

# **THE HEALTH IMPACT ASSESSMENT OF THE EUROPEAN EMPLOYMENT STRATEGY IN THE UNITED KINGDOM**

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## Executive Summary

### **Introduction**

This Executive Summary of the Health Impact Assessment (HIA) of the European Employment Strategy (EES) in the United Kingdom summarises the work undertaken by IMPACT. This was part of the 'Policy Health Impact Assessment for the European Union' project, funded by DG SANCO of the European Commission (EC). The project was responsible for synthesising a new HIA methodology (the 'EPHIA' methodology). EPHIA was then piloted on a selected EU policy (the European Employment Strategy) in Germany, Ireland and the Netherlands and across the EU, as well as in the UK.

HIA is a policy tool. EPHIA has been developed for use in policy planning across European institutions to help 'add health value' to decision-making. The aim of the HIA was:

### **To assess the potential health effects of the EES within the UK using the synthesised EU Policy HIA (EPHIA) methodology**

The primary purpose of this HIA is to test EPHIA on the EES. However the findings from this HIA are also being made available to policy proponents to contribute to future decision-making.

The European Employment Strategy aims to increase the employment rate across the EU as described in Table 1:

**Table 1 Aims of the European Employment Strategy**

<b>Increase the EU employment rate:</b>	<b>2005</b>	<b>2010</b>
Total	67%	70%
Women	57%	60%
Older people (55-64 years)		50%

It fosters full employment, quality and productivity at work and social cohesion and inclusion. The Employment Guidelines in 2003 identified priorities for action across the EU to help meet these aims.

### **The Employment Guidelines 2003**

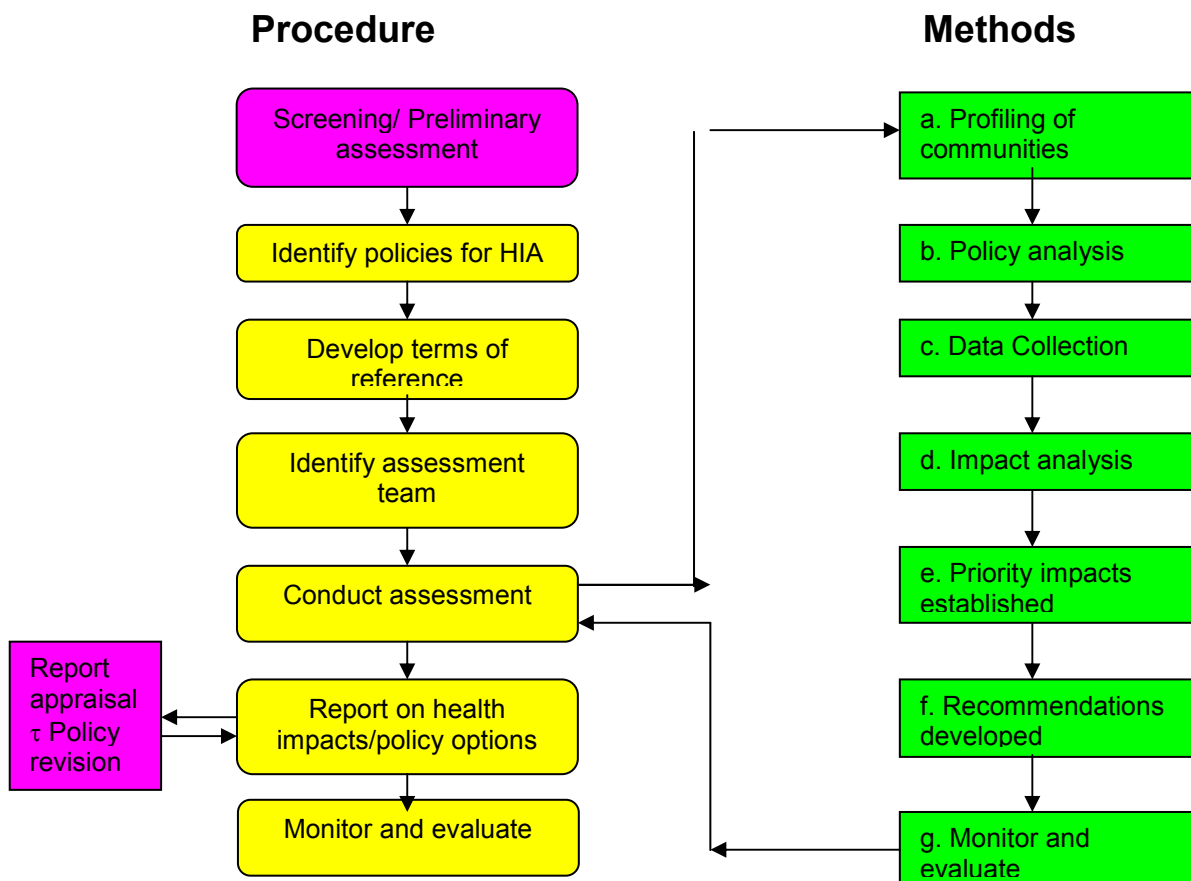
- Active and preventative measures for the unemployed and inactive
- Job creation and entrepreneurship
- Address change and promote adaptability and mobility in the market place
- Promote development of human capital and lifelong learning
- Increase labour supply and promote active ageing
- Gender equality
- Promote the integration of and combat the discrimination against people at a disadvantage in the labour market
- Make work pay through incentives to enhance work attractiveness
- Transform undeclared work into regular employment

The UK Employment Action Plan (UK EAP) is the national action plan developed in response to the Guidelines. It outlines action that the UK is undertaking to meet the Guidelines and their associated targets. National action plans are developed using an 'open co-ordination' method. The HIA was undertaken on the UK EAP.

## Methods

The HIA methods and procedure used were based on the draft EU Policy HIA (EPHIA) methodology (Figure 1). The process took approximately 50 days.

Figure 1 EU Policy HIA (EPHIA) methodology



The HIA methods involved the collection and analysis of both secondary (existing) and primary (new) data. Relevant secondary data were identified and retrieved from various data sources (section 4) for the development of the profile. The policy analysis also involved the collection and analysis of a range of policy documents; evidence from the literature was also gathered (section 5). Primary data were collected from stakeholders (people affected by the policy) and key informants (people with expert knowledge) (section 6). Evidence from all data was then aggregated and the health impacts of the EES characterised in the impact analysis (section 7). Where there is a convergence of the evidence from the different data sources this is regarded as strong evidence with a greater likelihood of the impacts occurring.

The limitations of the HIA were identified as the lack of access to various stakeholders, the availability of or accessibility to data, for example, the proportion of 'welfare to work' participants who leave the programme unemployed and exit the benefit system, and the lack of opportunity to generate quantitative data, for example, by modelling the health effects of increasing labour force flexibility.

## Results

### Impacts of the UK Employment Action Plan

#### **Increasing Employment and Reducing Unemployment**

There is evidence indicating the potential positive impact of UK EAP measures on reducing unemployment and increasing employment in the UK. Employment rates already exceed all EES 2010 targets. Although it is difficult to isolate the contribution of, for example, 'welfare to work' programmes from the influence of the strong economy on these employment changes, these and other UK EAP measures will probably contribute to potential employment gains in the future. However, the overall increase in employment during 2003 may be small, and the trend has been for a decline in the rate of increase.

Any increase in employment will have positive effects on the health of the population as a whole. Brenner has forecast a reduction in all cause mortality in the UK using an unemployment-GDP model with a lag of 2 to 14 years after the increase in GDP and employment. It is believed that this is primarily due to the increase in per capita income resulting from GDP growth. There is also likely to be short and long-term health benefits to the children of families where employment increases the household income and enhances the family environment. But there is evidence that not all employment is beneficial for health, and that some work characteristics can be as damaging to health as unemployment; this will be examined later.

However this increase in employment has not been uniformly shared across the UK. Certain population sub-groups have consistently had less favourable labour market outcomes, although this has improved for most groups since the mid-1990s. The groups and their relative disadvantage in employment outcome terms are described in Table 2.

**Table 2 Employment Rates (%) in the UK**

Population Groups	2001	2002	Difference (2002-2001)	Difference (2002 population group - working age)
working age (16-SPA*)	74.7	74.8	0.1	0
people with disabilities (and chronic health conditions)	47.4	48.6	1.1	-26.2
ethnic minority groups (all groups)	58.1	58.4	0.3	-16.3
ethnic minority groups (Bangladeshis)	-	42	N/A	-32.8
ethnic minority groups (Pakistanis)	-	46	N/A	-28.8
lone parents	49.8	50.1	0.3	-24.7
people with no qualifications	50.9	50.3	-0.6	-24.4
older people (50-SPA*)	70.3	70.5	0.3	-4.2
women	69.7	69.6	-0.1	-5.2

\* SPA = State Pension Age

There are also regional differences in employment, with the south east and south west in particular having above average rates of employment and the north east, Northern Ireland, London and Wales having below average rates.

There are complex sets of factors associated with each of these inequalities in employment. For many of these there appeared to be a sound analysis of the issues contributing to these inequalities, with resourced policy measures underway and a



clear political commitment to address them, for example, action to redress employment inequalities for people with no qualifications or with disabilities. For others, whilst recent policy developments are acknowledged, the priority for this action was less clear. As such it is anticipated that whilst the positive changes in employment rates for disadvantaged groups may continue there may be positive changes in employment rates for disadvantaged groups, these will be very small and will only marginally reduce the inequality gap. This will be discussed in more detail later.

There are likely to be small improvements in health for these groups associated with these slight increases in employment if they result in more income per capita. Many of these groups, for example, Pakistanis, Bangladeshis, people who are chronically sick or disabled, have poorer health than the population as a whole according to a number of health measures. Although 'direct health selection' is unlikely, that is, poor health itself increasing the risk of unemployment, it has been shown to be a risk for initial job loss and then subsequent re-employment. There is therefore a double disadvantage to people who have poorer health. In addition there are implications for the health of the children in these disadvantaged families. However, if the rate of increase in employment for these disadvantaged groups was to be greater than the working population as a whole, this may contribute to a reduction in the existing health inequalities.

### ***The Unemployment/Inactivity to Employment Transition***

It is probable that the 'welfare to work' measures advocated in the UK EAP (Guideline 1) will contribute to the growth in the economy in increasing the employment of 'job ready' participants. In addition, evidence from a range of data sources suggests that if similar processes are used to recruit participants to programmes as have been recently used there will probably be a number of associated positive effects. The evaluations of the various 'welfare to work' programmes have shown these positive impacts on participants to include:

- increased confidence,
- increased motivation,
- reduced isolation,
- reduced anxiety,
- gaining and retaining employment,
- participants moving off benefit.

A key positive feature across all the programmes has been the value attached to the one-to-one relationship established between the participants and the Personal Advisors (PA) or their equivalents. This was identified in documents and by stakeholders. Other important aspects of these programmes included flexible working arrangements, for example, part-time work or working at home, choice in training and work placements and positive relationships between the various employment or programme agencies and employers. The evaluation of the New Deal for Lone Parents impacts also showed a net saving of £1600 per participant to the Exchequer.

This evidence suggests that for people who are 'job ready', 'work first' approaches advocated in the UK EAP will potentially have short-term benefits to participants' mental health as a result of 'welfare to work' programmes. However, it is recognised that the proportion of 'job ready' within the unemployed or inactive population is shrinking, and that a 'core' long term unemployed or inactive group with, for example, skills and/or health problems remains. Evidence from similar 'work first'/'welfare to work' programmes in the US suggests the positive health effects, for example enhanced well being, are most likely to occur when there is an increase in household income compared with the benefit position. There is also evidence indicating that there may be associated benefits for the health and development of children in

households where parents move into employment. This is primarily as a result of enhanced parenting practices, as well as improvements in standards of living. For families with young children ensuring good quality childcare could potentially maximise the cognitive, social and emotional benefits even further.

However the evaluations of New Deal and the other programmes also revealed that these 'work first' approaches were less successful with people who were most disadvantaged in the labour market (Guideline 7). People with health problems, ethnic minority groups and people without basic skills or with outdated skills benefited least from such approaches, potentially being further disadvantaged in the labour market by interventions that did not meet their needs. Associated with this were some less successful features and potential barriers to participation. For example, employer attitudes, including discrimination, poor organisation and quality of some training. However, the recently introduced pilots such as Pathways to Work, Job Retention & Rehabilitation and Action Teams for Jobs may address many of these issues. Employment Zones (EZ) interventions seemed to have a greater success for longer term unemployed people compared with the New Deal programme specifically for the long term unemployed (ND 25 plus), the latter having negligible impacts on employability. Working Neighbourhood pilots are hoping to build on the EZ successes, whilst taking account of the local context. Evidence from the US has shown that the most 'hard to employ' quintile were more likely to be placed in low paid jobs. When the income from work was less than the income on benefit, there were poor prospects and the job was of poor quality, the mental health of participants deteriorated. There were also negative impacts on children, including a reduction in cognitive development and school performance and an increase in anti-social behaviour. These are obviously pitfalls to avoid in the UK.

It is difficult to separate out the impact of fiscal measures such as the National Minimum Wage and working tax credits designed to help reduce poverty and 'make work pay' (Guideline 8) from the total 'welfare to work' package. The US 'welfare to work' programme differs from the UK's in that financial assistance is time limited and there are sanctions if participants fail to comply with requirements, for example, refusing a job. In addition to people who leave the programme due to sanctions there are also people who become unemployed at the end of the programme, but who are not entitled to further financial assistance. Evidence from the US has identified the severe impacts of being without social protection on the health and well being of these people and their families as follows:

- hunger,
- food insecurity,
- rent arrears,
- living in overcrowded accommodation,
- increased incidence of hospitalisation of children.

Although the US and UK schemes are different it was not clear what proportion of UK 'welfare to work' participants who come off benefit may also be unemployed and potentially living in extreme poverty, such as reported in the US.

Other potential health impacts from the move from unemployment or inactivity to employment could be changes in health-related behaviour and health service use. The changes in health-related behaviour could be either positive or negative; there was insufficient evidence to predict these with any reliability. Similarly it is not possible to predict the change in health service activity, however it is probable that the frequency of use will change, which has implications for out of hours provision. In addition the focus on reducing inactivity due to ill health will undoubtedly impact on primary care professionals from the GPs' initial certification to chronic disease management with practice nurses and rehabilitation with occupational therapists. The 'unemployment/inactivity to employment transition' may also have a number of stages in terms of the effects on mental and physical health; for example there may

be an 'Anticipation Phase' for participants waiting to start a programme or be seen by a Personal Advisor. Analysis of other international welfare reforms suggest contextual factors appear to influence the impacts of interventions on participants, for example, when the changes are perceived as a net loss (financial, education, choice, esteem) or are introduced relatively quickly, the impacts on participants are more negative. This is reminiscent of the effort-reward imbalance model that has been used to explain the effects of psychosocial work characteristics on health outcomes. It is clear that more work needs to be done to construct a model explaining the relationship between different 'employment transition' factors and their impact on health.

