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Executive Summary

- Employment, along with income and education, is a key social determinant of health and health inequalities in Scotland.

- For working-age adults, being out of paid employment is bad for health, increasing the risk of premature mortality by more than 60% and increasing the risk of morbidity, especially poor mental health.

- Work which fails to protect against poverty, or harms the physical or mental health of workers, is also detrimental to health. For some it may be no better than being unemployed.

- Increasing the proportion of parents, especially lone parents, in sustainable work, which protects against poverty and maintain or improves their mental health, is likely to have a beneficial impact on the health and wellbeing of their children.

- In Scotland, there are challenges within the labour market related to:
  - Unemployment and underemployment, reflecting a lack of available work (both the number of jobs and number of hours) and personal circumstances;
  - In-work poverty, driven by low hourly pay, short-time working and personal circumstances (especially caring responsibilities) which prevent people from increasing hours where this is viable and would increase their income;
  - Poor quality work: depending on the definition used, 10-30% of people in Scotland work in jobs that are bad for their health;
  - Persistent unequal distribution of employment opportunities, geographically and by occupation;
  - A social security system which does not provide claimants with sufficient income to maintain their health.

- Achieving fair employment and good work for all would require action across a range of areas:
  - **Job creation** at a scale proportionate to need
  - **Increasing wages and social security benefits** for the working-age population
  - **Recognition of personal circumstances** (e.g. caring responsibilities, health problems) that limit labour market participation **and adaptation of work and public services to address these barriers**
  - Expansion of **free and subsidised childcare**

- **Making poor quality jobs better and making ‘middling’ jobs high quality**
- **Changing the social security system so that it protects the health of people not in employment and their dependents**

Introduction

NHS Health Scotland is a national health board working with and through the public, private and third sector to reduce health inequalities and improve health. Our vision is a Scotland in which all of our people and communities have a fairer share of the opportunities and resources to live longer, healthier lives.

Our mission is to reduce health inequalities and improve health through influencing policy and practice, informed by evidence, and promoting action across public services to deliver greater equality and improved health for all in Scotland[1].

This briefing note discusses the contribution *“fair employment and good work for all”* can make to improving population health and reducing health inequalities in Scotland.

What do we mean by fair employment and good work for all?

Fair employment and good work has two important aspects:

- **Fair employment and high quality work** reflects the quality of employment: both in terms of hours and earnings (and capacity for work to protect individuals against poverty) and the much broader range of work characteristics which have the capacity to create or destroy health.
- **Work for all** reflects the demand for labour: the quantity of jobs and vacancies available. A high aggregate level of demand for labour is a necessary starting point, but to truly offer work for all, opportunities should be distributed geographically and occupationally according to need so that people who want to work can find a job reasonably easily.

The definition also assumes that the social security system protects the health of working-age adults not in paid employment, in terms of conditions attached to claiming, the level at which benefits are set and the way the system is administered in practice. It is important to note that this definition of work is very conservative: it excludes those engaged in unpaid work (especially carers and those looking after home and family who may also be in paid employment and thus face a ‘double burden’).

Why is this important for health and health inequalities?

Many of the key factors (or ‘social determinants’) which are likely to improve reduce health inequalities and improve population health lie outside the scope of the National Health Service[2-4]. Employment, along with income and educational attainment, is one of these social determinants[5].

For working-age people, not being in employment increases the risk of premature mortality. A systematic review of more than forty international studies, published in 2012, concluded that mortality rates were 63% higher among the unemployed.[6] On balance, the evidence suggests this is a casual relationship, with unemployment driving higher mortality, even after taking lifestyle factors (such as smoking and obesity) into account[7,8].

Not being in paid work also increases the risk of poor mental health[9] and hospitalisations from specific (but not all) causes[10]. With the exception of those in full-time education (and some of the early-retired), these adverse consequences extend beyond unemployment to include working-age adults who are economically inactive, particularly those who describe themselves as permanently sick, looking after home and family or in other activities[11, 12]. A recent report using used Scottish Health Survey data found that being unemployed rather than in paid work increased the risk of having below average mental wellbeing by more than 73% for men and 95% for women, while being out of work and permanently sick increased the risk of low mental wellbeing fivefold for both genders[13].

While work has the potential to improve health, some jobs are as bad for health as unemployment[14,15]. The work characteristics that matter most in determining whether employment is beneficial or harmful to health include: job precariousness, pay, the physical work environment, the psychosocial work environment and the degree of worker representation[16]. Of the work-related factors that have been proposed to impact on psychosocial health, control at work may be the most important[17].

