

Improving our Nation's Health: A Whole-of-Government Approach to Tackling the Causes of Long-Term Sickness and Economic Inactivity

BCG Centre for Growth and NHS Confederation

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As part of BCG, the Centre for Growth's mission is to accelerate sustainable and inclusive economic growth in the UK by working with businesses, government and wider society to identify and deliver breakthrough outcomes.

The Centre for Growth brings together ideas, people and action to drive the UK forward. We focus on big shifts that build on the UK's sources of comparative advantage and capitalise on global megatrends poised to shape the future. We offer long-term strategic insight, extensive cross-sector expertise, platforms for dialogue and bias to action.

We sit at the intersection of the public and private sector, where joint action can deliver outsized returns and benefits. We believe that collaboration can achieve breakthrough change and that opportunities for disruption can energise the UK economy.

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Boston Consulting Group partners with leaders in business and society to tackle their most important challenges and capture their greatest opportunities. BCG was the pioneer in business strategy when it was founded in 1963. Today, we work closely with clients to embrace a transformational approach aimed at benefiting all stakeholders—empowering organisations to grow, build sustainable competitive advantage and drive positive societal impact.

Our diverse, global teams bring deep industry and functional expertise and a range of perspectives that question the status quo and spark change. BCG delivers solutions through leading-edge management consulting, technology and design and corporate and digital ventures. We work in a uniquely collaborative model across the firm and throughout all levels of the client organisation, fuelled by the goal of helping our clients thrive and enabling them to make the world a better place.

About NHS Confederation:

The NHS Confederation is the membership organisation that brings together, supports and speaks for the whole healthcare system in England, Wales and Northern Ireland. The members we represent employ 1.5 million staff, care for more than 1 million patients a day and control £150 billion of public expenditure. We promote collaboration and partnership working as the key to improving population health, delivering high-quality care and reducing health inequalities.



“We draw upon BCG’s global network of experts to develop actionable policy ideas, connect key decision-makers and build coalitions for change.”

Foreword

This report jointly produced by the NHS Confederation and BCG is important and timely.

Its primary focus is the rise in economic inactivity, most of it related to health and care needs which began before COVID-19, accelerated during the pandemic and has stubbornly persisted since. This is an issue that has leapt to public prominence recently with a number of reports including from the Institute for Public Policy Research (IPPR) and the Pathways to Work Commission chaired by former Health Secretary of State Alan Milburn. The previous government established the WorkWell programme with Integrated Care Systems—which the NHS Confederation is supporting and, since the election, both Wes Streeting and new Department for Work and Pensions (DWP) Secretary of State Liz Kendall have promised more action. This report describes the policies needed to return—as a first step—to pre-pandemic activity levels and in so doing to provide a major economic and fiscal boost to the nation.

For the NHS in particular, this links to our biggest challenge—money. There is a broad consensus in the service and among health experts that the NHS requires a major transformation to respond to changing patient needs, to achieve better outcomes and to be financially sustainable over the medium-term. However, as our own and international experience tells us, such a transformation requires sustained investment in innovation and improvement alongside 'double running' as new ways of working are established

alongside an existing system running at full capacity.

With this investment and as part of a broader strategy of prevention and health improvement it will be possible for us to bend downwards the medium-term demand care for health and care. If we fail to do so the proportion of public spending and national income spent on health services will crowd out other forms of investment and act as an anchor on the economy.

But how can we meet the medium-term economic imperative the new government has made future investment contingent on, when the short-term funding needed to kick start transformation is in such short supply? This is a conundrum to which the new government as yet has no answer. However, by demonstrating the major economic benefits of helping people with health issues stay in work and get back to work, the report offers a way forward. There is scope to create a benign feedback loop whereby public investment in improving population health and treatment reduces welfare costs and increases tax income thereby offering more scope for investment.

When it comes to specific solutions the paper explores some of the measures that could enable a significant improvement in economic activity rates. These can be further developed through wider analysis of the issue and identification of contextual, largely socio-economic, factors which contribute to deteriorating health and making it harder for people to retain and find employment.



Given my own review for former Prime Minister Theresa May which focused on work quality ('Good Work'), I welcome this recognition of the importance of working conditions as an element of the problem and a part of the solution.

The case for broadening how we measure the impact of investment and government 'joining up' across several departments to deliver on this is cogently made in this report. New thinking and approaches from the Treasury will be particularly vital. It seems that the government's policy development around health and employment is to be taken forward under the growth mission board and this is to be welcomed.

A whole government approach on health and work is part of a broader re-orientation. This report explores the conditions for a whole government or 'mission driven' approach. Critical to this is developing a shared vision, building new analytic and policy-making capacity and overcoming traditional departmental boundaries.

A new strategy for health and work relies upon Whitehall and particularly the Treasury addressing the connections between social and economic challenges and the positive and negative externalities of policy (and the absence of policy). Such joining up can also remove barriers to progress and open opportunities in many other areas. These range from a more entrepreneurial approach to capital investment by the health service, for example, seeing how such investment can contribute to local economic regeneration, to

a greater ability to address complex issues like homelessness where both the problem and the solutions require a cross departmental strategy.

Twenty-five years ago, the fall in employment rates among older men which began with the decline of manufacturing decades earlier was seen as an intractable problem. But economic and policy changes reversed this trend and contributed to higher levels of economic activity. We have done this before and, with the new ways of thinking and policy making outlined in this report, we can do it again.



Matthew Taylor
Chief Executive NHS Confederation



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Executive Summary

The UK faces a series of complex cross-cutting health challenges. Addressing these interrelated issues—from access to services to health and work—requires a fresh approach. Often, no single part of government can tackle these sorts of issues alone and too often the public sector is set up to treat the symptoms of a problem rather than an underlying cause. We must go further and think of the problem more dynamically through a whole-of-government approach (WGA).

A perfect example of this is the recent sharp rise in the number of people out of the workforce due to long-term sickness. This has significant impacts on individuals' wellbeing, as well as large fiscal and economic costs. It requires concerted cross-government action to reverse these impacts. This is why Boston Consulting Group and NHS Confederation partnered on this project to identify a set of practical actions government can take to make progress.

Since 2020, economic inactivity in the UK has risen by 900,000 people, with 85% of this increase due to those who are long-term sick. The UK has been an outlier among its peers over this period—on average EU countries have seen economic inactivity fall by 2.3 percentage points, while the UK's has risen by 1.1 percentage point. Around 375 million workdays are lost annually due to people being out of the workforce due to long-term sickness.

We estimate that reintegrating between half and three-quarters of those who have dropped out of

the workforce for reasons of ill health since 2020 could deliver a £109-177 billion boost to the UK's GDP (2-3% in 2029) and unlock £35-57 billion in fiscal revenue over the next five years.

Achieving this requires looking beyond just clinical care. Our new quantitative analysis of the wider social and environmental determinants of health shows that:

- Social and environmental determinants are often more important to health outcomes than clinical or behavioural factors, such as diet and exercise. For example, economic and working conditions explain more of the variance in health outcomes across England than behavioural choices.
- For some counties—depending on their performance compared to the rest of England—investing in tackling wider determinants could have more impact on health outcomes than investment in behavioural factors.
- Over the past seven years, changes in living conditions and crime are the factors that have driven most significant changes in health outcomes.

Given this and the fact those who are economically inactive due to ill health interact with many different parts of the healthcare system, reinforces the need for a whole of government approach. There are three key barriers which often prevent or hamper such cross-government working and which any whole of government approach to health must address:



- **A common purpose:** drive buy-in across all levels of the system for action on major complex challenges such as long-term sickness driving inactivity.
- **Collaboration and place-based decision-making:** with accountability structures that incentive collaboration and local-based decision-making.
- **Joined-up funding and resources:** that facilitates longer-term funding horizons where government has a shared view on how to maximise economic and social benefits from health investment and health is a cross-cutting Treasury priority.

Tackling these barriers also requires a change in how government approaches cross-cutting challenges. Typically, government takes the inputs it is working with as set, then strives to achieve outcomes on top of this rigid framework. This needs to be reversed. Outcomes should be targeted first, with inputs and outputs (policies) flexed to best suit these cross-cutting outcomes.

With that in mind we recommend a series of actions which can help to institute a WGA to health, with a specific initial focus on addressing the challenge of economic inactivity driven by long-term sickness. Our framework could equally apply to other health issues or any broader WGA.

The government should set the following outcomes targets:

- Return ~0.5 million people to the workforce, who had become economically inactive due to ill health post COVID-19.
- Return to 0% growth in the number of people economically inactive due to ill health.

To achieve these outcomes, the government could target several policy outputs which can be better facilitated by a WGA. These require action from both the public and private sector to be truly effective:

- **Integrated employment and health support:** supporting people with health challenges to get back into the workforce.

- **Employment conditions:** support to keep people working rather than dropping out.
- **Benefit provisions and in-work grants:** incentivising people to return to work by reducing risk.

Finally, government must reorganise the underlying inputs when it comes to setting up and delivering a WGA, organising inputs to break down the key barriers to tackling cross-cutting issues which cause ill health and long-term economic inactivity. We believe these comprise a series of immediate and longer-term actions that apply to the wide range of the social and environmental determinants of health:

Common purpose

- Short-term—Define a bold and ambitious goal to drive common purpose across government.
- Long-term—Leverage the new Health Mission Board to establish a Health Improvement Strategy and to proactively review policies for health considerations, enabling faster more joined-up action across government.

Collaboration and place-based decision-making

- Short-term—Institute new structures to change the way cross-government collaboration happens, including a novel approach to mission boards.
- Long-term—Increase local collaboration with joined-up priorities across ICBs and local authorities and embed best practice sharing across departments and governmental levels.

Joined-up funding and resources

- Short-term—Drive development of a new evidence base to underpin joined-up funding and resources.
- Long-term—Leverage this evidence base to address siloed and short-term funding approach and design incentives to encourage data sharing across all levels of government.



Chapter 01

The Case for Change

1.1 Introduction

The UK is at a crossroads when it comes to the nation's health. In the aftermath of the COVID-19 pandemic, pressures on the healthcare system have continued to rise despite health spending being at record highs. From the rise in waiting lists to the impact of ill health on work, there are several complex and interconnected challenges that need to be addressed as a priority.

Tackling these sorts of complex issues requires a new approach. The healthcare system alone cannot address the wide-ranging drivers of long-term sickness and ill health. Over 50% of health outcomes are influenced by non-healthcare factors, such as environmental conditions, lifestyle and social networks.¹ This was a central message of the [Marmot Review](#) on reducing health inequalities.

It is not just a case of throwing more money at the issue, though investment will be required. Too often the public sector is set up to treat the symptoms of a problem rather than an underlying cause. To tackle the fundamental drivers of the problem, and root causes of ill health, we must go further and think of the problem more dynamically through a whole-of-government approach (WGA).

This means looking at health as a priority across all areas of policy, with departments, agencies and partners taking a joined-up approach to health and wellbeing that is outcome-first focused. A whole-of-government approach to health and health improvement under the government's Health Mission Board will ensure that all departments recognise their role in supporting people to live healthier lives and to secure and retain good employment.



A prime example of this sort of complex challenge is seen in the stark rise in the number of people out of the workforce due to long-term illness. While many countries saw economic inactivityⁱ rise post COVID-19, the UK is alone among peers in seeing it continue to increase—all others have returned to their normal levels or below.

Many millions of working-age people in England who might otherwise be in stable employment are out of the workforce due to different illnesses (in some cases five or more conditions), requiring coordinated and early intervention. To keep these people in work on their return, there needs to be a holistic and creative future approach to public policymaking that supports this aim.

Not only does economic inactivity due to ill health have serious impacts on individuals' wellbeing, creating a social need for action, it also has significant impacts on economic inequalities and economic and fiscal costs to the economy. It is therefore no surprise that tackling the rise in long-term sickness, and its impact on employment and economic growth, is a top priority for the new government.² This applies both in terms of the policy developed and how it is delivered by the complex system of national, local and mayoral government.

Addressing the rise in long-term inactivity due to ill health is not simple. Although there was an increase in work and health support to tackle rising economic inactivity last year, existing efforts tend to focus either on managing the symptoms, largely via clinical interventions, or tweaking the benefits system. It is an exemplar of where a more joined-up approach across government, focused on tackling the complex underlying causes and bringing a variety of tools to bear can make a real and sustained difference.

This report, produced in partnership by Boston Consulting Group and the NHS Confederation, sets out why a whole-of-government approach to health is needed and how it can be taken forward by the new government. We focus on the recent sharp rise in economic inactivity driven by long-term sickness as a key example of the type of complex health and economic issues which cannot be tackled by the healthcare system alone. To reinforce this, we have produced new analysis of the quantitative link between health outcomes and the wider environmental and social determinants of health. Furthermore, based on analysis of data from the Office for National Statistics (ONS) and Eurostat, including previously unpublished data and a detailed economic model, we surface fresh insights on the economic and fiscal benefits of reducing economic inactivity due to long-term sickness.

With all that in mind we make several recommendations around how to establish a whole-of-government approach to improve the nation's health through the development and implementation of a health improvement strategy and supporting systems and engagement. We also outline how such an approach might facilitate early action on some specific policies to address the issue of economic inactivity driven by long-term sickness.

This report will be of interest to government and policymakers as well as the NHS, local delivery partners, funding organisations and stakeholders involved in work addressing the wider social determinants of health.

i. Economically inactive defined by ONS as 'people not in employment who have not been seeking work within the last four weeks and/or are unable to start work within the next two weeks.'



Defining a Whole-of-Government Approach (WGA)

For our purposes we define a WGA as a coordinated approach across different levels of government, departments and delivery partners in pursuit of a common set of cross-cutting goals and objectives. WGA signals that, for certain complex problems such as tackling the rise of long-term sick, economically inactive, there might be a need to shift from single-purpose organisations that deliver in silos to an integrated system where the interrelated political, social, health and economic factors of policies are addressed in coordination.

WGA is designed to maximise resources and ensure capital is deployed in the most impactful and efficient way across the entire public sector. A whole-of-government approach does not mean making fundamental changes to the machinery of government, or wholesale workforce reforms. Rather, it focuses on a coordinated approach across HMG to achieve common goals or to deliver required interventions.

1.2 The rise in long-term sickness

Recently, there has been much attention on the impact of long-term sickness on employment. However, the conversation often blurs distinct issues and fails to unpack the underlying drivers. We will establish some key facts:

- Rising sickness is present across the labour force, but the largest impact comes from those who have dropped out of the workforce and are now economically inactive, hence our focus for this report.

- Sickness and ill health have driven the rise in those out of the labour force in recent years.
- The conditions and demographics driving these impacts are complex and impacted by several factors beyond traditional healthcare.
- The UK's large and persistent rise in those out of the workforce due to sickness is unique among peers.

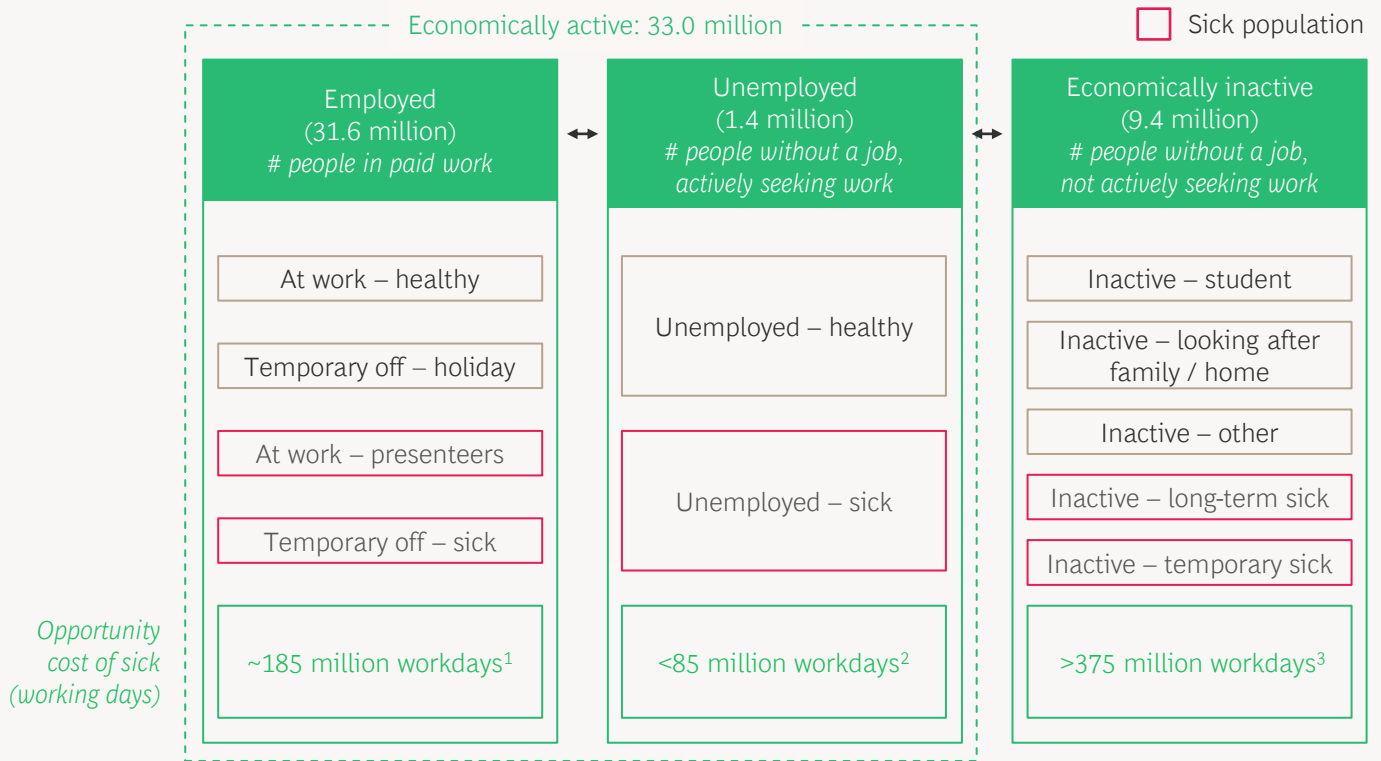
There are broadly three distinct groups that are relevant when thinking about how sickness impacts employment:

- Group one: Those who are sick in work. This consists of two groups: those signed off sick from work temporarily, and those who still go to work but whose sickness is impacting their productivity and performance (this is known as 'presenteeism').³
 - A recent report from the IPPR found that UK workers are relatively unlikely to take sick days and more likely to work through sicknesses.⁴
 - For example, over half of NHS workers report going into work despite feeling too unwell to perform their duties.⁵
- Group two: Those who are sick and unemployed—often these will be people who were previously employed but have become sick and this sickness is now impacting their ability to find employment.
- Group three: Those who are out of the workforce and economically inactive due to ill health. This cohort also consists of multiple groups, such as those who are long-term sick and those who are temporarily sick. Not all here have dropped out of the workforce, as some never entered—24% of the long-term inactive population have never worked, a proportion of these may be long-term sick. It is also worth noting that Barnsley Council's Pathways to Work report⁶ suggests that many more people in this group want to work than the labour force survey indicates.

To determine the impact of each of these groups on employment in the UK, we have estimated the number of workdays lost due to sickness across these groups:



Exhibit 1 – While Health Impacts Economic Outcomes Across All Working-age population, Inactive Long-term Sick Present the Largest Population



1. Based on the ONS estimate of workdays lost due to sickness absence from work; does not include impact of presenters.
 2. Under elevated assumption that 30% unemployed are due to sickness (similar to share of LT sick inactive), and, once at work, will return to work at national average hours (32 hrs/wk).
 3. Under conservative assumption that, once at work, will return only at a part-time (50%) capacity.
Note: Numbers reported for working-age population only (aged 16-64).
Source: ONS (“Sickness absence in the UK labour market”; “Employment in the UK”; “INAC01 SA: Economic inactivity by reason (SA)”, “HOUR01 SA: Actual weekly hours worked (SA)).

As Exhibit 1 above shows, the number of workdays lost in the UK due to ill health is significant. Annually, the following groups account for approximately:

- **Sick economically inactive group:** ~375 million lost workdays
- **Temporarily signed off work due to sickness:** ~185 millionⁱⁱ lost workdays
- **The sick unemployed:** ~85 million lost workdays (this is often a transitional category which converges to ‘at work’ or ‘inactive’ in the medium term).

While these different groups may require different interventions, there are likely to be many commonalities. In all cases early intervention is best, as is a focus on prevention before people leave the workforce and before the number of morbidities increases.

Given the size of the impact, we focus on those who are long-term sick and economically inactive. In many cases the logic of our analysis and our recommendations will be equally applicable to those who are sick employed or sick unemployed.

ii. This population only includes those who are temporarily off work and does not include presenters (because they are technically at work), who risk transition into sick inactive in the long-term. Presenteeism also results in lost work days due to lower productivity, but we have not produced an estimate of this effect given poor data on productivity differentials for presenters.



UK economic inactivity has risen by 900,000 people compared to pre COVID-19, 85% of which is due to long-term sickness

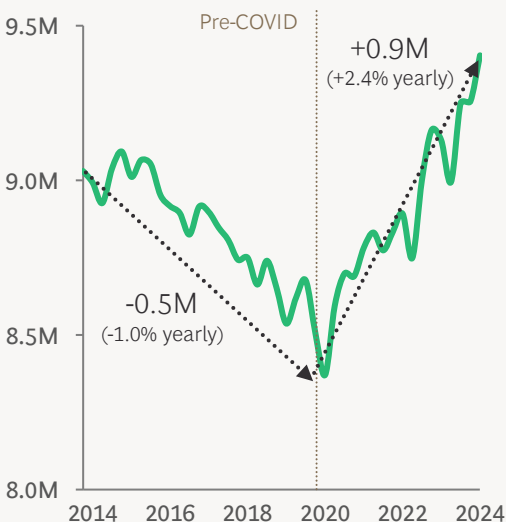
After reaching a historic low prior to the pandemic, the number of people out of the workforce in the UK has risen by 900,000. There are now 2.8 million economically inactive long-

term sick, representing around 30% of the total inactive population. Crucially, while the early post-pandemic days saw a rise in those taking early retirement or remaining in education, these trends have reversed. Now, 85% of this rise in economic inactivity is due to long-term illness (750,000).

Exhibit 2 – Long-Term Sickness Accounts for the Largest Share of Economic Inactivity in the UK, Contributing >80% to its Post-COVID Growth

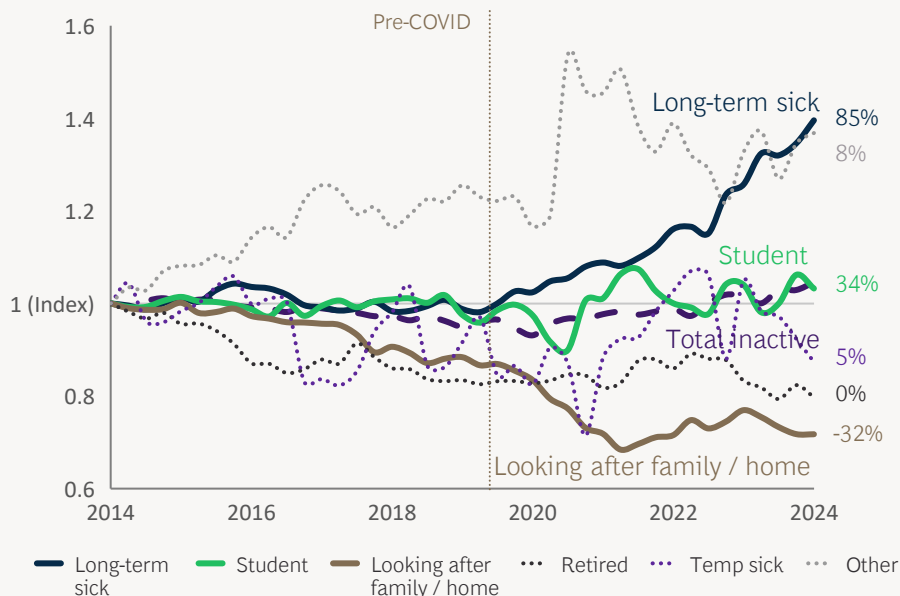
Inactivity reversed its trend post-pandemic, with no signs of slow down

economically inactive, million (Sep-Nov '13 – Dec-Feb '24)



Long-term sickness accounts for largest share of inactivity, with rapid acceleration post-pandemic

Index of economically inactive by reason (Dec-Feb '14=1) % contribution to change in inactivity post-COVID (Dec '23-Feb '24 vs Sep-Nov '19)



Source: BCG analysis of ONS data (INAC01 SA: Economic inactivity by reason (seasonally adjusted)).

Notes: "Other" additionally includes "Discouraged workers" category; quarterly changes are compared using non-overlapping three-month time periods per ONS recommendation; yearly growth rates for economically inactive calculated as Compounded Annual Growth Rates (CAGR) for "Sep-Nov '19 vs Sep-Nov '13" and "Dec-Feb '24 vs Sep-Nov '19" respectively.