### **Employment flexibility**

There is strong evidence that point to an increase in flexibility in the workplace which the UK EAP (Guideline 3) will contribute to. There are potentially both positive and negative health impacts associated with this increase in labour market flexibility. Employment trends have shown an increased demand for labour market flexibility, for example, in 'non-standard' employment contract types, such as part-time and temporary contracts. This is in response to globalisation and economic pressures that have companies trying to adapt to seasonal fluctuations in demand for goods and other peak production times, whilst controlling labour costs. There have also been developments in flexible production processes, for example, 'just in time' production. Other forms of labour market flexibility include 'numerical' - adjusting the size of the workforce - and 'functional' flexibility - adapting the tasks of workers - have also increased in the UK recent years.

Evidence has shown that part-time workers are more likely to report better health outcomes for six health indicators:

- job dissatisfaction,
- health-related absenteeism,
- stress,
- fatigue,
- backache,
- muscular pains.

regardless of the contract type, compared to full-time workers. Part-time employees are particularly more likely to be satisfied with their job. However, potential issues associated with part-time work are lower pay, employees feeling isolated or not as involved in the organisation, and receiving the same career development or training opportunities. Also part-time work is often unskilled work with poor working conditions.

However, there is strong evidence from a range of data sources of the negative health effects of being in an insecure job, whether through threatened unemployment, reduced working hours, temporary work or fixed term contracts, for flexibility purposes. The following health effects have been reported when jobs changed from being secure to insecure:

- changes in health-related behaviour, e.g. increase in smoking, reduction in physical activity in women,
- psychological effects, e.g. increase in depression, anxiety,
- physiological effects, e.g. increase in cardiovascular risk factors (hypertension),
- increase in the use of health services,
- increase in job dissatisfaction, e.g. twice as prevalent compared to permanent workers.

Other reported negative effects include reduced organisational commitment and performance. There is also some evidence suggesting that ethnic minority groups experienced more negative effects as a result of discrimination. Some studies (Burchell, 1996) have shown equivalent health scores for people in insecure jobs and unemployed people.

Evidence from the literature and key informants suggests that the psychosocial work factors associated with changes in job security and possible mediators for the health effects were:

- increase in control,
- increase in demand,
- loss of skill discretion,
- loss of support.

This is contrary to earlier job strain models where the level of control was seen as the key psychosocial work characteristic that could predict cardiovascular and other health outcomes of employees. However, evidence from Finland was that there was an increase in demand, but reduction in control and a loss of support. It has been suggested that during organisational change, the relationship between psychosocial work environment characteristics and health differ from a stable organisational state. Further research needs to be undertaken to explore this relationship.

Key informant evidence suggests that there are different responses to job insecurity depending again on contextual factors. If, for example, job insecurity is introduced into previously secure jobs (so that there is a change in perceived security or a loss in valued aspects of previous jobs) the impact on health is more severe. However, workers in secondary labour markets, that is, labour markets that are already insecure, do not appear to have such severe health impacts. Workers in these insecure, low skilled, poor quality jobs are often women and people from ethnic minority groups. What is clear though is that workers in insecure secondary labour markets are more likely to be exposed to physical and chemical hazards in the work environments, such as working in painful or tiring positions, high noise levels, and work involving repetitive tasks and movements. Compared with permanent workers, they tend to have less opportunity to develop skills at work and have less access to training. Safety concerns have been raised in some industries, for example, the petrochemical industry, where contingent workers were less experienced and skilled than direct-hire workers and yet received less health and safety training than direct-hire worker. They have less autonomy over their work and time and less opportunity to be involved in workplace decisions. The health effects of these psychosocial work conditions include musculoskeletal disorders and fatigue.

There is strong evidence that increasing workers' control, for example, decision latitude and participation, can benefit both physical and mental health, and mitigate against the harmful effects of job insecurity. Having information and co-worker, supervisor or trade union support were also identified as valuable buffers to the negative effects of job insecurity during organisational change.

The measures included under Guideline 3 - regulatory reform, promoting diversity of working arrangements, managing change and restructuring, and health and safety at work - are intended to develop a climate that enables labour market flexibility, whilst compensating for this with rights to flexible working arrangements for employees. The measures are also designed to protect against and limit the negative effects of labour market flexibility. It was beyond the scope of this assessment to examine each of these measures in detail. However based on the current evidence (above) of the:

- growth in labour market flexibility with it's associated negative health impacts,
- embryonic developments in flexible working arrangements for employees,

- early developments in mitigating measures, for example, following redundancies, but not necessarily other issues associated with job security,
- health and safety targets that may not meet the needs of the most vulnerable workers (contract type rather than occupation).

it is possible that in the short term these measures will have net negative health effects on the labour market as a whole. The impacts will be most severe on workers who move from secure to insecure jobs; the health impacts could be similar to those described above. In the most severe cases these health effects could be as detrimental as being unemployed. However although workers already in insecure jobs may not experience such negative health impacts when they are subjected to organisational change, they are more likely to be already exposed to more adverse physical and social working environments than permanent workers. As indicated above, secondary labour markets tend to be low paid, low skilled, poor jobs and are over-represented by women and people from ethnic minority groups. In the longer term, the development of flexible working arrangements for employees will possibly encourage more inactive people, for example, women, older people and people with disabilities into the work place. For those people in work, it may also help to reduce work-life imbalances with possible positive health effects; this will again most probably help parents with children and older workers. Finally those organisations supporting flexible working arrangements may find it acts as a useful employment retention measure.

### ***Employment to Unemployment Transition***

The Jobcentre Plus measures (Guideline 3) to mitigate against job losses will potentially reduce the extent of negative health effects associated with redundancy and unemployment.

As defined earlier, unemployment has a range of short and long-term negative health effects. The steepest decline in mental health is following recent unemployment.

### ***Preventing Unemployment***

Measures to develop the human capital of the population (Guideline 4) are likely to have long-term positive health effects for the population as a whole and for individuals. This relates to the increase in GDP and global competitiveness, from enhanced performance. Improving skills level increases performance. Skills and qualifications influence an individual's labour market position, their income, housing and other material resources.

There were some concerns however that some measures to improve employability of the long term unemployed are not proving effective, for example New Deal 25 plus.

### **Impacts of the European Employment Strategy on the UK Employment Action Plan**

There were conflicting views from stakeholders and key informants on whether there was an impact of the EES on the UK EAP and, by association, national employment policy. The policy analysis indicated that the UK has a leaning towards US economic and employment policy. However, the value of the EES appears to be in balancing this policy direction by emphasising the 'European Social Model' and influencing the UK's social agenda. The importance of this influence cannot be underestimated; there are worrying trends in US employment policy resulting in severe negative health impacts on the health of vulnerable individuals and their families.

Having said this it is disappointing that there seems to be less influence from the EES; for example on equity issues such as action to reduce the gender pay gap. Similarly in the spirit of this open co-ordination method, the added value of the EES would be enhanced by encouraging more sharing of good practice from the UK with

the rest of Europe, and vice versa. For example, the intermediate skills development programmes in Germany and the Netherlands.

### **Discussion and Conclusions**

Measures included in the UK Employment Action Plan, developed in response to the European Employment Strategy 2003 Guidelines, will probably contribute to UK employment gains during the year. This increase in employment is likely to be small. However it is difficult to isolate the relative contributions of the UK EAP measures on these employment changes from the impact of the strong economy.

There will be positive impacts on population health associated with these employment gains although it is estimated that there will a 2 to 14 year lag before these health gains materialise. There are also likely to be health benefits for the children of families where employment increases household income. But not all employment is beneficial to health; some work characteristics are as damaging to health as unemployment.

However there are certain population groups - certain ethnic minority groups, people with disabilities and poor health, people with no qualifications, lone parents, women and older people - who have consistently less favourable labour market outcomes than the working age population as a whole. There are complex reasons for these inequalities. Although there will be increases in employment for these disadvantaged groups, these will be small and will only marginally reduce the inequality gap.

There will be small improvements in health for these groups where these increases in employment result in increase in per capita income. However there are concerns that these groups also tend to be recruited to 'poor quality' jobs - jobs in the secondary labour market which are characterised by low pay, low skills, poor psychosocial and physical (hazardous) work environments, as well as being insecure. There are many negative health impacts associated with these 'poor quality' jobs, including depression and other mental health problems, musculoskeletal disorders, fatigue, job dissatisfaction. These groups have a tendency for poorer health than the population as a whole; having a poor quality job is a double disadvantage. There are also possible adverse health effects in children of these families.

The 'welfare to work' measures in the UK EAP (Guideline 1) will potentially benefit the unemployed or inactive who are 'job ready' in gaining employment. With an enhanced income they are likely to have improved long term health outcomes, in addition to short-term improvements in mental wellbeing. There are also possible developmental benefits to children. People who are not 'job ready' are less likely to benefit from 'work first' approaches; community-focused approaches such as Employment Zones are more likely to have positive impacts on employability. There are potential health impacts on, for example, health-related behaviour and health services, but these are speculative. Similarly there appear to be contextual factors that influence the impacts of interventions.

Measures to increase labour market flexibility (Guideline 3) may potentially have a combination of positive and negative health impacts. Positive health impacts are probable as a result of increases in flexible working arrangements such as part-time work and improvements in work-life balance, although there may be some negative impacts associated with psychosocial work factors such as increased isolation and reduced career opportunities. Negative health impacts are probable from changes in job security, including increases in cardiovascular risk factors, reductions in mental health and increases in health service use. In addition increases in poor quality precarious jobs will have negative health impacts as discussed above. It is possible that there will be net negative health effects on the working population as a whole as

current measures to help manage the impacts of labour market changes are not sufficiently well-developed to buffer these negative health impacts.

The impact of the European Employment Strategy on the UK EAP, and in turn national employment strategy is highly speculative. That is, it had a moderating effect on employment policy with a particular influence on the UK's social agenda. Nonetheless, this was felt to be highly important in protecting and improving the health of the working age population as a whole.

## **Recommendations**

### **Reduce the negative health effects of labour market inequalities by:**

- Making the reduction of labour market inequalities (LMI) for all disadvantaged groups (and their sub groups) a more explicit key priority of the Government
- Continuing the development of a comprehensive picture of the underlying causes of these LMI
- Ensuring action to reduce LMI is focused at these underlying causes
- Setting PSA targets for year on year reductions in LMI relative to the working age population as a whole

### **Enhance the positive and reduce the negative health effects of the unemployment/inactive to employment transition by:**

- Addressing differential access to 'welfare to work' programmes, for example, by introducing an interview with a Personal Advisor (PA) as soon as the unemployed or inactive register for benefits (as New Zealand model)
- Enhancing programme outcomes, for example:
  - ♦ identifying each participant's labour market barriers (including health) and action plans to address with PAs (New Zealand and Iceland models)
  - ♦ working with employers to overcome barriers identified
  - ♦ working with Local Strategic Partnerships to overcome other barriers
  - ♦ referrals into these programmes by primary care health professionals, voluntary sector
- Reducing differential programme outcomes, for example, developing specialist PAs to provide support and guidance to those groups most disadvantaged in the labour market (people with health problems, from ethnic minority groups, or without basic skills)
- Reducing differential programme outcomes, for example, building on the 'Pathways to Work Pilots' and developing/testing holistic approaches to action planning (New Zealand model) for participants who are not 'job ready' including:
  - ♦ referrals to mixed programmes (training/work placement)
  - ♦ referrals to 'Expert Patient Programmes' (disease management programmes run by the local Primary Care Trusts) for participants with chronic conditions
  - ♦ referrals to Sure Start or Sure Start Plus
- Undertaking prospective research to identify the short and long term health effects of 'welfare to work' programmes, including mixed programmes
- Collecting data on the short and long term effects of 'welfare to work' programmes on household income
- Collecting follow-up data on unemployed programme 'leavers' who do not re-register for benefits
- Considering the potential health impacts of 'welfare to work' programmes during programme planning

**Reduce the negative and enhance the positive health effects of employment flexibility by:**

- Improving the psychosocial work environment and employee health by actively promoted evidence-based approaches, for example:
  - ♦ demonstrating management commitment to improving working conditions and worker health
  - ♦ providing worker support from managers and co-workers
  - ♦ developing worker participation in the planning and implementation of individual business objectives
- Prioritising the widespread introduction of the Health and Safety Executive's Management Standards for Reducing Stress in the workplace, following the completion of the pilot
- Publishing the UK's performance against the EC's 'Quality Jobs' indicators and developing action plans to improve as necessary
- Undertaking more detailed research into the health effects of :
  - ♦ different dimensions of labour market flexibility
  - ♦ labour market flexibility/organisational change on different workers
  - ♦ improving work-life balance
- Considering the potential health impacts of employment policy during policy planning
- Adapting the Government's existing Regulatory Impact Assessment tool, which examines the impacts of all proposed legislation or policies on business, to include assessing the impacts on the health of the working age population as a whole and on groups disadvantaged in the labour market
- Introducing public sector procurement regulations that require contractors to submit evidence of their employment policies, for example, equality and diversity

**Reduce the negative health effects of the employment to unemployment transition by:**

- Introducing early health care interventions as part of the package of Jobcentre Plus 'managing change and restructuring' measures

**Enhance the positive health effects of preventing unemployment by:**

- Developing the skills and employability of groups disadvantaged in the labour market by designing programmes to meet their specific needs (see above)
- Assessing the health effects of these programmes (see above)
- Actively promoting the investment by employers in the training and development of all employees

**Enhance the impacts of the European Employment Strategy in the UK by:**

- Influencing UK employment policy in relation to reducing labour market inequalities for key disadvantaged groups, including access to employment, pay, training, 'quality jobs'
- Building on the open method of policy co-ordination to share good practice between Member States



## 1 Introduction

### 1.1 Background

IMPACT, the International Health Impact Assessment Consortium at the University of Liverpool successfully co-ordinated a bid, 'EU Policy HIA', with partners from Germany, Ireland and the Netherlands to assess the health impacts of a selected EU policy by:

- Synthesising a standard generic methodology for HIA of EU policies and activities
- Applying this HIA methodology to a selected EU policy at both EU and Member State levels
- Actively disseminating the findings and the lessons learnt

The project commenced in 2002 and synthesised a generic HIA methodology, EPHIA (version 1), in addition to selecting an EU policy to pilot the EPHIA v.1 methodology on.

This report describes the HIA pilot on the European Employment Strategy as applied to the United Kingdom.

### 1.2 Health Impact Assessment and the European Union

It is now generally accepted that non-health care policies are key determinants of public health. This reflects evidence from the Black Report (Townsend et al, 1982), The Health Divide (Whitehead, 1987) and more recently the Independent Inquiry into Health Inequalities (Acheson et al, 1998). Health Impact Assessment (HIA) builds on the understanding that a community's health is determined by a wide range of variable economic, environmental and psychosocial influences, as well as fixed factors such as heredity and age. HIA aims to identify what potential changes in health determinants might result from a new policy or project, for example an employment strategy, and what effects these changes might have on a defined population, for example communities affected by employment policies.

