savings and improved business performance. For example:

- replacing a fully trained nurse can cost an estimated £10,000 to £12,000[59]
- training a new bus driver costs around £8,500
- even in retail, where hiring and training costs are lower (£1,500), repeated turnover can damage business performance.*

For some businesses, the issue is not just the cost of replacing workers but the difficulty of finding new ones. Labour shortages have eased overall, but sectors such as health, social care and transport still struggle to recruit, partly due to an ageing workforce and rising health needs.[60,†]

Workforce health in the NHS

As the UK's largest employer, the NHS also faces some of the most pressing workforce health issues and would have a large prize from improving workforce health. A recent report found that poor mental health – connected to presenteeism, absence and turnover – cost the NHS an estimated £12bn in 2022, and that stronger mental health support could help save up to £1bn a year.[61] Case studies from leading NHS trusts show that investing in high-quality occupational health and wellbeing can deliver clear returns on investment, strengthening the case for wider action.[62]

* While significant, these recruitment costs are often smaller than the cost of productivity loss while filling vacancies and onboarding new staff.

† In December 2024, 28% of transport and storage businesses and 27% of human health and social work businesses with 10 or more employees reported experiencing recruitment difficulties, compared with an average of 18% for all businesses of this size.[60]

Benefits to the public finances

Each person with health challenges who remains in or returns to work helps reduce public spending and increase tax revenues, especially if their health improves or they do not develop a work-limiting health condition. Based on average costs from the Office for Budget Responsibility, these benefits could amount to:

- £11,400 a year in reduced welfare spending
- £5,900 in higher tax revenue
- £1,840 in reduced health care costs.[63,*]

Estimated impact of our proposals

The main benefits of our recommendations – for individuals, government and employers – are expected to come from helping more people stay in work despite health challenges, reducing the number who feel forced to leave employment. This would mean fewer people losing their incomes and relying on work-related health benefits. In this section, we set out initial estimates of the broader economic costs and benefits of two key proposals, informed by the available evidence.[†]

Potential outcomes

When fully operational, our recommendations for proactive caseworker-led support (recommendations 2 and 4) could lead to:

- 370,000 people a year engaging with early, caseworker-led support
- 25,000 fewer people leaving employment each year compared with a scenario where no extra support is provided.[‡]

The total number of people prevented from leaving work – and therefore the scale of the benefits to the public finances – would grow over time.[§] By year five, even after factoring in some subsequent workforce exits and the cost of delivering support (estimated at around £620m a year), modelling suggests that:

- 100,000 more people could be in work
- annual savings are expected to reach £670m
- total savings to government over 5 years could reach £1.1bn.

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* These figures have been updated to 2024/25 prices by the Health Foundation based on Office for Budget Responsibility estimates. Welfare spend does not include disability benefits, which are not directly linked to work status.

† This section focuses primarily on the expected impact of earlier practical support through the caseworker-led model (recommendations 2 and 4) rather than the full set of recommendations. It presents initial estimates of the broader economic costs and benefits based on available evidence but does not include individual-level impacts such as changes in income or quality of life.

‡ Other people will benefit from earlier returns to work through caseworker support, which also benefits employers. However, our focus here is on the impacts from preventing workforce exits.

§ While some people will still leave work later due to health or other reasons, the overall number remaining in employment should increase over time, leading to sustained increases in tax revenues and reductions in welfare spending.

Beyond this 5-year horizon, there would be significant savings to government – and gains to individuals – from increasing the chances of people staying in work throughout their working lives rather than moving onto benefits long term. This is particularly important for young people, as being out of work at the start of their careers could have lasting effects on their future earnings and job prospects. It could also enable workers in their 50s and 60s to continue working to older ages.

The projected increase in employment is linked to earlier access to practical, caseworker-led support, which would help more people with health challenges stay in work longer. This is based on cautious assumptions, including modest improvements in return-to-work rates.* It does not account for any additional impacts from improved financial support or incentives, beyond their role in enabling engagement with the caseworker-led support. More details on our methodology can be found in the accompanying annex.

There is strong evidence early intervention can help people stay in work.[64] However, the success of these reforms will depend on reaching those who need support, matching them with the right help and having enough skilled staff to deliver it. The overall impact will be shaped not just by policy design but by how well these measures are implemented and whether employers engage with them.

