Chapter 05
—Health & Wellbeing: An economic perspective
(#79–90)

Photograph by: Tim Dennell

Health & Wellbeing: An economic perspective

State of Sheffield 2018

On a global scale, the role of health as a component of human capital — and therefore its importance in economic development — has been acknowledged widely, as exemplified by the Commission on Macroeconomics and Health (CMH) in 2001. However, the focus has predominantly been on low to medium income countries, indeed the predominant thrust in developed countries has been to view health as a cost to be driven down[40]. This view has changed over recent years, with an emerging view that the health of a population is not just a product of a successful economy, but also one of the key determinants of inclusive economic development.

40. World Health Organisation Commission on Macroeconomics and Health, 2001

In the UK, the interplay between health and inclusive growth has been recognised, but this needs to be seen alongside the fact that the national policy areas and local systems involved in this issue (welfare, employment, public health and healthcare) are not traditionally well integrated.

This section will:

- Describe how poor health impacts on in-work productivity, on unemployment, on opportunities for future inclusive growth in the city, and also show how current employment trends can impact on resident's health.
- Provide some information on the current health of Sheffield's population
- Explain how poor health and disability can mask actual unemployment rates, making them look better than they actually are and will briefly describe some of the work already underway to combat inequities of employment opportunity

The impact of residents' health on creating an inclusive economy

One of the key issues impacting on our residents' ability to contribute and benefit from economic growth is their health. Therefore, health has a critical part to play in building an inclusive economy. Individuals with long-term health conditions or disabilities can suffer economic disadvantage unless there is a serious system-wide commitment to ensuring these conditions do not become a barrier to employment. Furthermore, having a population with long term health problems can impact upon economic growth as well as being costly to the public purse. As an example, cardiovascular disease, mental illness, obesity, diabetes, tobacco and alcohol[41] all have massive economic impacts as well as health impacts. For example in 1999 Liu et al. calculated the burden of cardiovascular disease purely related to productivity in the UK to be £2.91 billion. The same study showed the total annual cost of all coronary heart disease related burdens to be 1% of GDP and almost 11% of total NHS spend in that year[42].

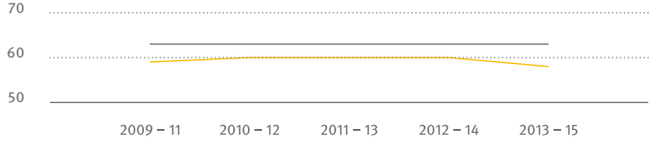
41. Marc Suhrcke, The contribution of health to the economy in the European Union, 2005

42. JL Liu et al., The Economic Burden of Coronary Heart Disease in the UK, 2002

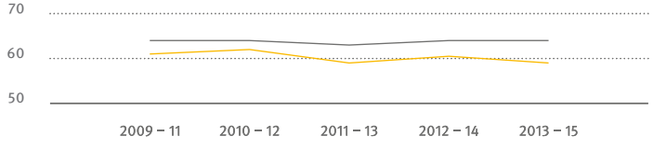
The cost, both financial and personal, of poor mental health is even more important. The cost of poor mental health to Government is between £24 billion and £27 billion. This includes costs in providing benefits, falls in tax revenue and costs to the NHS. The cost of poor mental health to the economy from lost output as a whole is even greater, at between £74 billion and £99 billion per year[43]. Mental health has significant implications for an individual's life chances, with poor mental health associated with smoking, obesity, and higher levels of personal debt. The employment rate for those who report mental illness as their main health problem is 42.7% compared to an employment rate of 74% for the total population. Of all long term sickness absence in England, 19% of it is attributable to mental ill health. Although mental illness forms 25% of national illness and mortality, only 10% of the NHS resource is spent on it, compared to 16% on cancer and 16% on respiratory diseases. This current imbalance of spend within the NHS may well have an adverse impact on the city's productivity.

43. Lord Dennis Stevenson and Paul Farmer, Thriving at Work, 2017

Healthy Life Expectancy at Birth: Males, Sheffield and England



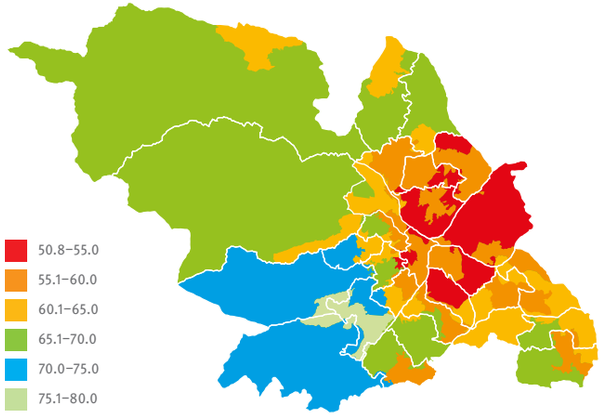
Healthy Life Expectancy at Birth: Females, Sheffield and England