Means-tested, ‘work-first’ social security regimes (of the type that operates within the UK and Scotland) are less likely to provide mitigation against the health-damaging effects of worklessness[18-20], and therefore perpetuate health inequalities. Where unemployment benefits are more generous (in terms of eligibility and the value of benefits paid), they can protect the mental health of the unemployed directly, as well as indirectly (by reducing the risk of poverty)[21].

Aspects of labour market disadvantage (and advantage) often overlap. It is often those at greatest risk of being out of work who are looking for (or have previously worked in) jobs which carry the greatest risk to their health (Table 1). Elementary, sales and customer service, process, plant and machine operative and caring, leisure and other service occupations predominate in the list of jobs that increase the risk to health of people employed in them.

Table 1: Employment types which are most likely increase the risks to health

	Broad occupational category
Unemployment rates[22]	Elementary; sales and customer service; process, plant and machine operatives
Low pay[23]	Sales and customer service; caring, leisure and other service; elementary
Lack of hours[24]	Elementary; sales and customer service; caring, leisure and other service
Insecure employment[25]	Elementary; associate professional and technical; caring leisure and other service
Physical risks[26]	Process plant and machine operatives; skilled trades; elementary
Low task discretion[27]	Process plant and machine operatives; elementary; Sales and customer service

Note: Examples of jobs defined as 'elementary occupations' include: labourers, warehouse staff, cleaners, kitchen and catering assistants, waiting and bar staff and security guards.

The Informing Investment to reduce health Inequalities (III) project modelled the impact of a range of interventions on population health and health inequalities in Scotland. It concluded that targeting employment growth to the most deprived areas, introducing a Living Wage and increasing benefit levels for the working-age population had a much more beneficial effect on reducing health inequalities than individual-level lifestyle improvement programmes. Based on modelling by the Scottish Public Health Observatory, over 10 years:

- A modest (10%) increase in the value of Job Seeker's Allowance (JSA), would result in 26,000 fewer 'years of life lost', 17,000 fewer hospitalisations and make a substantial impact on reducing health inequalities in Scotland.
- Increasing the National Minimum Wage to £7.20 per hour is estimated to result in 77,000 years of life gained and prevent 56,000 hospitalisations among the Scottish population
- A 10% rise in the value of the Working Tax Credit would result in more than 8,000 fewer years of life lost and 5,700 fewer hospitalisations[28]
- 50,000 extra jobs, targeted to the most deprived quintile in Scotland, would be likely to produce 29,000 fewer years of life lost and 1,100 fewer hospitalisations[29].

Finally, the benefits of fair employment and good work for all are likely to extend to children. Analysis of the Growing Up in Scotland study found that being continuously out of work was by far the strongest predictor of increased risk of persistent child poverty[30]. However, it is important to note that in-work poverty also affects children: more than half of the children in poverty (59%) in Scotland in 2012/13 lived in a household where at least one adult worked[31]. Childhood poverty is associated with poorer social, emotional and educational development in childhood (with long-term

adverse consequences for these children as they reach adulthood). Whether in or out of work, parents living in poverty also find it more difficult to support their children, both materially and because of the increased risk of mental health problems they face as a consequence of poverty[32],[33]. Lone parents, 92% of whom are women[34], are especially at risk, given they are most likely of any household type to report they are not managing well financially[35]. A 2013 report on parenting, poverty and poor health in Scotland argued that *"any attempt to invest in early years should include both improvements to financial circumstances and measures to reduce parental stress"*[36]. Supporting parents, especially lone parents, to move into sustainable employment that lifts them out of poverty and protects their mental health, can therefore help contribute to improved outcomes for children.

What is the current situation in Scotland?

Since 2012, unemployment has been falling and employment rising in Scotland. However, there a number of aspects to the Scottish labour market – some related to long-term trends, some reflecting the recession, and others linked to working-age welfare reform – that are clear obstacles to achieving fair employment and good work for all.

Worklessness

In November 2014, 395,120 working-age people in Scotland were claiming key out of work benefits: 11.4% of the working-age population[37]. Although below the peaks seen in the 1980s and 1990s, this is higher than the ~ 248,000 (<8% of the working-age population) who were claiming out-of-work benefits in 1979. The majority of people claiming out-of-work benefits in 2014 were doing so because of health problems which limited their capacity to work. In 2013, there were also between 126,000[38] and 187,000[39] children in Scotland living in households where no one was in paid employment, with direct and indirect adverse consequences for their health. Geographically and occupational inequalities in labour market demand persist within Scotland. Labour market demand remains low in West Central Scotland, Tayside and the Forth Valley; and for those seeking employment in elementary, sales, skilled manual and process occupations. In 2013, for every 10 unemployed people in Aberdeen City and Shire, there were approximately 10 vacancies; for every 10 unemployed people in Ayrshire, there was just one vacancy. Similarly, for every 10 unemployed professionals, there were 10 vacancies, while for every 10 unemployed people seeking elementary work, there just two[40]. Even before the 2008/09 recession, there was a shortfall of more than 95,000 vacancies in Scotland, once the 'hidden unemployed' on incapacity benefits were taken into account[41].