Further potential savings

With a more effective support offer and a stronger return-to-work guarantee, additional savings may be possible through re-engaging with existing recipients of incapacity benefits. Once people move onto health-related benefits, engagement is often linked to reassessments, the number of which has declined significantly since the pandemic. Rather than focusing on reassessing eligibility for financial support, the government could instead explore existing recipients' interest in returning to work and offer voluntary access to support to do so if they are able.

Impact of more generous statutory sick pay

A government commitment to reviewing statutory sick pay within this parliament presents an opportunity to strengthen income protection for workers while balancing business concerns. To give an indication of the potential impact, if statutory sick pay is set at 60 to 80% of earnings, capped at the median, payroll costs are estimated to rise by around £700m–£1.1bn a year. This represents just 0.1–0.2% of current payroll costs, though the impact would vary by sector.†

* Specifically, the analysis assumes a 20% reduction in exit rates following long-term absence, from around 10% a year to 8%, and that 60% of those leaving work after long-term absence move onto incapacity benefits – reflecting lower-end effect sizes from existing research. See the accompanying annex for more detail.

† These estimates do not assume any behaviour change. The annex accompanying this report includes a more detailed breakdown.

The initial effects of higher statutory rates are likely to include increased absence rates and higher upfront costs for employers.[65] However, these costs could be offset by the long-term benefits, including:

- fewer working days lost to sickness absence due to reduced workplace transmission
- higher productivity and lower recruitment costs from improved staff retention.

Evidence from past studies suggests these benefits could partially or even fully balance out the additional costs of a more generous statutory sick pay system.[66] The overall effect would depend on how employers and workers respond. Well-targeted rebates could help employers adapt to changes while promoting effective absence management.

Next steps

To help ensure our recommendations are made a reality, the Health Foundation is committed to further refining, testing and developing proposals and taking forward action for healthier working lives.

Two young employees meet in their office.

Credit: Koto

8. Conclusion

Health-related job loss can be reduced – but doing so demands a fresh approach. We believe intervening early, strengthening workplace support and building a fairer social security system can help people remain in work where possible and return to work quickly if they leave. With an ageing population and rising mental health challenges in the younger population, the time to act is now.

The changes outlined in this report require concerted effort from employers, government and communities alike. Employers who invest in disability inclusion and healthier working practices stand to benefit from improved staff retention, higher productivity and reduced recruitment costs. Policymakers must commit to sustained reform, targeting limited resources towards early prevention rather than late-stage intervention. Local partners, including health and care services, can ensure help is joined-up, practical and rooted in the realities of people's lives.

Crucially, this must be an ongoing process. People with health conditions and disabled people should be at the heart of the design, implementation and continuous improvement of reforms. This will require regular engagement and feedback mechanisms throughout the lifetime of these policies to ensure support remains effective, responsive and adaptable to real-world challenges. This approach is also key to rebuilding trust, particularly in moving away from the conditionality-driven and punitive models that have discouraged engagement.

The prize for investment and reform is a healthier, more productive workforce that strengthens the UK economy and improves prospects for millions of people at risk of leaving work.

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We also thank our Expert Advisory Group, which brought together over 20 leaders from local and national government, employers and worker representatives, academia, think tanks and the charity sector. In addition, several individual work and health experts contributed their time and insights through workshops and discussions. Together, their independent input and challenge helped ensure our work reflects the best available evidence.

This work would not have been possible without the insights and perspectives shared by people with lived experience. We sincerely appreciate the time and generosity of everyone who took part. Their contributions helped focus our work and inform our thinking. The quotes in this report reflect testimony from a range of sources, including video diaries, community and online workshops, peer research, interviews and focus groups.

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We look forward to continuing this work together.

Publications supporting the Commission for Healthier Working Lives

Health Foundation publications

Towards a healthier workforce: Interim report of the Commission for Healthier Working Lives. Commission for Healthier Working Lives (published by the Health Foundation); 2024

What we know about the UK's working-age health challenge. The Health Foundation; 2023

How can the next government improve the health of the workforce and boost growth? The Health Foundation; 2024

Employment, economic inactivity and incapacity: past lessons and implications for future policy. Professor Paul Gregg (published by the Health Foundation); 2024

Mental health trends among working-age people. The Health Foundation; 2025

Partner publications

Exploring the interactions between job quality, industries and health. Institute for Employment Studies; 2024

Work and health: international comparisons with the UK. Institute for Employment Studies; 2025

Discussion paper on the future of work and health. Institute for Employment Studies; Forthcoming

Supporting workers' health and access to better work: Exploring the role for government, services and employers. Learning and Work Institute; 2025