Given the speed and size of this rise, it is important to ask whether it is truly being driven by worsening health. There are two key points to note:

1. First, we found that the rise in sickness is not confined to those out of work: there are **broader trends of rising reported illness among those in work as well as out of work**. The rate of those reporting at least one health condition grew 4.2% across the entire working-age population post-pandemic, compared to 6.2% for those who are long-

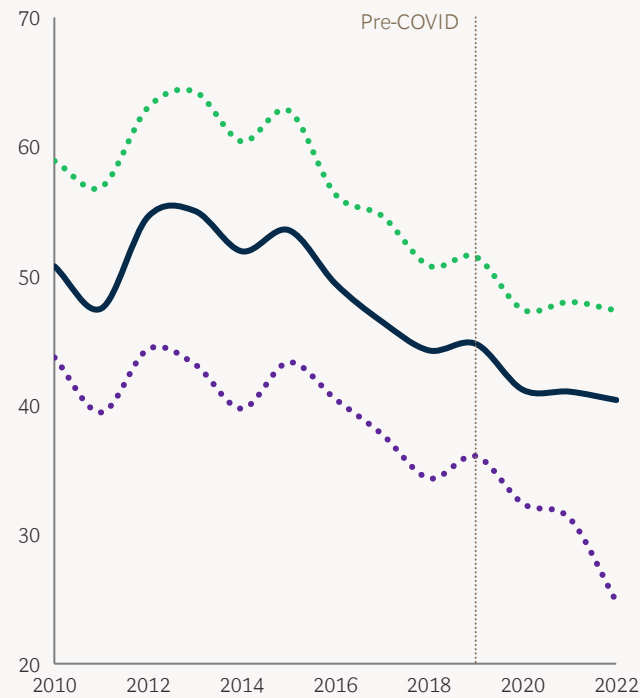
term sick and economically inactive. Similarly, for the entire working-age population, those that report five or more health conditions grew by 8.9% over this period, compared to 9.2% for the same group within the long-term sick and economically inactive. This indicates it is not simply those who are long-term inactive reporting higher levels of sickness but a broader trend of rising sickness and ill health in the population.



Exhibit 3 – Data Suggests That the Nation is Indeed Getting Sicker, With Health of Working Population and Long-Term Sick Inactive Declining at Comparable Rate

Longitudinal study shows that the nation might be feeling sicker¹

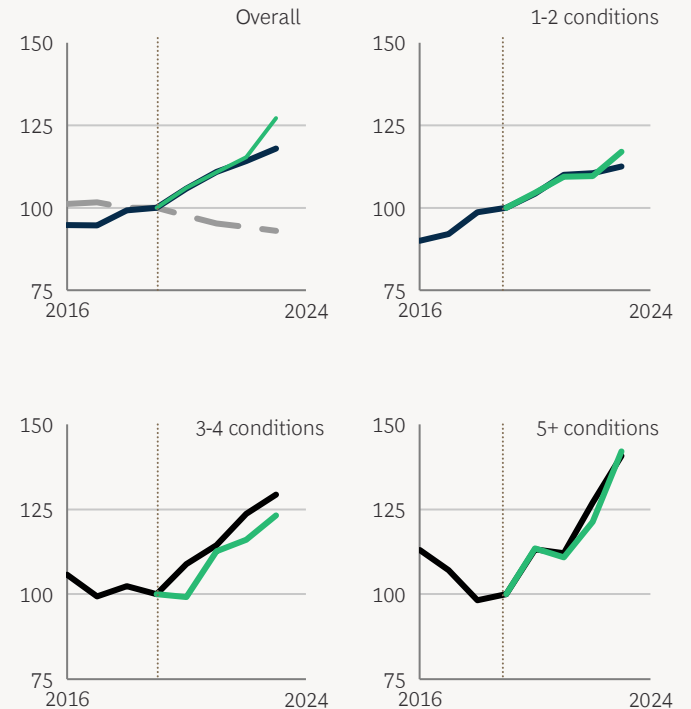
% people indicating having "Excellent" or "Very Good" health in UK



- All population
- Paid-employed
- Unemployed

Health of working age population was declining overall, at comparable rate²

of People reporting health conditions (index, 2019 = 100)



- All working age (no health conditions)
- All working age (with health conditions)
- Inactive due to long-term sick

1. Understanding Society.
 2. ONS ("Rising ill health and economic inactivity because of long-term sickness" report, Jul '23.
Note: Data for each year is as of Jan-Mar period.

2. Second, the evidence suggests there has not been any obvious change to the benefits system which further incentivises individuals to leave the workforce. We do not believe changes to the benefit system can explain the large rise seen in the long-term sick inactive. While we cannot definitively rule out benefits

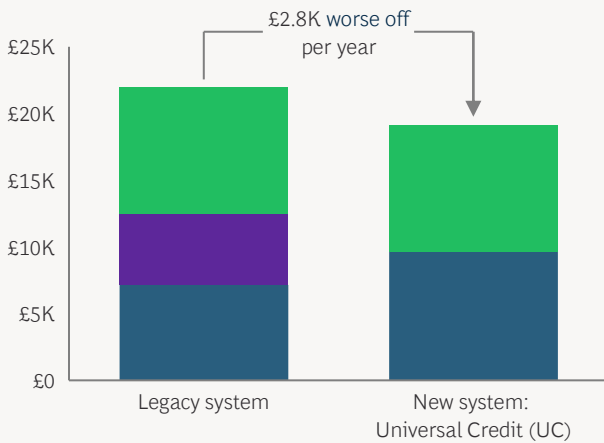
playing some role in the impact, the evidence suggests at the very least it is highly unlikely to account for the large and sustained rise. In fact, individuals receiving disability benefits are £2,800 worse-off a year under Universal Credit (UC) compared to the pre-UC benefits structure.⁷



Exhibit 4 – Revamp of the Universal Credit System has Reduced Incentives for People to Remain on Benefits

At individual level, benefits for long-term sick decreased with new system

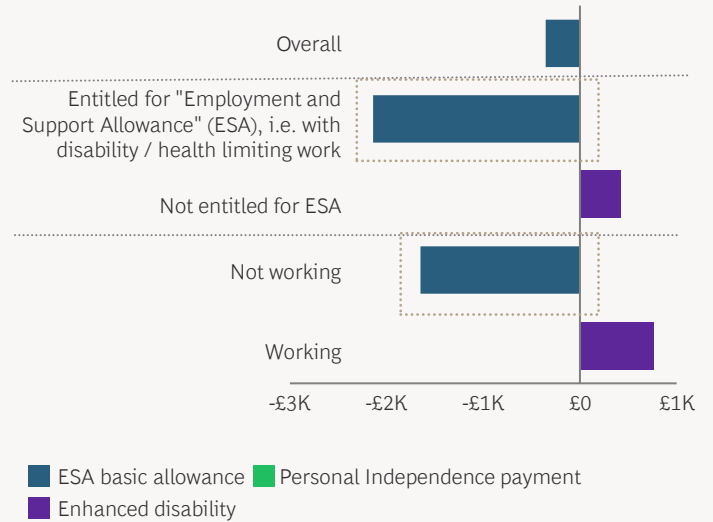
Estimated yearly income for a single person in receipt of benefits (2024-25)



Source: Resolution Foundation analysis ("In Credit?" briefing note, Apr 24)

At household level, new system benefits working households instead of those with disabilities

Estimated average change in annual family benefit entitlement between legacy system and Universal Credit (2024-25)



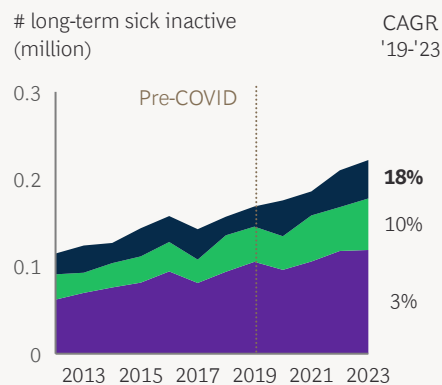
1.3 Drivers of long-term sickness

The prevalence of multiple conditions, especially mental health and musculoskeletal issues, is driving long-term sickness.

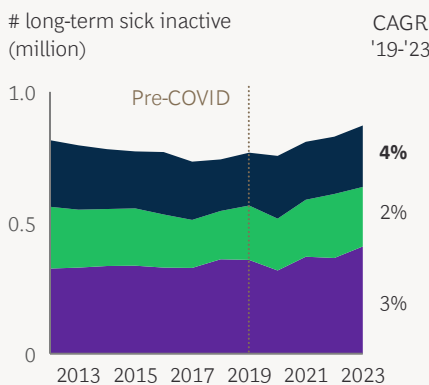
The rise in long-term sickness is causing people to drop out of the workforce, but what is driving the uptick in sickness and who is it impacting most?

Exhibit 5 – Long-Term Sickness Affects Various Demographics, Showing Growth Across Different Ages and Morbidity Complexities

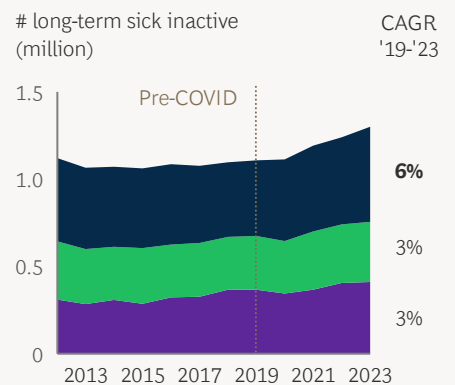
16-24 years old



25-49 years old



50-64 years old



Source: BCG analysis of unpublished ONS Annual Survey data.

5+ conditions 3-4 conditions 1-2 conditions



Two main groups have driven the recent rise in the population of long-term sick economically inactive: 18-24-year-olds and 50-64-year-olds, with the latter accounting for 55% of all inactive long-term sick. The fact that the older group has been a key driver is not surprising (health deteriorates as people age), but the rise among 18-24-year-olds is both surprising and concerning (given this should be the healthiest group in the population).

Another feature of both groups is the rapid rise in those reporting multiple conditions. Over 40% of the 50-64-year-old demographic report five or more conditions and they have been the fastest growing cohort within that group since 2019. However, even more concerning is the rapid rise among those in the youngest age group reporting five or more conditions. This was the fastest-growing segment across all age ranges, seeing an 18% compound annual growth rate (CAGR) between 2019 and 2023.

In terms of conditions, musculoskeletal (MSK) and mental health issues account for around 50% of all those reported by the long-term sick economically inactive. Data shows that growth in mental health conditions in this population extends beyond the pandemic impact, steadily rising since 2017/18 and remaining the most reported condition among 16-24 and 25-49-year-olds.ⁱⁱⁱ The previously steady downward trend in MSK conditions reversed to growth post-COVID-19, particularly driven by 50-64-year-olds.

Those reporting an unspecified condition account for 15% of the long-term sick economically inactive and this segment has been growing consistently. Long COVID-19 may be a contributor to this growth in recent years, but the segment has been growing prior to 2020 (6% CAGR between 2012 and 2019 across all age ranges). The ONS estimates that 3% of the UK population is experiencing long COVID-19,⁸ and a survey of workers^{iv} by the Trade Union Congress found that 50% of respondents were experiencing disadvantage at work due to long COVID-19.⁹

The emergence of long COVID-19 is unlikely to explain the UK's outlier status. There is limited evidence to indicate that the impact of long COVID-19 has been via economic inactivity as opposed to presenteeism, and there is no strong evidence suggesting that the UK population is disproportionately affected by long COVID-19 compared to other countries with high infection rates during the pandemic. For instance, the French Public Health Agency estimated a 4% prevalence of long COVID-19, which is similar to the ONS' UK estimates. Likewise, the European Union estimated a 3% prevalence across the EU, although this figure was based on the ONS' UK study.¹⁰ The impact of long COVID-19 deserves further study, but the data available does not show a conclusive link with the recent rise in economic inactivity.

The UK is an outlier, with rising economic inactivity compared to its peers

The final question posed by our analysis is whether all of this could be a result of COVID-19 and therefore common to many countries. However, the data and evidence show that this is not the case and that the UK is an outlier compared to similar countries. Exhibit 6 shows that while many European countries saw a rise in economic inactivity during the pandemic and in the immediate aftermath, they have all seen levels fall back to previous levels or below.

iii. See accompanying Methodology for detailed data.

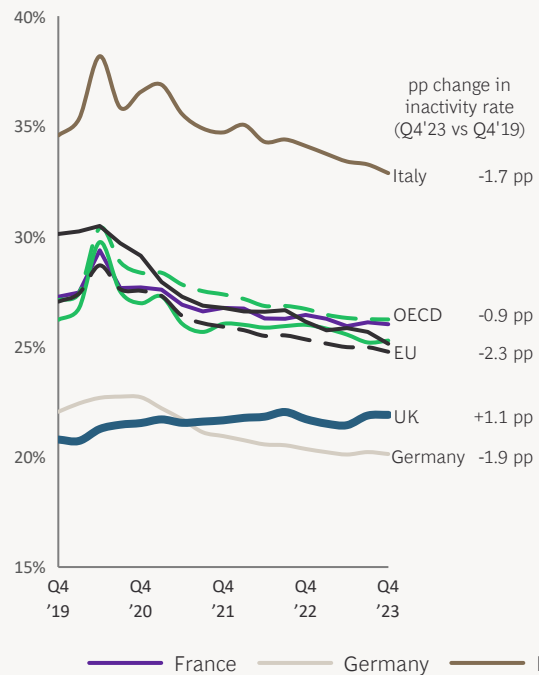
iv. Online survey of workers, receiving around 3,500 responses.



Exhibit 6 – UK Is the Outlier With Continued Inactivity Growth Post-Pandemic, Largely Driven by Long-Term Sick

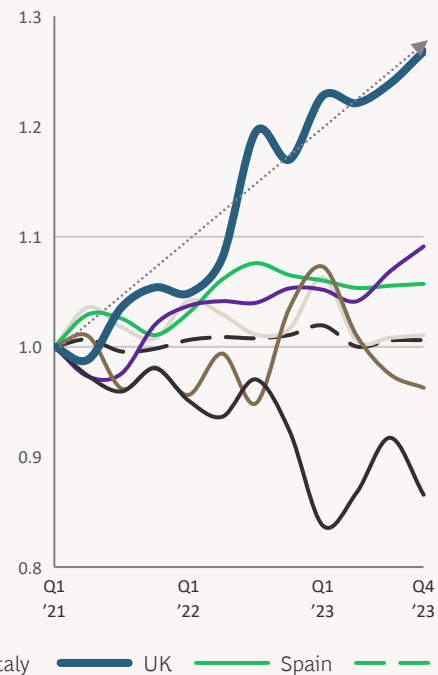
While inactivity increased at the onset of COVID-19 across peers, UK is the outlier with persistent inactivity growth

Economic inactivity rate (%)



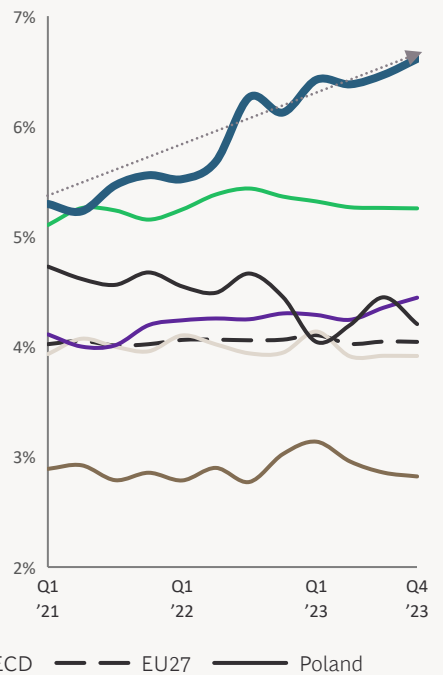
Inactivity due to ill health in peer countries across EU bloc has not been growing as rapidly as in the UK...

Index of inactive due to illness or disability (Q1 '21 = 1)



... reflected in marginal changes in their share within total population, in contrast to consistent growth in UK

Inactive due to illness or disability (as % of total working age population)



Source: BCG analysis of data from OECD, ONS, Eurostat and unpublished Eurostat LFS data.

Notes: All reported data is for the working age population (15-64); economic inactivity rates for Germany and “OECD average” are OECD estimates; reported UK figures for inactivity due to illness covers only “long-term sick” inactive and does not include “temporary sick” inactive category; data is reported for population aged 16-64.

Levels and drivers of inactivity vary from country to country (given, for example, cultural differences in female and young people’s labour force participation), so there are nuances when comparing the UK to peers. As an example, while Italy has higher inherent levels of inactivity (at 33%), it is driven by high levels of female inactivity (42% vs. 29% EU average) with an emphasis on ‘family’ as one of key reasons.¹¹ Therefore, while the UK has one of the lowest levels of overall inactivity, this is not the best metric to look at as it is driven by ingrained wider social and cultural issues. This is also true when comparing historic levels in the UK. While similar levels of inactivity were seen a decade

ago, the key factor is not the absolute level but the marginal change, the factors that have driven that change, and therefore what it means for economic output.

Since 2021, the UK has shown the fastest growth in both the overall level of economically inactive and those who are economically inactive due to long-term sickness (Exhibit 6). The UK now has the largest share of inactive due to sickness in the total population, at 7%. These are trends and drivers which are not seen in any other peer country, nor seen historically in the UK.




1.4 What are the economic and fiscal benefits of tackling the problem?

We estimate that reducing long-term sick inactivity could boost the UK's GDP by £109-177 billion and fiscal revenue by £35-57 billion over the next five years.^v These estimates demonstrate the 'size of the prize' for addressing the issue, rather than savings derived from a specific policy to tackle it.


The estimated benefits stem from two factors:

- Reintegrating 0.3 to 0.6 million people who became long-term sick inactive from 2019 into the labour force.
- Reverting long-term sick inactive growth rates back to their long-term trend of around 0%, by preventing the active population from entering inactivity due to sickness.^{vi}

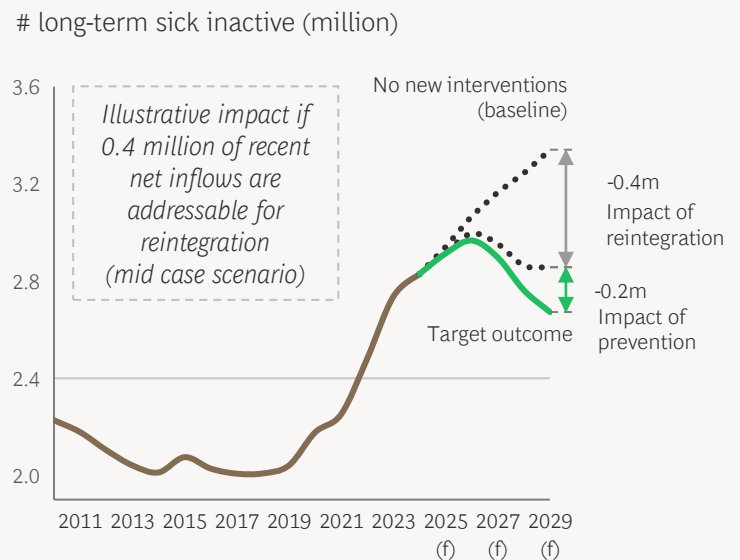
Exhibit 7.1 – Our Analysis Focuses on the Estimation of Potential Gains From Reversing Two Key Post-COVID Outcomes



Reintegrating a share of ~0.75 million people, who became long-term sick inactive post-COVID, into the labour force.



Reverting long-term sick inactive growth rates to 0% by preventing the active population from entering inactivity due to sickness.



Source: BCG analysis of ONS and IFS data.

Notes: "Reintegration impact" means an addressable share of 0.75 million long-term sick inactive (calculated as long-term sick inactive stock increase from Oct-Dec '19 to Dec-Feb '24) will return to work within five years, three cases of addressability are defined- 0.3 million (low), 0.45 million (mid), 0.6 million (high), pacing of reintegration across five years follows S-shaped curve with acceleration in '27; "prevention impact" means growth rate of long-term sick inactive will converge to 0% by 2029, "baseline" assumes long-term sick inactive yearly growth rates to follow IFS forecast for Incapacity Benefits growth.

It is often noted that those who are long-term sick economically inactive have been part of this group for some time and, as such, it is hard to reintegrate them into the workforce. However, we believe that the last few years have seen a material change in the type of people becoming

long-term sick inactive, partly due to the speed of the rise in this group. Based on ONS data, we identify a low, mid and high case for the number that could be credibly reintegrated into the workforce:

v. See Methodology Annex for detailed approach and assumptions for economic and fiscal impact calculations.

vi. Note: This does not mean we will hit the pre-COVID-19 absolute levels of long-term sick inactive (due to continued growth).



- In the low case, we see 300,000 people being reintegrated, covering those who have come into long-term sick inactive directly from the workforce or from being temporarily sick in the past few years.
- In the mid case this rises to 450,000, through including those who were previously students or retired but shifted to long-term sick, suggesting this became the main reason for inactivity and that they could (and might want to) return to the workforce if it were tackled.
- The high case sees the number rise to 600,000, by including those that became long-term sick from being inactive due to long-term caring responsibilities. Since long-term sickness became their primary reason for inactivity, solving this could see them return to the workforce, not least since they may not have continued their caring responsibilities while themselves unwell.

Based on this **we estimate that achieving the two aims of reintegration and prevention could unlock approximately £35-57 billion in fiscal funds over the next parliamentary term to 2029.** This is a cumulative impact, with gains accelerating as more people are reached by the efforts to reintegrate and maintain the labour force. By 2029, we estimate the annual impact to reach £19 billion in the mid case scenario. These gains come primarily from:

1. Improved income tax receipts from getting more people into the workforce (£3 billion in year five)
2. Reduced benefits spending due to higher incomes and therefore less reliance on benefits (£8.5 billion)
3. Lower healthcare spend on this group since their health would have improved (£1.2 billion)

4. Wider secondary fiscal benefits from improved economic output boosting tax receipts (£6.8 billion).

If reintegration and prevention are maintained, the fiscal benefit will continue beyond 2029. In such a scenario, we would see fiscal gains of at least £19 billion (mid case) every year thereafter.

It could also boost economic output by £109-177 billion over the next five years, subsequently generating an additional £62 billion in GDP annually from 2029 onwards in the mid case scenario, representing 2% of real GDP. This stems from:

1. Direct boost to economic output from having an additional 450,000 people in the workforce (£31 billion in year five)
2. An indirect benefit from the knock-on effects of the increased economic demand from these additional workers (£20 billion)
3. Wider economic impact of reinvestment of fiscal savings (£11 billion).

The estimated 'size of prize' of tackling long-term sick inactivity is significant in any context. However, in the context of a fiscally challenging outlook for the UK, it signifies a genuine opportunity to not only improve population health and the wellbeing of many, but also to improve the UK's fiscal position and help drive economic growth. The estimations also demonstrate a broader lesson—the fiscal and economic benefits of tackling some of the structural economic and health challenges facing the UK are likely to deliver larger benefits than tinkering with fiscal policy. They also highlight that some upfront investment—either in time, money or broader resources—would likely be worthwhile to enable this challenge to be tackled for both health and economic gains.

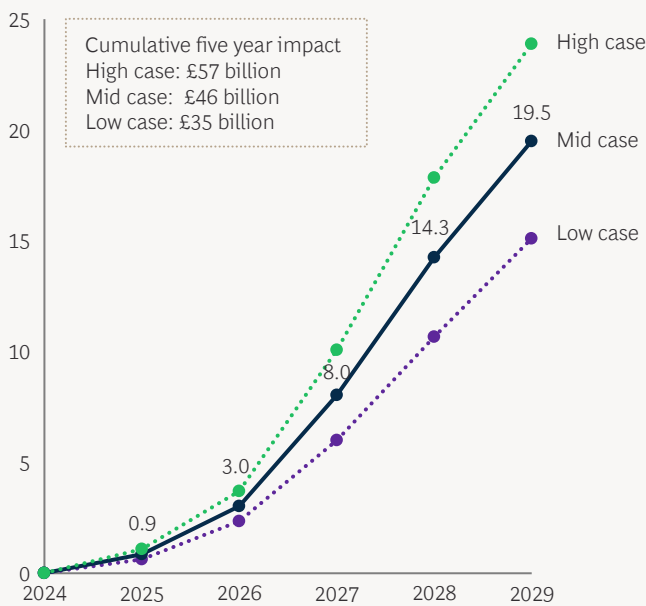


Exhibit 7.2 – Prevention and Integration are Estimated to Unlock Over £35-57 billion of Fiscal Funds Across Five Years of the Current Government

Annual fiscal impact gradually rises as more people re-enter or remain in the workforce (and accumulates over five years)

Annual fiscal benefits is a mix of reduced spending and higher tax revenue (also accumulates over five years)

Estimated fiscal impact (£billions)



Factor of impact	Impact in '29 (mid case)
Direct fiscal impact	£12.7 billion
1. ↑ receipts of income tax (from salaries of reintegrated and prevented)	£3.0 billion
2. ↓ spend on benefits (due to loss of UC and PIP eligibility)	£8.5 billion
3. ↓ spend on health care (due to positive impact of work on health)	£1.2 billion
Secondary fiscal impact	£6.8 billion
4. ↑ receipts of corporate tax (from extra profits of firms employing long-term sick)	£2.3 billion
5. ↑ receipts of VAT / sales tax (from long-term sick spend of extra income)	£4.5 billion

Source: BCG analysis of data from ONS, OBR, HM Treasury, DWP, Oxford Economics.

Note: Secondary fiscal impact is calculated based only on the economic impact of increased output and does not include economic impact of fiscal reinvestment.




Chapter 02

A Whole-of-Government Approach to Health in the UK

2.1 The wider social determinants of health

With the estimated benefits of addressing this issue now clear, our focus shifts to potential solutions. Tackling this challenge is complex because health is influenced by many factors, most of which sit beyond clinical care. In his review, 'Fair Society, Healthy Lives' (the Marmot Review),¹² Prof. Sir Michael Marmot noted:



“Social inequalities in health arise because of inequalities in the conditions of daily life and the fundamental drivers that give rise to them: inequities in power, money and resources. These social and economic inequalities underpin the determinants of health: the range of interacting factors that shape health and wellbeing. These include material circumstances, the social environment, psychosocial factors, behaviours and biological factors.”