Data Source: Sheffield Director of Public Health Report, 2017

As outlined in the first section of this report, inclusive growth in a city is dependent on the health and wellbeing of the population since they are the principal component of the economic infrastructure. Without a healthy workforce productivity will be low and consumers will also spend less locally if they are unable to work because of their health. Sheffield has lower healthy (i.e. long-term condition free) life expectancy for both men and women compared to the national average. Even more concerning is the fact that life expectancy is 10.1 years lower for men and 7.6 years lower for women in the most deprived areas of Sheffield than the least deprived areas. The female healthy life expectancy gap between most and least deprived areas is 21 years (see map below). For men, this difference is almost 25 years.

Middle Super Output Areas 2011
Female Healthy Life Expectancy



These stark inequalities at national and local geographies are not solely a health issue, they also represent a significant economic challenge. Generally speaking, people are living longer, but in Sheffield the onset of a long term health condition such as diabetes, musculoskeletal problems, or respiratory illnesses like COPD happens, on average, much sooner in life meaning that people spend more of their remaining lifetimes in poor health. As a consequence, they may spend more years being economically inactive and unable to both engage with, and benefit from, the local economy.

The number of people with two or more chronic health conditions (known as multi-morbidity) is an increasingly significant component of the healthy life-expectancy gap, and is impacting the city-wide economy. The combined costs of sickness absence, lost productivity through worklessness, and health-related productivity losses are estimated to be over £1 billion annually in Sheffield. This is around the same amount as the whole NHS budget in the city.

Photograph by: Tim Dennell

Health, good work and the gig economy

Increasing the number of employment opportunities does not guarantee a path to inclusive growth and improved health. Work can be a cause of stress and common mental health problems: and therefore 'bad' jobs can have an adverse impact on the health of the population. In Sheffield in 2014-15 almost 100,000 days were lost to work-related stress, depression or anxiety.

One of the emerging areas of concern in this respect is the emergence of the gig economy. A gig economy is an environment in which temporary positions are common and organizations contract with independent workers for short-term engagements (e.g. to deliver a takeaway meal). We see an emerging picture in Sheffield of an increasing number of people working increasing numbers of jobs and average hours worked, with reduced job security as compared to the traditional economy. A local study by Citizens Advice Sheffield on insecure employment in Sheffield supports this view, and details the interaction of these issues with individual's health[44].

It is also noticeable that there has been a significant increase in people classed as self-employed over the past 5 years[45]. This may be due to increased innovation and entrepreneurship, but may also be an indication of the gig economy growing. The health and wellbeing consequences of growth in this sector will require careful examination over the coming years. Nationally the gig economy comprises about 1.1 million people, which is roughly equivalent to the NHS workforce[46]. Benefits to the individual include greater flexibility of hours worked at the expense of job security. There are also emerging concerns that the digital platforms that often underpin gig working are not substitutes for line managers or co-workers — they have no regard for the individuals' mental health, capacity to work on a given day, and algorithms can de-register workers over productivity issues which can creates stress and anxiety[47]. Not only does traditional employment guarantee rights and protections in the labour market, but it is also an important source of public revenue, accounting for a greater share of taxes per capita than self-employment[48].

44. Sheffield Citizen's Advice Bureau, Insecure Employment Report, 2017

45. ONS Annual Population Survey, 2017

46. Brhmie Baleram, Making the Gig Economy Work for Everyone, 2017

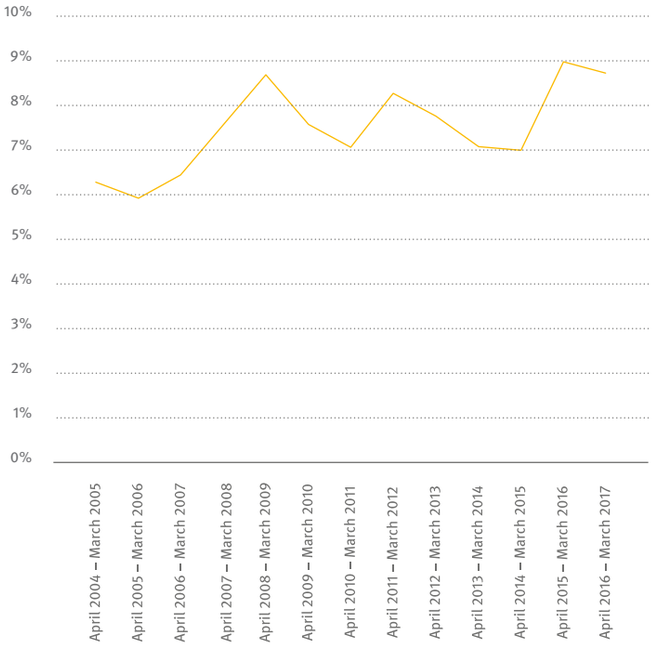
47. Financial Times, Mental Health and the Gig Economy, 2017