In-work poverty

A total of 480,000 working-age Scottish adults (15%) were living in relative poverty in 2012/13 before housing costs[a]. More than half of these (250,000 people) were living in households where at least one adult was in employment. The proportion of working-age people living in relative poverty was relatively stable in Scotland following a short peak in 2000. In-work poverty rates followed a similar trend. Low wages are an important factor here: a substantial minority (44%) of the working poor are already working ≥40 hours a week[42], but in 2014, someone earning the minimum wage would have to work 80 hours a week to reach gross median earnings for a full-time employee in Scotland[43]. There were also 110,000 children in Scotland living in households where at least one adult worked[44].

The recession has also left its scars on the labour market. Real wages fell sharply in 2009 and have remained fairly flat since 2012. The number of people working part-time in 2014 because they could not find full-time work was almost twice as high as in2007 (110,000 vs. 59,000) and remains at historically high levels. Levels of involuntary temporary employment are higher than pre-recession levels, but are below their peak level in the mid-1990s. These trends are important because of higher risk of poverty in working households where no-one has a full-time job[45].

The number of adults in Scotland who were self-employed was at a historically high level in 2014. This reflects long-term trends, though the growth in self-employment accelerated in the 2008/09 recession and its aftermath. Self-employment is associated with increased mental wellbeing (for some)[46]. However, this must be offset against the increased risk of poverty[47], especially as earnings for the self-employed have fallen more sharply than for employees since 2006[48, 49].

Low quality work

The prevalence of low quality work in the United Kingdom is not high compared to other European countries, though lower rates are observed for the Netherlands and Denmark. Nevertheless, depending on the definition used, between 10% and 30% of those in employment are in jobs whose characteristics are likely to be detrimental to health[50, 51]. More than half of working-age adults who leave benefits for work move into elementary or sales occupations[52] – job types which, as noted above, expose them to a higher risk of poor health. Preliminary estimates suggest the picture is similar for Scotland. Looking in more detail:

- In 2014, KPMG/Markit estimated that 19% of earners in Scotland were paid below the Living Wage in 2014[53].
- In 2013, 18% of adults in employment in Scotland reported they seldom/never had control over how they did their work, and 19% they only sometimes had

[a] This will be updated when the Households Below Average Income (HBAI) figures for 2013/14 are published on the 25th June 2015.

control. Control at work was lower among women and those in semi-routine or intermediate occupation[54].

Working-age social security

The working-age social security system in Britain and Scotland fails to protect individuals or their families who are out of work against poverty and is punitive rather than supportive [55-57]. It has been argued that benefit levels for working-age people in Britain are set at too low a level to adequately protect against poverty and poor health[58]. At 2014 prices, a single working-age adult living alone would require an income of £110 per week (after housing costs) to meet the minimum required for a healthy income[59, 60]. Actual benefits for single working-age adults (after housing costs) are currently set at £72 per week[61].

Since the late 1980s, the eligibility criteria to access (and continue to receive) out-of-work benefits has also been progressively tightened, including the introduction of Job Seeker's Allowance (JSA) and then the New Deal programme. Since 1995, the medical test for Incapacity Benefits claimants has been carried out by doctors working for the Department for Work and Pensions (and its predecessors), and the test of fitness for work has been toughened three times[62, 63]. Since 2012, lone parents whose youngest child is aged five years or over are no longer entitled to Income Support but instead are eligible to claim Job Seeker's Allowance (with its associated conditions on work-search activity).

Recent welfare reforms, including the stricter sanctions regime that began in October 2012 for JSA claimants and December 2012 for Employment Support Allowance (ESA) claimants, have intensified the increases in conditionality. Between October 2012 and September 2014, more than 131,000 JSA claimants were sanctioned in Scotland. In 2014, more than two-thirds (68%) of GPs in Britain reported that they had seen evidence that their patients' health was being harmed by reductions to their benefits[64]. There is also evidence that sanctioning JSA claimants fails to improve their prospects of moving into sustained employment and in some cases may actually reduce it[65-67]. The impact of sanctions extends beyond claimants to their families, with an estimated one child affected for every six JSA claimants sanctioned[68].

What can be done?