His review focused on well-established social determinants of health, including:

1. Inequalities in early childhood development and education
2. Employment and working conditions
3. Housing and neighbourhood conditions
4. Standards of living
5. Freedom to participate equally in the benefits of society

It is widely accepted that these health determinants, largely beyond individual control, affect quality of life and life expectancy. For example, in England, healthy life expectancy is over 18 years lower for the most deprived compared to the least deprived.

Policy significantly impacts individuals' exposure and response to potential drivers of ill health. This can be through direct effects (such as quality of housing), indirect effects (such as allocation of regional investment and training funding) or consequential effects (for example choices and opportunities shaped by existing inequities). The public sector already acknowledges that employment is a crucial determinant of health; the long-term unemployed have lower life expectancy and worse health than those in work.^{vii} Unemployment also affects children, who are nearly twice as likely to fail at all stages of education if raised in workless households.¹³

Poor quality, insecure employment and unemployment can worsen mental and physical health, potentially leading to economic inactivity and increased need for primary or secondary care interventions.¹⁴

Many of the determinants of health lie outside of the NHS and Department of Health and Social Care's (DHSC) purview. The case of economic inactivity driven by long-term sickness is a prime example of how wider social determinants of health require solutions directed beyond just the healthcare or benefits systems. The health system often responds to but does not create or influence broader social determinants of health.^{viii} **Annex A** details government efforts to date and **Annex B** provides background on current NHS structures.

2.2 A new look at the impact on health outcomes

While the impact of social and environmental determinants of health outcomes is well known, there is limited systematic quantitative analysis evaluating all these determinants within a single model in the UK. Additionally, there is a lack of clarity on which social determinants are most important and in which scenarios or locations. This makes it challenging to tailor policy priorities that address these wider determinants effectively.

To address this issue, we examined the quantitative link between wider determinants of health and health outcomes in England over recent years. Exhibit 8 lists the determinants of health we used, taken from the ONS Health Index.¹⁵

As a measure of health outcomes, we considered the rate of preventable mortality per 100,000 people under the age of 75.¹⁶ Our data spans seven years (2015-2021) and covers 143 counties in England.

vii. The Joint Work and Health Directorate (DWP, DHSC) has recently launched the WorkWell initiative, which provides £64 million to 15 integrated care boards (ICBs) in England to design local work and health assessment and support services. The pilots are intended to bring together ICBs, local authorities, Jobcentres and other local partners to support individuals to manage their conditions and receive support that would enable them to stay in work or return sooner.

viii. The previous government undertook significant work to address the social determinants of health, such as establishing the Joint Work and health Unit in 2015, publishing *Improving Lives - The Future of Work, Health and Disability* in 2017 and creating integrated care systems at the local level in 2022.



Exhibit 8 – Key Analysis Variables Span Across Two Major Categories: ‘Healthy Lives’ and ‘Healthy Places’

Healthy Lives		Healthy Places	
Physiological risk factors	<ul style="list-style-type: none"> High blood pressure Low birth weight Overweight and obesity in adults Overweight and obesity in children 	Living conditions	<ul style="list-style-type: none"> Air pollution Household overcrowding Noise complaints Road safety Rough sleeping
Behavioural risk factors	<ul style="list-style-type: none"> Healthy eating Physical activity Sedentary behaviour Alcohol misuse Drug misuse Smoking STIs 	Access to services	<ul style="list-style-type: none"> Distance to GP services Distance to pharmacies Distance to sports/leisure facilities Internet access Patients offered acceptable GP appointments
Protective measures	<ul style="list-style-type: none"> Cancer screening attendance Child vaccination coverage 	Crime	<ul style="list-style-type: none"> Low-level crime Personal crime
		Economic and working conditions	<ul style="list-style-type: none"> Child poverty Job-related training Unemployment Workplace safety

Source: ONS (The Health Index for England).

We sought to answer two complementary questions:

1. Historically, how did counties with better performance in various health determinants fare with regard to preventable mortality?
2. How have within-county changes across time impacted preventable mortality?

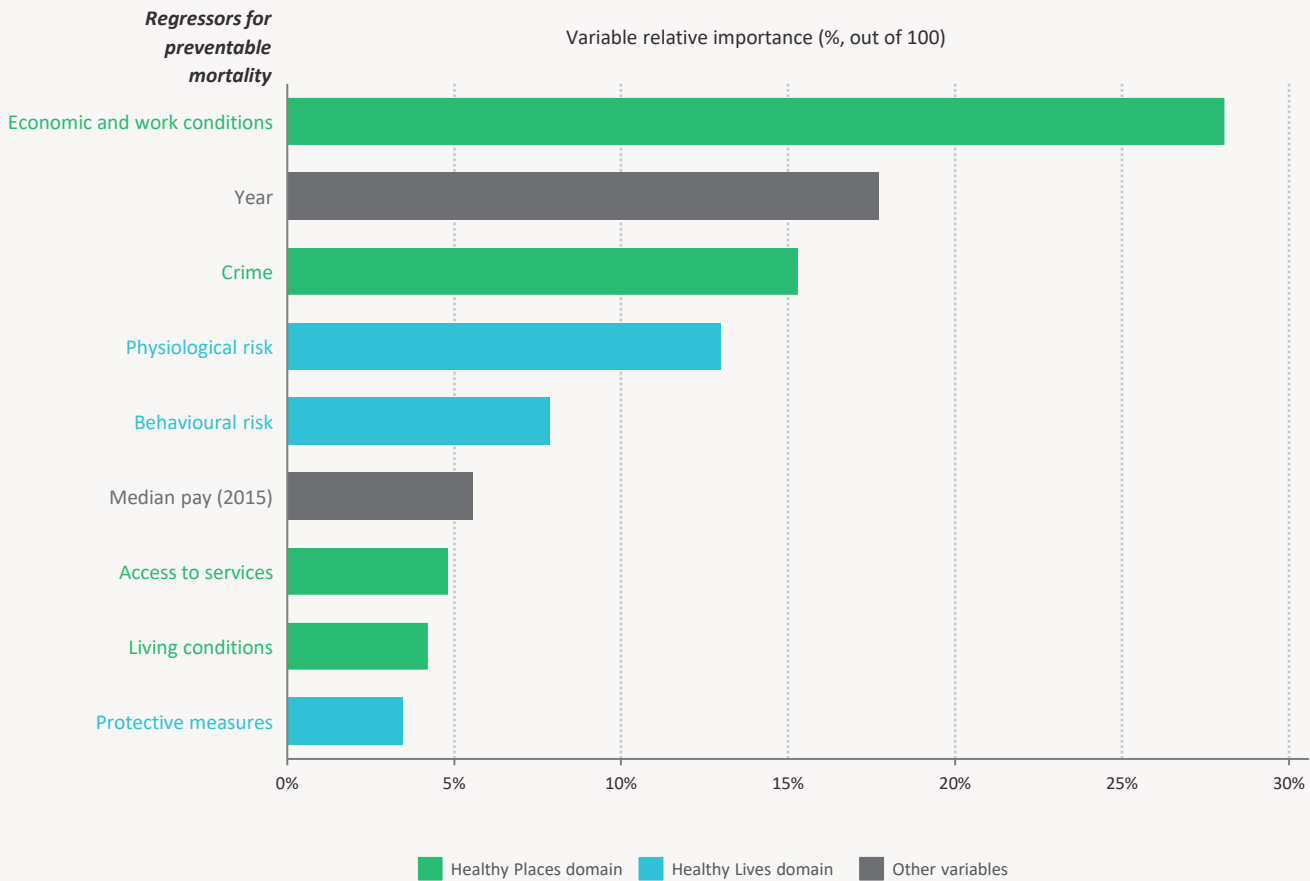
In answering the first question, we aim to confirm the expected correlations between health determinants and health outcomes. Answering the second question allows us to infer what will happen to preventable mortality in a county, if a specified health determinant improves. A summary of the corresponding statistical approaches and key insights from these analyses are outlined here, with further details in the **Methodology**.

1) Historically, how did counties with better performance in various health determinants fare with regard to preventable mortality?

We performed a cross-sectional correlation across counties to determine which health determinants most strongly correlate with preventable mortality rates, our chosen proxy for aggregated health outcomes. Exhibit 9 shows the relative importance of each variable (as percentages summing to 100) in this correlation. The model includes determinants beyond the ONS Health Index to account for the effects of COVID-19 and pay differentials. For example, the ‘Year’ variable captures the explanatory effect of time-specific factors on preventable mortality. This means it controls for the significant impact of COVID-19 in 2020 and 2021. As expected, variables closely linked to deprivation (economic and work conditions and crime) account for close to half of the model’s explanatory power.



Exhibit 9 – A Number of Social and Environmental Factors Are Strongly Correlated With Health Outcomes Across UK Counties



Source: BCG analysis of data from Office for Health Improvement & Disparities (PHE Fingertips) and ONS (The Health Index for England: 2015 to 2021).

Exhibit 10 displays the marginal effect plots for each key variable in our cross-correlation model. These curves illustrate the relationship between these health determinants and preventable mortality, generally indicating that counties

performing better than the national average (1.0) for a given determinant tend to have lower preventable mortality rates (per 100,000 people) and vice versa.



Exhibit 10 – Social and Environmental Factors Generally Correlated With Health Outcomes in the Expected Direction



Source: BCG analysis of data from Office for Health Improvement & Disparities (PHE Fingertips) and ONS (The Health Index for England: 2015 to 2021).
 1. Implied preventable mortality rate (“E03 – Under 75 mortality rate from causes considered preventable”).
 2. 1.0 = England avg. higher – better.



For the variables with significant explanatory power (economic and work conditions, crime, physiological risk, behavioural risk), the curves illustrate the expected direction of relationship between these health determinants and preventable mortality. For example, counties with ~20% worse performance in behavioural risk factors compared to the national average had the highest levels of preventable mortality.

There are two key insights to draw from this first statistical approach:

1. The wider determinants of health are highly relevant. Counties that perform differently to the England average across key socio-economic and behavioural factors tend to see a corresponding, and often very significant, variation in preventable mortality (a proxy for aggregate health outcomes).
2. The shapes of the curves are highly relevant for policy prioritisation. For example, a 10% improvement in economic and work conditions would likely reduce preventable mortality more than a 10% improvement in behavioural risk, for a county achieving the national average score for both variables.

Other variables (access to services, living conditions, protective measures) have low explanatory power in the model (less than 5%). For these variables there is a high likelihood that correlation is being subsumed by other variables and in some cases skewed by unaccounted for effects.

For *access to services* we observe an unexpected positive correlation with preventable mortality. This is partly driven by a rural/urban split, whereby urban centres enjoy better access to services but also higher preventable mortality for other reasons. Once this split is controlled for, the correlation weakens. A similar unexpected correlation was observed in previous analysis of female health access and female health outcomes, explained by several unaccounted effects including the fact that

funding is, to some extent, directed to areas with the greatest need.¹⁷

For *living conditions* we also see an unexpected correlation. This is driven largely by the dominance of other variables.

For *protective measures* there is limited correlation with preventable mortality, with skewed results at the extremes due to small sample sizes. When these extremes are removed, a slight negative correlation emerges, as would be expected.

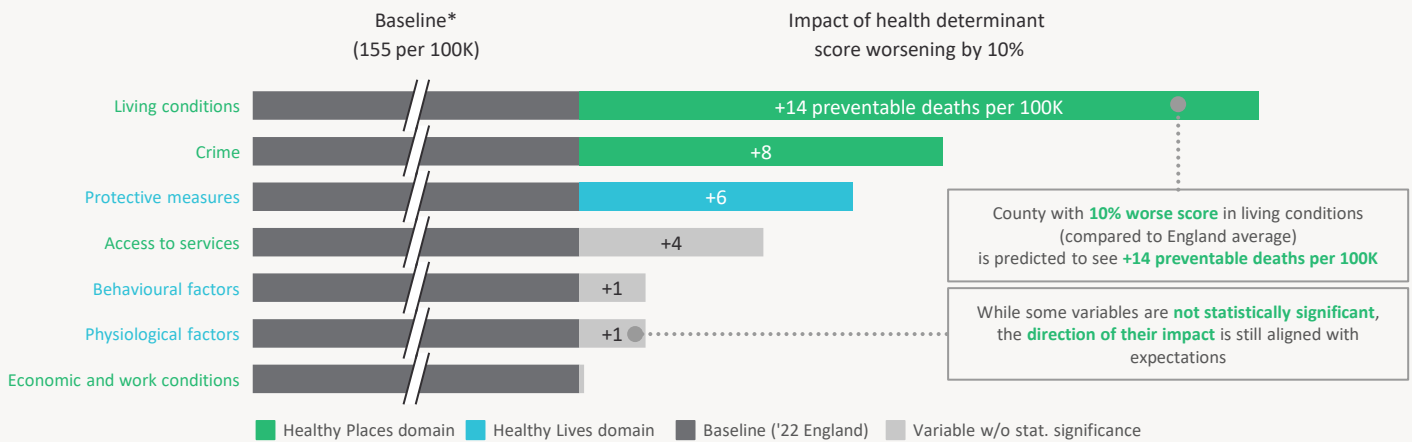
2) How have within-county changes across time impacted preventable mortality?

To more clearly identify any causal links between wider determinants and health outcomes, we examined within-county variation in health determinants over seven years to estimate how changes impacted preventable mortality.

Exhibit 11 highlights the factors that have meaningfully shifted health outcomes in the past seven years.



Exhibit 11 – Social and Environmental Risk Factors Demonstrate Significant Impact on Preventable Mortality Outcomes



1. Variables without statistical significance at 10% confidence level.

Model: Panel Data Fixed Effects, 143 Countries; 7 time periods ('15-'21), "E03 – Under 75 mortality rate from causes considered preventable" dependent var, control for time, HAC robust errors.

Model evaluation results: LSDV R-squared = 0.91, jointly significant regressors (P-value<0.001), significant time control (P-value<0.001), significant fixed effects (P-value<0.001).

Source: BCG analysis of data from Office for Health Improvement & Disparities (PHE Fingertips) and ONS (The Health Index for England: 2015 to 2021).

The analysis reveals that deterioration in risk factors affecting population at the collective level (known as the 'Healthy Places' domain) had a stronger impact on preventable mortality rates. For example, a 10% decrease in the living conditions score is predicted to have led to an additional 14 preventable deaths per 100,000 people in a county between 2015 and 2021. Similarly, a 10% decrease in the crime score is predicted to have led to an additional eight deaths per 100,000 people in a county.^{ix}

The analysis also reveals some factors, particularly those affecting individuals (known as the 'Healthy Lives' domain), have not shown a statistically significant impact. This does not mean they have no impact on health outcomes; rather, it suggests that these determinants have not primarily driven changes in health outcomes over the past seven years.

The absence of statistically significant results for some factors can be explained by:

1. Limited sustained improvement or deterioration of a health determinant across the seven-year timeframe. For example, only 26% of counties showed a cumulative change in economic and working conditions of more than ±3%, compared to 53% for living conditions.
2. Changes to some health determinants, such as physiological risk, may require more than seven years to significantly impact preventable mortality.

The key insight from our second statistical approach is clear: over the past seven years changes in 'healthy places' variables have had a greater impact on preventable mortality than changes in 'healthy lives' variables. This is an important finding given the traditional focus placed on clinical or behavioural factors which fall into the 'healthy lives' category. Our analysis underscores the importance of wider social determinants of health, in turn emphasising the need for a whole-of-government approach to solving cross-cutting health challenges.

ix. When disaggregated, the crime score is mainly driven by low-level rather than personal, violent crime. This might point towards an underlying 'economic' factor (such as deprivation) which is correlated with low-level crime.



Both statistical approaches covered a broad sweep of counties, to draw overarching conclusions. Within the **Methodology** we share detailed findings of more granular analysis. Within our second statistical approach, we segmented counties by gross median income and performance of health determinants versus national averages. At a summary level, we found that:

- The impact of changes in living conditions is 1.4x stronger for counties in the lowest income segment as compared to counties in medium and high-income segments.
- The economic and working conditions variable does show a statistically significant effect for counties in the medium income segment (+9 preventable deaths per 10% score deterioration).
- Some variables display non-symmetric effects. For example, counties which underperform on crime see preventable mortality increase by +9 as compared to being an average county, but there is no statistically significant effect when counties over-perform.

Our analyses deliver an important message. Social and environmental determinants of health clearly have strong influence over health outcomes and, depending on the local context, there may be times where they are more impactful than clinical factors. This reinforces the need to focus on wider determinants of health if seeking to address growing long-term sickness and inactivity in the population. To us, a true WGA to health is the best way to do this.

2.3 Why a whole-of-government approach is needed

The fact that wider social and environmental determinants of health play such a key role is not the only reason why a whole-of-government approach is needed. The interplay of health and economic inactivity is an issue which cuts across many parts of the government and healthcare

system. When people engage with public sector healthcare, they touch a wide array of different departments and organisations, not just the NHS or DHSC. To demonstrate this, we have developed two citizen journeys to show how someone who is long-term sick and economically inactive might interact with the healthcare system. We have drawn our examples from some of the fastest-growing segments of the long-term sick, economically inactive population: 50-64-year-olds with five or more comorbidities and 16-24-year-olds with a single health condition.

These citizen journeys highlight three key points:

1. Of the multiple factors that influence an individual's health, many sit outside the direct control of the NHS or DHSC.
2. Frequently, the range of departments that provide services to long-term sick, economically inactive people can grow significantly over time (and, as such, so will the cost), meaning early intervention to prevent this is particularly important.
3. It can be incredibly complex for the individual to know how to navigate the web of services provided by different departments, meaning they often fall through gaps or fail to properly make use of the help on offer.



Exhibit 12.1 – Citizen Journey 1



Citizen Journey 1 | Jamie: Economically inactive person, aged 55 with multiple health conditions (chronic back pain, coronary heart disease, type 2 diabetes and asthma)

Meet Jamie, a 55-year-old former hospital porter from a low-income background in a mid-sized UK city. Jamie was generally fit and healthy until several years ago when a back strain at work went unmanaged. Below you can read his full story, which details his journey and the parts of government and society he engages with along the way. Jamie's story underscores the need for a cross-government approach to designing and delivering services. Early intervention for Jamie's back strain could have prevented his health declining and wider support may have eased the social, financial and emotional impacts he experienced. Ultimately, a more joined-up approach to his health may have stopped him from dropping out of the workforce long-term and reduced the number of engagements he had with government services.

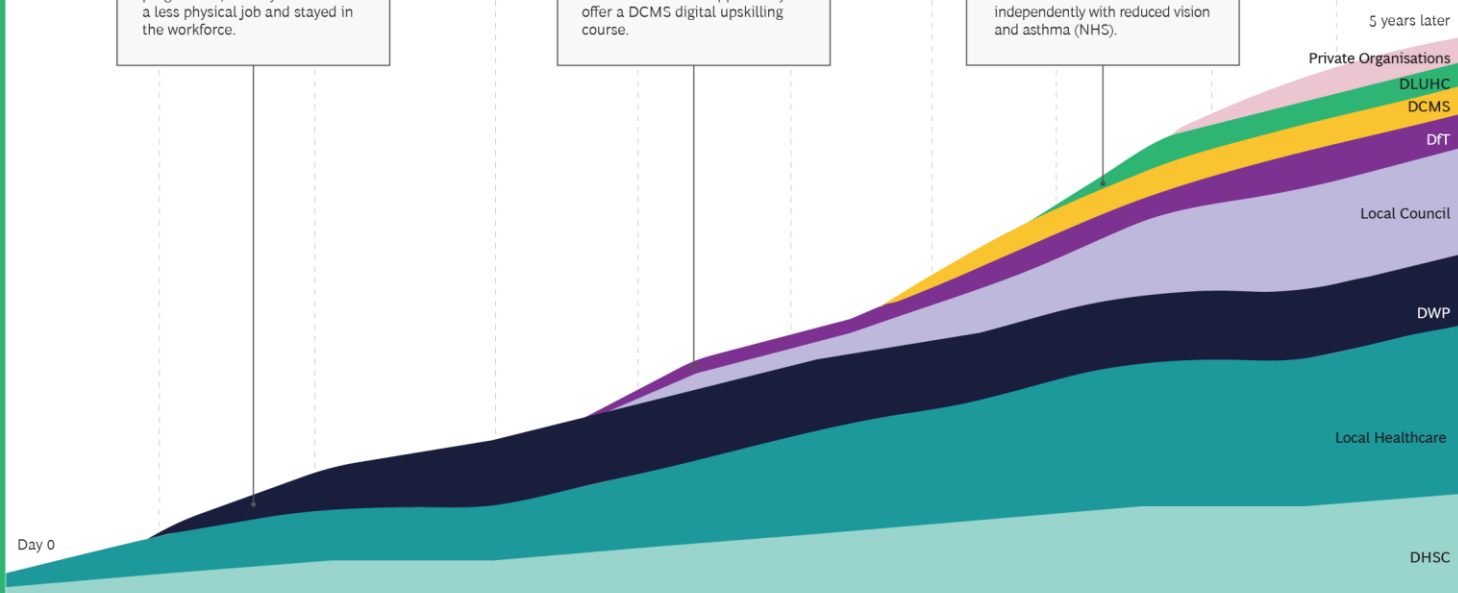
Meet Jamie

Depts. involved in policy and delivery of services

Inflection point 1:
If Jamie had been offered a DCMS digital skills course, he may have been able to access online physiotherapy and prevent condition decline. There could be a role for employers in flagging when employees are, or are at risk of being, digitally excluded. Although a manual job was not suitable for Jamie whilst his back was injured, if he had the opportunity for retraining or reskilling through a DfE programme, he may have taken a less physical job and stayed in the workforce.

Inflection point 2:
If Jamie had been offered NHS, community, or affordable public transport, he may have been able to attend Healthier You appointments and maintained his broader ability to travel. If there were better mechanisms to flag when individuals are eligible for free or discounted transport, Jamie could have been proactively advised on how to access support, for example by using resources at local libraries or post offices. This point in Jamie's journey would have been another opportunity to offer a DCMS digital upskilling course.

Inflection point 3:
An environmental health inspection (local council) of Jamie's social housing would have recommended Jamie move to alternative safer housing (DLUHC) due to the damp and mould. This may have prevented his asthma from worsening. A change in housing and a recent new health diagnosis could have triggered an occupational therapist assessment of Jamie's new housing. Suitable adaptations could then have been made to make it easier for him to live independently with reduced vision and asthma (NHS).



1. Jamie is generally fit and healthy, he has mild asthma that does not require medication.

He works full-time in a job he enjoys. He rarely engages with government or the health system.



2. Jamie strains his back at work.

He is temporarily signed off work and engages with DWP to access short-term employment support. He is also referred to online physiotherapy (DHSC / local healthcare system) but is unable to attend as he can't access online services. Since his injury, Jamie's interaction with government and health systems has increased.



3. Undertreated injury evolves into chronic back pain.

This forces Jamie to leave work. He applies for work capability assessment to receive Universal Credit (including LCWRA) from DWP. Although he was already engaging with DWP services in relation to his short-term employment support, the process for long-term support expands the scope of services he is receiving from them.



4. Jamie engages in a Work and Health Programme and Restart Scheme.

Despite participating in the scheme, his chronic pain and declining mobility means he struggles and his health continues to deteriorate, necessitating more healthcare appointments.



5. Referred to Healthier You (diabetes prevention programme).

As he is high risk, Jamie is referred to a local NHS diabetes prevention programme. However, his ongoing back pain means he can't drive to appointments and public transport (DFT) is expensive. Jamie doesn't know that support for transport is available to him and he is consumed with managing existing healthcare and employment services.



6. Diagnosed with type 2 diabetes, referred to specialist nurses for checks.

Jamie becomes overwhelmed with the number of different appointments and specialists; he struggles to manage and is discharged for missed attendance. He tries to manage his condition through occasional physical activity at a local leisure centre.



7. Vision deteriorates due to type 2 diabetes.

His poor eyesight means he can no longer get to the local leisure centre (DCMS), further worsening his diabetes. He becomes increasingly socially isolated.



8. Multiple hospital admissions due to asthma.

Conditions in Jamie's social housing (DLUHC) deteriorate as his health worsens. Damp and mould exacerbates his asthma.



9. As his asthma and fitness worsens, he is unable to go very far to the shops.

Limited local, affordable and healthy options mean his diet gets worse.



10. Jamie develops coronary heart disease.

The GP refers him to secondary care due to the complexity of this amongst his other conditions.

Exhibit 12.2 – Citizen Journey 2



Citizen Journey 2 | Sam: Economically inactive person, aged 24 with mental health condition (depression) and background of alcohol dependency, parent of a young child

Meet Sam, a 24-year-old former retail worker in a small UK city. Sam enjoyed a fulfilling life until experiencing a family bereavement and the end of a long-term relationship. As Sam's mental health deteriorates, she finds it increasingly hard to manage and stay in work. Sam's story highlights the need for a comprehensive government approach to service design and delivery. Early, targeted actions from departments beyond DHSC, aimed at improving her health, could have prevented Sam from falling out of the workforce. Additionally, it may have reduced the number of interactions (and associated costs). Whilst many services may have been available to Sam, the complexity of these – exacerbated by her increasing isolation – make them very difficult to navigate. A more joined-up approach may have addressed this.