48. Brhmie Baleram, Making the Gig Economy Work for Everyone, 2017

Percent of Self-employment

Data Source: NOMIS — (2017)

— Percent Self-employed

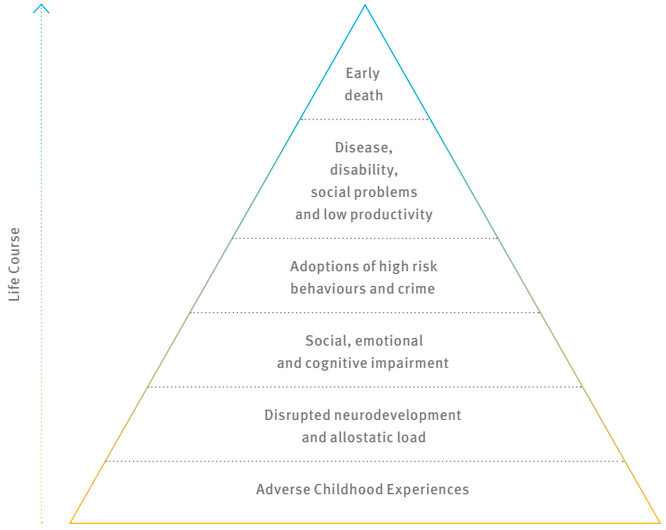


Health, economic inactivity and unemployment

Health problems are a key barrier to engagement in the labour market. If the city is serious about promoting inclusive growth it needs to consider ways in which to remove the barriers that people with long term health conditions and disabilities encounter when accessing employment. The ONS defines economically inactive as "People not in employment who have not been seeking work within the last 4 weeks and/or are unable to start work within the next 2 weeks", while the unemployed are classified as "... those without a job who have been actively seeking work in the past 4 weeks and are available to start work in the next 2 weeks"[49]. In Sheffield, of the non-working city population, there are currently over four times more economically inactive people than there are unemployed. The jobless who suffer from health problems or disabilities generally claim incapacity benefits instead of unemployment benefits. They are therefore omitted from the main unemployment statistics that are collected[50]. This classification can mask the true level of unemployment in the city. We do know that health is a major contributor to economic inactivity AND unemployment in the city, but we also know that underlying structural inequalities and the variation in the wider determinants of health (such as poverty, education or housing) in Sheffield also have an important mitigating effect on this relationship. For example, although 48% of Employment and Support Allowance (ESA) recipients are noted as having a 'mental or behavioural disorder', there is evidence to suggest that those with similar conditions from less deprived backgrounds are more likely to be able to secure and prosper in work[51].

Future trends in our workforce health also impact on our ability to make growth more inclusive over the coming years. Currently 1 in 3 people of working age have a long-term health condition, and over half of that subgroup say their health is a barrier to the type or amount of work they can do. By 2030, on current trends, 40% of working age people will be affected by poor health. Again, the distribution of this barrier is not equal, with the poorest populations of the city having a 60% higher level of long term conditions[52].

Young people are a particularly important group in this debate. Any attempt to build a more inclusive economy has to account for and secure the health & wellbeing and skills development of the labour force of tomorrow — i.e. the young people of today. As the Sheffield Director of Public Health Report for 2017 has highlighted, the importance of tackling adverse childhood experiences (such as suffering abuse or neglect) is paramount, as these can have lifelong consequences for health, social and emotional wellbeing, and economic opportunities and productivity[53].



Data Source: Public Health Wales NHS Trust (2015). Adverse Childhood Experiences and their impact on health harming behaviours in the Welsh adult population. Page 7

This "life course" approach has relevance for tackling the challenge of making growth more inclusive. We know that around half of mental health conditions start before the age of 14, and preventing poor mental health in young people is a critical factor in developing an inclusive economy with a sustainable future. Young people with disabilities account for 7% of the 16-24 population, but make up 16% of the total NEET (not in education, employment or training) group. The employment rate gap between people with and without disabilities widens from 27.8 percentage points at the age of 23 to 36.2 percentage points at the age of 24. This has significant implications for developing longer-term ambitions around inclusive growth.