The elements of this approach have much in common with the established field of environmental impact assessment (EIA), and build on this methodology. However it has been recognised that impacts on human health were not an explicit concern of EIA. As such HIA methodologies have been developed. The Departments of Health in England, Northern Ireland, Scotland, and Wales (e.g. DoH, 1999) now recommend HIA on new policy or project developments at national and local levels.

Article 152 of the Treaty of Amsterdam (Commission of the European Communities, 1999) made explicit the commitment of the European Union (EU) to ensure that human health is protected in the definition and implementation of all Community policies and activities. However there has been no accepted methodology for assessing the impacts of EU policies on health within the Community, although many organisations are carrying out Health Impact Assessments (HIA) at regional or Member State level. More recently, the proposal for a decision by the European Parliament and Council in the field of public health (Commission of the European Communities, 2002a) included objectives to 'support the development of health impact assessment methodologies and other relevant tools' (Commission of the European Communities, 2002a, objective 4.2) and to 'support pilot projects on the health impact of Community policies and actions' (Commission of the European Communities, 2002a, objective 4.3).

The 'EU Policy HIA' project is contributing to the EC's commitment to develop HIA methodologies and ensure EU policies protect human health.

### **1.3 Aim of the HIA pilot**

The aim of the HIA pilot is:

**To assess the potential health effects of the EES within the UK using the synthesised EU Policy HIA (EPHIA) methodology.**

Specific objectives include:

- To undertake a detailed analysis of the EES, Employment Guidelines, UK Employment Action Plan and associated policies
- To define and profile the communities affected by the EES, with particular attention to health inequalities
- To identify a sample frame and methods to select stakeholders from affected populations
- To collect and analyse qualitative and quantitative data
- To analyse the impacts on key health determinants and health/wellbeing outcomes from the assembled evidence for two scenarios:
  - Forecasts from baseline (no EES)
  - Forecasts from policy (with EES)
- To prioritise impacts and develop recommendations for Department for Work and Pensions

## 2 Summary of the European Employment Strategy and United Kingdom Employment Action Plan

### 2.1 Background and context

The European Employment Strategy (EES) was launched following the Luxembourg Jobs Summit in November 1997. An evaluation of the first five years carried out in 2002 identified major challenges and issues for the future of the EES. It also emphasised the need to revamp the EES and realign it more closely to the Lisbon Strategy.

### 2.2 The EES: a key component of the Lisbon Strategy

The Lisbon European Council (Commission of the European Communities, March 2000) set itself a new strategic goal for the next decade:

***'...to become the most competitive and dynamic knowledge-based economy in the world, capable of sustainable economic growth with more and better jobs and greater social cohesion.'***

The strategy was designed to create the right conditions for full employment and to strengthen cohesion by 2010. The Council considered that the proposed interventions would, by 2010:

- increase the EU employment rate to 70%,
- increase the proportion of women in employment to over 60%.

The Stockholm European Council (Commission of the European Communities, March 2001) added three additional targets:

- increase the EU employment rate to 67% by 2005,
- increase the proportion of women in employment to 57% by 2005,
- increase the proportion of older people in employment to 50% by 2010.

The Barcelona European Council (Commission of the European Communities, March 2002) confirmed that full employment was the overarching goal of the EU and called for a reinforced EES in an enlarged EU.

### 2.3 Co-ordination of Employment Policies at EU level

The EES is designed as the main tool to give direction to and ensure co-ordination of the employment policy priorities for Member States at EU level. The Luxembourg European Council initiated 'the Luxembourg Process' as a means of ensuring effective co-ordination of national employment policies at EU level. This consists of the following elements:

#### **Employment Guidelines**

These is an annual agreement on a series of common objectives and targets for employment policy by the European Council (Heads of State & Government), following recommendations from the Commission, consultation with the European Parliament and Committees. In March 2003, The Council agreed to:

- Limit the Guidelines in number
- Define appropriate targets
- Consider the Broad Economic Policy Guidelines (BEPGs) and the internal market strategy in conjunction with the employment guidelines in a 'Guidelines Package'
- Give the 'Guidelines Package' a three year perspective

### **National Action Plans**

Each Member State draws up an annual National Action Plan describing how these Guidelines will be put into practice nationally.

### **Joint Employment Report**

The Commission and Council jointly examine each NAP and present a Joint Employment Report. The Commission presents a new proposal to revise the Employment Guidelines accordingly next year. The Council also agreed (July, 2003) to receive an 'Implementation Package' every January, which will report on the conclusions of the review of the implementation of EU policy guidance on BEPGs, the Joint Employment report and the Internal Market.

### **Recommendations**

The Council may decide, by qualified majority, to issue country specific recommendations, as was the case in 2003.

## **2. □ 'The Employment Guidelines □ A European strategy for full employment and better jobs for all'<sup>1</sup>**

The Employment Guidelines (Commission of the European Communities, 2003) state that Member States should foster the following three overarching objectives:

- Full employment
- Quality and productivity at work
- Social cohesion and inclusion

And that these should be equally pursued.

### **Full employment**

Member States should aim to achieve full employment by implementing a comprehensive policy approach incorporating demand and supply side measures. Policies shall contribute towards achieving on average for the European Union:

- an overall employment rate of 67 % in 2005 and 70 % in 2010,
- an employment rate for women of 57 % in 2005 and 60 % in 2010,
- an employment rate of 50 % for older workers (55 to 64) in 2010.

## **2. □ Improving quality and productivity at work**

Increasing employment rates must go hand in hand with raising overall labour productivity. Quality at work can help increase labour productivity and the synergies between both should be fully exploited. This represents a specific challenge for social dialogue.

### **2.6 Social cohesion and dialogue**

Economic and social cohesion should be promoted by reducing regional employment and unemployment disparities, tackling the employment problems of deprived areas in the European Union and positively supporting economic and social restructuring.

### **2.7 Specific Guidelines**

There are 10 priority action areas with a gender mainstreaming approach across each priority area:

- Active and preventative measures for the unemployed and inactive
- Job creation and entrepreneurship
- Address change and promote adaptability and mobility in the market place
- Promote development of human capital and lifelong learning
- Increase labour supply and promote active ageing

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<sup>1</sup> European Council Decision 2003/578/EC

- Gender equality
- Promote the integration of and combat the discrimination against people at a disadvantage in the labour market
- Make work pay through incentives to enhance work attractiveness
- Transform undeclared work into regular employment
- Address regional employment disparities

### **2.7.1 Guideline 1: Active and preventative measures for the unemployed and inactive**

Under this action Member States are required to develop and implement active and preventative measures for the unemployed and the inactive designed to prevent them entering into long-term unemployment. They are also to promote the sustainable integration of unemployed and inactive people into employment.

Specifically Member States are to ensure that:

- every unemployed person is offered a new start before reaching six months of unemployment in the case of young people and 12 months of unemployment in the case of adults in the form of training, retraining, work practice, a job, or other employability measure, combined where appropriate with ongoing job search assistance,
- by 2010, 25 % of the long-term unemployed participate in an active measure in the form of training, retraining, work practice, or other employability measure, with the aim of achieving the average of the three most advanced Member States.

### **2.7.2 Guideline 2: Job creation and entrepreneurship**

This action focuses Member States on increasing jobs (quantity and quality) by supporting innovation, entrepreneurship, investment capacity and supportive business environments. Sector developments include R&D, services and new enterprises.

Supported by the process of benchmarking of enterprise policy and the implementation of the European Charter for Small Enterprises, policy initiatives will focus on:

- simplifying and reducing administrative and regulatory burdens for business start-ups and small and medium-sized enterprises (SMEs) and for the hiring of staff, facilitating access to capital for start-ups, new and existing SMEs and enterprises with a high growth and job creation potential (see also BEPGs, guideline 11),
- promoting education and training in entrepreneurial and management skills and providing support, including through training to make entrepreneurship a career option for all.

### **2.7.3 Guideline 3: Address change and promote adaptability and mobility in the market place**

This action tasks Member States with facilitating worker and business flexibility and adaptability to change, whilst protecting the security and interests of workers in particular via the social partners.

Member States are required to review and, where appropriate, reform overly restrictive elements in employment legislation that affect labour market dynamics and the employment of those groups facing difficult access to the labour market, develop social dialogue, foster corporate social responsibility, and undertake other appropriate measures to promote:

- diversity of contractual and working arrangements, including arrangements on working time, favouring career progression, a better balance between work and private life and between flexibility and security,
- access for workers, in particular for low skill workers, to training,
- better working conditions, including health and safety; policies will aim to achieve in particular: a substantial reduction in the incidence rate of accidents at work and of occupational diseases,
- the design and dissemination of innovative and sustainable forms of work organisation, which support labour productivity and quality at work,
- the anticipation and the positive management of economic change and restructuring.

#### **2.7.4 Guideline 4: Promote development of human capital and lifelong learning**

This action requires Member States to implement lifelong learning strategies by developing quality education and training systems so that skills needs of the future can be met in a knowledge-based society.

In accordance with national priorities, Member State policies will aim in particular to achieve the following outcomes by 2010:

- at least 85 % of 22-year olds in the European Union should have completed upper secondary education,
- the European Union average level of participation in lifelong learning should be at least 12.5 % of the adult working-age population (25 to 64 age group).

In addition, policies will aim to achieve an increase in investment in human resources.

#### **2.7.5 Guideline 5: Increase labour supply and promote active ageing**

Through this action Member States will promote an adequate availability of labour and employment opportunities to support economic growth and employment, taking into account labour mobility, as indicated in specific guideline 3.

In particular, they will:

- increase labour market participation by using the potential of all groups of the population, through a comprehensive approach covering in particular the availability and attractiveness of jobs, making work pay, raising skills, and providing adequate support measures,
- promote active ageing, notably by fostering working conditions conducive to job retention such as access to continuing training, recognising the special importance of health and safety at work, innovative and flexible forms of work organisation and eliminating incentives for early exit from the labour market, notably by reforming early retirement schemes and ensuring that it pays to remain active in the labour market; and encouraging employers to employ older workers,

In particular, policies will aim to achieve by 2010 an increase by five years, at European Union level, of the effective average exit age from the labour market (estimated at 59.9 years in 2001).

#### **2.7.6 Guideline 6: Gender equality**

Member States will, through an integrated approach combining gender mainstreaming and specific policy actions, encourage female labour market participation and achieve a substantial reduction in gender gaps in employment rates, unemployment rates, and pay by 2010.

Member States should remove disincentives to female labour force participation and strive, taking into account the demand for childcare facilities and in line with national patterns of childcare provision, to provide childcare by 2010 to at least 90% of children between three years old and the mandatory school age and at least 33% of children under three years of age.

### **2.7.7 Guideline 7: Promote the integration of and combat the discrimination against people at a disadvantage in the labour market**

Member States will foster the integration of people facing particular difficulties on the labour market, such as early school leavers, low-skilled workers, people with disabilities, immigrants, and ethnic minorities, by developing their employability, increasing job opportunities and preventing all forms of discrimination against them.

In particular, policies will aim to achieve by 2010:

- an EU average rate of no more than 10% early school leavers,
- a significant reduction in each Member State in the unemployment gaps for people at a disadvantage, according to any national targets and definitions,
- a significant reduction in each Member State in the unemployment gaps between non-EU and EU nationals, according to any national targets.

### **2.7.8 Guideline 8: Make work pay through incentives to enhance work attractiveness**

This action directs Member States to reforming financial incentives with a view to making work attractive and encouraging men and women to seek, take up and remain in work. In this context, Member States should develop appropriate policies with a view to reducing the number of working poor. They will review and, where appropriate, reform tax and benefit systems and their interaction with a view to eliminating unemployment, poverty and inactivity traps, and encouraging the participation of women, low-skilled workers, older workers, people with disabilities and those furthest from the labour market in employment.

The action is keen to ensure adequate social protection but to monitor replacement rates and benefit duration, ensuring effective benefit management coupled with job search.

In particular, policies will aim at achieving a significant reduction in high marginal effective tax rates by 2010 and, where appropriate, in the tax burden on low paid workers, reflecting national circumstances.

### **2.7.9 Guideline 9: Transform undeclared work into regular employment**

Member States should develop and implement broad actions and measures to eliminate undeclared work, which combine simplification of the business environment, removing disincentives and providing appropriate incentives in the tax and benefits system, improved law enforcement and the application of sanctions. They should undertake the necessary efforts at national and EU level to measure the extent of the problem and progress achieved at national level.

### **2.7.10 Guideline 10: Address regional employment disparities**

Member States are tasked with reducing regional employment and unemployment disparities by implementing broad approaches. The potential for job creation at the

local level, including in the social economy, should be supported and partnerships between all relevant actors should be encouraged.

Member States will:

- promote favourable conditions for private sector activity and investment in regions lagging behind,
- ensure that public support in regions lagging behind is focused on investment in human and knowledge capital, as well as adequate infrastructure (see also BEPGs, guidelines 18 and 19).

## **2.8 Governance, Partnership and Financial Resources**

### **Governance**

Within the Council's decision Member States are charged with ensuring effective implementation of the Guidelines within all their regions and locally. This reflects the stated 'strong political commitment from all parties concerned'. However, whilst the Guidelines have been adopted and Member States are requested 'to take them into account in their employment policies', it is recognised that there is no legal compulsion for Member States to do this.

### **Partnership**

Social partners at national level are recommended to be involved to ensure the effective implementation of the Employment guidelines particularly concerning Guidelines 3 to 8. At European levels, social partners are also encouraged to support national partners. At inter-professional levels they are to report on their contribution to the Guidelines implementation, whilst at sector level they will report on their respective actions.

### **Financial resources**

The Guidelines state that '... the potential of the Cohesion and Structural Funds and the European Investment Bank should be fully exploited.' (Commission of the European Communities, 2003). European funding through the Community is potentially through European Social Fund (ESF) as well as Structural Funds. However primarily the Guidelines will be implemented by national funding.