Meet Sam

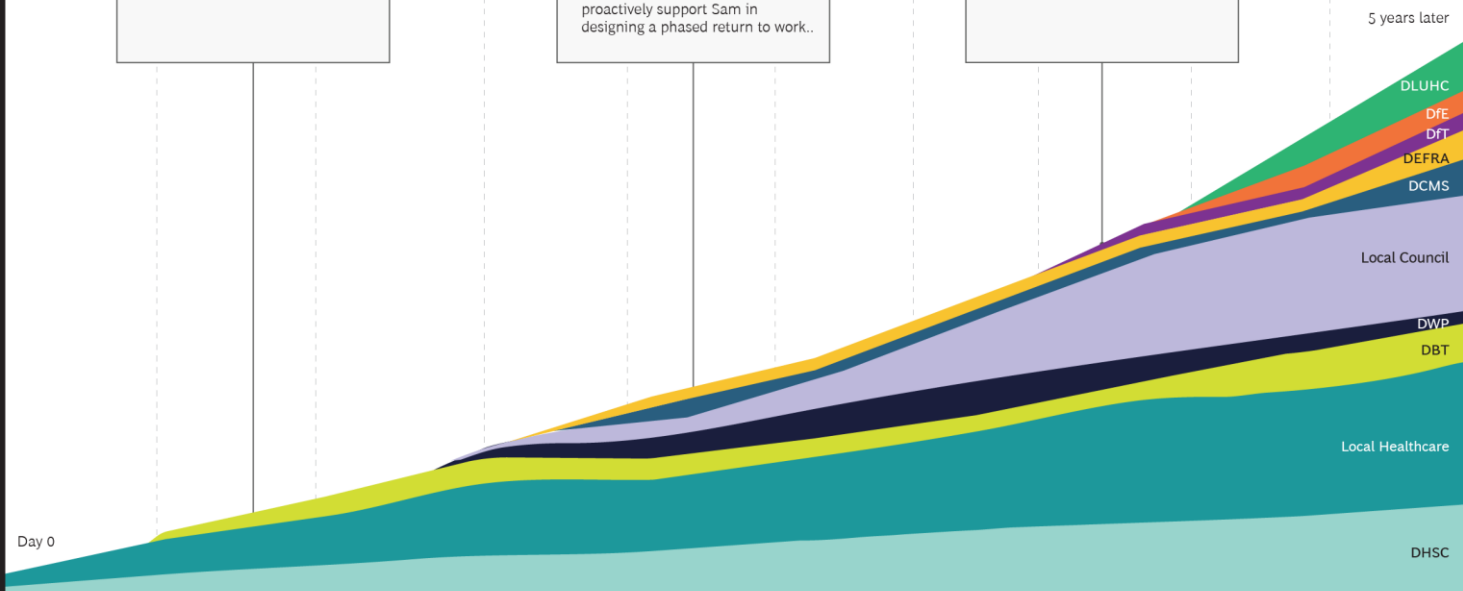
Depts. involved in policy and delivery of services

Sam's story

Inflection point 1:
A lack of flexible working ultimately resulted in Sam leaving the workforce. At this stage it is possible the government (DBT) could work together with employers to provide support and options for those struggling. If Sam's case had been flagged to DFE to offer her reskilling or retraining, it may have opened up alternative flexible employment.

Inflection point 2:
Limited provision of green space and exercise facilities reduced Sam's ability to act on medical advice, keeping her away from work. Targeted interventions to offer additional exercise opportunities as well as further education on the topic (DEFRA, DCMS) may have helped and brought her closer to re-entering the workforce. If DWP were made aware that Sam was successfully engaging with alcohol dependency programs, they may have been able to proactively support Sam in designing a phased return to work..

Inflection point 3:
DLUHC's lack of knowledge and data on Sam's wider circumstances worsened her isolation, pushing her further from the workforce. If local healthcare could provide the wider context of Sam's situation, a more appropriate housing situation may have been identified.



1. Mental health deteriorates.

Sam experiences a family bereavement and the end of a long-term relationship. At this stage, she has very limited interaction with health or government systems.



2. Develops depression.

As Sam's mental health deteriorates, she struggles to balance health appointments and shifts at her retail job. Despite trying, she was unable to agree a flexible contract with her employer and consequently left her job.



3. Develops alcohol dependency.

Sam's mental health continues to decline – she now has severe depression and loses her job. To cope, she increases her alcohol consumption which eventually leads to alcohol dependency.



4. Starts receiving Universal Credit and support from mental health services.

Sam accesses an outpatient mental health service specifically for alcohol dependency and employment counselling through the Individual Placement and Support in Primary Care (IPSPC) service (local council). By this point, she is engaging with multiple different government and health services.



5. Struggles to follow all the recommendations to improve mental health.

Sam can't implement exercise recommendations for depression due to limited access to green spaces (DEFRA) and exercise facilities (DCMS).



6. Alcohol dependency improves, but depression persists.

Sam has a positive experience with the drug and alcohol team at Turning Point and is able to address her dependency. However, her depression persists and she struggles to afford rent after losing her job, forcing her to move in with friends.



7. Becomes pregnant. Sam is offered social housing (local council).

At this point, the level of health and government support Sam is receiving significantly increases again.



8. Gives birth but becomes increasingly socially isolated.

Sam's new social housing is over an hour away from her hometown and her friends and family. The route is long on public transport and she struggles to make the journey with a newborn. She becomes increasingly isolated.



9. Begins new family support programmes.

Sam is encouraged to engage with a local Sure Start centre (DFE) and Supporting Families programmes (DLUHC). As a new mother, she is navigating parent services for the first time – on top of the services for her mental health, housing and unemployment.



10. Can't attend meetings with mental health services and UKSPF-backed local employment support.

As Sam's child is so young, she doesn't qualify for free childcare and without support from friends and family, her caregiving responsibilities make it difficult to access support. She is not aware of local charities and private organisations that may be able to provide help.

Citizen Journey 1 highlights the rapid rise in interactions with multiple services over time, revealing several critical inflection points. Early and integrated interventions at these inflection points could potentially prevent further health decline.

Citizen Journey 2 shows how even a single health condition, not adequately addressed, can escalate into more significant problems. Providing the right support, from the right team at the right time, could allow effective intervention to alter the trajectory of an individual's journey and return them to full health and to the workforce.

Taken together, the journeys illustrate the interconnected nature of employment, housing, transportation and social support when it comes to those who are long-term sick economically inactive. Addressing complex issues such as the rise in long-term sick inactive requires a whole-of-government approach, in which various parts of the public sector work together to make timely interventions that improve health outcomes.

If executed properly a WGA can make policy more agile and responsive to complex cross-cutting challenges. The rise in long-term sick inactive is just one of these challenges, but there are plenty which could also fit the bill. For example, homelessness has a variety of underpinning drivers. But single parts of the system are often not incentivised to act on their own. Considering the issue in the round, including health and economic impacts, could help underpin concerted action.

2.4 Current landscape and government decision making

It is worth pausing briefly to understand the complex policymaking landscape we currently operate in. The civil service comprises: 518,885 civil servants,¹⁸ 24 ministerial departments, 20

non-ministerial departments and 427 agencies and other public bodies,¹⁹ in addition to 382 principal councils or unitary authorities.²⁰ Decision-making and delivery sit across multiple levels and organisations have complex, often overlapping, or fragmented remits. Among this, the Treasury plays a critical role in the orchestration and funding of government policy. In many ways it is the only true cross-government department, given the role it plays in allocating and determining funding.

Recent reforms have looked to leverage this fact. The newly established Evaluation Task Force is a joint Cabinet Office-HM Treasury unit providing specialist support to ensure evidence and evaluation sit at the heart of spending decisions.²¹ While the task force determines the viability and value of large-scale projects before and after inception, it does not review proposals in terms of their potential to achieve wider cross-government objectives, for example to address health outcomes.

This speaks to a wider challenge across current decision-making frameworks in government—there is no duty and often little opportunity to consider the impact which policy might have, either positive or negative, on health outcomes (beyond health and safety regulations). While this happens narrowly in the Department of Health and Social Care and the NHS, it rarely happens elsewhere. To the extent it does, it is ad hoc and patchwork. There are opportunities to consider other impacts but not those on health. For example, economic and environmental impacts are considered in detail through impact assessments and/or the budgetary process, while a public sector equality duty was created under the Equality Act 2010 for all legislation. There, processes vary widely across policy areas but do nevertheless exist.



2.5 Current barriers to cross-government working

A whole-of-government approach has long been recognised as a useful tool with which governments can drive change in complex, wide-ranging issues such as health. However, it is difficult to find a universally successful application of this approach in the UK or elsewhere. There are plenty of reasons for this—not least, it often makes sense for government or the public sector to operate in well-defined silos.^x

However, for a whole-of-government approach to be truly successful, it must traverse silos at both horizontal (within central government) and vertical (across levels of government) levels. This means overcoming a series of institutional and cultural barriers. In this section we will draw from existing literature and insights from a series of expert interviews with senior stakeholders across the policy, healthcare and government space to establish the key barriers that need to be overcome when instituting a whole-of-government approach.

We evaluated the effectiveness of cross-government collaboration across five key dimensions from vision to funding and culture, at both the national and local level and between the two. From this we identified 12 key barriers to effective cross-government collaboration.

2.6 International and domestic best practices

To supplement our assessment of common barriers and better calibrate our recommendations, we evaluated international and domestic examples of large-scale cross-government working. Our case studies (see Exhibit 14 for a summary) illustrate how common barriers have been successfully addressed. Further information and background on each case study can be found in **Annex D**.

Through these examples, we have identified several best practices and key learnings that could be applied to implementing a whole-of-government approach to health. Whilst they are not without their own challenges and none are perfect, they do demonstrate how specific actions or processes can address particular barriers. Of course, there are also learnings from areas that were not as effective or impactful.

x. Much work has already been done on where these silos exist and how government could be working collaboratively—see for example the Public Accounts Committee report on cross-government working and the National Audit Office's 'Cross-government working: Good practice' guide'.



Exhibit 13 – Main Barriers Across Each Dimension Assessed Within, and at the Interface of, Central and Local Government



Vision

- **Case for change:** The need for action is not understood or articulated, success measures are not outlined.
- **Senior sponsorship and leadership:** Poor senior sponsorship and credibility. The thread of leadership between the levels is weak resulting in disjointed approaches.
- **Common purpose:** There is a lack of buy-in for the vision. It is not understood how everyone's work contributes towards strategic objectives and how the system should work together.



Structure and Governance

- **Collaboration directive:** There is no direction to work collaboratively. Performance is not assessed on contributions to wider strategic goals. Where models of collaboration are used, they are inconsistent.
- **Accountability and governance:** One Accounting Officer bears the majority of the risk and reward. Governance structures are complex, duplicative or non-existent. Accountability is associated with allocating blame.
- **Decision-making level:** it's not clear who is needed to set strategy or deliver (leaders and partners). Decision-making is not made at the right levels and top-down directives lack operational feasibility.



Funding, Investment and Planning

- **Funding horizons:** No dynamic funding or ability to react flexibly. Focus on short-term with no long-term certainty.
- **Funding silos and incentives:** Funding is siloed across all system levels, with no collaborative planning or link back to strategy. Outcomes, performance and funding are not connected. Financial and resource planning is separate. Organisations are not recognised for delivering on cross-cutting areas.



Resourcing, Capabilities and Tech

- **Data and digital:** Suboptimal digital systems and complex architecture make it hard for departments and bodies to collaborate. Data is not consistently shared, analysed or usefully implemented.
- **Workforce planning:** it's hard to find and utilise the right people, skills and capabilities. There's a lack of PMO, data and financial skills at all levels of the system.



Culture

- **Trust and collaboration:** collaborating is viewed as increasing risk not bringing additional value. Trust between different system levels is deteriorating. Silos deepen as you descend an organisation. There is change fatigue in teams.
- **Shared learnings and innovation:** A fear of public scrutiny and a perverse risk and reward system drives a culture where organisations are not willing to share challenges in the moment or thereafter; the mechanisms to do so also don't exist. Limits culture of innovation and continuous improvement.



Exhibit 14 – Best Practice Case Studies and Key Successes



Vision

National Disability Insurance Scheme (Australia):

- Widespread buy-in to a shared vision from the Prime Minister to local operational staff.
- Compelling case for change tailored to interests of each stakeholder organisation.
- Common purpose embedded so momentum continued beyond tenure of individual leaders.
- A noble goal improved job satisfaction, skill retention and productivity, particularly in a sector with high staff turnover.
- People with lived experience co-designed policies to ensure they were impactful for target population.



Structure and Governance

Harm to Hope (UK):

- Delivery unit sat across the key departments, facilitating cross-government buy-in and communication.
- A national outcomes framework aligned to departmental objectives and centralised evaluation allowing local partners to focus on clear delivery outcomes.
- A new Combatting Drugs minister reported directly to the PM.
- A single senior was responsible for each local partnership providing clear accountability at each level.
- Decision-making was devolved with autonomy to co-ordinate local funding.



Funding, Investment and Planning

Green New Deal (South Korea):

- Funding for short-term and long-term work was separated to ensure quick-wins weren't prioritised over strategic programmes.
- Budget was increased by attracting private investment and incentivising industry investment in green technologies.
- Release of long-term funding was contingent on progress, promoting accountability and reassuring private investors, whilst reducing the administrative burden of repeated funding applications.



Resourcing, Capabilities and Tech

U.S. Presidents Emergency Plan for AIDS Relief (US)

- Building local capacity prioritised, which improved sustainability of work and empowered host regions to self-sustain.
- Data exchange platforms allowed experts to share best practices and lessons, improving inter-agency decision-making and allowing fraudulent schemes to be identified.
- Real-time data reinforced case for change and helped secure a 30-fold increase in financial commitment. It also allowed resources to be allocated on emerging priorities.
- Staff were trained with the necessary data analysis skills to ensure teams could utilise data properly.



Culture

Government Digital Services (UK):

- Established data platforms to share learnings across government.
- Cross-government 'service communities' provided a forum to discuss technologies, challenges and new research.
- All levels empowered to propose ideas, driving a culture of innovation and supporting talent retention.
- 'Firebreaks' allowed individuals to pursue self-directed work of potential interest to the organisation for a week every quarter.
- Published performance data and source code instilling an expectation that digital solutions should be comprehensible and transferable.



Chapter 03

How to Tackle Economic Inactivity Through a Whole-of-Government Approach in the UK

At this stage it is worth recapping what we have found so far. The UK has seen a rapid rise over the past few years in economic inactivity, primarily driven by long-term sickness. The evidence suggests the UK population is getting sicker, and that the UK is unique in this regard. The benefits of tackling this issue could be significant—both in terms of economic/fiscal benefits but also quality of life improvements. However, this is not a simple issue to solve. These sorts of health challenges are driven not solely by clinical factors or behavioural choices, but by a wider array of social and environmental determinants of health. Our analysis of the wider determinants of health outlines the importance of economic and work conditions and crime in predicting health outcomes. These determinants, alongside others, fall outside of the control of the healthcare system or the individual. Furthermore, those who find themselves economically inactive due to sickness touch many parts of the public sector during their journey, with multiple opportunities to treat them being missed.



To find a solution to this intractable issue in the UK (and others like it), there needs to be a whole-of-government approach to health. This would enable the real underlying causes of rising sickness to be tackled early on in a person's journey. This is easier said than done. There are many barriers to true cross-government working (some for good reason) and there are few examples of this being done well globally. Nonetheless by understanding these barriers and case studies elsewhere, we can begin to draw together what is needed for a whole-of-government approach to health in the UK.

In this section we set out a framework for how to adopt a whole-of-government approach and

then specifically consider how this can be tailored to tackle the issue of economic inactivity driven by long-term sickness. Of course, in many cases our basic approach can apply to any form of whole-of-government approach.

3.1 The three must-haves for a successful whole-of-government approach

We have identified three must-have elements for a successful whole-of-government approach. Exhibit 15 below brings together the key barriers in each of these areas. We then set out how each should be approached to help ensure a more successful approach.

Exhibit 15 – Key Barriers Distilled Into Three Key Themes; Propose Focusing Input Solutions Around These Themes



Whilst the 12 barriers (outlined in exhibit 13) exist to different extents across all levels of the health ecosystem, the key challenges can be distilled into three themes.

1. Lack of common purpose

The system lacks common purpose with no long-term vision, senior sponsorship or buy-in for objectives.

- Work focuses on achieving short-term impact and is not aligned to strategic objectives.
- Improving health is seen in conflict with, or not complementary to, non-health organisation objectives causing lack of ownership within and across departments.
- It's not clear what long-term success looks like and what the interim measures of progress are.
- Central government plan based on inputs and resources instead of working back from desired health outcomes.

2. Funding and resource silos

Funding is not dynamic or linked to performance, impact or strategy.

- Resource intensive funding landscape that favours those able to bid, not those with highest need.
- Proliferation of small grants that are very specific and short-term, making funding strategic long-term programs difficult.
- Siloed funding and national contracting/frameworks set prices and mean there is little ability to redeploy funding locally.
- Poor data gathering and sharing means funding and resources cannot be deployed on need and effectiveness of interventions is not evaluated.

3. Poor collaboration

Delegation not devolution from central government, with no direction or incentive to work collaboratively on health outcomes.

- Perverse risk and reward system that does not incentivise collaboration and means organisations do not get credit for contributing to cross-cutting aims.
- Local systems work towards central targets/objectives that do not represent their unique context – reinforcing a 'medical first' approach.
- Local system's capacity taken up with demands from 'above' — this is especially acute for managerial resource.



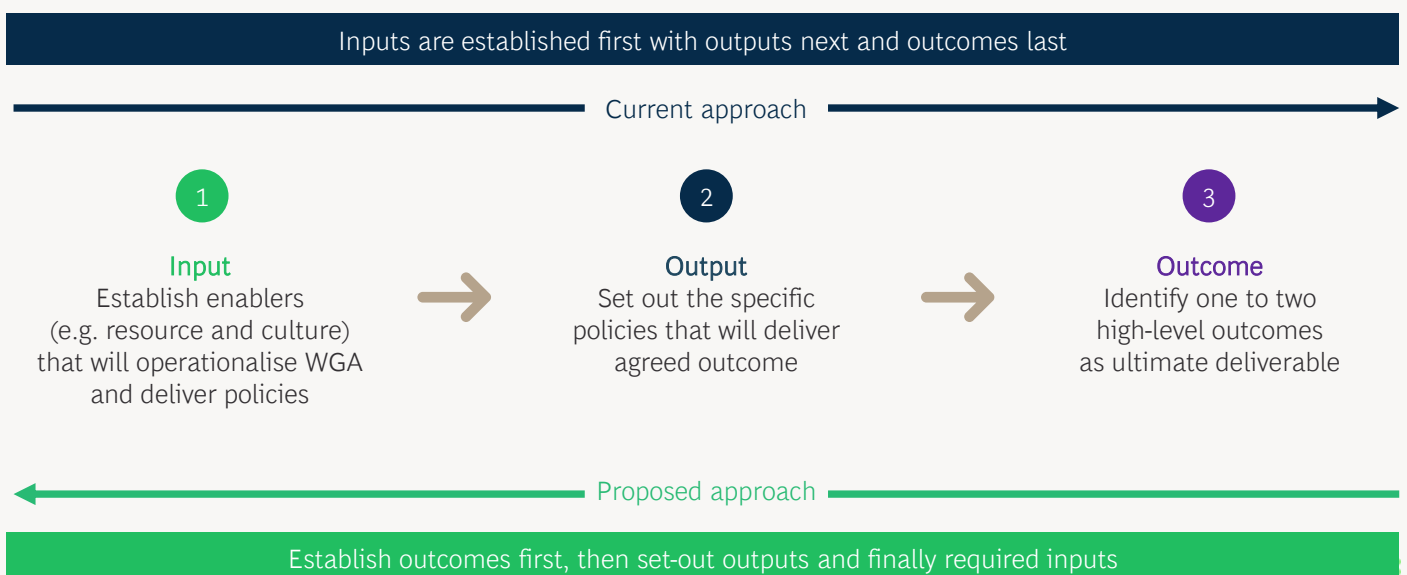
- **Common purpose:** Instil a common purpose across stakeholders to get necessary traction and buy-in across all system levels. Establish a clear case for change and define the long-term vision as well as near-term success metrics. Establish strong political and senior official sponsorship to drive accountability and unite all levels. Illustrate the benefits of involvement for each part of the system and ensure progress towards the vision is a top priority for all.
- **Collaboration and place-based decision-making:** Develop accountability structures that drive collaboration while allowing for local decision-making where appropriate. Incentivise and reward collaborative working both horizontally and vertically and promote shared learning forums to disseminate and discuss best practices.
- **Joined-up funding and resources:** Establish funding mechanisms that allow longer funding horizons and flexibility for necessary reallocations. Ensure funding mechanisms incentivise cross-governmental collaboration and sufficient resources are allocated to support objectives. Identify where

departmental/organisations should be sharing data to enable collaborative working and timely evaluations. Establish mechanisms to help drive shared understanding about the best approach to maximising economic and social benefits of health spending, as well as maximise the health benefits of other spend.

3.2 An outcomes-driven approach

A true whole-of-government approach also requires a fundamental change in how problems are perceived and how governments approach cross-cutting challenges. For the most part governments take inputs—vision, structure/governance, funding, resource and culture—as given and set. They then look at what outputs—policies—they can construct using these set inputs and what outcomes they can then hope to achieve or are realistic. As noted above this sort of siloed decision-making often makes sense—changing inputs is not easy and is not always required. However, when it comes to complex cross-cutting challenges this approach is often inadequate. It leads to fragmented policy-making and sub-optimal resource allocation.

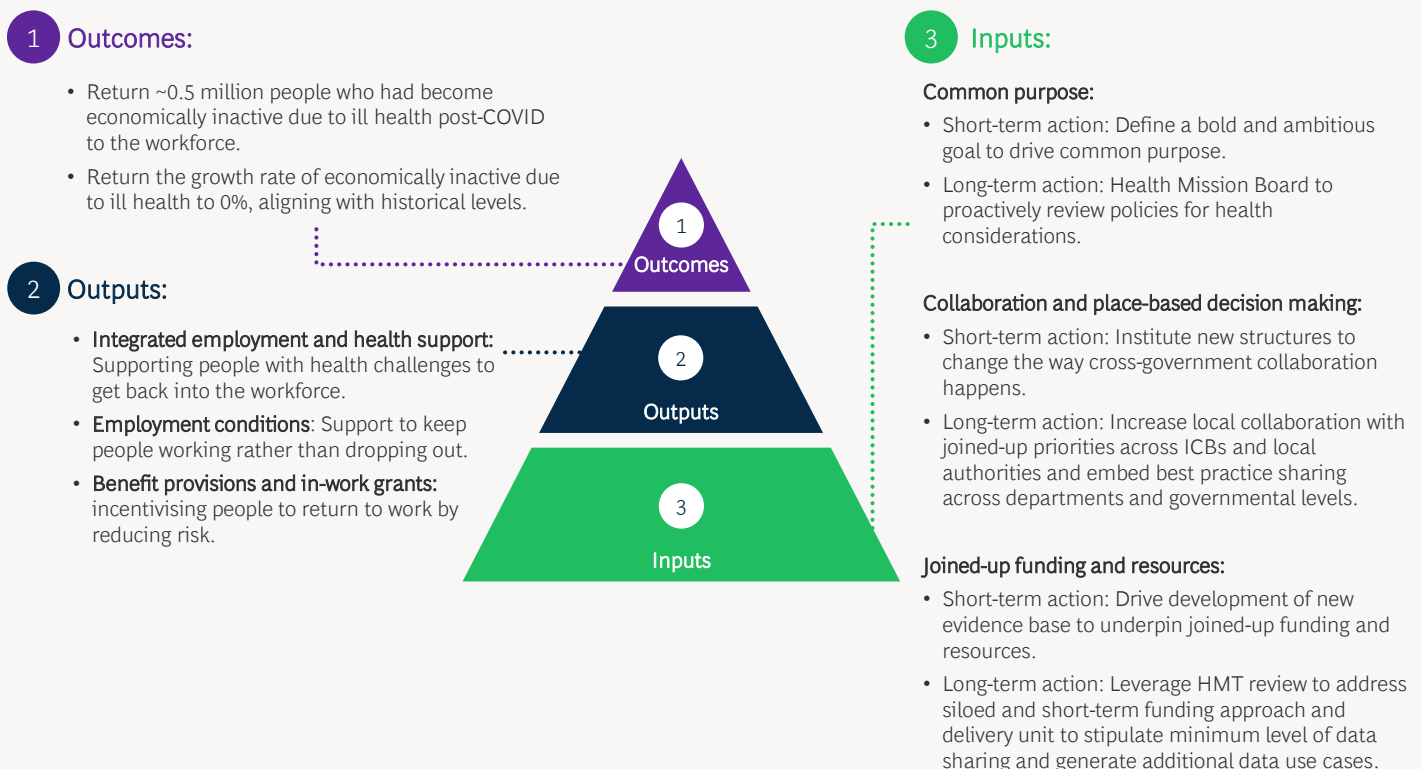
Exhibit 16 – Government Approach to Cross-Cutting Strategy



Instead, when it comes to a whole-of-government approach, we believe a more 'right-to-left' approach is needed, flipping this traditional approach on its head. Clear outcomes should be defined first, ensuring there is common purpose and a clear goal in mind for all to aim at. From this, the outputs can be identified which can best help achieve the desired outcomes. Finally, the right organisation of inputs should be determined based on these desired outcomes and outputs. This means that there must be a fresh approach to inputs, breaking out of traditional silos and ensuring collaboration is a priority, not an afterthought. Without this sort of fresh approach, the pervasive barriers to whole-of-government working are likely to persist and attempts to deliver cross-cutting policies are liable to fail.

To that end, we propose two outcomes to drive action in this space, followed by three steps which could better tailor outputs to tackle the rise in economic inactivity and ill health. We then propose a set of actions across the short- and long-term to change the way inputs are organised to better support tackling complex cross-cutting issues, such as economic inactivity driven by ill health. Together these steps will provide a stronger foundation from which the public and private sector can work together to address the significant challenge of the recent rise in inactivity driven by ill health.