49. Office for National Statistics, 2017

50. Christina Beatty, Steve Fothergill and Tony Gore, The Real Level of Unemployment 2017, 2017

51. Christina Beatty, Steve Fothergill and Tony Gore, The Real Level of Unemployment 2017, 2017

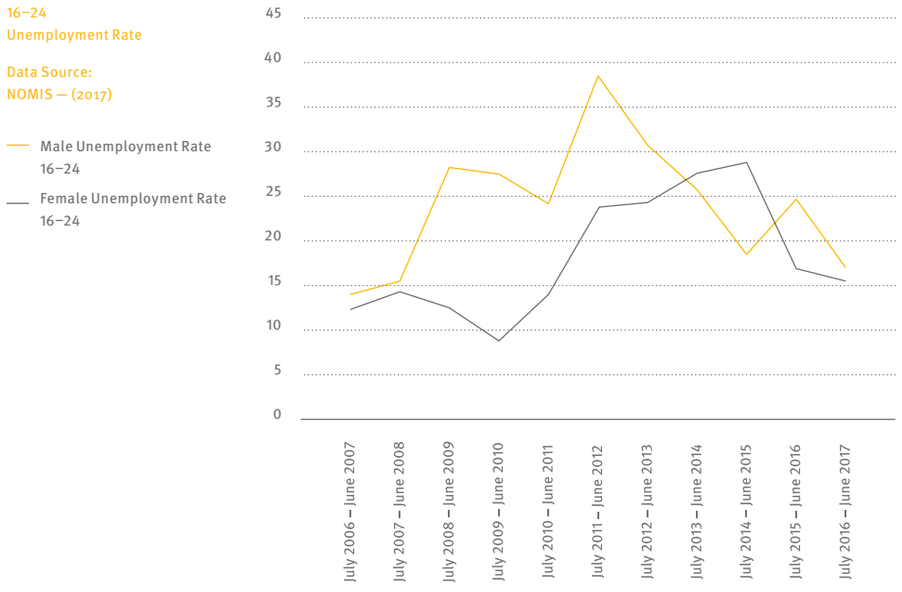
52. Public Health England, Health and Work Infographic, 2017

53. Sheffield City Council, Director of Public Health Report, 2017

Young people who are NEET are known to experience poor health and wellbeing, have worse life-chances and future employment prospects than their peers, and be more likely to engage in risky health behaviours and be less likely to engage with the local economy. Over the last ten years, the unemployment rate for people aged 16-24 has fluctuated, with a pronounced difference in the rate for men and women emerging, peaking in 2009-10 at 27.9% for men and 9% for women (an 18.9 percentage point difference). The rate for young men peaked in 2011-12 at 38.5% and has fallen almost linearly since, while the rate for young women continued to rise, peaking in 2014-15 at 28.8%, some 10% higher than the rate for men in the same year. In 2015-16 the trend flipped again, with the rates for men rising while that for women fell, and in 2017 the rates were 17.1 and 15.7% for men and women respectively. This is the first time the rate for both young men and women has been below 20% since 2007-08 so this trend should be encouraged and built upon.

16–24
Unemployment Rate

Data Source:
NOMIS — (2017)



The Sheffield response

Across the Sheffield City Region organisations have secured over £18 million to trial new ways of reconnecting sick and disabled people into the world of work. This is one of the first concerted attempts anywhere in the country to integrate the health and employment systems more effectively. Nevertheless sustained effort will be required in strategically aligning this programme and to make it easier for residents, clinicians, employers and communities to take advantage of these as part of our efforts to develop an inclusive economy. Local partnerships between the NHS and local government have also recognised the importance of employment in the long-term health of the population and have agreed joint activity to deliver some of the changes whereby clinicians start to 'see work as a clinical outcome' — a critical success factor in this agenda.

Conclusion

This chapter has evidenced the complex relationship between health and the economy in Sheffield, including a number of emerging challenges, such as the changing nature of work and the so-called 'gig economy'. In doing so it illustrates an important aspect of health in the city and provides us with strong evidence of the need to foster inclusive growth by breaking down the traditional barriers between social, economic and health. These challenges are deep and long-standing in Sheffield— we have significant gaps within the city and between Sheffield and the national average on healthy life expectancy. To overcome these challenges will need a concerted, coordinated effort across a wide range of public, voluntary and community groups, but this will be a vital step if we want to create an inclusive economy in Sheffield that all can benefit from.