## **2.9 United Kingdom Employment Action Plan**

The Department of Work and Pensions responded to the 2003 Guidelines and co-ordinated the production of the United Kingdom Employment Action Plan 2003 (DWP, 2003). This provides an overview of the existing economic and labour market context and current UK employment strategy programmes and targets, citing examples of good practice. It then considers existing UK employment and education measures, in particular against the ten Guideline action areas as follows;

**Table 3 Summary of UK Employment Action Plan**

<b>EES Guidelines</b>	<b>UK Policies/interventions</b>
1. 'Active and Preventative Measures for Unemployed and Inactive'	<ul style="list-style-type: none"> <li>• Job seekers' allowance regime</li> <li>• Compulsory work-focused interviews for economically inactive benefit claimants</li> <li>• New Deals (NDs)</li> <li>• Job Centre Plus - modernisation of employment &amp; benefits service</li> </ul>
2. 'Foster entrepreneurship and promote job creation'	<ul style="list-style-type: none"> <li>• Supporting small business</li> <li>• Regulatory reform</li> <li>• Women entrepreneurs</li> <li>• Access to finance</li> <li>• Building an enterprise culture</li> </ul>
3. 'Address change and	<ul style="list-style-type: none"> <li>• Regulatory reform</li> </ul>



<p>promote adaptability and mobility in the labour market'</p>	<ul style="list-style-type: none"> <li>• Promoting diversity of working arrangements</li> <li>• Managing change and restructuring</li> <li>• Health &amp; Safety at Work</li> <li>• EU-wide vacancies</li> </ul>
<p>4. 'Promote development of human capital and life long learning'</p>	<ul style="list-style-type: none"> <li>• England: 'Skills Strategy' and 'Skills for Life' programme</li> <li>• Wales: 'The Learning Country', 'Skills and Employment Action Plan' and 'Basic Skills Strategy'</li> <li>• Scotland: 'Life Through Learning: Learning Through Life', 'Futureskills Scotland', 'Business Learning Accounts', 'Modern Apprenticeships', 'A Partnership for a Better Scotland'</li> <li>• Northern Ireland: 'Essential Skills for Living Strategy', 'Peace &amp; Reconciliation in NI', 'Border Region of Ireland'</li> </ul>
<p>5. 'Increase labour supply and promote active ageing'</p>	<ul style="list-style-type: none"> <li>• Older people: Age Positive campaign, 'Simplicity, security and choice: working and saving for retirement'</li> <li>• Lone parents: ND for lone parents, working tax credits, childcare provision, other benefits support</li> <li>• Immigrants: 'Highly skilled Migrants' programme</li> </ul>
<p>6. 'Gender equality'</p>	<ul style="list-style-type: none"> <li>• Gender pay gap: 'Employment Act, 2002'</li> <li>• Occupational segregation review</li> <li>• Women in Science, Engineering and Technology initiatives</li> <li>• Work-Life Balance, flexible working and other rights for parents</li> <li>• National childcare strategy and WTC for childcare</li> </ul>
<p>7. 'Promote the integration of and combat the discrimination against people at a disadvantage in the labour market'</p>	<ul style="list-style-type: none"> <li>• UK NAP on social inclusion</li> <li>• Ethnic minorities: 'Ethnic Minorities and the Labour Market'</li> <li>• Disabilities: 'Disability Discrimination Act, 1995' (to be amended in 2004), ND for disabled people</li> </ul>
<p>8. 'Make work pay through incentives to enhance work attractiveness'</p>	<ul style="list-style-type: none"> <li>• Working Tax Credit</li> <li>• National minimum wage (NMW)</li> <li>• Other fiscal policies</li> </ul>
<p>9. 'Transform undeclared work into regular employment'</p>	<ul style="list-style-type: none"> <li>• Incentives: Tax-benefit reforms, e.g. WTC, NMW, Regulatory reforms,</li> <li>• Prevention: business registration, National Insurance numbers, benefit claimants</li> <li>• Detection &amp; punishment: 'Social Security Fraud Act, 2001',</li> <li>• Public awareness: 'Targeting Fraud', benefits of legitimate work</li> </ul>
<p>10. 'Address regional employment disparities'</p>	<ul style="list-style-type: none"> <li>• Regional Development Agencies devolved responsibilities for economic growth and competitiveness</li> <li>• 'Frameworks for Regional Employment and Skills Action' (FRESAs)</li> <li>• National Strategy for Neighbourhood Renewal</li> <li>• Job Centre Plus</li> <li>• Local Strategic Partnerships</li> <li>• ESF and ERDF</li> </ul>

## **2.10 Governance, Partnership and Financial Resources**

The UK EAP describes a broader partnership model than the social partnership arrangements proposed in the Guidelines, involving local government and voluntary sectors in both the development and delivery of the National Action Plan. It also indicates that although social partnership arrangements are not 'institutionalised', task forces and discussions at national and regional level have been able to agree recommendations between all the relevant parties.

The voluntary sector is identified in the UK EAP in connection with community-based initiatives focusing on social exclusion, but also in terms of their effect on economic inactivity and welfare dependence through community development. ESF monies have enabled community organisations to respond to particular barriers to employment and work.

Local authorities' role to promote economic, social and physical well being of their communities is identified as key in delivering employment policy locally in conjunction with their Local Strategic Partnerships (LSPs) and Regional Development Agencies (RDAs). Local authorities also work in partnership with other agencies to interpret and implement Government policies through LSPs and other partnerships, e.g. New Deal, Skills strategy. Once more ESF money is seen as '...vital to achieve the objectives of the European Employment Strategy and the National Action Plan.'

The UK EAP was not explicit in terms of the financial resources allocated from the Treasury to this. However, it describes the 'policy frame of reference' for UK Structural Funds that support labour market and human resource development, contributing to EES and which is co-ordinated by the Department of Work and Pensions. The 'policy frame' is also the reference point for other programming documents on employability and HR priorities; these programme plans define the resources for each policy field.

## **2.11 The European Council recommendations to the United Kingdom**

Within the Council recommendations to Member States it was recognised that the UK exceeds the overall employment target including targets for women and older people. However, attention was drawn to the relatively low rate of productivity, which was in part attributed to the low skills base, particularly basic skills. In addition equity issues such as the gender pay gap and lack of access to training for some categories of workers were also highlighted.

Although, relatively, levels of unemployment are low, concerns were raised about the rising proportion of working age people who are claiming sickness or incapacity benefit, particularly in view of the differential distribution of economic inactivity in certain areas and communities: lone parents, households with no-one in work, certain ethnic minorities, male older workers, people with disabilities and the low skilled.

As such the Council recommended the following to the UK

### ***Recommendation 1: Prevention and activation***

Implement active labour market policies, focus attention on inequalities in access to the labour market or at risk of unemployment, the working poor and the inactive

UK response: action associated within Guideline i

### ***Recommendation 2: Labour supply and active ageing***

Ensure those that are able to work have opportunities and incentives to do so in particular by modernising sickness and disability schemes

UK response: action associated within Guideline v

*Recommendation 3: Gender equality*

Address the underlying factors of the gender pay gap, in particular improve the gender balance across occupations and sectors, increase access to training for low paid women and part-time workers.

UK response: In addition to action associated within Guideline iv 'Pathways to work', incapacity benefit reforms, New Deal for disabled people, Working Tax Credit (WTC) is being delivered.

*Recommendation 4: Social partnership*

Contribute to addressing productivity and quality of work issues by further developing social partnership at all levels.

UK response: In addition to action associated within Guideline iii voluntary involvement of employees and businesses in national policy development has been undertaken.

### 3 Methods

#### 3.1 Introduction

This section summarises the 'EU Policy HIA' (EPHIA) methodology and describes the methods used in this HIA to collect and analyse the primary and secondary data.

#### 3.2 EPHIA methodology overview

##### 3.2.1 Aims

The aim of the EPHIA methodology is:

**'To estimate the effects of a DG proposed policy on the health of affected populations by the systematic application of rigorous methods, tools and procedures.'**

The methods and procedures used in this Health Impact Assessment (HIA) reflect the generic EPHIA methodology. This is summarised below:

**Table 4 EU Policy HIA Methods and Procedures**

HIA procedures	HIA methods
Establish a Steering Group and Terms of Reference	Profile the area and communities
Carry out the health impact assessment	Policy analysis
	Data collection - involve stakeholders and key informants
Negotiate the favoured option(s)	Impact analysis - assess the importance, direction, scale and likelihood of predicted impacts from all data collected
Monitor and evaluate	Consider alternative options
	Make recommendations for action - enhance positive or mitigate negative impacts
	Monitor and evaluate

### 3.2.2 Values

The EPHIA methodology is underpinned by an explicit set of values as described below:

<p><b>Shared Ownership</b> - the assessment should be jointly owned by the assessors, DG proposing the policy, DG SANCO and the Secretary General's office</p> <p><b>Socio-environmental model of health</b> - the assessment should identify potential impacts on a broad range of health determinants - economic, social, physical environment, lifestyle factors - which are known to or believed to have a known causal relationship with health outcomes</p> <p><b>Democratic/Public involvement</b> - the populations affected should be involved in the process, e.g. through their elected representatives or where the likelihood, latency, scale and severity of the impacts warrants the involvement of members of affected communities themselves</p> <p><b>Robust</b> - the assessment should include detailed design, rigorous methods and validated tools and measures</p> <p><b>Reducing health inequalities</b> - the HIA should assess the differential distribution of impacts across the population; a special focus is on reducing health inequalities</p> <p><b>Objective</b> - the identification of data sources and samples, the collection and analysis of data, and the identification of evidence of impacts from this data should be based on recognised research quality standards, ensuring the objectivity in the assessment</p> <p><b>Transparent</b> - the assessment should have explicit, open methods and procedures, including decision-making</p> <p><b>Sustainable</b> - both short and long-term impacts should be identified as well as the sustainability of recommendations</p> <p><b>Ethical</b> - the assessment should be ethical in all aspects of data collection and analysis, the identification and valuing of different evidence, development and negotiation of recommendations and in reporting</p> <p><b>Practicable</b> - the methods used and recommendations developed should be practicable and achievable</p>
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### 3.2.3 Establishing a steering group

An important influence in planning and undertaking a health impact assessment is the engagement and commitment of key stakeholders to the process and outcome of the assessment. It is important to have a steering group comprising of key stakeholders with a range of expertise and perspectives that can also 'open doors' and ensure the outcomes of the health impact assessment are acted upon. A partnership approach is more likely to facilitate ownership and develop a more realistic understanding of what can and cannot be achieved when reviewing any recommendations for changing a policy, programme or project.

Potential members of a HIA Steering Group were selected from policy proponents, stakeholders - individuals or groups who have a 'stake' in the policy under investigation - and key informants - 'experts' or 'specialists' in the specific policy field, in this case 'employment' and 'employment and health'.

**Table 5 HIA Steering Group - identified membership**

HIA Assessment Team	Department for Work & Pensions
Employment policy academic	Department for Education & Skills
Employment and health academic	Department of Health/HDA
Confederation of British Industry	Trade Union Congress
National Unemployment Centres	

Terms of reference for the Steering Group were developed in addition to terms of reference for the EES (UK) HIA (Abrahams et al, 2003). The EES (UK) HIA terms of reference defined the scope and research design of the HIA.

### **3.3 Data collection**

#### **3.2.1 Documentary analysis**

The documentary audit and analysis in EPHIA describes four document sources:

- The policy proposals and supporting documentation - in this case the Employment Guidelines (Commission of the European Communities, 2003) and the UK Employment Action Plan (DWP, 2003)
- Official policy documents at national level related to the main proposed outcomes of the UK EAP
- Evidence of the social, economic, political, cultural and scientific context of the policy
- Evidence from the literature defining the relationship between policy interventions, the effects on health determinant and health outcomes, and 'determinants of determinants' - in this case a literature review was undertaken to consider up to date evidence on the relationship between employment and health and unemployment and health

The audit involved document and literature searches followed by their systematic qualitative and quantitative analysis in order to identify:

- the rationale, context and strategies of the policy
- the targeted populations and sub-populations who are affected, positively or negatively, by the policy
- key informant and stakeholder sample groups
- the health determinants affected and if known the magnitude of the effects
- health promotion opportunities
- the impacts of the proposed policy on other policies and vice versa
- the results from output evaluations of other similar policies

#### **3.2.2 Health and demographic profile**

Existing routine data was collected from a variety of different sources, e.g. the Office for National Statistics (ONS) to define the baseline position of the following data categories:

- Populations, e.g. population total, composition by age, gender
- Health status, eg mortality rates, perceived health & well being
- Health Determinants, e.g. unemployment, economic activity rates
- 'Determinants of determinants', e.g. mode of travel to work

#### **3.3.3 Stakeholder and key informants**

The purpose of participatory, qualitative approaches is to gather evidence from the experience, knowledge, opinions and perceptions of populations affected by the policy (stakeholders) and people with expert knowledge (key informants). This evidence:

- provides a more in-depth picture of the range of health determinants affected by the policy
- provides a detailed understanding of how they think this impacts on health outcomes and why
- contributes to prioritisation of impacts
- provides a valuable perspective on health inequalities
- contributes to a robust HIA process by using triangulation (multiple methods)
- supports better policy-making

Purposive and random sampling methods were used to generate the initial organisational stakeholder and key informants groups, followed by snowball sampling. Representatives from the following organisations were invited to participate:

**Table 6 Stakeholder and Key Informant Groups invited to participate in the HIA**

<b>Stakeholder/Key Informant Category</b>	<b>Stakeholder/Key Informant</b>
Organisational stakeholder - health	Health Development Agency (2) Health and Safety Executive
Organisational stakeholder - policy proponents	Department for Work & Pensions Department for Education and Skills Department of Trade & Industry
Organisational stakeholder - relevant to the policy	Her Majesty's Treasury Department for the Environment, Food and Rural Affairs Office of the Deputy Prime Minister Social Exclusion Unit
Organisational stakeholder - regional government	North West Development Agency
Organisational stakeholder - social partners	Confederation of British Industry Trade Union Congress Chartered Institute of Personnel Development
Organisational stakeholder (NGO/VS) - special interest groups	Commission for Racial Equality Equal Opportunities Disabilities Rights Commission Low Pay Commission Third Age Employment Network National Unemployment Centres
Key informants - Employment & health	University College, London European Foundation for Improvement of Living & Working Conditions
Key informants - Employment	Manchester Business School Institute for Employment Research

Planned data collection methods consisted of:

- Focus groups in a workshop format, followed by
- One to one semi-structured interviews (telephone and face-to-face)
- Observation notes and written submissions
- Email discussion group

### **3.2.3 Stakeholder and key informant engagement process**

This engagement process was as follows:

- Once organisations had been identified from sampling, a 'fieldwork plan' was developed
- Initial contact was made by telephone
- Confirmation of the interview date/time/venue was made in writing
- Details of the HIA, a summary of the EES and UKEAP and the question themes for the interview were circulated with the confirmation letter
- Consent forms were completed by interviewees
- Expenses were reimbursed (where appropriate)

### 3.3.5 Development of question guides

The HIA team at IMPACT developed two question guides: one for employment stakeholders and key informants and one for stakeholders and key informants with a background in health and employment. Each was designed with a number of themes (table 6), which started with broad open questions and then focused down to more specific questions; all had supplementary questions and prompts. Table 6 summarises the key themes used for community and organisational groups and individuals. A health impact matrix was used to record the potential positive and negative impacts of the UKEAP.