High rates of worklessness, in-work poverty and bad work are not inevitable. Between 1948 and 1973, unemployment rates in Britain averaged less than 3%[69]. This was also a period during which regional policies to promote a more even distribution of employment across Britain were pursued most vigorously.[70] It is notable that spatial inequalities in mortality were also at their narrowest in the late 1960s and early 1970s[71].

Reviewing the potential 'trade-off' between raising the quality of work and the quantity of job opportunities available, Carré *et al.* (2013) concluded that there is not necessarily a trade-off between the quantity of job opportunities and the quality of work – and if

anything, countries with higher quality employment also tend to have higher employment rates[72].

Several European countries (Netherland, Denmark, Sweden, Austria) manage to combine low rates of in-work and out-of-work poverty with high employment[73]. A handful of countries (notably Denmark and the Netherlands) have also managed to achieve the 'quadruple' challenge, of having a low proportion of low quality jobs as well[74].

Table 2 (next page) sets out some options that could contribute to achieving fair employment and good work for all in Scotland, drawn from across the relevant literature. These include:

- **Job creation** measures at a scale proportionate to need
- **Increasing wages and social security benefits** for the working-age population
- Recognition of **personal circumstances** (e.g. caring responsibilities, health problems) that limit labour market participation and **adaptation of work and public services to address these barriers**
- Expansion of **free and subsidised childcare**
- **Making bad jobs better and making 'middling' jobs good,** including increasing wages
- **A social security system that protects the health of the unemployed**

As discussed elsewhere[75-77], action across multiple areas will be required if fair employment and high quality work for all in Scotland is to be achieved. For example, increasing hourly wages alone may not address in-work poverty if underemployment remains high and childcare places limited; and job creation alone may not improve working-age health if the value of out of work benefits remains low, conditionality in the social security system high, and the quality of jobs (including low wages) is ignored.

Conclusions

Attaining fair employment and good work for all can play an important role in reducing health inequalities and improving population health. Achieving this goal would mean:

- Increasing the quantity and quality of paid employment available
- Address the personal circumstances that reinforce worklessness and working-age poverty
- Redesigning social security to protect the health of those not in paid employment and address personal circumstances.

Historical and international evidence suggests that these are credible aspirations, which if met, would be an important step in achieving a fairer, healthier Scotland.

Table 2: What can be done to promote fair employment and good work for all in Scotland?

Aspect	What could be done?
Job creation measures at a scale proportionate to need [78-81]	• Making full employment a key objective of economic policy. • Investing more in demand-side measures, proportionate to need, targeted at older industrial regions and providing a greater mix of employment opportunities. • Creating more public sector employment through investment in public services • Expansion of other employment (e.g. Community Jobs Fund, Intermediate Labour Market (ILM))
Recognition of personal circumstances (e.g. caring responsibilities, health problems) that limit labour market participation and adaptation of work and public services to address these barriers [82,83,84,85]	• Recognition of these personal circumstances by employability services • Promoting staff behaviour and attitudes that are respectful , empathetic and avoid stigmatising people in an already difficult situation • Learn from successful programmes e.g. Working for Families Fund in providing specialist support to parents • A 'health first' approach to supporting people with long-term health conditions into sustainable work • Good quality, person centred financial inclusion model • Progression in-work learning and adult skills that increase earnings, not just formally credit existing skills or meet basic legal requirements (e.g. health and safety) • Provide additional opportunities for adults aged over 25 years to gain new qualifications which increase their earning capacity, rather than simply formally recognise existing skills already being used in low-paid jobs • Appropriate workplace adjustments to accommodate people with health conditions and disabilities
Expansion of childcare [86]	• Expansion of free or subsidised high-quality childcare
Increase wages [87]	• Increase the statutory national minimum wage • Continue to promote the adoption of a Living Wage by employers
Making bad jobs better and making 'middling' jobs good [88,89, 90]	• Promoting employee voice in the workplace, to increase 'control' at work. • Management discretion to ensure workers get adequate hours (e.g. by keeping headcount low) • Promote a 'high road' business strategy in manufacturing

	• Setting and enforcing a minimal floor on employment conditions (through legislation and procurement conditions) • Assistance to small and medium employers to upgrade their business processes.
A social security system that protects the health of the unemployed[91]	• Acknowledging the value of unwaged work, including caring and volunteering • Provides appropriate financial advice and support to help people move into decent work • Increase the value of carers allowance • Consider increasing the value of other out of work benefits • Ensuring decisions on claimants' financial payments are accurate, timely and fair • Reduce the number of assessments for those with disabilities and/or long-term health conditions • Review the benefit sanctions regime for working-age adults and monitor the health and employment outcomes of those who are sanctioned

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