An exploration of local variations in health and job outcomes across the UK. Learning and Work Institute; 2025

Balancing work and care: Approaches to improving support. Learning and Work Institute; Forthcoming

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Appendix

Table 1: Type of sick pay offered, by sector and size, 2018

Sector/size/total	Statutory sick pay	Above statutory sick pay	Neither	Do not know
Agriculture and energy	43%	28%	22%	7%
Manufacturing	58%	31%	9%	1%
Construction	57%	24%	14%	6%
Distribution, hotels and restaurants	62%	24%	11%	4%
Transport and comms	51%	35%	10%	5%
Financial, professional and admin services	47%	32%	15%	6%
Public admin, education and health	52%	38%	6%	3%
Other services	56%	19%	20%	5%
Small	55%	26%	14%	5%
Medium	46%	47%	3%	5%
Large	16%	77%	0%	6%
Total (employers)	54%	28%	13%	5%
Total (employees – grossed estimates)	42%	52%	4%	3%

Source: Tu T, et al. *Sickness absence and health in the workplace: understanding employer behaviour and practice;* Ipsos MORI, 2018. Employer base: 2,564.

Table 2: Share of UK employers funding workforce health initiatives, by initiative type

Which, if any, of the following workforce health initiatives has your organisation funded over the past 12 months? Please select all that apply	Share of employers
Employee assistance programmes (eg confidential counselling, mental health helplines, wellbeing apps, financial wellbeing apps)	56%
Workplace adjustments for employees with health conditions (eg ergonomic furniture, adaptive technology, flexible hours, remote working options)	53%
Preventative health initiatives (eg on-site health checks, vaccination drives, physical fitness or mindfulness programmes)	34%
Occupational health services (eg external providers for assessments, in-house occupational health advisors, tailored return-to-work plans)	41%
Skills or training programmes on workforce health (eg workshops for managers on supporting employees with health needs, mental health first aid training)	42%
Health apps or technology to support workforce health and wellbeing (eg wellbeing apps, adaptive technology)	32%
Other	2%
N/A – my organisation has not invested in any workforce health initiatives	20%

Source: The Health Foundation analysis of YouGov UK employer survey data. Sample size 1006. Fieldwork conducted 2 January to 7 February 2025. The survey was carried out online, with figures weighted and representative of all UK businesses.

Table 3: Share of employers reporting that the workforce health initiatives they funded were effective in improving workforce health outcomes

And how effective, if at all, do you think these initiatives have been in improving workforce health outcomes?	Net: Effective	Net: Not Effective	Don't know
Employee assistance programmes (eg confidential counselling, mental health helplines, wellbeing apps, financial wellbeing apps)	74%	20%	7%
Workplace adjustments for employees with health conditions (eg ergonomic furniture, adaptive technology, flexible hours, remote working options)	88%	7%	5%
Preventative health initiatives (eg on-site health checks, vaccination drives, physical fitness or mindfulness programmes)	81%	10%	10%
Occupational health services (eg external providers for assessments, in-house occupational health advisors, tailored return-to-work plans)	71%	23%	6%
Skills or training programmes on workforce health (eg workshops for managers on supporting employees with health needs, mental health first aid training)	78%	16%	6%
Health apps or technology to support workforce health and wellbeing (eg wellbeing apps, adaptive technology)	61%	31%	8%

Source: The Health Foundation analysis of YouGov UK employer survey data. Sample size 1006. Fieldwork conducted 2 January to 7 February 2025. The survey was carried out online, with figures weighted and representative of all UK businesses.
Note: respondents were asked whether the initiatives they had funded were 'very effective', 'somewhat effective', 'not very effective', 'not at all effective' or 'don't know'.

About the Health Foundation

The Health Foundation is an independent charitable organisation working to build a healthier UK.

Health is our most precious asset. Good health enables us to live happy, fulfilling lives, fuels our prosperity and helps build a stronger society. Yet good health remains out of reach for too many people in the UK and services are struggling to provide access to timely, high-quality care.

It doesn't have to be like this. Our mission is to help build a healthier UK by:

- improving people's health and reducing inequalities
- supporting radical innovation and improvement in health and care services
- providing evidence and analysis to improve health and care policy.

We'll achieve this by producing research and analysis, shaping policy and practice, building skills, knowledge and capacity, and acting as a catalyst for change.

Everyone has a stake and a part to play in improving our health. By working together, we can build a healthier UK.

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