**Table 7 Themes for workshops and focus groups**

<b>Employment Question Themes</b>	<b>Employment and Health Question Themes</b>
Unemployment trends in the UK, e.g. <ul style="list-style-type: none"> <li>♦ Population sub-groups most affected? Why? How?</li> <li>♦ Affects on quality of life? Priorities?</li> </ul>	Effects of unemployment on health and well being, e.g. <ul style="list-style-type: none"> <li>♦ Physical, psychosocial health/wellbeing? How (causal relationship)?</li> <li>♦ Population sub-groups most affected? Why?</li> </ul>
Employment trends in the UK, e.g. <ul style="list-style-type: none"> <li>♦ Employment types?</li> <li>♦ Low pay?</li> <li>♦ Employee involvement?</li> </ul>	Effects of employment on health and well being, e.g. <ul style="list-style-type: none"> <li>♦ Employment types?</li> <li>♦ Low pay?</li> <li>♦ Employee involvement?</li> <li>♦ Who? How?</li> </ul>
Effective interventions to reduce unemployment, e.g. for <ul style="list-style-type: none"> <li>♦ Long-term unemployment?</li> <li>♦ Economically inactive?</li> </ul>	Effects of interventions to reduce unemployment on health and well being, e.g. <ul style="list-style-type: none"> <li>♦ IB claimants' interviews?</li> </ul>
Effective employment interventions, e.g. to <ul style="list-style-type: none"> <li>♦ Increase productivity?</li> <li>♦ Increase innovation?</li> </ul>	Effects of employment interventions on health and well being, e.g. <ul style="list-style-type: none"> <li>♦ Increase flexible working?</li> <li>♦ Employee involvement?</li> </ul>
Potential effects of the Employment Guidelines in the UK, e.g. <ul style="list-style-type: none"> <li>♦ EU EES/Guideline targets?</li> <li>♦ Other health determinants - average income, educational attainment etc</li> </ul>	Potential effects of the Employment Guidelines in the UK, e.g. EU EES/Guideline targets, on health and wellbeing?

### 3.3.6 Transcription and data analysis

As soon as possible after each interview the facilitator wrote down their broad impressions about how the interview went and any limitations or procedural variations they were aware of. Notes that were taken during the interviews were used to supplement the recorded transcripts. One-to-one interviews (face to face and telephone) were tape recorded and transcribed verbatim. Qualitative data was coded according to the themes generated, and analysed systematically for similarities and differences (Knodel, 1993; Silverman, 1993).

Content analysis - the systematic identification and analysis of key words and phrases in documents, transcripts, field notes and recordings - has been used to analyse qualitative data.



### 3.□ **Impact Analysis**

Impact analysis involves assembling evidence of impacts from the different data sources, qualitative and quantitative, and defining:

- Health impacts - the health determinants affected and the subsequent effect on health outcomes
- Direction of change - indicates a health gain (+) or loss (-)
- Latency - when the impact will occur - immediate, short, medium or long term
- Measurability - refers to the measurability of the impact, quantitative (impacts that can be measured by direct indicators), qualitative (non-quantifiable opinions or perceptions), estimable (quantifiable impacts that cannot be measured directly, but can be estimated by proxy measures)
- Scale - severity of the impact (mortality, morbidity and well being) and the size/proportion of the population affected - is represented by the number of symbols as follows:

Severity/population proportion	High	Medium	Low
Death	---- or +++++	--- or +++	-- or ++
Illness/injury	--- or +++	-- or ++	- or +
Well being	-- or ++	- or +	negligible

- Likelihood - definite (retrospective HIA only) , probable, possible or speculative, based on the strength of evidence (e.g. evidence from systematic reviews or meta analyses) and number of sources (e.g. literature, stakeholders/key informants, documents)

### 3.□ **Limitations to the study**

All studies have limitations. In this study, the engagement of particular stakeholder groups and individuals proved difficult. In addition there was limited appropriate national epidemiological evidence on e.g. employment contract type and health status to enable quantitative projections to be made. Other threats to reliability and validity have been minimised by a robust research design including the use of multiple methods. A more detailed evaluation of the EPHIA methodology is being undertaken separately to this report.

## 4 Health Profile

### 4.1 Introduction

The UKEAP has the potential to affect a range of health determinants and, directly and indirectly, the health status of the population. The profile would ideally consist of trend (time series) data from these potentially affected health determinants as well as key health indicators providing a baseline picture on which the UKEAP will impact; however in reality not all these data are routinely collected or are readily available. As such this section presents data from existing data sets. The following indicator groups relevant to the UKEAP were selected for data collection and analysis:

**Table 8 'Ideal' EES (UK) indicator set for profiling**

Indicator Group
<p><i>Demographics</i></p> <ul style="list-style-type: none"> <li>• Population status - total, composition by gender, age</li> <li>• Population by ethnicity</li> <li>• Population by dynamics</li> <li>• Population by socio-economic status</li> <li>• Population by household composition</li> <li>• Population by disability</li> </ul>
<p><i>Health</i></p> <ul style="list-style-type: none"> <li>• Vital statistics - births, age of mother, deaths, inequality of deaths</li> <li>• Health status - occupational morbidity, sickness</li> <li>• Health status - self-reported, limiting long-term illness</li> <li>• Health status - life expectancy</li> </ul>
<p><i>Health determinants</i></p> <ul style="list-style-type: none"> <li>• Unemployment and economically inactive - total, by gender, age, ethnicity, disability, lone parent status, qualifications, regions</li> <li>• Long term unemployed</li> <li>• Undeclared work</li> <li>• Benefit claimants - jobseekers' allowance, incapacity benefit (IB)</li> <li>• Work/employment - rate, types</li> <li>• Income - average income, low pay, pay gaps (by population sub-groups)</li> <li>• Working days lost through illness</li> <li>• Productivity</li> <li>• Employers recognised as Investors in People</li> <li>• Total and social investment by employers</li> <li>• Employers with employee participation schemes (union and non-union)</li> <li>• Employers with occupational health services</li> <li>• Educational attainment</li> <li>• Small business start ups and closures</li> <li>• Working conditions</li> <li>• Accidents at work</li> <li>• Travelling to work - distance, time, mode</li> <li>• Child care provision</li> </ul>
<p><i>Health Services</i></p> <ul style="list-style-type: none"> <li>• Primary care access</li> <li>• Emergency admissions</li> </ul>

## □.2 **Methods and Source Materials**

This profile has been produced using a wide range of source materials. These include the Office for National Statistics, The General Register Office for Scotland, The Northern Ireland Statistics and Research Agency, The Department of Work and Pensions, The Department of Health, The Department of Trade and Industry, and the Health and Safety Executive; other sources are identified, as relevant, in the text.

Data and analysis have been retrieved from, for example, the 1981, 1991 and 2001 Census, the Labour Force Surveys and a range of health and occupational health surveys. The United Kingdom (UK) is made up of England, Scotland, Wales and Northern Ireland; Great Britain (GB) does not include Northern Ireland. Statistical data has been gathered depending upon availability. Some data is only available at GB or national levels.

## □.3 **Population**

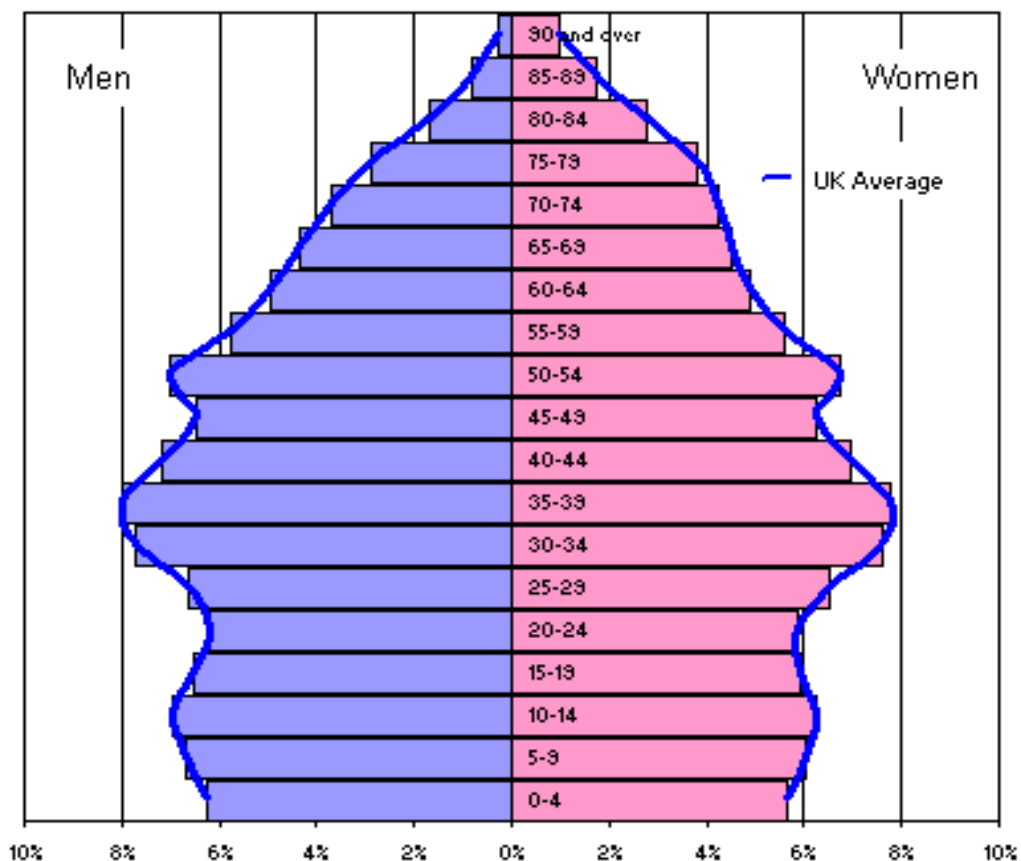
### 4.3.1 **Age/Gender Structure**

One of the most important aspects of the population is its age/gender composition. The ability to meet employment demands depends on the labour 'supply' - the population. Changes in the balance between the three main age groups of the population (children, labour force, and pensionable age) will have many social, economic and resultant health implications. For example, an increase in the elderly population will make more demands on the health service; it is also generally accompanied by a reduction in the working age population that supports dependent populations (The General Register Office for Scotland, 2001).

### 4.3.2 **The United Kingdom**

The UK population has increased by just under 1.5 million people since 1991; this represents an increase of 2.4 percent. The UK population has grown by 17 percent since 1951. This is a relatively slow rate of growth within the current EU. The average growth for the EU was 23 percent during the same 50-year period. This is considerably smaller than the 80 percent growth rate in the USA. The 2001 Census (ONS) was the first ever to report the numbers of people over the age of 60 (21%) as being higher than the numbers of children under the age of 16 (20%).

**Figure 2 Age/Gender Pyramid for the United Kingdom (Source: ONS, 2001)**



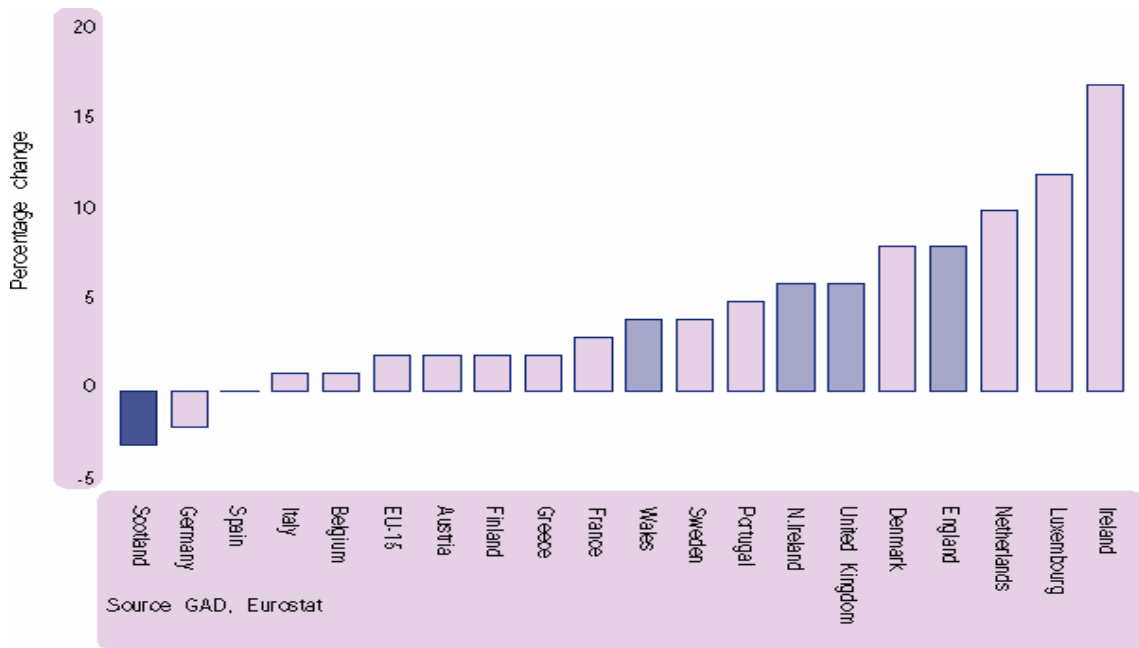
### 4.3.3 Geographical variations

Within the UK there are population differences, including different rates of growth and age structure. England has the largest population with 83.6% of the UK population. Within England there are also regional variations with decline in the North East and North West mirrored by growth in the South East and South West. Wales represents 4.9% of the UK population; it has an older population than the UK average which is on the increase. Scotland makes up 8.6% and has been declining over the last 20 years, partly from a declining birth rate. Northern Ireland consists of 2.9% of the UK population; it has the youngest population in the UK and the largest growth.

### 4.3.4 Population projections

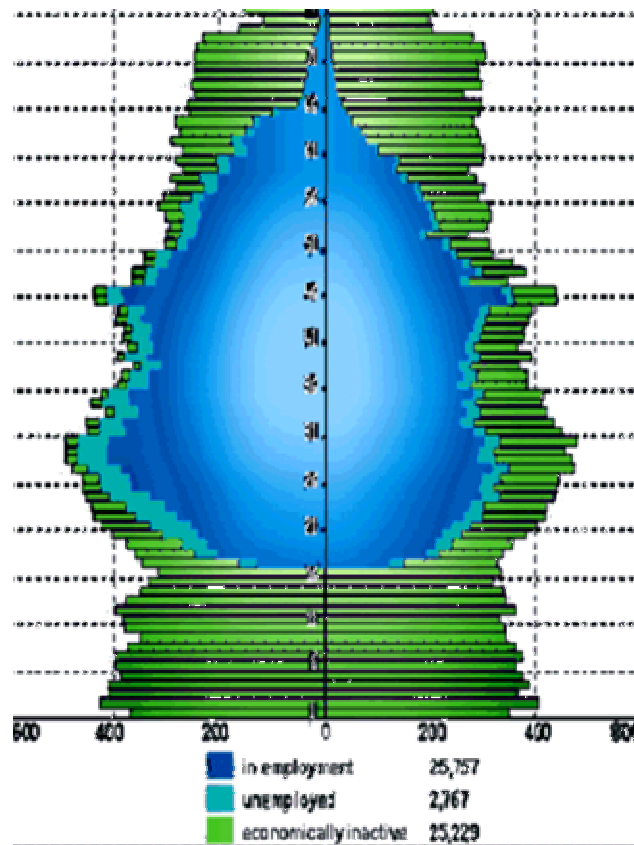
The estimated population projections to 2020 place the United Kingdom in the middle of the EU in terms of population growth. These estimates enable consideration of the potential effects of a declining rate of births and an ageing population on a range of factors, especially the labour market, economic activity, productivity, education, health and other public services.