Exhibit 17 – Our Key Recommendations from Outcomes to Outputs and Inputs



3.3 Outcomes: The ultimate deliverables

We can now start to apply this framework to a WGA to health designed to help tackle long-term sickness driving economic inactivity. Given our analysis set out in chapter one, we would propose two key outcomes be targeted:

- Return ~0.5 million people to the workforce who had become economically inactive due to ill health post COVID-19 (~5% of the economically inactive population) and;
- Return the growth rate of economically inactive due to ill health to 0%, aligning with historical levels.

Of course, these would likely be part of a wider set of health targets and interventions which will make up the health mission of the new government.

They—along with the wider actions we will set out—should also form part of the development of a cross-government health improvement strategy to bring together organisations and drive cross-government collaboration. This could be within the newly announced Health Mission Board's remit. Such a strategy could outline the government's key health improvement outcomes and set out specific short- to long-term actions. These should cover all determinants of health, from employment to housing and education, and be predicated on national and regional data. It is therefore important that those involved in developing the strategy go beyond just health organisations and local government.

A cross-government health improvement strategy of this nature should, ideally, be generated via formal engagement with mayoralities, county councils and NHS organisations. In particular the National ICP Forum now being established by DHSC and subject to approval by the new Secretary of State for Health and Social Care. We know the new government's mission-driven approach will

be a core driving principle of the NHS 10 Year Plan, so it's important a health improvement strategy and health mission board work cohesively. To ensure it is both holistic and deliverable, it should also involve the voluntary sector and patient experience groups to ensure the true identification of the barriers to health improvement at all system levels, while also addressing the different needs and delivery challenges at place level. We envisage a health improvement strategy incorporating existing initiatives and government plans across the social determinants of health, building on these where appropriate to meet those short- and long-term health improvement objectives.

3.4 Outputs: Proposed policies on reducing economic inactivity and its future growth

With these outcomes in mind, we turn to potential outputs (policies) that could be beneficial in tackling economic inactivity driven by long-term sickness. Our aim here is not to be exhaustive but to highlight the types of policies which could be effective and, specifically, ones which we think will be better facilitated or improved by a WGA.

There is significant work which can and is being done to improve healthcare outcomes, notably reducing waiting times. But when it comes to economic inactivity driven by long-term sickness, the issue goes wider than just immediate clinical care. Our analysis has underlined the importance of wider social determinants of health, such as economic and working conditions and crime, on overall population health. Our analysis indicates that these wider determinants share a common thread—they often represent somewhat of a proxy for deprivation in an area. Furthermore, they can sometimes reinforce one another. For example, poor economic and work conditions can set the context in which crime rates tend to increase.



This section is focused on how a whole-of-government approach can bring a broader perspective to how we improve overall population health, including through improvement of wider health determinants. The expectation is that supporting people to find, return to and remain in work will also have a positive effect on other social determinants of health, such as crime, possibly through reducing deprivation.

A cross-cutting shift is likely to be needed. Our employment support and welfare system is broadly set up to target helping unemployed people back into work. Yet with unemployment at 4.4% (still near record lows and well below the level seen for much of the past 50 years in the UK), this is not the challenge currently facing the UK. Economic inactivity and specifically that driven by long-term sickness is the real challenge. This will mean pivoting approaches across all the key areas of focus set out below.

- **Integrated employment and health support**—supporting people with health challenges to get back into the workforce.
- **Employment conditions**—support to keep people working rather than dropping out.
- **Benefits provision and in-work grants**—incentivising people to return to work by reducing risk.

Successful policy implementation across these focus areas would help to both reintegrate a share of long-term sick to the workforce and prevent flows into the long-term sick inactive population from the workforce. Our analysis indicates a corresponding 'size of the prize' in the range of £35-57 billion cumulative fiscal revenue over the next five years and a boost to the UK's GDP in the range of £109-177 billion.

3.4.1 Integrated employment and health support

Integrated employment and health services,

especially place-based programmes, have the potential to be beneficial but are often fragmented and poorly targeted. Leveraging a WGA to streamline services and provide a single entry point could help more people stay in or return to work. This is particularly crucial given the rising levels of sickness amongst those in paid employment, with over half now considering their health to be less than 'excellent' or 'very good', compared to just 35% in 2013. We support the government's recent statements about making Department for Work and Pensions (DWP) a department of work not welfare. There are a few steps that might help this become a reality, for example:

- As outlined in the Pathways to Work report, local health services should be more closely integrated with employment support and services. As the body responsible for writing their integrated care strategy, integrated care partnerships (ICPs) can and should play a key role in developing new work, health and skills plans. Previous work and health interventions, such as the Fit for Work service, have failed partly due to limited integration with the health system and therefore low referrals from GPs. Considering at a future date and post-evaluation, wider roll out of the WorkWell programme beyond the 15 ICSs piloting it currently. WorkWell is a DWP and DHSC programme aimed at addressing long-term inactivity due to ill health. Due to go live in October 2024, WorkWell aims to support 60,000 individuals to stay, return or start work through early intervention health and employment support. A key part of the programme is funding to WorkWell sites to join-up work and health support into a coherent local strategy. Given 50% of individuals who are long-term sick and economically inactive report mental health and or MSK conditions, support which targets these areas should be a priority through the programme.



- Building on WorkWell, further co-locating community services within Jobcentres could create a one-stop-shop, improving accessibility and reducing administrative burden. Integrating services like social prescribing link workers, Citizens Advice Bureau, VCSE organisations and retraining services can enhance timely support delivery for the economically inactive and provide hubs to which employees can be referred as part of our earlier comments on in-employment social prescribing. This would build on the government's recently announced Back to Work Plan and commitments to launch a new national jobs and career service and local work, health and skills plans. It could also be linked to the government's devolution and local economic growth plans as part of the holistic, whole-of-government approach we are proposing. There could be value in reviewing the way in which career advice, support and access to jobs can be delivered outside of Jobcentres and within community settings more broadly, for example, by expanding work coaches in GP surgeries and/or further expanding employment advice in NHS talking therapies. This would recognise the different needs and services of geographical and urban communities. There are already examples of effective co-location in other settings, such as primary care networks. We support co-locating services whether in Jobcentres, GP surgeries other settings, providing it is the most effective location based on local need.

3.4.2 Employment conditions

Achieving the objective of returning the growth rate of economically inactive due to ill health to 0% will require a successful whole-of-government approach that seeks to address work-related issues and conditions to better support people to stay in work. Our analysis of

social determinants of health indicates the same. Across England, over/underperformance on economic and working conditions is the strongest predictor of health outcomes amongst the social determinants of health.

Each of these proposals would be better facilitated by a whole-of-government approach and could help address some of the underlying causes of rising long-term ill health and therefore of the rise in economic inactivity we have seen. Delivering these changes, through legislation or guidance and then operationally as part of the further devolution of powers to local level, would place health and work at the centre of local economic growth strategies. It would directly link delivery to the existing provision at local level, including through the voluntary sector, or through the development of new provision as a result of local funding decisions. Importantly, the provision of social prescribing and mental health first aid outside of traditional health settings would also support the return to work of the economically inactive where, as our data underscores, mental health and MSK issues are a key barrier to obtaining and retaining employment.

A. Social prescribers

These roles are designed to address the wider social determinants of health. They are fulfilled by link workers, sometimes known as community referrers, who direct and support people in accessing a range of local non-clinical health and wellbeing services, for example, housing, employment training, creative activities or counselling. There could be an opportunity to bolster and improve the functioning of these types of roles in a couple of ways:



- Cooperation between DHSC, DWP and the Department for Business and Trade (DBT) to mandate employers to provide access to social prescribing, in the workplace. This would help identify and address some of the social determinants of health (such as poor living conditions or accessibility issues) before a person drops out of the workforce because of them.
- There may also be value in having a formal role for employers, allowing them to directly refer employees into the system. As well as better links into social prescribing to offer volunteering and/or flexible working opportunities to help stop individuals dropping out of work or helping those who cannot yet find paid full-time roles. Social prescribers can provide an early intervention for people who are struggling at work. This would allow for additional support and a form of triage to better support an individual's needs, including for those with MSK conditions who would benefit from a referral to occupational health.

These improvements could be particularly effective in addressing the segment experiencing the fastest percentage growth in economic inactivity, 18–24-year-olds. This group may be more likely to engage with social prescribing in an employment setting than primary care, which they may not interact with as frequently. Targeting this segment is crucial to prevent long-term disengagement from the workforce amongst the youngest members of society.

B. Mental health first aiders

We see an active role for employers in supporting access to mental health services and/or mental health first aiders in the workplace. For many, other health conditions including MSK can have negative impacts on

mental health. Increasing provision and access to mental health support has the potential to positively impact health more broadly and prevent individuals reaching inflection points where their health is at risk of further deteriorating (as seen in the citizen journeys in section 2.3). Potential policies could include:

- Direct training of staff to provide in-house mental health first aiders, which is common in many public and private companies today, trained by recognised and accredited bodies. It could alternatively be through contracting a company to provide mental health first aiders on a third-party remote basis. For smaller companies that may struggle to accommodate this, they can as a minimum actively signpost employers to external support offered by voluntary organisations.
- Ensuring employees can access this type of support during work time, whilst accommodating business need, would also support staff to remain in employment where poor or deteriorating mental health might lead to sickness absence and, in the longer term, to possible economic inactivity

Additional enhancements of employment conditions

We see a further two potential areas of focus here: providing additional in-work support, including flexible working arrangements and expanding health and wellbeing support for employees. Actions here could include:

- Building on current government plans mandating the right to request flexible working from day one, for example by enabling other forms of unpaid or paid leave to be requested as part of managing a health condition.



- Additional provision of special leave for those with children, who are carers of the sick or of family members who are otherwise debilitated, whether paid or unpaid, which may help further support individuals at risk of inactivity or longer-term sickness absence.

The key to success here will not be simply expanding working and leave arrangements but ensuring employers are supported to implement provisions flexibly and creatively. The government should develop clear frameworks for organisations to help them interpret and apply guidance effectively. Flexible working or special leave works best when designed and used based on individual circumstances. Therefore, it is important that organisations can adapt models, and government does not mandate one-size-fits-all approaches. Employers and government have much to gain if they can help drive a cultural change in the use of such policies. Concerted action here could help keep individuals in work, preventing them from having to leave the workforce in the long term.

The government's proposed Fair Work Agency could support the Health Mission Board to integrate these initiatives into the health improvement strategy and to drive a joined-up approach across departments. Where legislative action is needed, the proposed Employment Rights Bill could provide a vehicle for some of these adjustments (where in scope).

3.4.3 Benefits provision and in-work grants

While the benefits system is unlikely to incentivise individuals to leave the workforce, potential cliff-edges in benefits support may deter or hinder individuals from returning to work. This has been acknowledged by the government and highlighted as an issue in the 2020 Plan for Jobs and Employment Support.²²

The Back to Work Plan is rightly looking at reducing cliff-edges and several pilot schemes extending support for individuals entering the workforce are already under way.²³ However, we believe there is an opportunity to go further still to alleviate risks, for example:

- Making it easier for people to regain benefits if they quickly fall back out of the workforce. For example, currently if after a probationary period employment is not confirmed, individuals must restart the Universal Credit process. The five-week minimum wait between application and payment acts as a deterrent for re-entering the workforce, particularly where the employment on offer is precarious. While loan advances are available for those falling out of employment involuntarily, many are reluctant, or feel unable, to use them whilst Universal Credit is reinstated. Ensuring individuals can quickly restart their Universal Credit claim for a period (such as six months) after they join the workforce could help to provide more financial security, especially for those entering less secure employment types. This is important as financial security has an influence on many of the wider social determinants of health and can help reduce social and behavioural risks such as poor housing, diet and exercise. This means Universal Credit should instead be paused while the individual returns to work, until such time as that employment is secure and probation has been successfully concluded. This would require operational change within the benefits system but is achievable in practice.
- Access to Work offers individuals with physical or mental health conditions tailored support for returning, staying in, or changing work. However, there may be a lack of awareness of the scheme among employers and further investment may be required, given the size of current numbers awaiting support. There is also an opportunity for DWP and DBT to provide more support to employers, including specific training for HR professionals who are supporting staff to return to the workplace.



3.5 Inputs: Operationalising a whole-of-government approach to solving economic inactivity

This brings us to the inputs that underpin the outcomes and outputs, and are the key to making a whole-of-government approach work. As explained in Chapter 2, the key barriers and the learnings to overcome them are usually found in how government is organised in delivery of a WGA. In this section we will look at a series of actions for how government can approach a WGA differently to improve the chances of success. This will cover both short-term and longer-term actions.

3.5.1 Short-term priorities

In our interim report (which has been rolled into this full report) we outlined three immediate actions for government. Here, we will flesh out these priorities, noting that since we published our interim report a new government has been formed and some actions have already taken place in the form of a new cross-cutting health mission.

We proposed three definitive day-one actions for a new government in our interim report. These were:

1. **Define a bold and ambitious goal to drive common purpose across the public sector.**
2. **Institute new structures to change the way cross-government collaboration happens and help to deliver these new priorities.**
3. **Drive development of new evidence base to underpin the creation of more joined-up funding and resources.**

We believe these three areas should still be an immediate priority for government to implement a whole-of-government approach to health.

Step 1—Define a bold and ambitious goal to drive common purpose across the public sector

Aim: Instil the common purpose across stakeholders to get necessary traction and buy-in across the public sector to jointly solve the challenge. Clearly define long-term vision and near-term success, coupled with strong senior sponsorship to unite all levels across one goal.

Action: PM to declare cross-government priority on improving health outcomes. There should be immediate direction from the PM that improving health outcomes, beyond securing the future of the NHS, is one of a few key cross-government priorities for this parliament. This includes highlighting the expectation and key role of all departments and levels of government to drive towards that objective across all of the social determinants of health. Establishing a health improvement strategy should be a key part of this, supporting the other actions we outline below and as a consequence of detailed cross-government and local system engagement and data analysis on the social determinants of health.

- The PM needs to define high-level health outcomes to strive for, such as reducing preventable mortality rates and improving quality of life through improved population health. But beneath these headline goals more specific binding outcomes are necessary, such as addressing economic inactivity driven by ill health (other specific outcomes could include reducing health inequalities, for example). As set out above, this could include aiming to reintegrate approximately 0.5 million people who became long-term sick inactive post COVID-19 back into the labour force and return the growth rate back towards its long-term trend of around 0%.

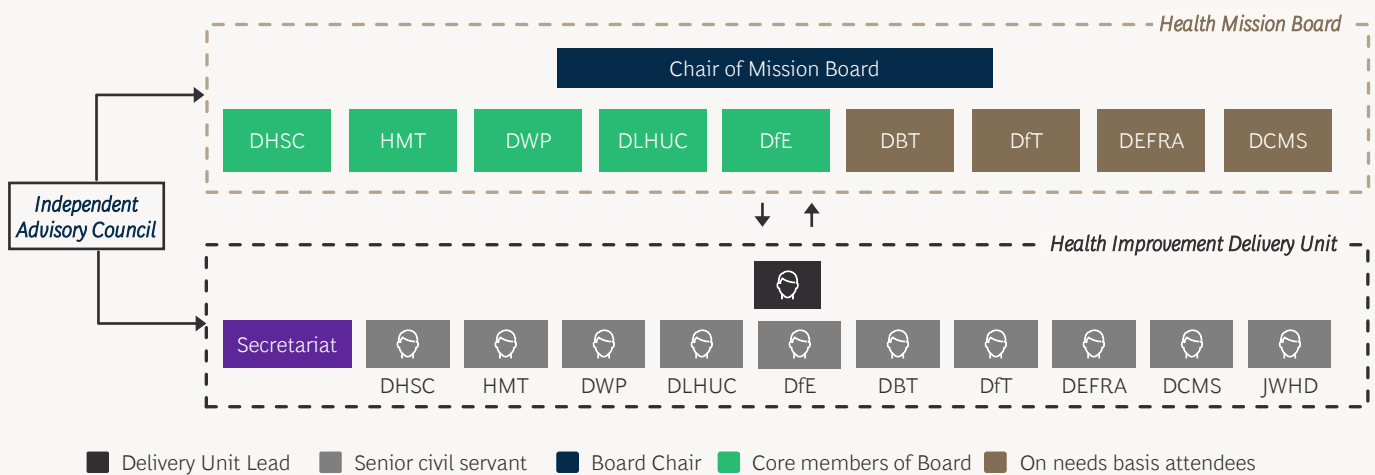


Step 2—Institute new structures to change the way cross-government collaboration happens and help to deliver these new priorities

Aim: Drive better collaboration across government with novel accountability structures to ensure efficient delivery of cross-cutting objectives. Incentivise and reward collaborative working both horizontally and vertically and promote shared learning forums to disseminate and discuss best practices.

Action: In our interim report, we discussed creating a new Health Improvement Board to drive a whole-of-government approach. Since then, the new government has announced the creation of a Health Mission Board, as part of its wider approach to its five key cross-cutting missions. This is welcome and essentially mirrors our proposal for a Health Improvement Board. However, creating the new board alone is not sufficient. As we previously explained, it is important to note that just setting up another cabinet committee in the usual way is unlikely to make much of an impact. A new approach is needed, with an emphasis on cross-government collaboration, accountability and delivery.

Exhibit 18 – Proposed Structure of a New Health Mission Board and Delivery Unit



Health Mission Board: Aligned with wider mission governance structure and chaired by a senior figure. A mission board should include SoS from key depts, with full-time attendance from core and optional from wider depts. The Board is a decision-making body, developing own policy and driving implementation.

Board Chair: The chair of this Board should be a central senior figure, ideally the PM or DPM. They must have a strong political mandate to drive accountability across the SoS.

Delivery Unit: Consists of senior civil servants from each dept, with a 50:50 split of their time between this unit and their own depts – to remain embedded within their own dept, whilst also accountable to both their own SoS and Delivery Unit Lead. The number and ratio of representatives from each department is illustrative.

Delivery Unit Lead: Should be Perm. Sec. level SRO who sits within CO, accountable to PM and deputy PM rather than individual SoS. Responsible for designing metrics and tracking performance.

Secretariat: Directly accountable to the Delivery Unit Lead, driving operational efficiency across both the Delivery Unit and the Health Improvement Board.

Independent Advisory Council: Panel of leading industry experts across areas including labour force economics and public health, amongst others. Provide input to DU and Board to guide policy formation and act as external challengers on government actions.



This board (or another such as the growth mission board) should have a Health Improvement Delivery Unit attached to it, rather than relying solely on siloed department work and evidence. It should have at least a Director General-level senior responsible officer (SRO) to drive the work of the board and the delivery unit across government. This individual should be based in the Cabinet Office and accountable to the PM or Deputy PM, not to an individual secretary of state. It would be a senior civil service role but there should be a focus on the skills necessary to deliver across departments. It could be advantageous to bring in an experienced external appointment, who might be able to take a fresh approach. This specific delivery unit could sit alongside others focused on other health priorities (for example, with a more clinical focus) under the Health Mission Board or alongside those focused on wider priorities if sitting under another of the mission boards.

Senior civil servants from each department split their time 50:50 between the delivery unit and their own departments. They should be accountable for cross-government delivery and supported with the tools to drive this. This setup ensures they remain embedded within home departments to drive the necessary behaviour change for cross-departmental work, whilst also being accountable to the delivery unit lead. A secretariat sits alongside the delivery unit and supports the work of the board.

Additionally, the establishment of a council of leading experts in areas such as labour force economics and public health, among others, could provide input to both the Health Improvement Delivery Unit and Health Mission Board more broadly. Again, this can and should apply to the wider approach to missions as well. A council such as this could guide policy formation and act as external challengers to

governmental actions. It is important that this group has both an inward and outward facing role, so that it can feed into policy development but also retain an independent external voice to hold government to account when needed.

Taken together, this setup means that the board would be able to develop its own evidence and analysis while also wielding the tools and power to drive implementation of the decisions it takes. This is fundamentally different to the usual setup which relies solely on siloed departmental evidence and then only on individual departments for delivery. This change should be reflected at both the political level and official levels.

Finally, this team should also include some stakeholder engagement and management to ensure views are fully represented and incorporated. Together with the council of experts, officials should engage with various parts of the system to fully understand challenges and where a WGA is truly needed and can make a real difference. To do this they could leverage existing governance structures and those which are in train (such as the National ICP Forum as proposed in the Hewitt Review and which is expected to be signed off shortly).

Step 3—Drive development of a new evidence base to underpin the creation of more joined-up funding and resources

Aim: Break down the existing siloed approach to funding and resourcing. Leverage, rather than dismiss, HMT's unique position as one of the few truly cross-government functions. Generate an evidence base and proof of concept to underpin the establishment of novel funding mechanisms that allow longer funding horizons and flexibility for necessary reallocations.



Action: PM to direct HMT to review cross-government spending on areas that impact the determinants of health and generate a plan for amending the funding approach to: 1) improve health outcomes by allocating spending more efficiently; and 2) generate wider economic benefits from this improved allocation. This review should be completed by the end of the year. It could, for example, examine how X spend in housing could save Y in health and X action in housing could return Y number of people back to the workforce who are currently long-term sick inactive. These recommendations can then be trialled in a few local areas, with a view to being fully rolled out at the upcoming Spending Review. To aid this, HMT should undertake the cost and benefits of these policies in conjunction with the Office for Budget Responsibility.

3.5.2 Follow-up proposals to bolster initial actions to drive long-term impact

In the medium term it will be important to build upon these three initial actions, further reorganising inputs to support a whole-of-government approach to health in a way which can be sustained over time. Below we set out a series of actions to achieve this, specifically centred around the three must-haves set out in section 3.1.

Common purpose

Action: Health Mission Board to proactively review policies across departments for health considerations and to drive cultural shift

Often other departments or parts of the public sector lack the knowledge, expertise or capacity to fully consider the potential health impacts of policies and actions (be those positive or negative). Health impact assessments (HIAs) have been suggested by many commentators as a way to try to address this. While they could have a role to play, on balance we believe that it

would be likely that if introduced they would come into play at the final stage of policy design and would become a tick-box exercise with limited relevance (which can sometimes happen with impact assessment approaches in HMG).

We recommend that part of the Health Improvement Delivery Unit's role should be to assess the health consequences of decisions, driving changes to policies as required, early in the process. It could act as a clearing house to enable faster more joined-up action in areas affecting health and/or help to make the broader case for action and investment where there is clear cross-societal benefit, but possibly not obvious benefit for a single actor within the system. For example, tackling homelessness or investing in increasing access to sports and fitness activity.

Specifically, expertise within the delivery unit can be used to evaluate policy proposals and decisions by collating evidence on the impact to facilitate knowledge-based decision making. The unit should proactively seek out and engage in policy design within departments to ensure health is considered at all stages of policy making. This could involve reviewing planned policies at an early stage to ensure they consider health outcomes, but it could also include driving policy formulation in areas outside of healthcare which they believe could have profound health benefits.

A step further could be to require policies which reach a certain threshold in terms of size (monetary value) or breadth (population impact) to be reviewed by the board for health impacts. Finally, we would recommend that any form of assessment conducted by the delivery unit or by the mission board has been informed by comprehensive engagement with place-based health and local government leaders, and that consideration is given to their publication as part of the transparency of the whole-of-government approach we are proposing.



Collaboration and place-based decision-making

Action: Increase local collaboration with joined-up priorities across ICBs and local authorities

Fundamentally, integrated care systems (ICS) were established to deliver more joined-up care to local populations.²⁴ Both the successes and complex challenges facing ICSs are well-covered, for example by the Hewitt Review. More information on ICSs and the Hewitt Review can be found in Annex B and C respectively.

One of the key challenges for a whole-of-government approach is the lack of collaboration, specifically the lack of incentives and support for different parts of the system to work together. This is particularly true when it comes to health and healthcare, not least because the system is complex across both national and local levels. If a whole-of-government approach to health has any hope of succeeding, it needs to address this issue.

Integrated care strategies, produced by each integrated care partnership, are a key mechanism for ICSs to deliver on improving population health and reducing inequalities.²⁵ However, full delivery of these strategies by ICBs and local authorities, in partnership with the third sector, is currently hampered by several factors. Common to both are the ever-increasing resource constraints. This necessitates prioritisation, making it impossible to deliver in all high-need areas. A related challenge, primarily for ICBs as highlighted in the Hewitt Review is the multitude of targets. Often, national and local priorities conflict and local priorities are frequently crowded out given accountability lines and top-down mandates. Consequently, when considering statutory aims, the aim should be to be direct but concise—focusing on fewer aims to have greater impact.

The government will need to work very closely with ICPs, which will play a key role in the work, health and wider prevention agendas. Recognising and supporting the role

of ICPs as part of the whole-of-government approach and development and implementation of the health improvement strategy will be critical to its success at local level. This is particularly true given the need to build on existing statutory duties and ensure delivery autonomy linked to local need. As ICPs further develop, including through the proposed National ICP Forum and via ongoing implementation of the recommendations of the Hewitt Review and the work of the NHS Confederation's ICS Network, the whole-of-government approach will need to be adapted to accommodate those developments to secure the longer-term objectives on health and work and the wider social determinants of health.

Despite their cross-cutting position, ICPs could be better supported to drive forward integrated, cross-system initiatives. The NHS Confederation is working with ICP members to develop proposals for what this may look like across areas such as resourcing and information. For example, on the latter, a whole-of-government approach requires authorities to access a dataset that acts as a 'single source of truth'. This does not currently exist but would help develop common purpose, identifying individuals and locations to prioritise for intervention to assist in either returning to work or preventing from leaving the workforce, collaboration and transparency around achieving shared outcomes.

Action: Embed best practice sharing across departments and governmental levels

When working collaboratively, especially in a novel way as is required for a whole-of-government approach, it is critical to be able to share best practices and learnings free from a culture of blame.

In Chapter 2 we set out the common barriers to shared learning. They centre on two things: not having the mechanisms to facilitate shared learning and not having the culture to do so. We must address these, at both local and central levels.