**Figure 3 Projected percentage population projections in EU Countries 2000-2020**



The clear relationship between the population structure and economic activity is illustrated below:

**Figure 4 Relationship between population structure and economic activity in the United Kingdom (1992-2001)**



### 4.3.5 Analysis

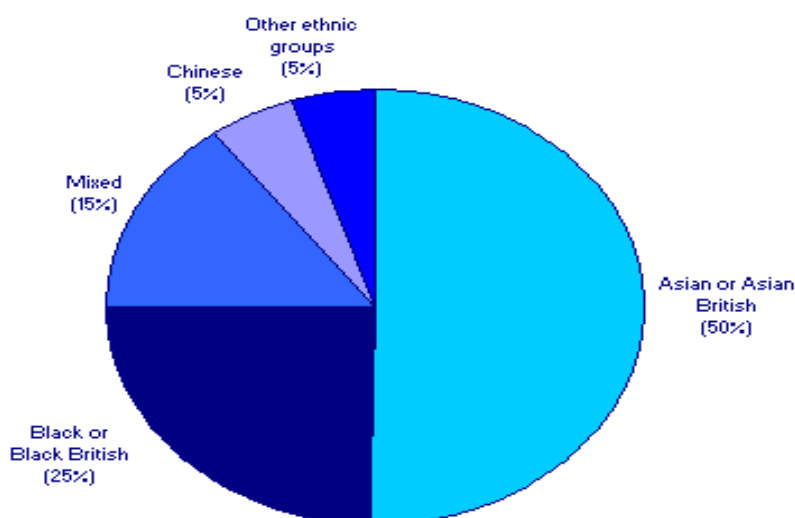
Analysis of these population data identifies current issues with short and longer-term implications for employment strategy. Firstly, the population is ageing across the UK; in some countries, e.g. Scotland, and regions, e.g. South West this is more pronounced due to migration as well as the increased longevity of the post war baby boom population. Secondly, there is a declining birth rate. The ratio of dependants to working population is currently 628 per 1,000 (GAD, 2000); this ratio needs to be maintained in the future, e.g. by increasing the retirement age of the population and encouraging previously economically inactive groups to become active. The national and regional variations in population structure may affect inward investment and employment opportunities.

### 3.5.6 Population: Black and Minority Ethnic (BME) Groups

There is a great deal of epidemiological evidence to show that people from black and minority ethnic (BME) groups tend to enjoy fewer health and socio-economic benefits than the majority white population. The following analysis considers the proportions of BME groups within the United Kingdom and the implications for employment.

According to the 2002 UK Census, over 54 million of the population was White (92 per cent). The remaining 4.6 million (or 7.9 per cent) people belonged to other ethnic groups. Indians were the largest of these groups, followed by Pakistanis, those of mixed ethnic backgrounds, Black Caribbeans, Black Africans and Bangladeshis. The remaining minority ethnic groups each accounted for less than 0.5 per cent of the UK population and together accounted for a further 1.4 per cent. There were almost 691,000 White Irish people in Great Britain (GB) accounting for 1 per cent of the GB population. In GB the number of people who came from an ethnic group other than White grew by 53 per cent between 1991 and 2001, from 3.0 million in 1991 to 4.6 million in 2001 (ONS). The 1991 Census did not cover ethnicity in Northern Ireland; as such information for GB alone is considered.

Figure 5 BME Population by Ethnicity (Source: ONS, 2001)



Ethnic minority groups are mainly concentrated in urban areas, particularly Greater London, Greater Manchester, West Yorkshire and the West Midlands. Nearly three-quarters of the ethnic minority population live in these metropolitan counties, compared with less than a quarter of the white population. Individual ethnic groups are even more concentrated, for example over 80% of the black African population live in Greater London. It is argued that such concentrations reflect economic but also discriminatory constraints so that social support is sought from people with shared cultures and beliefs. It is estimated that ethnic minority populations will increase over the next 20 years, although the extent of this increase is difficult to predict.

### 3.5.7 Population: Household Composition

In England and Wales there are 21,660,475 households (Census in ONS, 2001), and 30.0 per cent of these (6.5 million) are one-person households - up from 26.3 per cent in 1991.

**Table □ Household composition in England and Wales, 2001 (Source: ONS)**

Household composition	Numbers
One person households	7,395,015
Married couple households	8,975,623
Cohabiting couple households	1,969,156
Lone parent households with dependent children	1,602,032
Lone parent households with non-dependent children	771,340
Other households	3,766,223

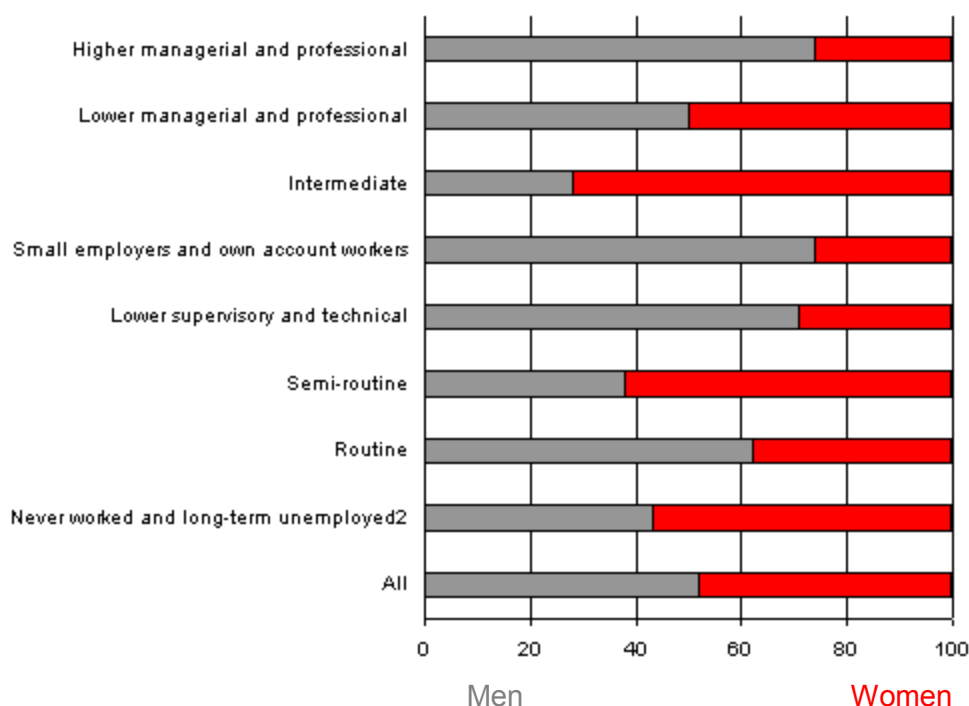
Nearly half of the single-person households are pensioners. Lone parent households, together with births outside marriage, have seen a marked increase in recent times in the UK. For example, over 90% of births in the early 1970s were within marriage (ONS, 2000), the percentage of births outside marriage rose from 12 percent in 1980 to 27 percent in 1989. Women from manual (occupation) class background were (in 1995) 2 ½ times more likely to have a birth outside marriage than woman from a non-manual background. Unmarried women in the manual social class group have the highest rate of low birth-weight rates (ONS, 1995).

People in the United Kingdom are, over time, choosing to have children at progressively later years in life. This together with an increase in women without children has resulted in lower fertility rates and smaller average family sizes.

### 3.5.8 Population: Socio-Economic Status

The proportion of the population within different socio-economic groupings is often a useful guide as to relative wealth and deprivation. The data illustrates the percentages of residents across the UK within different occupational socio-economic groupings.

**Figure 6 Percentage of the population of working age (16-64 years) by sex and socio-economic group (Source: LFS, 2001)**



There has been a steady shift towards more skilled occupations for both men and women over the last 20 years (GHS, 1995). This has been most pronounced for women who doubled their number in professional occupations and increased by 150% the proportion of women employers and managers. With the increase in skilled occupations there has been a similar decline in the proportion of unskilled and semi-skilled workers. With the reclassification of occupational groups in 2000 it is difficult to make a direct comparison with previous categories, however there is still an upward trend towards increasingly skilled employment, including self-employment.

Gender variations exist at the higher professional levels, with more than three times the proportion of men compared with women in these senior roles; this may reflect career breaks taken by women to have families and work/life conflicts inhibiting women taking up these positions. However more women than men occupy positions classified as 'semi routine' and 'routine': 23% and 15% for women compared with 12% and 15% for men. Another noticeable difference is the low proportion of women to men in the 'small employers' and 'supervisory/technical' categories: 11% and 15% for men compared with 5% and 6% for women. It is noted that 4% of men and 6% of women have never worked or are long term unemployed.

### 3.5. □ Population Dynamics: Migration

The UK has had a net gain in migrants since the early 1980s; long-term migration trends are estimated at approximately 130,000 per year from 2002-based projections. England and Wales are estimated to be net gainers (Table 10) with Scotland and Northern Ireland being net losers. Assumptions have been made about migrant and visitor 'switchers' as well as asylum seekers. It is estimated that the majority (nearly 90%) of these migrants will be of working age.



**Table 10 Long-term annual net migration assumptions for the 2002-based projections**

	<b>Total</b>	<b>International</b>	<b>Cross-border</b>
<b>England</b>	+124,000	+128,000	-4,000
<b>Wales</b>	+8,000	+4,000	+4,000
<b>Scotland</b>	-1,500	-1,500	0
<b>Northern Ireland</b>	-500	-500	0
<b>United Kingdom</b>	+130,000	+130,000	0

Employment strategy needs to be reflective of the diverse nature of the workforce, now and in the future, as well as looking to ensure equal access to employment opportunities across the UK.

### 3.6 Health

#### 4.4.1 Vital statistics

Vital statistics for 2001 are as follows:

**Table 11 Vital statistics per 1,000 population (all ages) for 2001**

	<b>Numbers</b>	<b>Rate</b>
<b>Births</b>	669,100	11.3
<b>Deaths</b>	602,300	10.2
<b>Natural change</b>	66,800	+1.1

There is an increasing trend for women to be delaying having children. In 1981, 65% of live births were to women in their twenties, compared with 25% in their thirties. By 2001 an equivalent proportion (45%) were born to women in their twenties and thirties with more women (30%) having their babies in their early thirties than in their late twenties (27%). In addition to this there is a decline in the number of births from 634,500 in 1981 to 594,600 in 2001.

There are clear inferences for employers and employment strategy from these data, e.g. workforce planning, gender pay issues following career breaks; however, there are also issues for education and health services that need to be considered.

As can be seen from

Table 12 below the greatest reductions in all cause mortality for men over the 1986-1999 period is in social classes I & II. Although there was also a decrease in mortality in social classes IV & V, the ratio of deaths for IV & V to deaths in I & II has increased, i.e. there is an increase in the rate of deaths for men from manual classes compared with professional and managerial classes - in 1997-99 for every 4 deaths from social classes I & II there were 7 deaths for men from social classes IV & V, compared with 6.76 in 1986-92.

The social inequalities in death rates that also existed for women have been reduced over the past decade. The biggest reduction in death rates between 1986-1999 have been in social classes IV & V with a 21% decrease compared with a reduction of only 13 % for I & II. Thus the ratio of deaths between IV & V and I & II is also falling.

There is an undoubted occupational legacy influencing the relative death rates for men and women from different social classes. It will be important to ensure that proposed employment strategies consider the potential health implications on health inequalities.

**Table 12 Trends in all cause mortality by social class 1986–1999, males aged 35–64, directly age-standardised death rates (DSR) per 100,000 person years (England & Wales).**

<b>MEN</b>						
<b>Social Class</b>	<b>DSR</b>			<b>% Change</b>		
	1986-92	1993-96	1997-99	1986-92 to 1993-96	1993-96 to 1993-96	1986-92 to 1997-99
I&ii	460	379	347	-17	-8	-24
IIIN	480	437	417	-9	-5	-13
IIIM	617	538	512	-13	-5	-17
IV&V	776	648	606	-16	-6	-21
Ratio IV&V:I&II	1.69	1.71	1.75			
Non-Manual	466	396	371	-15	-6	-20
Manual	674	577	546	-14	-5	-19
<b>WOMEN</b>						
<b>Social Class</b>	<b>DSR</b>			<b>% Change</b>		
	1986-92	1993-96	1997-99	1986-92 to 1993-96	1993-96 to 1993-96	1986-92 to 1997-99
I&ii	274	262	237	-5	-9	-13
IIIN	310	262	253	-15	-3	-18
IIIM	350	324	327	-7	1	-7
IV&V	422	378	335	-10	-11	-21
Ratio IV&V:I&II	1.54	1.44	1.41			
Non-Manual	289	257	246	-11	-4	-15
Manual	379	344	330	-9	-4	-13

#### 4.4.2 Life expectancy

Data (ONS, 2003 - appendix 4) indicates that life expectancy at birth for the population as a whole has shown significant improvements in the UK over the last two decades. Whilst there is still a longevity advantage to women over men, there are indications that this gap is narrowing. Thus in the UK in 1981, 1991 and 2000 men's life expectancy was 70.8, 73.2 and 75.3 years respectively. Over the same period, women's life expectancy was 76.8, 78.7 and 80.1 years respectively. Healthy life expectancy has also increased to 66.6 years for men and 68.9 for women, up 2.2 years for both. However in addition to the gender variation in life expectancy, there is also a regional variation with men and women living longer in England, compared with Wales and Scotland faring the worst of all. This is reflected at sub regional level as well with a distinct north-south divide.

Inequalities in life expectancy are also observed by social class, which can be classified according to occupation. Although life expectancy at birth has increased over the past 30 years the inequalities in relation to social class are instantly apparent – for example, in 1997-99 the difference in life expectancy between 'professional' and 'unskilled' people was, for women, 5.7 years and, for men, 7.4 years. Between 1972-76 and 1992-96 the gap between these social classes widened from 5.5 years to 9.5 years and then narrowed again by 1997-99.

**Table 13 Life expectancy at birth by social class**

England & Wales	Years					
	1972-76	1977-81	1982-86	1987-91	1992-96	1997-99
<b>Males</b>						
Professional	72.0	74.7	75.1	76.7	77.7	78.5
Managerial and technical	71.7	72.4	73.8	74.4	75.8	77.5
Skilled non-manual	69.5	70.8	72.2	73.5	75.0	76.2
Skilled manual	69.8	70.0	71.4	72.4	73.5	74.7
Semi-skilled manual	68.4	68.8	70.6	70.4	72.6	72.7
Unskilled manual	66.5	67.0	67.7	67.9	68.2	71.1
All males	69.2	70.0	71.4	72.3	73.9	75.0
<b>Females</b>						
Professional	79.2	79.9	80.4	80.9	83.4	82.8
Managerial and technical	77.0	78.1	78.5	80.0	81.1	81.5
Skilled non-manual	78.0	78.1	78.6	79.4	80.4	81.2
Skilled manual	75.1	76.1	77.1	77.6	78.8	79.2
Semi-skilled manual	75.0	76.1	77.3	77.0	77.7	78.5
Unskilled manual	73.9	74.9	75.3	76.2	77.0	77.1
All females	75.1	76.3	77.1	77.9	79.3	79.7

Source: Longitudinal Study, Office for National Statistics

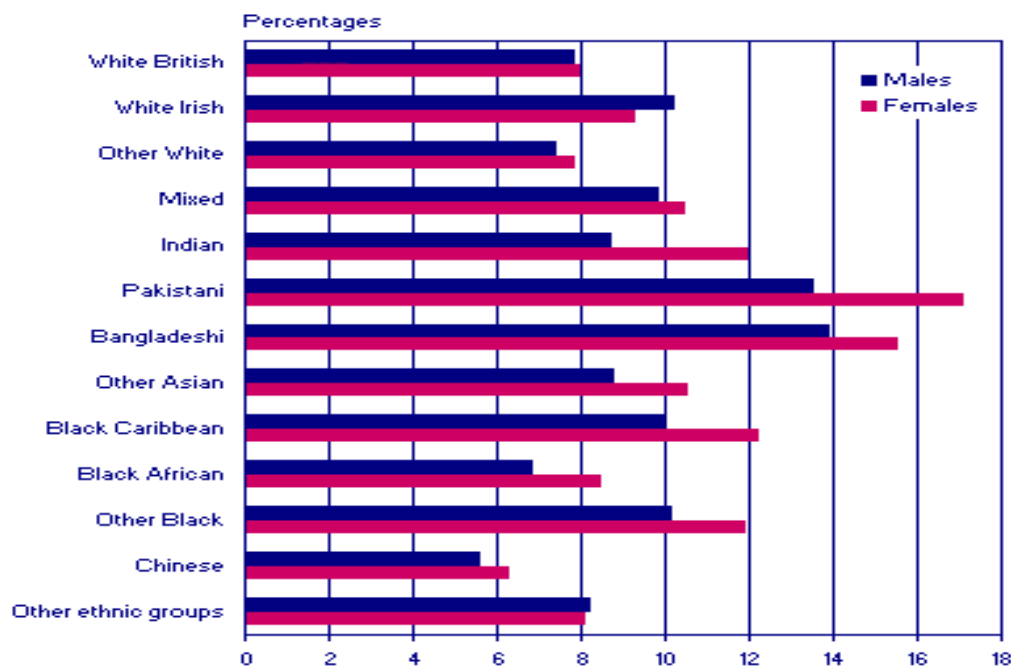
Life expectancy, and particularly healthy life expectancy, has clear implications for employment strategy in relation to labour supply planning, e.g. extending the average working life. The inequalities in life expectancy by gender, region and social class also need to be considered. Although data on healthy life expectancy by region or social class were not available it is likely that they will follow similar patterns.

#### 4.4.3 Self-reported health status

Reporting poor health has been shown to be strongly associated with use of health services and mortality. It is also clear that long-term illness or disability can affect economic activity and so is particularly important in the context of employment strategy. Data from the 1999 Health Survey for England on the Health of Ethnic Minority Groups (TSO, 2001) showed that although women as a whole had higher GP contact rates than the general population White Irish and Pakistani women in England had higher access rates compared to the total female population. For males, Bangladeshi men were three times as likely to visit their GP than men in the general population after standardising for age.

In 2001, over 10 million people recorded they had a limiting long-term illness, which restricted daily activities. There were marked variations in rates of long-term illness or disability between men and women and different ethnic groups in England and Wales; in some groups the difference between men and women in their rates of disability was much greater than in others. In the Indian, Pakistani, Black Caribbean and Black African groups, women had higher rates than men. In the White British and White Irish groups it was men who had higher rates than women. After taking account of the different age structures of the groups, Pakistani and Bangladeshi men and women had the highest rates of disability. Rates were around 1.5 times higher than their White British counterparts. Chinese men and women had the lowest rates.

**Table 14 Self-reported poor health by ethnic minority group and sex (Source: ONS, 2001)**



#### 4.4.4 Work-Related Injuries and Morbidity

Ensuring effective health and safety policy and practice at work is of obvious importance in an employment strategy: an organisation needs to be productive whilst protecting and enhancing the health of its workers. The monitoring and surveillance work of the Health & Safety Executive and Local Authorities, in addition to the support they give to businesses in developing effective health and safety practice, is essential to this. The monitoring and surveillance work of the Health & Safety Executive and Local Authorities, in addition to the support they give to businesses in developing effective health and safety practice, is essential to this. Overall the self-reported work-related ill health (SWI01/02) prevalence in Great Britain stood at 2.3 million people in 2001/02.

From the Labour Force Survey (2002) in 2000/01 the working days lost from injury were 7,257,000 across all industries, a rate of 27,900 per 100,000 workers. From SWI01/02 an estimated 28 million working days (120 per 100,000 workers) were lost due to ill health across all industries and the illness was ascribed to the current or most recent job.

The following summarises key points in occupational morbidity and injuries from workplace accidents in the UK:

- Trend data suggest a decrease in work-related ill health for all illnesses.
- Trend data indicates that ill-health due to stress has doubled over the last 10 years and is nearly twice as high as EU-9 levels (Eurostat, 2003).
- Musculoskeletal disorders has slightly increased in 2001/2 compared with 1998/9, but had a lower prevalence rate than in 1990.
- Men had a greater proportion of work-attributed morbidity than women and accounted for more of the working days lost.
- Among people of working age, the prevalence rate and days lost per worker generally increased with age, especially among men.

- In terms of socio-economic classification, lower managerial and professional workers had the highest prevalence numbers and rates
- Occupation groups with the highest overall self-reported ill-health rates in 2001/02 included protective services (e.g. police), health and social welfare associate professionals (e.g. nurses), skilled construction and building trades, and teaching and research professionals.
- There was a decrease in the rate of reported fatalities resulting from accidents in the workplace in 2002/03 to 0.8 per 100,000; this reflects the downward trend observed over the last 20 years.
- There was an increase in the rate of reported serious injuries in 2002/03 to 113 per 100,000 workers from 110.9 in 2001/02; the rate increased in agriculture, construction, manufacturing, and service sectors.
- There was a decrease in the rate of reported injuries resulting in an absence from work of 3 days or more of 2.4% to 501.1 per 100,000 workers.
- Global estimates (LFS) of the level of reported non-fatal injuries was 41.3% showing an on-going fall since 1997/98.
- Over 33 million working days were lost in 2001 due to ill-health.

As anticipated there is a high incidence of occupational disease related to previous exposure to agents or risks (THOR, 2002). Analysis by geographical area, in terms of overall self-reported illness prevalence, shows Wales with one of the highest rates and Scotland with the lowest.

The industry sectors public administration and defence, education, and health and social work had high overall self-reported prevalence rates in both 2001/02 and the previous survey in 1998/99; all had high rates for stress, depression or anxiety, and health and social work also had a high rate for musculoskeletal disorders. In addition the agriculture, construction, extraction & utility supply and manufacturing sectors are revealed by various sources to have relatively high prevalence or incidence rates for several types of work-related ill health.

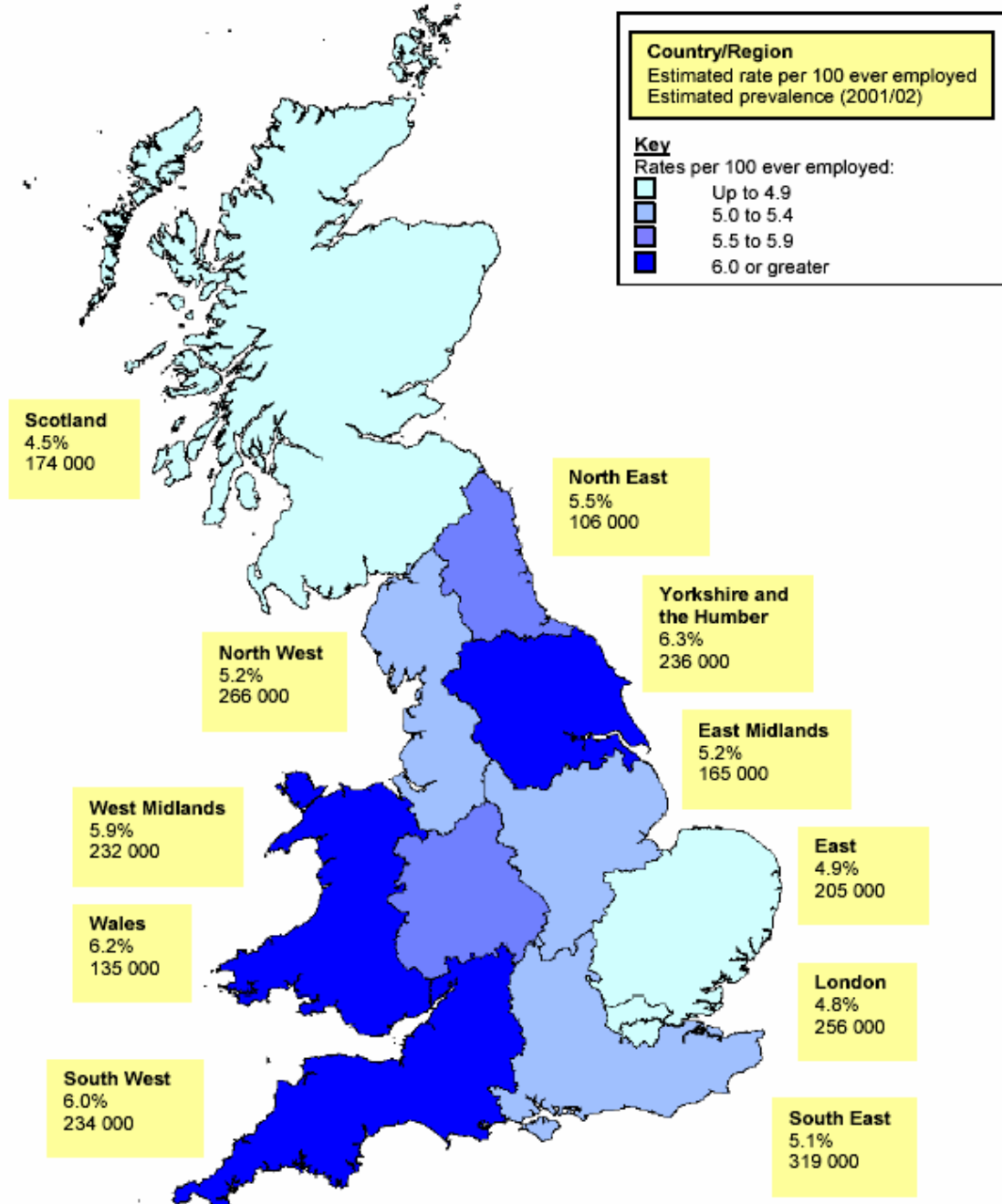
Surveillance data for musculoskeletal disorders and mental health problems, e.g. stress, show little change in the most recent year, 2002. The estimated incidence of occupational asthma and of contact dermatitis has not changed much recently, although the data for asthma indicates a possible decrease in the last three years.

Figure 7 illustrates the occurrence of work-related (self-reported) illness throughout Great Britain and allows comparison between countries and regions.

With an estimated 6.2% of people (ever employed) suffering from a work-related illness, Wales had a statistically significantly higher prevalence rate than Great Britain (5.3%) and than England (5.4%). The rate for Scotland, at 4.5%, was significantly lower than the rate for England and for Great Britain as a whole.

Within England, the government office regions with the highest prevalence rates were Yorkshire and the Humber, the South West and the West Midlands, all of which were statistically significantly higher than the rates for England and Great Britain as a whole. London and the East carried the lowest prevalence rates, both being statistically significantly lower than those for England and Great Britain.

Figure 7 Self-Reported Work-Related Illnesses by Countries and Regions



## □□ Employment

### 4.5.1 Employment and activity rates

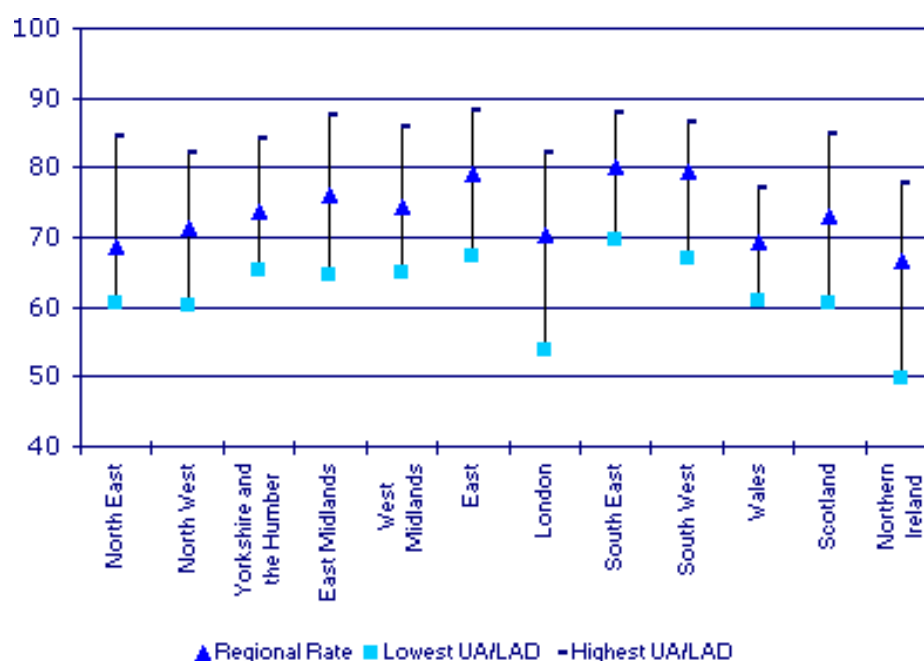
Employment is defined in accordance with International Labour Organisation (ILO) definitions, and includes employees, self-employed, people who do unpaid work in a family business and people on government-supported training and employment programmes. The employment rate is the proportion of people of working age (16-59 for women and 16-64 for men) who are in employment.

The proportion of people in employment varies widely between and within regions. London is the region with the broadest spread of employment rates for people of working age (at the local authority level), ranging between 53.9 per cent and 82.2 per cent in 2001-2. Across the UK, the lowest employment rate (within a local authority area) was Strabane in Northern Ireland at 49.7 per cent. The highest was 88.3 per cent in Welwyn Hatfield in the South East of England.