Building on the success of Government Digital Service (GDS) where lessons and pitfalls were openly shared, and a culture of trust and transparency was championed, central government could adopt a similar approach for whole-of-government working. It will be important to take the most effective components of those used for GDS and expand further. It should then be piloted and continually assessed to ensure it is achieving its aims effectively. Additionally, top-down leadership should be open and honest about their challenges and best practices, to encourage similar behaviour throughout the organisation. The delivery unit will be critical in setting the culture and expectations here. The unit's role should be to drive forward work while capturing challenges and disseminating lessons, without bias to the success stories only.

A similar cross-departmental mechanism needs to take place at local level, including further embedding of integrated care partnerships as the government's devolution plans for England take effect.

Joined-up funding and resources

Action: Leverage HMT review to address siloed and short-term funding approach

It is important that we do not pre-empt the findings of the HMT review that we have called for above. However, the approach to funding is consistently raised as a barrier to a whole-of-government approach. There should be a rethinking of the public investment model and the assumptions that underpin the funding approach to health policy. This will need to include a fresh approach to tackle two key issues. First, that funding is often too short-term which creates uncertainty, and second, that it is often rigidly siloed, which makes moving funding between priorities difficult and makes

sharing funding to jointly tackle problems very rare.

With that in mind, it is crucial to ensure a new system will include some key principles. These are:

- ensuring funding is flexible
- funding will be committed longer-term to allow for investments
- funding will be dynamic to re-allocate to priorities as required.

Furthermore, as it stands, performance and funding are not often explicitly linked. To ensure effective accountability, these two must be better interlinked.

We know that short-term funding for local services increases uncertainty and restricts capacity and service scope, potentially undermining effectiveness. Given the economic and fiscal context it is not realistic to propose a significant uplift in local authority or central government funding.

However, there are potential opportunities to better join-up funders and private sector organisations with delivery partners. For example, implementing shared funding models more widely, such as a Shared Investment Funds, could bring together local partners and funders, ensuring access to more sustainable funding.

Finally, whatever mechanism is chosen, it is important this is viewed as iterative. It is unlikely to be fully fit-for-purpose, solving all barriers, in its first version. However, as with many steps needed to establish a whole-of-government approach, it is important to take the first step and work towards a better way of working and delivery for the population.



With this in mind, it is important that the HMT review process becomes ingrained over the medium term, assessing and iterating funding models and specific funding streams. As it stands, the allocation of funding at the department level is almost entirely disconnected from the performance review process, while at the local level it is tied to a culture of bidding which benefits those best at managing the application process, not those in need or where spending has been effective.

Action: Health Improvement delivery unit to stipulate minimum level of data sharing, and generate additional data use cases to incentivise data sharing across departments

As noted in our analysis of the barriers to whole-of-government approaches, the lack of good quality integrated data is often a major obstacle to cross-government working. As it stands, there is no real incentive for different departments or parts of the system to share data with each other. Sharing data often requires cleaning and integrating it—which takes time and resource—often for little immediate benefit for a specific department if the use is for something beyond the immediate goals of the department or organisation.

The Health Mission Board, given its cross-governmental role, should mandate a minimum level of data sharing from all departments to aid the cross-cutting health mission. Data that will be most impactful and help deliver on cross-governmental working and outcomes should be prioritised. Ideally this would be held in a central repository, managed by the Health Improvement Delivery Unit. Every department that contributes their data, would also have access to data provided by other departments.

For example, the Ministry of Housing, Communities and Local Government and local

authorities will to some extent hold detailed data on housing and living conditions. As our analysis in section 1.4 demonstrated, this is one of the wider determinants of health that can have a significant impact on health outcomes. However, there is no incentive to curate this data in a way that is useful from a health perspective. They also do not necessarily have access to the health outcomes/impact data with which it must be combined to be most useful. There are countless examples of this across the system.

Data could also be used to create a realistic target or goal at ICS level for the number of inactive people that could feasibly transition into the workforce. Real-time data on key conditions driving inactivity such as mental health and MSK could be incorporated into metrics, which would allow ICSs to monitor progress and deploy resources most effectively. Instead of increasing targets from central government on ICSs, this should come from ICSs and central government together, to support a more flexible, tailored approach to tackling economic inactivity based on local need.

We could even go as far as allowing some budgetary flexibility to help aid and facilitate data sharing. In the example above, DHSC may see such value in the housing and living conditions data that it would be willing to fund the curation and cleaning of said data. Sufficiently flexible mechanisms should be put in place to allow this. This, combined with ensuring it is made clear that such collaboration is a priority and vital to delivering the cross-cutting health mission, can help to create clear incentives for better data sharing.

The delivery unit could play a role in identifying data that each department holds and establishing which aspects could be beneficial to other departments to improve policymaking and delivery of services.



3.6 Essential components of a whole-of-government approach to health

Bringing all this together we can see that there will be three key elements to a whole-of-government approach to health:

1. Drive action on the major complex health challenges facing the UK, with a clear common purpose on each.
2. Establish new mechanisms to drive collaboration and delivery across the system, with a central function to help ensure the bigger picture benefits are always kept in view.
3. Revamp the approach to funding to allow longer funding horizons and flexibility for necessary reallocations. Drive shared understanding about the best approach to maximising economic and social benefits of health spending.

3.7 Conclusion

It is clear no one area of government can meaningfully address the UK's complex health and inactivity challenges. The large and sustained rise in those economically inactive with ill health not only has negative impacts for those individuals but impacts their families, communities and the country as a whole. As we have outlined, there are significant social, fiscal and economic benefits to addressing the underlying drivers of economic inactivity due to health. However, a fundamentally different approach is needed if these are to be realised.

Government must work to join up all parts of the system, from delivery organisations to central departments. This can be achieved by instilling a common purpose—to address the rise in economic inactivity—in all stakeholders, and setting-out a clear long-term vision for achieving the end goal. There should be clear

accountability structures which empower place-based decision-making and incentivise collaboration and shared risk and rewards. Funding must be designed to allow for greater long-term certainty, with resources allocated based on delivering priority objectives. Our analysis of the social determinants of health highlights that economic and working conditions are among the strongest predictors of health outcomes, informing our choice of proposed policies. Additionally, targeting the rising levels of long-term sickness and inactivity among 18-24-year-olds is essential to prevent long-term disengagement from the workforce, reduction in income growth and declining productivity amongst this age group. If left unchecked, these effects can harm national economic prospects.

Overcoming the common barriers to effective cross-government will not come easily but as demonstrated through our international best practices, is possible, and can then be applied across all of the social determinants of health through the establishment of a Health Improvement Strategy.

Underpinning this is a deliberate shift from government to an outcomes-first approach. This is paramount for ensuring a WGA is implemented and policies and resources are designed and distributed for maximum impact. The UK must steer clear of seeking short-term solutions for long-term structural issues.

It is vital that the rise in economic inactivity and ill health is a top priority for government if the UK is to improve health outcomes and boost economic growth, enabling the government to address the wider social determinants of health with capacity for increased investment in turn.



Annex A: Work to Date on the Social Determinants of Health and Economic Inactivity

In 2015, the Joint Work and Health Unit was set up between Department for Work and Pensions and Department of Health and Social Care in recognition of the importance of employment as a wider determinant of health. In 2017, the Government published the paper 'Improving Lives - The Future of Work, Health and Disability'²⁶ following publication of the Taylor Review.²⁷

The Improving Lives paper sets out a plan for change, focusing on key measures involving employers, communities and review or revision of the health and welfare systems. They are likely to also form part of the Health Foundation Expert Panel review due to report in 2025.²⁸ However, they do not address the question of economic inactivity/unemployment from a whole-of-government perspective.

The government recognises the need for tailored work and health support to help people with health conditions and disabled people to remain in, return to and thrive in work. The Spring Budget and Autumn Statement 2023 saw a significant expansion in work and health support to tackle rising levels of economic inactivity due to long-term sickness.

Most recently the Joint Work and Health Directorate launched the WorkWell initiative, which provides £64 million to 15 integrated care boards (ICBs) in England to design local work and health support services. The pilots are intended to bring together local authorities, Jobcentres and other local partners to support individuals to manage their conditions and receive support that would enable them to stay in work or return sooner.

On Thursday 11 July 2024, Liz Kendall confirmed the government's commitment to its manifesto Back to Work Plan and said tackling economic inactivity is central to the government's number one mission of growing the economy.



There are three pillars to the government's Back to Work Plan:

- A new national jobs and career service to help get more people into work and on in their work—bringing together Jobcentre Plus and the national careers service.
- New work, health and skills plans for the economically inactive, led by mayors and local areas.
- A youth guarantee for all young people aged 18 to 21 that will mean opportunities for training, an apprenticeship or help to find work, to prevent young people becoming excluded from the world of work at a young age.

The government has also announced:

- A new Employment Rights Bill, which will update worker rights including banning zero-hour contracts and ensuring sick pay and parental leave are available from day one of employment
- A Skills England Bill to bring together businesses, providers, unions, mayoral combined authorities (MCAs) and national government to ensure we have the highly trained workforce that England needs
- An English Devolution Bill to deliver the government's manifesto commitment to transfer power out of Westminster and into our local communities, allowing them to take

back control and drive economic growth.

These announcements build on a range of work ongoing, or recently implemented, addressing the wider drivers of ill health, set out below. These may be continued or revised by the new government:

- A Call for Evidence on Fit Note reform and reforms to the Work Capability Assessment with the aim of improving the incentives and gateways into support.
- Improving support for people in Jobcentres (including disability employment advisors and additional work coach time for disabled people and people with health conditions). A new voluntary supported employment programme called Universal Support and employment advisers in NHS Talking Therapies. Support provided directly to individuals (including Access to Work grants) and support for employers to provide inclusive work environments (including the Disability Confident scheme and occupational health reform).
- The development of integrated care partnerships and the recommendations of the Hewitt Review. For more information on integrated care partnerships see **Annex B**.
- Devolution and Place (the Levelling Up White Paper).



Annex B: Background on Integrated Care Systems and Partnerships

Legally established in July 2022, ICSs cover England and build on existing partnerships across the country. ICSs have a clear focus on prevention, better outcomes and reducing health inequalities, with the aim of maximising citizen outcomes.

The 42 ICSs in England are local partnerships that bring health and care organisations together to develop shared plans and joined-up services. They are formed by NHS organisations and upper-tier local councils and also include the voluntary sector, social care providers and other partners with a role in improving local health and wellbeing. They aim to:

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- help the NHS support broader social and economic development.

The NHS organisations and upper-tier local authorities in each ICS run a joint committee called an integrated care partnership (ICP). This is a broad alliance of partners who all play a role in improving local health, care and wellbeing. They may also include social care providers, the voluntary, community and social enterprise sector and others with a role in improving health and wellbeing for local people such as education, housing, employment or police and fire services.

Each ICP must develop a long-term strategy to improve health and social care services and people's health and wellbeing in the area. They may also take on additional responsibilities, as agreed locally between the members.

Integrated care boards (ICBs) are NHS organisations responsible for planning health services for their local population. There is one ICB in each ICS area. They manage the NHS budget and work with local providers of NHS services, such as hospitals and GP practices, to agree a joint five-year plan which describes how the NHS will contribute to the ICP's integrated care strategy.



Upper-tier local authorities are responsible for social care and public health services in their ICS area, as well as other vital services that contribute to health and wellbeing such as housing, education, leisure and transport. They must have regard to the ICP's integrated care strategy when planning and making decisions.

ICSs have the flexibility to make their own decisions about how partners work together in their area. Most larger ICSs have a number of place-based partnerships that design and deliver integrated services for particular areas within the ICS. Like the ICP, they involve a wide range of people interested in improving health and care.

As ICPs continue to establish themselves in local areas, there is a key opportunity to ensure

structures can engage vertically with central government as part of a future cross-government agenda on health and economic inactivity.

The new government may potentially also approve proposals from the NHS Confederation to the Department of Health and Social Care linked to recommendations in the Hewitt Review for a national ICP Forum which would bring together the chairs of each of the 42 ICPs in England as a voice to government on future policy making across the social determinants of health.



Annex C: The Hewitt Review and the Levelling Up White Paper

1. The Hewitt Review

Commissioned in November 2022, the Hewitt Review set out to consider the oversight and governance of integrated care systems (ICSs). In its recommendations the review stated that:

- There is currently no cross-government, national equivalent of the wide partnership involved in an ICS. To enable successful integration in systems, parallel integration across Whitehall is needed. I recommend that the government leads and convenes a national mission for health improvement designed to change the national conversation about health, shifting the focus from simply treating illness to promoting health and wellbeing and supporting the public to be active partners in their own health. To underline its importance, this could be led personally by the prime minister.
- This new mission should be supported by appropriate cross-government arrangements, possibly including a revived Cabinet Committee that includes a senior minister from all relevant departments, as well as DHSC's Office for Health Improvement and Disparities, NHS England and the new Office for Local Government.
- An early priority should be the creation of a National Health Improvement Strategy, identifying priority areas and actions.
- These priorities should then be taken into account when setting the mandate for the NHS as well as developing NHS planning guidance and other material for systems.



2. The Levelling Up White Paper

The Levelling Up White Paper (LUWP) introduced the devolution framework and the four key principles that would guide future devolution discussions: effective leadership; sensible geography; flexibility; and appropriate accountability.

The level and scope of powers delegated by central government is specific to each devolution deal, with greater powers being devolved where there is a mayoralty. However, overall, there has been a significant scale of devolution to date of powers in relation to transport, infrastructure, housing and planning, as examples.

Until recently, there were ten areas with mayoral devolution in England: Greater London, West Midlands, Greater Manchester, Liverpool City Region, West Yorkshire, South Yorkshire, Cambridgeshire and Peterborough, Tees Valley, West of England and North of Tyne. Not all of these are metro mayors and each has a unique, negotiated, devolution settlement.

Mayoral devolution has now been extended to three new areas in 2024 following the local elections of 2 May: York and North Yorkshire, East Midlands and more of the North-East. It will be extended further in 2025 to Suffolk, Norfolk, Greater Lincolnshire and Hull and East Yorkshire. Additional non-mayoral devolution deals will go live in 2025 in Lancashire and Cornwall.

As stated in a recent NHS Confederation review of devolution,²⁹ there are a number of powers and budgets have been made available to most areas in devolution deals since 2014, with the most notable being:

- Investment funds: 30-year investment fund, equating annually to between £15 million and £38 million, that can be flexibly allocated to support local economic growth.
- Adult Education Budget (AEB): Funds education and training courses for adults aged 19 and over.
- Business support: 'Growth hubs' which help local businesses access services such as accountancy.
- Fiscal powers: In addition to the power to impose a precept on council tax bills, most combined authorities retain all business rate revenues collected in their area.
- Transport: Most devolution deals have included a multi-year transport investment budget. Going forward, the aim is eventually to replicate the simplified, consolidated funding settlement given to greater London.
- Planning and land use: Many combined authorities have the ability to create spatial plans for the use of land in their area (such as for infrastructure and housing).



Annex D: International and Domestic Best Practice Case Studies

1. Vision: Australia's National Disability Insurance Scheme

Successes from NDIS can to some extent be attributed to widespread buy-in to a shared vision at all levels from the Prime Minister to local operational staff.

Exhibit 19.1 – Vision Best Practice Case Study

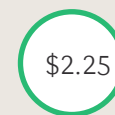
Australia: National Disability Insurance Scheme (NDIS)

Background

A cross-government approach to supporting individuals with a disability to gain independence, to access new skills or employment and to enjoy improved quality of life through policies in education, housing, justice and transport. From 2013, the NDIS introduced personalised support packages that afforded individuals greater autonomy over funding allocation across different services to best support their goals. Central government established funding policies and regulated providers, while local area coordinators (LACs) agreed individualised plans that leverage community services.

NDIS currently provides support to over 500,000 individuals with disabilities. The scheme, which has streamlined services and improved funding flexibility for a fairer system, is an example of widespread buy-in to a compelling vision.

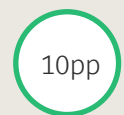
Outcomes



returned to economy per \$1 spent



↑ employment for participants aged 15-24



↑ parents and carers in employment (to >50%)

Best practice

- **Shared vision:** widespread buy-in to the vision from the PM to local delivery staff with a clear common purpose.
- **Thread of leadership:** strong leadership connections with empowered local leadership and a robust intergovernmental agreement between state and territorial levels.
- **Person-centred policy:** service users and those with lived experiences embedded into policy design.

Pitfalls

- **Ballooning costs:** costs at maturity were revised by ~2x.
- **Premature go-live:** programme was launched a year early before adequate workforce and digital architecture was in place.
- **Integrating policy:** poor integration with existing programmes resulted in complexities.
- **Change resistance:** concerns around integrating state and territorial services.

Learnings

The case for change is crucial for securing cultural motivation and investment. Aligning priorities at all levels of government reduces bureaucratic friction caused by competing priorities. Consultation with end users validates case for transformation and lends credibility to the common purpose.



2. Structure and Governance: Harm to Hope

The Harm to Hope programme is an example of how to design governance structures at the interface of central and local government to successfully drive collaboration across system levels.

Exhibit 19.2 – Structure and Governance Best Practice Case Study

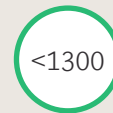
UK: Harm to Hope

Background

Established in 2021, in response to the Independent Review of Drugs, Harm to Hope is the UK government's 10-year plan to reduce prevalence of drugs misuse and bring down the cost to society of drugs.

Harm to Hope takes an integrated approach to tackling illegal drug-related illness and deaths by reducing drug demand, restricting supply and building recovery communities. A Combating Drugs Minister was appointed to deliver a WGA to tackling the growing impact of drug misuse, with a Joint Combatting Drugs Unit (JCDU) sitting across six departments (Home Office, MoJ, DWP, DLUHC and DoE). The strategy and JCDU is an example of how to design and implement robust governance structures to facilitate cross-government working.

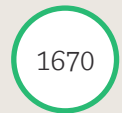
Outcomes



Country lines closed



Drug tests on arrest



Additional drug and alcohol treatment staff

Best practice

- **Strong accountability:** dedicated minister reporting directly into the PM.
- **Collaboration across departments:** cross-governmental delivery unit, whose progress is assessed by ability to deliver cross-cutting work through an outcomes framework.
- **Devolved decision-making:** strong local leadership, empowered to make place-based decisions and deploy funding as local context.

Pitfalls

- **Fragmented funding streams:** multiple funding streams with duplicate administrative requirements and different reporting mechanisms. Uncertainty of long-term strategy funding incentivising short-term actions over longer-term strategic investments.
- **Workforce planning:** slow to publish workforce strategy, regular retendering for services causing job insecurity and challenges recruiting and retaining staff.

Learnings

Empowered senior leadership and Prime Minister sponsorship with clear lines of accountability and responsibility across each level. A delivery unit whose performance is evaluated on their ability to drive forward cross-governmental work and an outcomes framework that drives accountability and ensures clear direction for work.



3. Funding, Investment and Planning: Green New Deal

The Green New Deal (GND) is an example of dynamic funding that allows for investment in long-term strategic work.

Exhibit 19.3 – Funding, Investment and Planning Best Practice Case Study

South Korea: Green New Deal

Background

The Green New Deal was launched in 2020 as one pillar of a wider Korean New Deal (KND), which addressed the social and economic impact of the pandemic (24% decline in export industries, ~400,000 job losses), whilst mitigating environmental cost (as the 7th largest CO2 emitting nation). Evolved from the 2008 Green Growth Policy the cross-government vision of the Green, Digital and Human New Deals focusses on forging a sustainable path for economic growth. The deals aimed to create 340,000 new jobs in low carbon and digital industries and grow GDO by 49 trillion KRW within two years.

The Green New Deal is a large stimulus package to boost the country's economic and post-pandemic recovery and is an example of how funding streams can be designed to achieve ambitious and sustainable transformation, tackling broader challenges.

Outcomes



Growth in number of companies with NRE technologies



Growth in number of employees in NRE sectors



Tonne reduction in GG emissions (2010-11)

Best practice

- **Protected funding streams:** investment for long-term strategic work kept separate from short-term work.
- **Diversified funding:** allocation linked to job creation targets with a focus on attracting private investment to increase impact.
- **Leveraged existing initiatives:** Built on rather than replaced the previous green growth strategy, meaning that individuals who had invested effort were not disengaged by another round of change.

Pitfalls

- **Lack of bipartisan support:** Leaves the work vulnerable to political cycles, undermining long-term potential.
- **Poor public confidence:** critics believe economic priorities overshadow environmental concerns and the focus is on increasing quantity but not quality of jobs.
- **Monitoring and Evaluation impact:** insufficient research into impact failed to validate targets, with little evidence of impact on job creation.

Learnings

Establishing clear, separate funding streams for different types of work meant 'quick-wins' were not prioritised over longer-term work. A more financially sustainable funding model also provided additional financial certainty.



4. Resources, Capabilities and Technology: US President's Emergency Plan for AIDS Relief (PEPFAR)

PEPFAR successfully used digital systems and prioritised workforce planning, identifying then addressing gaps in local capabilities.

Exhibit 19.4 – Resources, Capabilities and Technology Best Practice Case Study

USA: U.S. Presidents Emergency Plan for AIDS Relief (PEPFAR)

Background

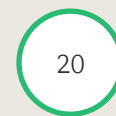
Since its inception in 2003, PEPFAR is the largest commitment by any nation to address a single disease in history. PEPFAR is a WGA established to optimise the impact and cost-effectiveness of global health initiatives by promoting collaboration between 15 government agencies. Originally set-up with a five-year timescale and \$1bn of budget, the programme has been reauthorised every five years since with \$100bn in funding to date. PEPFAR is funding treatment/prevention programmes, building local healthcare capacity and monitoring impacts. It is overseen by USAID and implemented by DoHealth and Human Services, DoCommerce, DoDefence, DoLabour, treasury and Peace Corps.

Operating in countries with stretched resources has forced PEPFAR to develop a strategy for identifying and addressing capability and technology gaps to maximise the impact of aid.

Outcomes



Lives saved



People received life-saving therapy



People accessed HIV testing

Best practice

- **Long-term resource sustainability:** focus on building local capabilities to ensure long-term sustainability, with funding contingent on gradual increases in host country responsibility.
- **Data sharing:** developed a platform for interagency data exchange to share analysis techniques and make data-driven decisions. Able to flex priorities and funding based on emerging real-time data.

Pitfalls

- **Cultural and social considerations:** programme mandated 1/3 prevention spending on faith-based or abstinence-until-marriage campaigns, with limited groups able to benefit. Policies did not always align with target countries' cultural norms or existing public health strategies.
- **Layers of bureaucracy:** complex drug approval processes, which prevents PEPFAR from delivering more cost-effective generic drugs.

Learnings

Supporting and empowering local partners to tackle ongoing, or wider, challenges increases the potential impact and sustainability of investment. The ability to share data in a timely manner promotes collaborative and evidence-based decision making and allows early identification of unintended consequences.



5. Culture: UK Government Digital Services (GDS)

The UK GDS succeeded in instituting a culture change by embedding long-term digital skills within departments and helping to ensure the spread of best practice.

Exhibit 19.5 – Culture Best Practice Case Study

UK: Government Digital Services (GDS)

Background

GDS is a government unit within the Cabinet Office formed in 2011 responsible for digitising many government services. Centralising digital government services presented a huge cultural shift from siloed operations to shared development and ownership of digital infrastructure, with Mike Bracken (former GDS Executive Director) declaring “all of our successes have been a direct result of collaboration”.

The digital transformation of over 2,000 government services addressed the fragmentation of user experience, human and financial costs of duplicated work and challenges to inter-departmental data exchange. GDS pioneered "Government as a Platform": a bank of core digital infrastructure from which government departments build their own systems, reducing costs and allowing departments to focus on tailoring services.

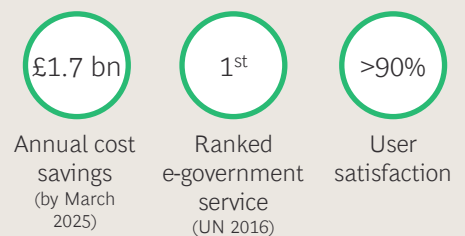
Best practice

- **Shared learnings:** sharing lessons, pitfalls and mistakes heavily encouraged with a culture of learning and data exchange.
- **Transparency:** committed to embedding “trust, transparency and equity” by publishing performance data for digital services and providing open access to source code.
- **Collaboration:** representatives from every government department and devolved administration, culture of 'looking sideways' to break down silos.

Learnings

Establishing collaborative platforms fosters a culture of cross-government working and encourages staff to innovate and share challenges. It also supports departments to navigate barriers more quickly, avoiding bad practices and common pitfalls. People at all levels of an organisation are encouraged to contribute and share learnings with trust between system levels.

Outcomes



Pitfalls

- **Cultural barriers:** concerns around digital transformation taking power from leaders led to a culture of hesitance at first.
- **Digital skills:** continued difficulties recruiting and retaining digital and technical skills, with strategies focusing on resourcing during initial implementation with a lack of long-term certainty.
- **Resilience to leadership changes:** success was heavily reliant on individual leaders.



Methodologies and Supplementary Analysis

Economic and Fiscal Impact Calculations

Overview

Our calculations aim to estimate the potential impact of reducing long-term sick inactivity, focusing on demonstrating the 'size of the prize' rather than savings derived from specific policies. We are not implying that the estimated benefits will be easy or guaranteed to realise.

We estimate two primary streams of impact:

- **Fiscal impact:** Potential savings or additional funds for HM Treasury, such as increased income tax receipts or reduced benefits expenditure.
- **Economic impact:** Additional Gross Domestic Product (GDP) that could be generated or sustained within the UK economy from people returning to the workforce.

Each stream's calculation is broadly divided into two key components:

- estimating the total number of individuals affected by efforts to reduce long-term sick inactivity.
- estimating the per-person fiscal and economic value.

We calculate these impacts for three age groups (16-24, 25-49 and 50-64 years) over the next five years, aligning with the new parliament's term.

The following sections provide detailed information on the approaches and assumptions used.



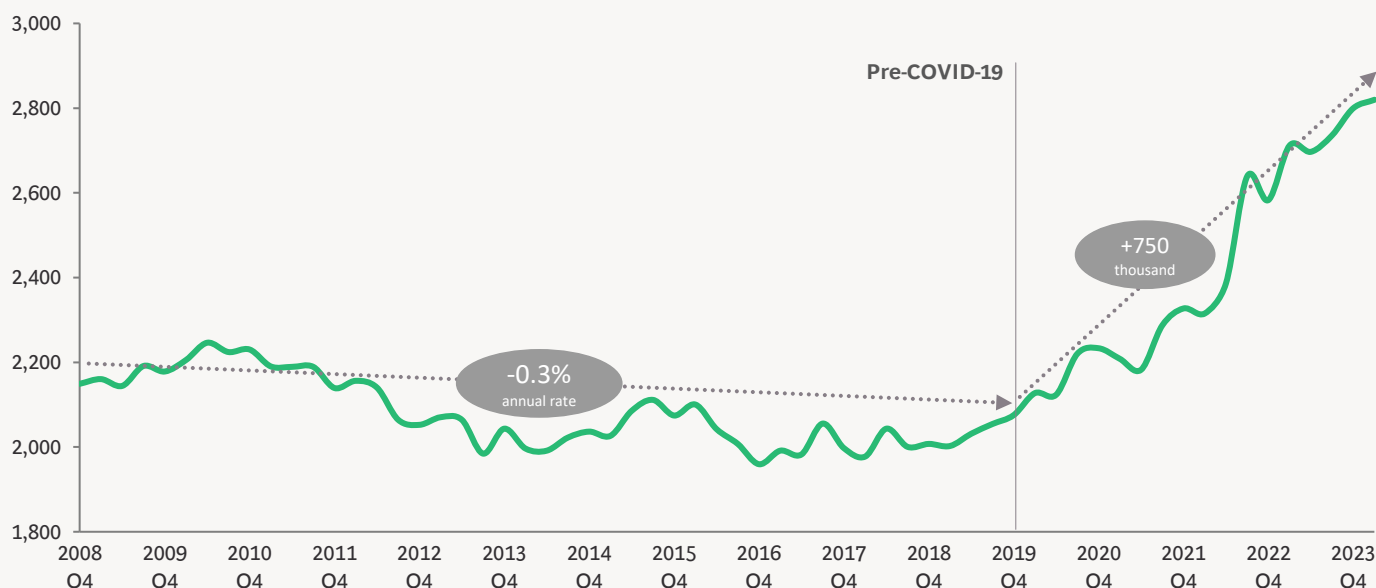
Individuals affected by efforts to reduce long-term sick inactivity

Addressing the total stock of 2.8 million long-term sick inactive is unrealistic, as the population inevitably has an inherent 'steady-state' share of those unable to work due to long-term illness or disability. Furthermore, the longer someone is out of the workforce, the less likely they are to be reintegrated. Indeed, in the five years prior to the COVID-19 pandemic, the population of long-term sick inactive remained relatively stable at around two million, with short-term inflows and outflows cancelling each other out. Therefore our focus is on two key outcomes post-COVID-19:

- **Reintegration:** The number of long-term sick inactive individuals increased by approximately 0.75 million post-COVID-19. We estimate the impact of returning a share of these individuals to the labour force.
- **Prevention:** Net inflows to the long-term sick inactive population have continued to grow post-pandemic. We estimate the impact of reverting the growth rate of net inflows to pre-COVID-19 levels (0%).

Supplementary Exhibit 1 – COVID-19 Reversed a Flat Trend in Long-Term Sick Inactivity, With the Number Growing by 750,000 Since Q4 2019

long-term sick inactive (thousands, Q4'08 - Q1'24)



Sources: BCG analysis of ONS data.

Notes: Reported pre-COVID-19 annual rate of -0.3% calculated as CAGR between Q4 2019 and Q4 2008; reported post-COVID-19 change of 750K in long-term sick inactive calculated as change between Q1 2024 and Q4 2019.

Reintegration

Reintegration efforts will have a sustained fiscal and economic impact, but not everyone who became long-term sick inactive post-COVID-19 is a candidate for reintegration. Using ONS data,³⁰ we categorise long-term sick individuals (since 2019) by their previous labour force status and assess their potential for reintegration:

- 1. Low case (300,000 people):** Those coming from employment, unemployment or temporary sickness. These groups are considered the most addressable for reintegration because the former two come directly from the labour force and for the 'temporarily sick' inactive health is the primary blocker for employment (which we are suggesting to address).
- 2. Mid case (450,000):** Includes the low case groups plus prior students and working age retirees. The transition from student or retirement status may indicate they are no longer inactive for those previous reasons and are instead inactive due to ill health. This suggests that if their health improves, they could return to the workforce if they wish.
- 3. High case (600,000):** Includes the mid case groups, plus those coming from caring responsibilities. As with the others, given long-term sickness is now seen as their primary reason for being out of the workforce, improving their health would remove one barrier to labour force participation. Additionally, resolving the health issues of those they care for could reduce caring responsibilities, enabling them to pursue employment that was previously not possible.

For our detailed calculations and estimates we split the overall long-term sick inactive into the three age groups outlined above, making assumptions as to the age split for net inflows.^{31, xi}

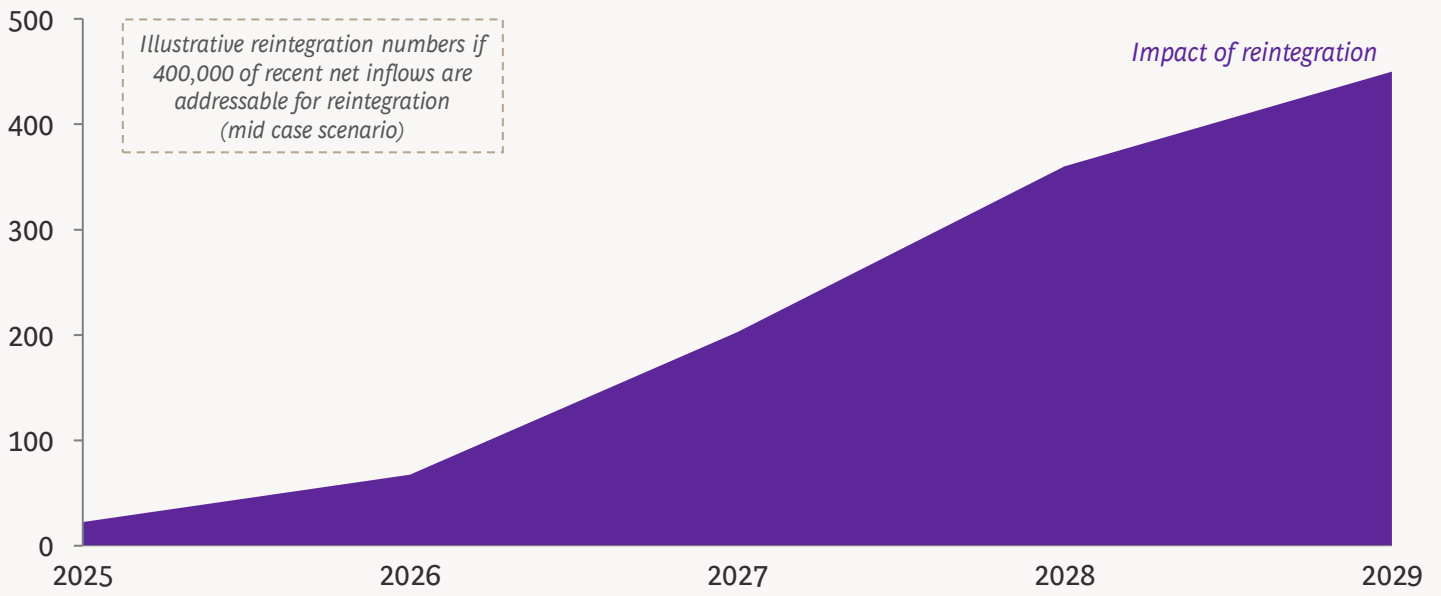
For all three cases/scenarios we outline, we recognise the return to work is unlikely to happen uniformly or immediately. Instead, to highlight the potential benefit of reintegrating these people, we make a stylised assumption based on how policy measures often see take-up and impact. This produces the assumption that efforts to reintegrate the addressable population into the labour force will realise their impact across the next five years following an S-curve with acceleration around 2027.

xi. Our analysis of published ONS data and unpublished ONS LFS data indicates marginal changes in the age structure of the long-term sick inactive population since 2019, with a slight increase in the 16-24 age group (contributing 9.3% of the total in 2023 vs. 8.3% in 2019) due to recent growth within this population. For our calculation, we apply the age split for net inflows as follows: 10% for ages 16-24, 36% for ages 25-49 and 54% for ages 50-64. This may be a slightly conservative assumption given the possible overweight towards the 16-24 age group.



Supplementary Exhibit 2 – Reintegration Will Aim to Return Addressable Share of Long-Term Sick Inactive Into Labour Force Across Next Five Years

long-term sick inactive returning to labour force (thousands)



Sources: BCG analysis; S-curve assumption based on "Digital Efficiency Report", UK Cabinet Office and Central Digital & Data Office, Nov '12.

We base our S-curve assumption on the HMG analysis of 17 cases of the take-up of digitised transactional services³² in the context of building the UK's Government Digital Service (GDS) initiative. While the underlying topic of these case studies differs from the topic of inactivity, GDS represents one of the most successful examples of a cross-government effort to drive change. As discussed in the interim report, potential efforts to reduce inactivity will require a similar concerted whole-of-government effort; therefore, we consider a similar stylised S-curve realisation of impact in our assumptions.

Here we are not making a forecast or projection of what we expect to happen or what certain policies would lead to. We are producing a stylised scenario to help estimate the potential size of the impact over the course of the next parliament.



Prevention

Preventing individuals from leaving the workforce maintains their economic and fiscal contributions.

To calculate the number of people impacted in this category, we first established a baseline scenario for the growth rates of long-term sick inactivity over the next five years. As a proxy, we used the Institute of Fiscal Studies' (IFS)^{33, xii} five-year forecast for incapacity benefits caseload, given historically strong correlation with long-term sickness. We also did a cross check against recent forecasts for long-term sickness from the OBR and Resolution Foundation.

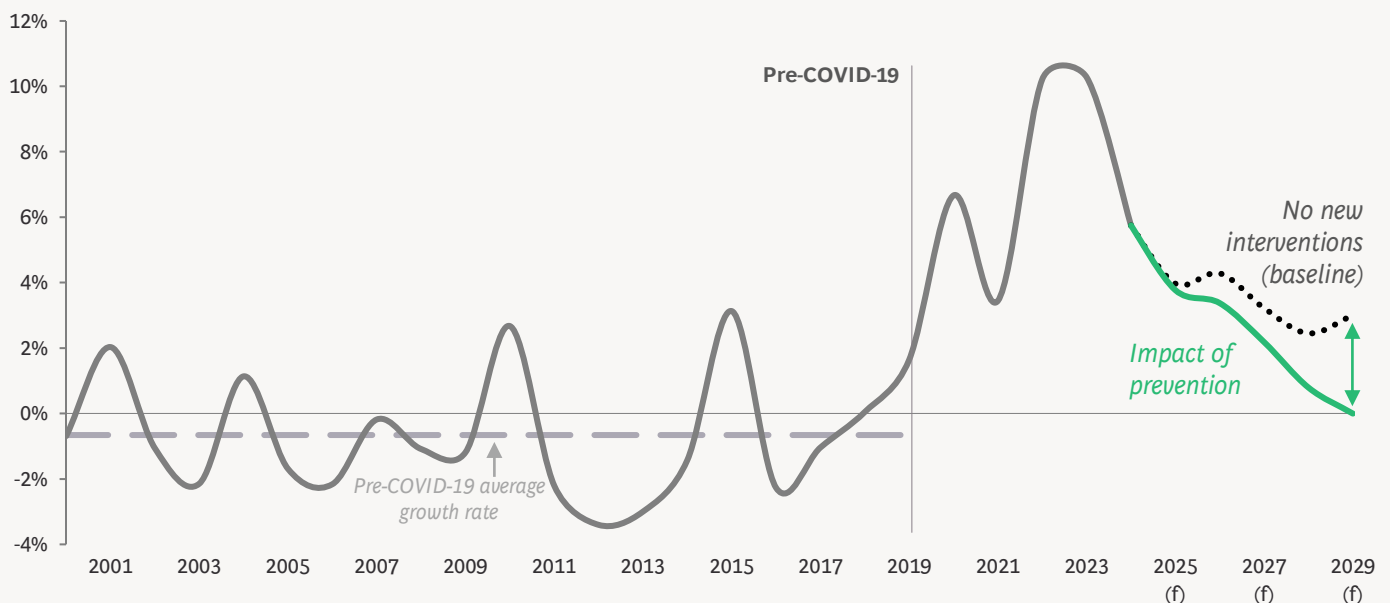
We set a corresponding five-year target where

interventions aimed at prevention achieve the pre-COVID-19 0% growth rate by 2029. Again, we paced the gradual reduction of growth rates according to an S-shaped curve, with acceleration of impact around 2027.

To calculate the impact, we determined the difference in growth rates between the baseline prevention scenarios. We then applied this growth rate delta to the long-term sick inactive population at the start of each year, for each age group. To obtain the long-term sick inactive figures for each year, we created a flow model that consecutively calculates inflows (based on growth rates with prevention) and outflows (based on reintegration assumptions) for each year.

Supplementary Exhibit 3 – Prevention Will Focus on Gradually Reducing Net Inflow of Active Population Into Long-Term Sick Inactivity

Growth rate for long-term sick inactive population (% , 2000-2029)



Sources: BCG analysis of ONS and IFS data.

Notes: 2024 long-term sick growth rate assumed equal to IFS forecasted growth rate of Incapacity Benefits for 2023-24 vs 2022-23; baseline scenario follows IFS forecasted yearly growth rates for subsequent years (2024-25 – 2028-29); pre-COVID-19 average growth rate defined as 20-year CAGR (1999-2019) for number of long-term sick inactive.

xii. Assumed identical growth curve for 25-49 long-term sick inactive population, adjusting by +2.0pp for the 18-24 population and -0.5pp for the 50-64 population. Our analysis of unpublished ONS LFS data indicates that the population of long-term sick inactive aged 16-24 has been growing substantially faster at 7.1% CAGR ('23 vs. '19), as compared to those aged 25-49, growing at 3.2% CAGR ('23 vs '19).



We assumed that the per-person fiscal and economic impact for those reintegrated and for those prevented from leaving the labour force is the same, hence we refer to the impact of 'returning to the labour force' (and see this as equivalent to the impact of being 'prevented from leaving the labour force').

Fiscal impact

We estimate the direct and secondary fiscal impacts of returning long-term sick inactive individuals to the workforce:

Direct fiscal impact

- **Increased receipts of income tax and national insurance contributions:** those returning to work will be taxed on their income.
- **Reduced benefits spending:** returning to work reduces eligibility for Universal Credit (UC) and Personal Independence Payment.
- **Reduced healthcare spending:** improving health tends to lower healthcare costs.

Secondary fiscal impact

- **Increased receipts of corporate tax:** additional economic value generated by employment likely increases corporate tax revenue.
- **Increased receipts of VAT/sales tax:** increased income tends to lead to higher consumption and VAT receipts.

Below, we outline our calculation approach and the mid case assumptions used for each component.

Increased receipts of income tax and

national insurance contributions

We calculate income tax receipts by multiplying an assumed salary by the effective tax rate, which includes both income tax and National Insurance contributions. The calculation varies by age groups and employment type (full-time or part-time).

Depending on the age group, we assume that 70-80% of individuals will return to full-time employment and that total annual income ranges from £27,500 to £36,500 for full-time workers and £9,000 to £13,500 for part-time workers, in line with national averages.³⁴ Accordingly, the effective tax rate for full-time workers is 15-18% and 0-2% for part-time workers.³⁵ We assume that workers will return at full capacity, working hours in line with national averages.

We estimated an average annual per-person fiscal gain of approximately £4,650, comparable to the Office for Budget Responsibility (OBR) estimate³⁶ of £5,222 per-person tax loss due to lower employment of long-term sick.

Reduced benefits spending

We split the calculation into changes in spending on Universal Credit (UC) and Personal Independence Payment (PIP).



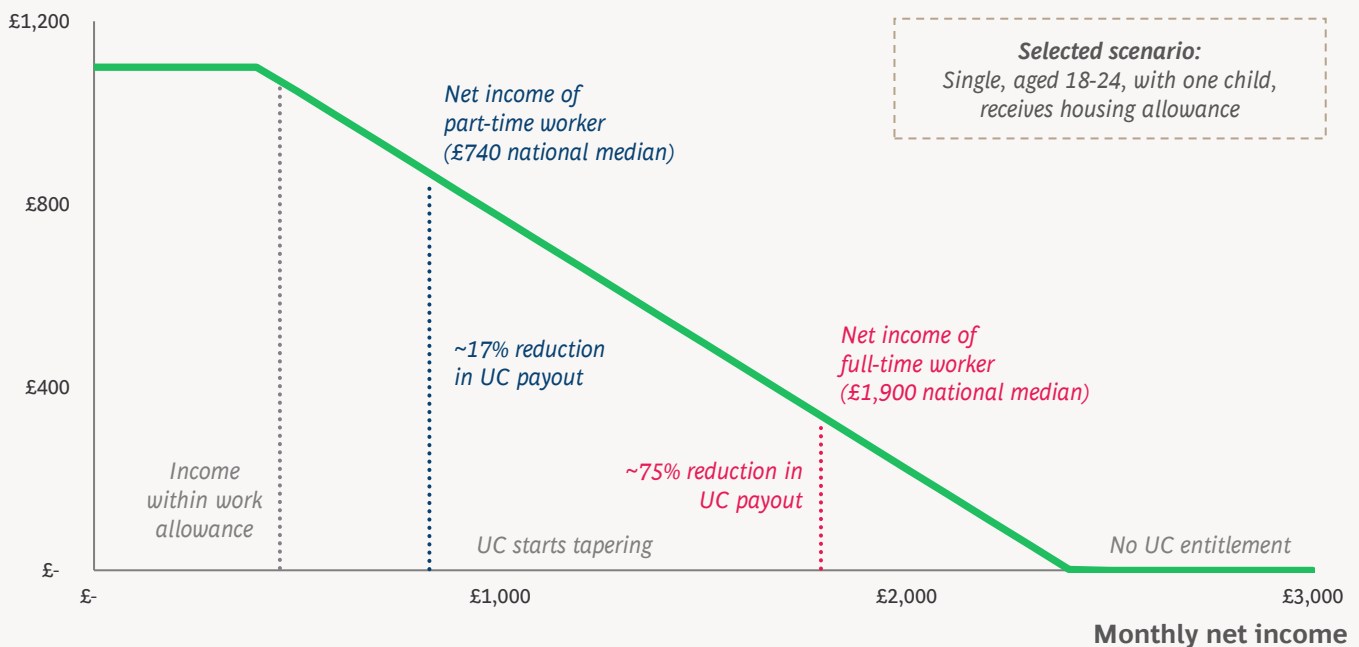
Universal Credit (UC)

Based on the Office for Budget Responsibility (OBR) analysis,³⁷ we assume 82% of the long-term sick inactive population receive UC benefits. Returning to work will impact UC recipients in two ways. Firstly, we anticipate that all employed individuals will subsequently lose eligibility for the 'Limited Capability for Work and Work-Related Activity' component of UC, as they will demonstrate work capacity by engaging in employment. Secondly, receipt of income will trigger the tapering of payouts for other UC components (basic allowance, housing allowance and children allowance) at a rate of -£0.55 for every extra £1 of income, once income surpasses the work allowance threshold.^{38, 39}

In practice, claimants receive different combinations of UC components and have different applicable work allowance thresholds, leading to varying levels of impact if they return to employment. We separately calculated specific scenarios (for example, a single person aged 18-24, receiving housing benefits and allowance for two children, returning to full-time work) to calculate impact outcomes. To aggregate these into a final, per-person, impact number for each age group, we averaged the scenario results, weighting them by implied scenario probabilities based on Department for Work and Pensions (DWP) Stat-Xplore data.^{40, xiii}

Supplementary Exhibit 4 – Prevention Will Focus on Gradually Reducing Net Inflow of Active Population Into Long-Term Sick Inactivity

Monthly Universal Credit (UC) payout



Sources: BCG analysis based on the official Universal Credit guidance and Turn2us calculator simulations.

Note: Calculations assume that an individual does not receive "Limited Capability for Work and Work Related Activity" (LCWRA) Universal Credit component as their return to work demonstrates work capacity.

xiii. We use the national proportions for all households on UC as a proxy for assumptions on the prevalence of characteristics within the long-term inactive category. The assumptions are as follows: single person (83% of households with UC), receiving housing allowance (64%), with one child (19%) or two children (29%). Opposite categories are calculated as the remaining share of 100%, for example, couple household (17%). Assumed prevalences are multiplied to calculate the joint prevalence for a specific scenario.



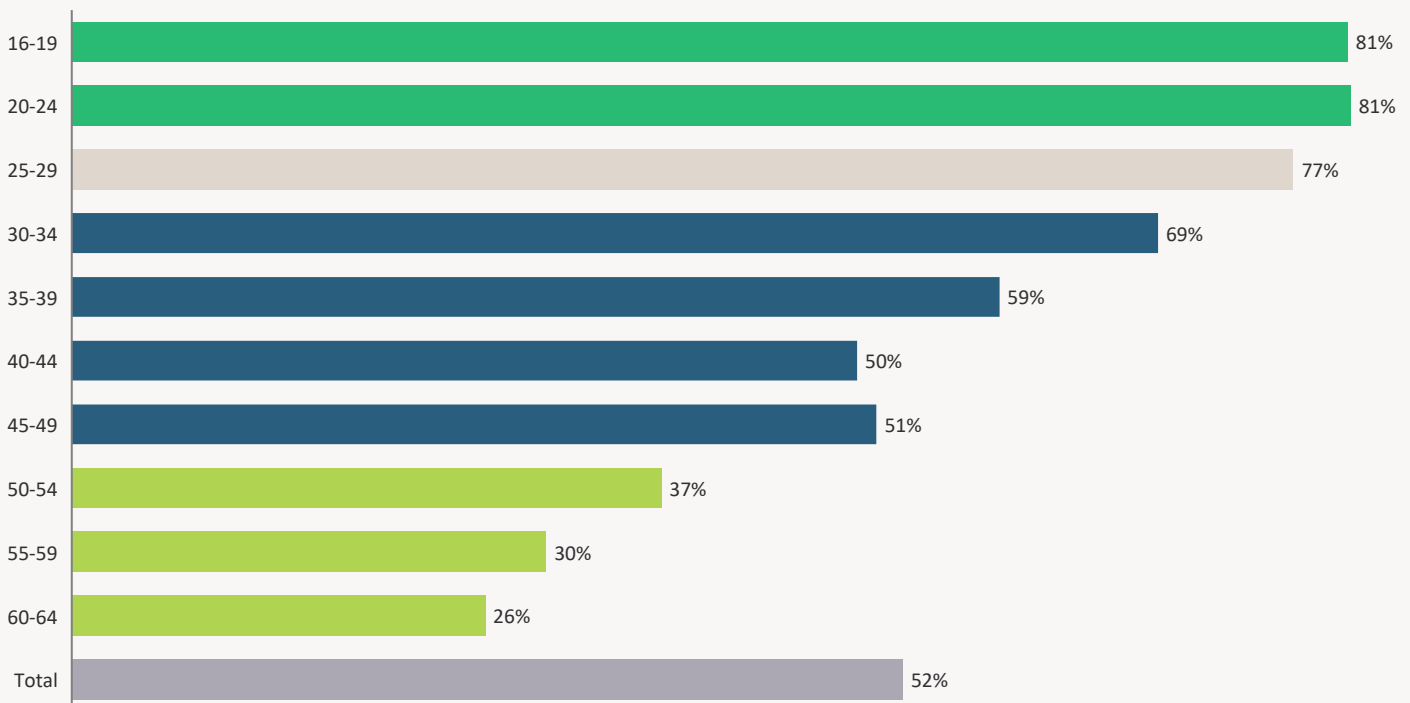
Personal Independence Payment (PIP)

Similarly, based on the OBR analysis,⁴¹ we assume that around 63% of the long-term sick inactive population receive PIP benefits, at an annual per-person cost of £6,890.

Based on DWP Stat-Xplore data,⁴² psychiatric conditions contributed to 81% of the net increase in PIP caseloads (Jan '24 vs. Nov '19) for claimants aged 16-24, 61% for those aged 25-49 and 30% for those aged 50-64.

Supplementary Exhibit 5 – Over Half of Post-COVID Net Inflows to PIP Caseloads Are From People With Psychiatric Disabilities

Net inflows to PIP caseloads with main disability being psychiatric, by age group (% of total net inflows to PIP, Nov-19 vs. Jan-24)



Sources: BCG analysis of DWP Stat-Xplore data ("PIP Cases with Entitlement", Table "PIP 2 – Caseload by Main Disability").

We assumed that for PIP claimants whose main condition is non-psychiatric, returning to work would be unlikely to remove their PIP benefits. For PIP claimants whose main condition is psychiatric, we assume that the right treatment regime could significantly improve their condition and therefore remove eligibility for PIP. While this is a somewhat simplistic assumption,

we lack detailed data to make a more nuanced one at this stage. There is no doubt that there are a range of complex psychiatric conditions which will be incredibly difficult to treat. It is thought more likely that very few of these are captured in our target population here, since we are focused on the recent move of those into long-term sick in the past few years.



Reduced healthcare spending

We estimate average annual savings in healthcare costs to be £1,850 per person, based on a reduction in treatment costs as individuals return to work and improve their health. This is as per OBR⁴³ estimates of the average annual cost of providing care for an economically active person without health problems and our mid case assumption that treatment costs for long-term sick individuals is 100% greater than for those in work.

Increased receipts of corporate tax

We employ a macro-level approach to estimate the additional corporate tax revenue that could be generated from increased employment. Using data from the HMT Red Book 2024,⁴⁴ we calculate the tax-to-GDP ratio for each tax component, specifically 4.4 per cent for corporate tax. On the scale of the overall economy, we do not expect the potential reversal of post-COVID-19 long-term sick inactivity outcomes to fundamentally change the tax structure. Therefore, we assume that a similar tax-to-GDP ratio would apply to any new economic output generated.

This approach follows and builds upon the methodology introduced by the Department for Work and Pensions (DWP)⁴⁵ and updated by Oxera⁴⁶ to estimate the foregone exchequer tax flowbacks due to health-related worklessness. These publications similarly estimate the flowback rate for in-scope taxes as a percentage of GDP based on the Red Book. While we chose to perform a bottom-up granular calculation for income tax and national insurance, we employ the same approach for corporate tax and VAT/sales tax as outlined in Section 3.5.

Based on our estimates of economic impact, which we discuss in detail below, we project an annual per-person economic impact of £70,000-£84,500, depending on the age group. We then apply the corporate tax-to-GDP ratio of 4.4% to these estimates to calculate the potential corporate tax revenue.



Increased receipts of VAT/sales tax

Using data from the HMT Red Book 2024,⁴⁷ we calculated a VAT-to-GDP ratio of 8.9%, which we applied to our economic impact estimates.

This approach may overestimate the impact, due to the marginal nature of changes in take-home income for those returning to work from inactivity. Specifically, individuals receiving UC and/or PIP already gain some disposable income from benefits. Their employment will replace part or all of this income and may add some extra disposable income. The potential change in consumption for these individuals will be driven by the additional disposable income on top of the benefits they were receiving. Therefore, the total increase in economic output for an individual may not proportionally correspond to an increase in their consumption, leading to a smaller potential increase in VAT/sales tax receipts.

However, considering the redistribution of funds within the economy, one might argue that replacing benefits with income still frees up those funds to be spent in another way which benefits national income. This could be through tax cuts, meaning the wider population have more money to spend on consumption, or through other government spending which could aid consumption. While the effect is unlikely to be 1:1, in aggregate, this could still lead to higher overall consumption. This suggests that the overestimation from using the VAT-to-GDP ratio might not be significant.

The logic behind the redistribution of welfare funds also underpins our assumption concerning overall fiscal gains can be channelled by HM Treasury into additional spending on public services and public investment, thereby generating further economic impact. Specifically, we exclude the fiscal gains from reduced spending on benefits from our calculations of the economic benefits of fiscal reinvestment because we assume redistribution.

Economic impact

Our estimation of economic impact is driven by three factors:

- **Increased economic output:** Direct output generated by those returning to employment.
- **Secondary impact of increased economic output:** Additional inputs from adjacent sectors can spur further output.
- **Economic gain from fiscal reinvestment:** Fiscal gains can be reinvested by HM Treasury into public services, public investment, welfare and/or tax cuts.

Below, we outline the approach to calculation and the key assumptions for each factor.



Increased economic output

We calculate economic output as total yearly Gross Value Added (GVA) by multiplying assumed per-hour productivity, number of hours worked weekly and number of working weeks annually. Depending on the age group, we assume that 70-80% of individuals will return to full-time employment and that all individuals will work 45 weeks a year.^{xiv} We assume that full-time workers work around 27.5 hours per week and have per-hour productivity of £37 in line with the national average.⁴⁸ We assume part-time workers work around 16-20 hours per week (depending on age), and output have per-hour productivity of £24, which is the average for the 'administrative and support services' sector. These assumptions are applied to the addressable population aged 25-49. We adjusted the assumptions by -20% for those aged 18-24^{xv} and by -5%^{xvi} for those aged 50-64.

Secondary impact of increased economic output

The ONS produces analytical 'input-output' tables⁴⁹ to model the relationships between different industries and how increased outputs in one industry impact production in another. Specifically, the ONS provides estimates of Type I multipliers, which are the ratios of 'direct' impact to total impact ('direct' + 'indirect'). We applied ONS estimates for the Type I multiplier for GVA to the size of the 'direct' impacts estimated, to calculate the corresponding 'indirect' impacts.

As long-term sick inactive individuals return to work across a range of industries, we needed to create an aggregated version of the ONS multipliers to account for this diversity. We computed the average multiplier weighted by the corresponding share of GVA that each industry contributes to the total GVA of the economy.⁵⁰ This calculation resulted in a

multiplier of 1.64, meaning that, on average, an additional £1 of direct GVA output leads to an additional £0.64 of indirect GVA output.

Economic gain from fiscal reinvestment

An established approach exists for estimating the economic benefits of fiscal reinvestment, involving the concept of the 'fiscal multiplier.'^{xvii} This multiplier indicates how an additional £1 of fiscal spending can lead to an economic gain of £x. The size of this effect depends on the type of fiscal spending, such as spending on public investments (known as CDEL), public services (RDEL), welfare spending (AME), or tax cuts. Additionally, the economic effect of fiscal spending is not concentrated within a single year but is typically estimated to have a persistent, though gradually declining, impact over several years.

The Office for Budget Responsibility (OBR) periodically produces estimates of fiscal multipliers for the UK economy; we leveraged the latest OBR release⁵¹ from November 2023 in our calculations. When reinvesting the fiscal gain, we assume that HM Treasury will follow the current distribution between public spending types: CDEL (8%), RDEL (35%) and AME (57%).⁵² Later on, we illustrate how the calculation would change if HM Treasury were to reinvest fiscal gains 100% into RDEL or 100% into AME instead.

As discussed, it is critical to distinguish between fiscal gains that are generating net additional impact. As such, we do not use fiscal gains attributable to reduced spend on benefits and healthcare—these funds are already part of the spend and will be redistributed accordingly. Our average per-person fiscal gain relevant for fiscal multiplier calculation is around £15,000.

xiv. (260 calendar weekday work days – 8 bank holidays – 28 statutory time-off) / 5 days a week.

xv. We based this assumption on the corresponding difference of approximately 20% in salaries for those aged 18-24 as compared to those aged 25-49.

xvi. Various sources indicate different views on the impact of age on productivity, with the IMF suggesting potential declines ([Why Productivity Growth is Faltering in Aging Europe and Japan](#)), while Age UK ([Productivity and age](#)) suggest a lack of relationship between productivity and age. We assumed a more conservative, marginal decrease in productivity of -5% as compared to population aged 25-49.

xvii. The IMF ([Fiscal Multipliers: Size, Determinants and Use in Macroeconomic Projections](#)) and various OBR publications ([Fiscal multipliers Box Sets](#)) provide helpful context on the method and its application.



Our calculation of the total fiscal multiplier effect combines the relevant per-person fiscal gain, the five-year fiscal multiplier curve and the cumulative number of people impacted. We assume that each year, HM Treasury will continue to reinvest fiscal gains from the corresponding period. We only present the impact to 2029, but these reinvestments will continue to make an impact beyond 2029.

Variation of assumptions for fiscal/economic impact factors

We stress-test our estimates by holding the addressable population constant at the mid case scenario (450,000), but varying underlying assumptions on economic and fiscal impact factors. The tables below illustrate resulting changes to the total five-year fiscal and economic impacts.

Supplementary Exhibit 6 – Accounting for Possible Variations in Assumptions, Estimates of Fiscal Impact Could Range Within 10–15% of the Reported Figures

Factor of impact	Key assumption (mid case)	Total fiscal impact across 5 years (£ billion)		
		Low case	Mid case	High case
1. ↑ receipts of income tax and NI contribution	75% return to full-time work, rest – to part-time work	☆ 42.2 (65% full-time)	45.6 (75%, national avg)	☆ 49.1 (85% full-time)
	Return to national median salary	44.7 (5% lower)	45.6 (national median)	46.4 (5% higher)
2. ↓ spend on benefits	82% of LT sick inactive receive Universal Credit	44.6 (77%)	45.6 (82%, OBR est)	46.7 (87%)
3. ↓ spend on healthcare	LT sick inactive treatment is 2x than for "at work" person	☆ 44.3 (1.5x, OBR est)	45.6 (2x, OBR est)	☆ 47.0 (2.5x)
4. ↑ receipts of corporate tax	4% effective tax rate on GVA	44.4 (3%)	45.6 (4%, HMT Red Book)	46.8 (5%)
5. ↑ receipts of VAT/sales tax	9% effective tax rate on GVA	☆ 43.2 (7%)	45.6 (9%, HMT Red Book)	46.8 (10%)
Impact with all ☆ critical variation incorporated		38.6	45.6	50.5

☆ Critical variation

All estimates use mid case assumption of 0.45 million reintegration target

Supplementary Exhibit 7 – Similarly, Economic Estimate Ranges Within 10–30% of the Reported Figures, When Multiple Assumption Variations Are Combined

Factor of impact	Key assumption (mid case)	Total economic impact across 5 years (£ billion)		
		Low case	Mid case	High case
1. ↑ economic output	75% return to full-time work, rest – to part-time work	☆ 131.0 <i>(65% full-time)</i>	143.0 <i>(75%, national avg)</i>	☆ 154.9 <i>(85% full-time)</i>
	Full-time workers generate nat. avg GVA (£37/hr), part-time – "support" sector GVA (£24/hr)	☆ 136.2 <i>(5% less GVA)</i>	143.0 <i>(national avg)</i>	☆ 149.8 <i>(5% more GVA)</i>
	Work national # of working weeks (45 weeks)	136.9 <i>(43wk due to absence)</i>	143.0 <i>(45wk, national avg)</i>	-
2. Secondary impact of ↑ economic output	+£1 GVA of output leads to +£0.64 extra GVA across supply chain	☆ 122.8 <i>(+£0.4)</i>	143.0 <i>(+£0.64, ONS IOAT)</i>	155.9 <i>(+£0.8)</i>
3. Economic gain from fiscal reinvestment	HMT reinvestment follows existing public spending split	☆ 137.8 <i>(100% on pub. service)</i>	143.0 <i>(existing spend split)</i>	☆ 144.2 <i>(100% on welfare)</i>
Impact with all ☆ critical variation incorporated		103.1	143.0	163.7

☆ Critical variation

All estimates use mid case assumption of 0.45 million reintegration target



Wider social determinants of health

Data sources

Dependent variable ('health outcomes')

We chose *under 75 mortality rate from causes considered preventable (all genders)* as our dependent variable due to its sensitivity to determinants of health without being overly granular or volatile. We considered *life expectancy and prevalence of long-term conditions*, but *life expectancy* responds more slowly to changes in health determinants and *prevalence of long-term condition's* granularity may introduce noise.

Data was extracted from the PHE fingertips database for *E03 - under 75 mortality rate from causes considered preventable (one year range)*. This indicator is under *Public Health Outcomes Framework* (indicator ID: 93721) and defined as:

- Directly age-standardised mortality rate from causes considered preventable, per 100,000 population, in those aged under 75 years.
- Deaths are preventable if effective public health and primary prevention interventions could avoid most deaths from the underlying cause.
- ICD-10 codes categorise preventable deaths, following OECD and Eurostat guidance.⁵³

Independent variables ('health determinants')

We used the ONS Health Index for England, leveraging the ONS' work to collect, clean and standardise data, as well as to combine correlated raw data points into composite scores. Further, the ONS approach was informed by the Marmot Review to define variables like 'healthy places', indicating consistency with our research goal.

We used underlying first-level components of composite scores:

- We considered the *behavioural risk factors, physiological risk factors* and *protective measures scores* which are components of the composite *Healthy Lives score*.
- We considered the *access to services, crime, living conditions and economic and working conditions scores* which are components of the composite *Healthy Places score*.
- We excluded the *children and young people* variable (insignificant statistical results, lower relevance) and *access to green space* (low within-county variation).

Additional variables

To act as a control and produce more granular analysis we also considered income levels across each county using the *gross median weekly pay* dataset from the ONS⁵⁴ (2015 data).

Data granularity and timeframes:

We analysed data for 143 Counties and UAs across England, as determined by the PHE Fingertips dataset. Other data sources were linked to the PHE fingertips data using Government Statistical Service (GSS) area codes.

Data is at a yearly level, spanning 2015-2021 per ONS Health Index data availability.



Data processing and manipulations

The ONS Health Index provides normalised scores, with 100 as the national average in 2015. We normalised the data further to keep the national average at 100 each year, focusing our analysis on changes in health determinants relative to the national average.

This improved ease of interpretation of the analysis. For example, a shift of a score from 105 to 106 indicates a one percentage point increase in the county's distance from national average performance.

We also created an *income tertile variable* to segment counties into three groups of equal size based on 2015 *gross median weekly pay*.

Cross-sectional correlation: methodology

To analyse the cross-sectional correlation between preventable mortality and health determinants, we used a multivariate regression approach with a Gradient Boosting regression model implemented in Alteryx.⁵⁵ This model identifies the relative importance of each variable in predicting preventable mortality and generates marginal effect plots to illustrate the impact of variable changes. Crucially, the model results indicate correlations, which may not have causal links. So we cannot, from this analysis alone, suggest that if county A improves on health determinant X it will see a reduction in preventable mortality.

Model specification:

- 25,000 maximum number of trees in the model
- 10-fold cross validation
- 0.001 shrinkage
- Two-way interaction depth (i.e. one predictor might depend on another predictor)
- 10 minimum required objects in each tree node

'Causal' analysis: methodology

To make causal inferences more clearly, we used a Panel Regression approach with a 'Fixed Effects' model implemented in Gretl. This model controls for unobserved fixed characteristics of counties, hence reducing omitted variable bias.

Model details:

- Arellano robust standard errors
- Passed the test on joint named regressors and Wald joint test on time dummies (both with P-value < 0.01)
- LSDC R-squared = 0.90
- Within R-squared = 0.66

We rejected pooled and 'Random Effects' models based on statistical tests. The 'Fixed Effects' model focuses on the impact of cross-time changes, rather than baseline values.

The drawback of the approach is the reliance on observing significant within-county variation for variables. For example, a variable with low within-county cross-time variation will not be useful for the model and hence access to green space was excluded from the set of independent variables.



'Causal' analysis - additional insights and caveats

We performed two further granular cuts of our within-county variation analysis:

1. Grouping counties into low, medium and high-income segments.
2. Grouping counties as 'underperforming, average and 'over-performing' relative to national averages for health determinants.

For the first granular cut, English counties were grouped according to gross median income levels^{xviii} to control for the impact that income levels have on health outcomes. We observed that:

- *Living conditions* remained a statistically significant variable across each group, but the impact was 1.4x stronger for counties in the lowest income group as compared to counties in medium and high-income groups.
- Variation in *economic and working conditions* showed a particularly strong effect for the medium income group of counties (10% deterioration in score predicting +9 preventable deaths per 100,000).
- Variation in *protective measures* had a stronger effect for low and high-income groups (particularly driven by child vaccination initiatives), whilst showing a more modest effect for the medium income group of counties.

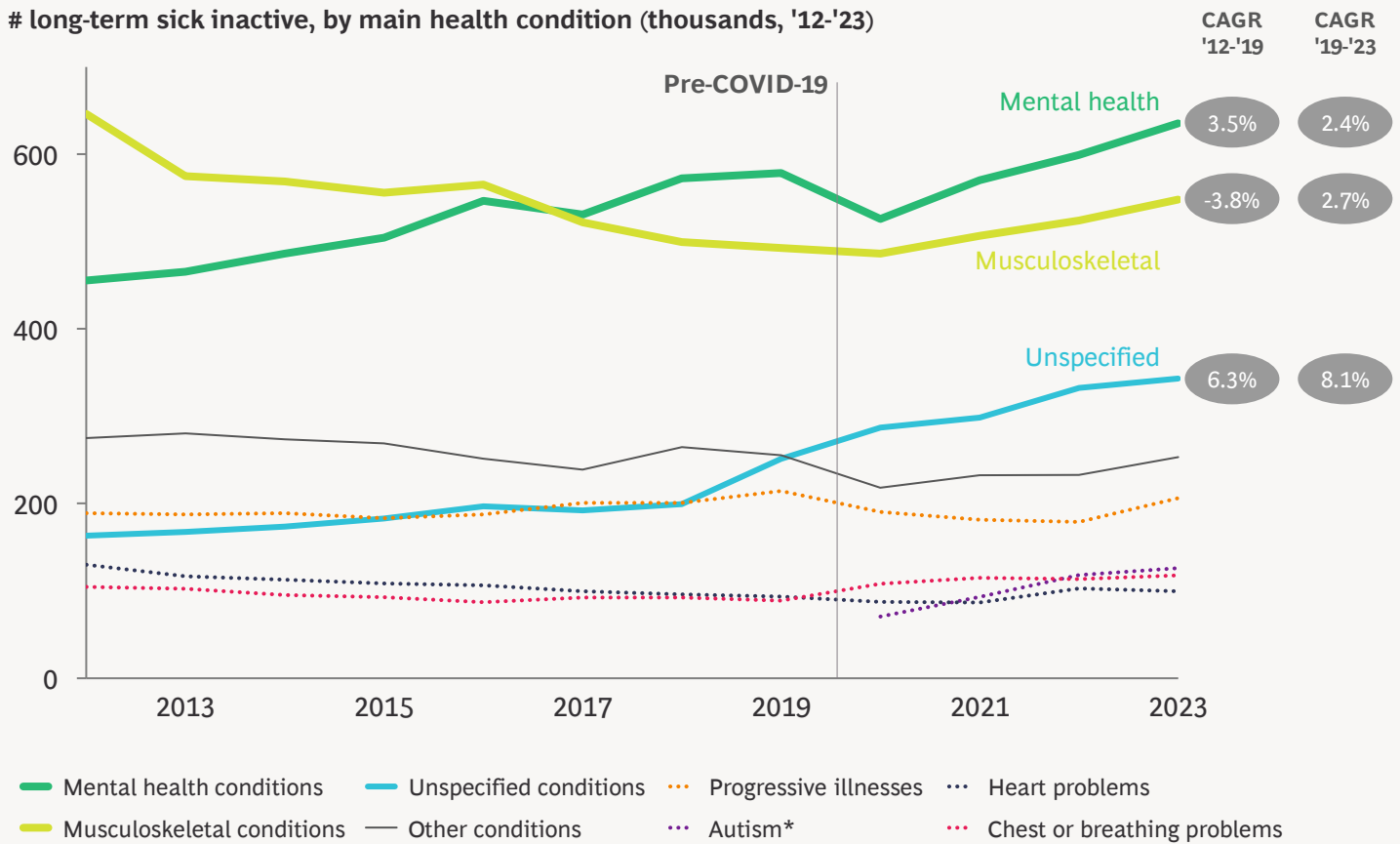
For the second granular cut, we categorised counties performing more than 5% worse than the national average for a particular health determinant as 'underperforming', those more than 5% better as 'over-performing' and the remaining as 'average'. We observed that:

- Variations in *access to services* become statistically significant; becoming an 'underperforming' county in terms of *access to services* predicts +6 preventable deaths per 100,000 as compared to an 'average' county.
- Similarly, becoming an 'underperforming' county in terms of economic and work conditions predicts +9 preventable deaths per 100,000 as compared to an 'average county'.
- There are important non-symmetric effects at play. For example, if a county is 'underperforming' in terms of *crime*, preventable deaths are predicted to increase by +9 per 100,000 as compared to an 'average' county. However, there is no statistically significant reduction in preventable deaths when a county 'over-performs' on *crime*.

xviii. Defined by gross median weekly pay in 2015.



Supplementary Exhibit 8 – Over Half of the Long-Term Sick Report Mental Health or Musculoskeletal Conditions As Their Main Illnesses



Source: BCG analysis of unpublished ONS Annual Population Survey data.
Notes: "Other conditions" includes epilepsy, learning difficulties, allergies, difficulty in seeing or hearing, conditions of stomach, liver, kidney, skin; "Mental health conditions" includes depression, bad nerves, mental illness, phobia, panics
 * Data for Autism available from 2020.

Additional exhibits

We wanted to understand the nature of the health problems the long-term sick inactive population might be facing and how the prevalence of conditions has evolved over time. Musculoskeletal (MSK) and mental health issues account for ~50% of all those reported as main conditions by the long-term sick economically inactive.

Much is made of COVID-19's impact on the population's mental health, but within those who are economically inactive, data shows that there has been steady rise in mental health prevalence in the last decade. MSK conditions have started growing again post-COVID-19 after

declining for many years beforehand. Unspecified conditions are also on the rise. The Labour Force Survey (LFS) does not provide any further information on what these are. But it cannot be explained purely with 'Long COVID' or other COVID-19-related illnesses, given that the rapid growth far pre-dates COVID-19.

We also see that the most prominent primary illnesses of the long-term inactive have strong links to a range of secondary conditions, further outlining the complex interplay between physical and mental health for those who are economically inactive. For example, over 50% of people who indicated MSK as their primary condition for inactivity also suffer from issues of mental health.



Supplementary Exhibit 9 – Over Half With MSK As Primary Condition Also Report Depression or Bad Nerves, Highlighting Interplay Between Physical and Mental Health

% of long-term sick who have the following secondary conditions



Source: BCG analysis of ONS data ("Rising ill health and economic inactivity because of long-term sickness, UK: 2019 to 2023", 26 Jul 2023).
Note: Data is as of Jan-Mar '23 period.



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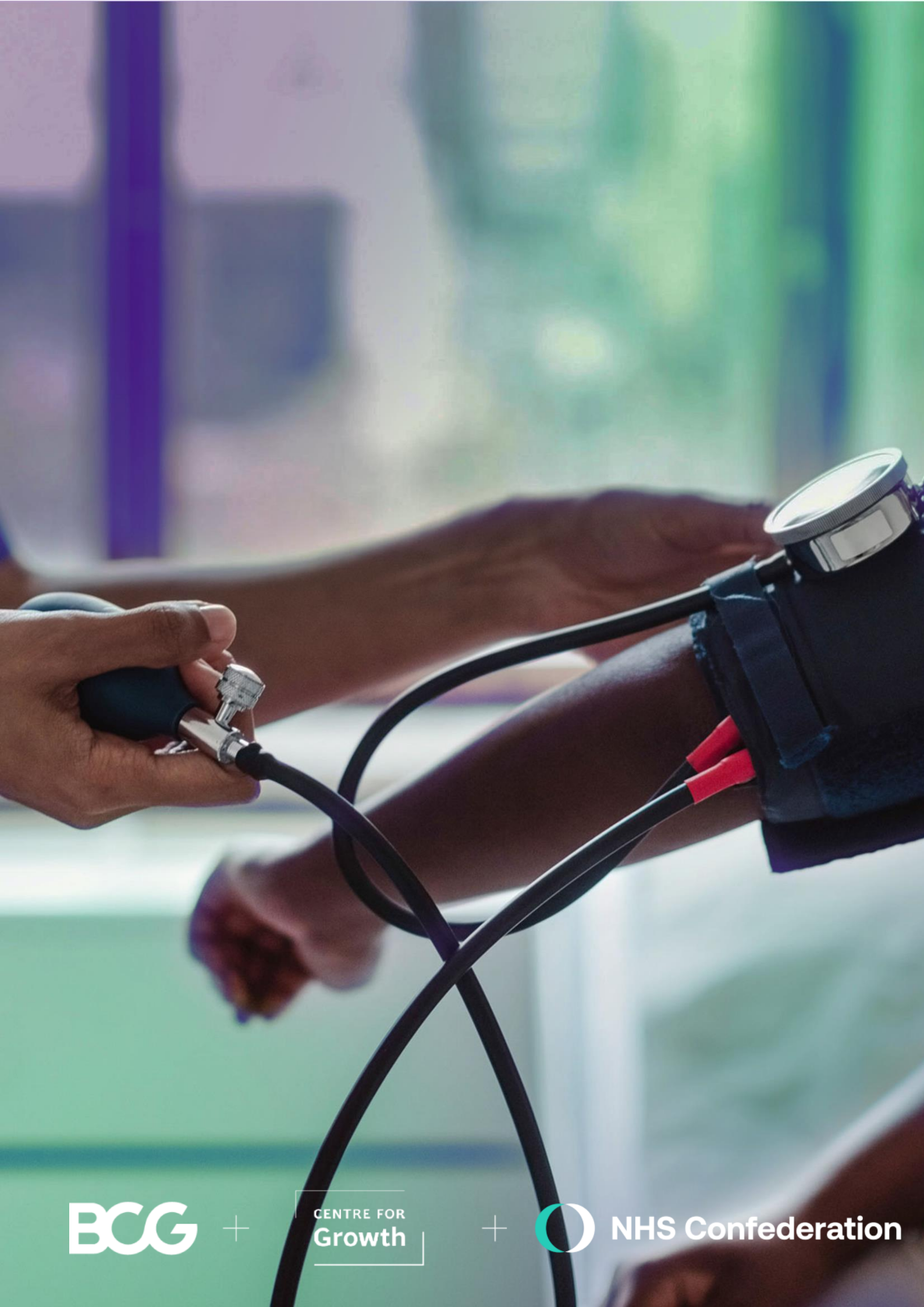


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