Looking at the countries and regions of the UK, in March 2001 to February 2002 the employment rate ranged from 66.7 per cent in Northern Ireland to 80.0% in the South East (excluding London). The equivalent UK rate was 74.4 per cent. The area with the least variation between districts was Wales.

As with employment, London had the broadest spread of unemployment rates, ranging between 3.9 per cent and 12.3 per cent at the local level. The unemployment rate went from 3.3 per cent in the South East to 7.4 per cent in the North East, with an average for the UK of 5.0 per cent. The East of England had the narrowest spread, ranging from 3.2 per cent to 5.6 per cent.

**Figure 8 Employment rate (and range) by region in 2001/02**



**UA = Unitary Authority LAD = Local Authority District**

**Table 15 Economic Activity 16-74 years (Source: ONS, 2001)**

<b>STATUS/1000s</b>	<b>UK</b>	<b>England</b>	<b>Wales</b>	<b>Scotland</b>
Employed	25, 621	21,650	1,145	
Employees	24,436	20,604	1,099	2,118
Self-employed	3,170	2,710	147	227
<b>TOTAL</b>	<b>27,794</b>	<b>23,459</b>	<b>1,256</b>	<b>2,366</b>
Unemployed	1,587/ 1,459	1,189	72	173
Long term unemployed	452	360	23	
Student (economically active)	1,106	918	48	
Student (economically inactive)	1,994	1,661	106	
Retired	5,768	4,812	307	
Looking after home/family	2,743	2,316	133	
Permanently sick/disabled	2,465	1,885	191	
Other inactive	1,371	1,102	72	

In spite of the trend of increasing employment rates and the associated fall in unemployment over the last 10 years, economic forecasts from the Treasury (HMT, 2003) indicate that unemployment claimants will increase over the next 3 years from 0.97 million in 2003 to 1.05 million by 2007. Whilst longer-term employment trends are fairly optimistic, a challenge for employment strategy is to impact on inactivity levels that have fairly flat trends.

#### **4.5.2 Employment by gender and age**

As illustrated in the table below, in addition to the regional differences in employment, there are also clear gender and age variations in employment rate. The most pronounced gap is in the 35-49 years period when there is 16.7% between men and women in employment, but also between 50 and 59 years when there are 13.7% fewer women in paid employment. Whilst it is accepted that employment is only one category of economic activity, socio-economic data presented earlier suggests that in the case of women this is not compensated by higher rates of self-employed women. It may reflect women looking after the home and/or family. However interestingly fewer women are also employed when they are younger (16-25 years) which may reflect proportionately more women taking part in further/higher education or training.

In addition there were considerable differences between men and women employed in senior positions both in the public and private sectors. Whilst the proportion of



women in key positions and in public life increased between 1970 and 1999 there is still some way to go before parity with men is established. The latest figures available show 5 per cent of police officers at superintendent and above are women; 18 per cent of senior civil servants; and 24 per cent of secondary school head teachers. In 1998 women held 32 per cent of public appointments. Putting these figures in context, just over half of all secondary school teachers (52 per cent) in 1997 and a similar proportion of civil servants (51 per cent) in 1998 were female. In 1999, 16 per cent of all police officers were female. In the Opportunity 2000 survey of 186 organisations held in 1999, women formed 46 per cent of the private sector workforce, but only 10 per cent of executive directors and top administrators.

**Table 16 Employment rates by age (Source: ONS, 2001)**

Age group/years	Employment rate Total	Employment rate Men	Employment rate Women
16-59/64	74.8	79.6	69.7
16-17	60	67.3	53.2
18-24	42.2	40.8	43.6
25-34	67.9	71.6	64.1
35-49	79.5	88	71.3
50-59/64	81.8	88.8	75.1
60+	70	71.9	67.4
65+	9.2	8.7	9.4

### 4.5.3 Employment by ethnic group

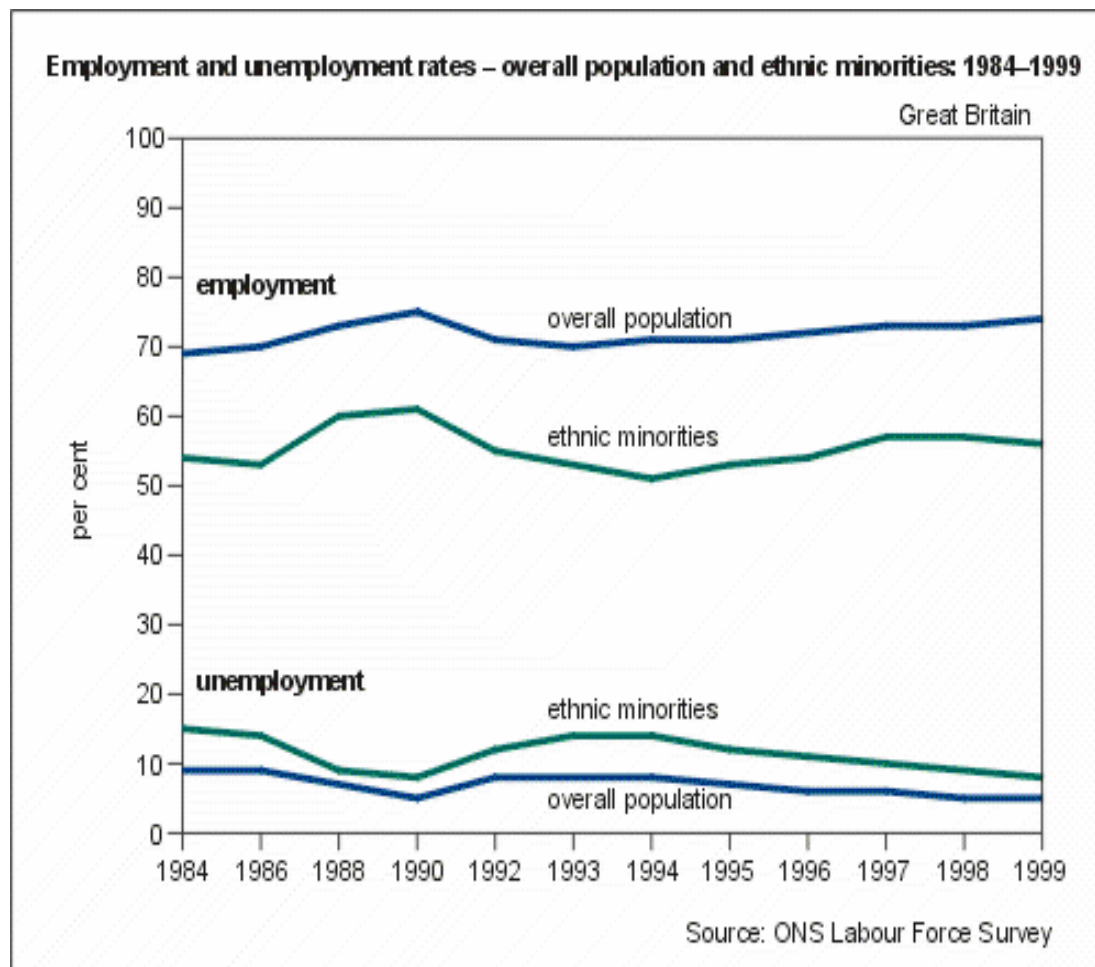
Whilst the UK has been fairly successful at reducing unemployment, particularly long term unemployment, employment and activity rates of BME groups have been consistently and significantly lower compared with their white counterparts (Figure 9). In 2002 (Table 17) there was a maximum difference of 25% between employment rates for white and all BME groups, and between different ethnic groups there was also a variation up to a maximum of 15%. Unemployment of BME groups at 13% was also significantly higher than the overall unemployment rate of 7.7% in 2002. Data also indicates that there is a higher rate of inactivity in BME groups, with 33.9% inactive compared with 26.9% for the working population overall; this may account for a proportion of the lower employment rate.

There are complex reasons for the gap between rates such as differences in educational and vocational skills, which may come about because of poverty, and social exclusion. Whilst this might explain some variation of employment/unemployment rates an analysis of employment/unemployment rates of highly qualified people still shows a disparity between white and BME groups. Social exclusion is reinforced by unemployment, which results from poor education, drawing people into a life-long vicious circle. Cultural differences may also play a part since some communities require family members to take more traditional domestic roles. It is obviously of key importance for employment strategy to address these disparities. This suggests that in spite of the Race Relations Act (1975) and Race Relations (Amendment) Act (2000) race issues in employment are not being adequately addressed. The implications for health and social harmony are more than apparent.

**Table 17 Employment Rates by Ethnicity (Labour Force Survey, 2003)**

	<b>White</b>	<b>All BME groups</b>	<b>Mixed</b>	<b>Asian or Asian British</b>	<b>Black or Black British</b>	<b>Chinese</b>	<b>Other ethnic group</b>
<b>Employment (16-5□/64)</b>	77	59	67	58	64	63	52
<b>Unemployment (All 16+)</b>	5	13	12	12	14	*	15
<b>Economic Activity (16-5□/64)</b>	80	68	77	66	74	68	62

**Figure 1** Employment and unemployment rates - overall population and ethnic minorities: 1984-1999



#### 4.5.4 Employment by disability

Whilst disabled people represent nearly 20% of the population, less than half (49%) are in employment. 53.6% are actively seeking work, with 46.4% being economically inactive; however 14.4% of those currently inactive would like to work.

Another challenge for employment strategy is to enable more disabled people's engagement with the labour market and to address barriers that might prevent this.

**Table 18 Employment Rates by Disability/Long term health problem (Labour Force Survey in ONS, 2003)**

	Men (Per cent)		Women (Per cent)		All (Per cent)	
	Disabled	Not Disabled	Disabled	Not Disabled	Disabled	Not Disabled
Economically Active	57.2	91.2	49.7	78.8	53.6	85.3
In Employment	51.6	86.4	46.1	75.3	49	81.1
Full-time	45	79.1	24.3	43.8	35	62.4
Part-time						
Unemployed	6.7	7.2	21.7	31.4	13.9	18.7
Unemployed	5.5	4.8	3.6	3.5	4.6	4.2
Less than one year	3.7	3.7	2.7	3	3.2	3.4
At least one year	1.8	1	0.8	0.5	1.4	0.8
Unemployment rate (ec. active unemployed)	9.7	5.2	7.2	4.5	8.6	4.9
Economically inactive	42.8	8.8	50.3	21.2	46.4	14.7
Wants Job	14.8	2.4	14	5.4	14.4	3.8
Does not want job	28.1	6.5	36.3	15.8	32	10.9

#### 4.5.5 Employment for older people

70.5% of older people (50 years to SPA) were economically active in 2002 compared with 74.7% of the working population, and 8.6% working past retirement age. There is a slight upward trend with a 0.5% increase from the previous year. Whilst this level of activity is positive, employment strategy will look to build on this.

#### 4.5.6 Employment for lone parents

Only 58.1% of lone parents were economically active in 2002 with 50.1% being employed. There is a slightly upward trend with 0.2% more lone parents economically active than in 2001, which may reflect the additional support for childcare that is being provided. However it represents a very low level compared with the working age population as a whole (74.7%), and needs to be considered in the context of the increase in lone parent households. Once again, this low level of economic activity compared with the population as a whole has significant implications for employment strategy.

#### 4.5.7 Employment and educational attainment

As indicated earlier, in the UK and across the industrialised world there is a trend of increasing the skills-base of the workforce. This is also reflected in economic activity rates: people with no qualifications are less likely to be economically active (56.2%)

than the working population as a whole (74.7%). Interestingly, BME groups are still less likely to be in employment compared with the working population rate even when they have high level qualifications: 69.3% compared with 74.8%. There is a similar pattern for people with disabilities: 61.2% with high-level qualifications are employed.

Medium to long-term employment strategy therefore needs to be closely linked to lifelong education and training strategies.

#### 4.5.8 Employment types and flexibility

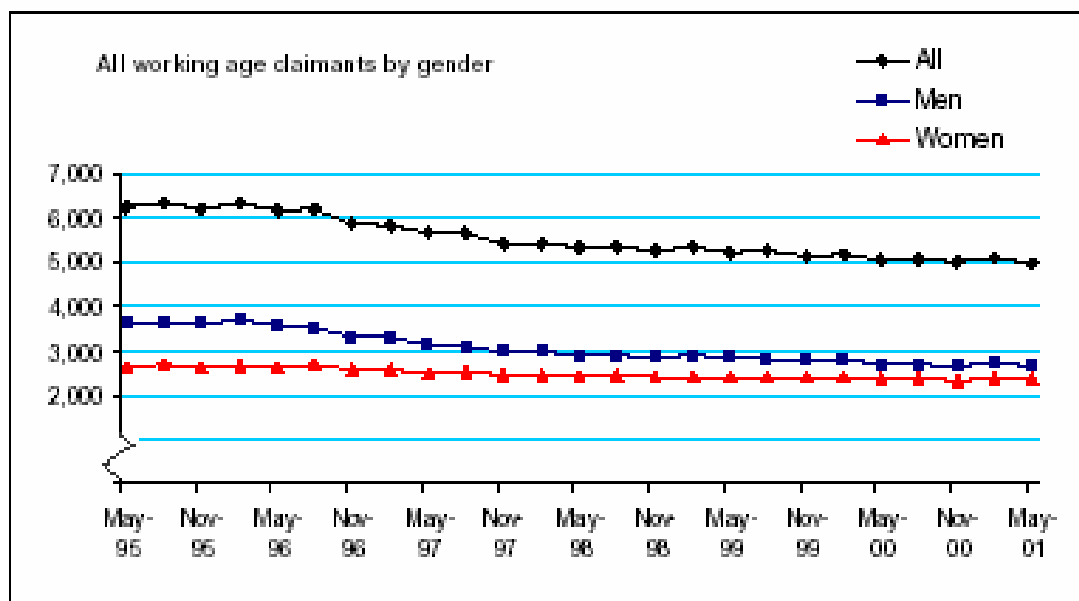
The UK has a diverse range of employment types. In 2002, 25.2% of employees were working part-time, with 80% of these being women. This represents a high level of part-time employment compared with other Member States, but may not truly equate with part-time work in other countries due to the diversity of working hours in the UK. In addition 11.5% of the working population are self-employed, 74.8% are in full-time employment and 5.6% are on temporary contracts.

The Workplace Employee Relations Survey (DTI, 1998) also revealed a growth in flexible labour market practices, for example, non-standard employment contract types (increase in 33% of part-time employment in 5 years), contracting out services (increase incidence of 11%), functional flexibility (25% organisations trained to be adaptable). In addition to labour market flexibilities there were also flexible working arrangements such as flexi-time (one third) and parental leave (25%).

#### 4.5.□ Benefit claimants of working age

Figure 10 shows the trend for a reduction in benefit claimants. From the working age population, in May 2001, just under 5.0 million people (14%) were claiming a key benefit, 47 % of whom were women (DWP, 2002, cited by ONS, 2003).

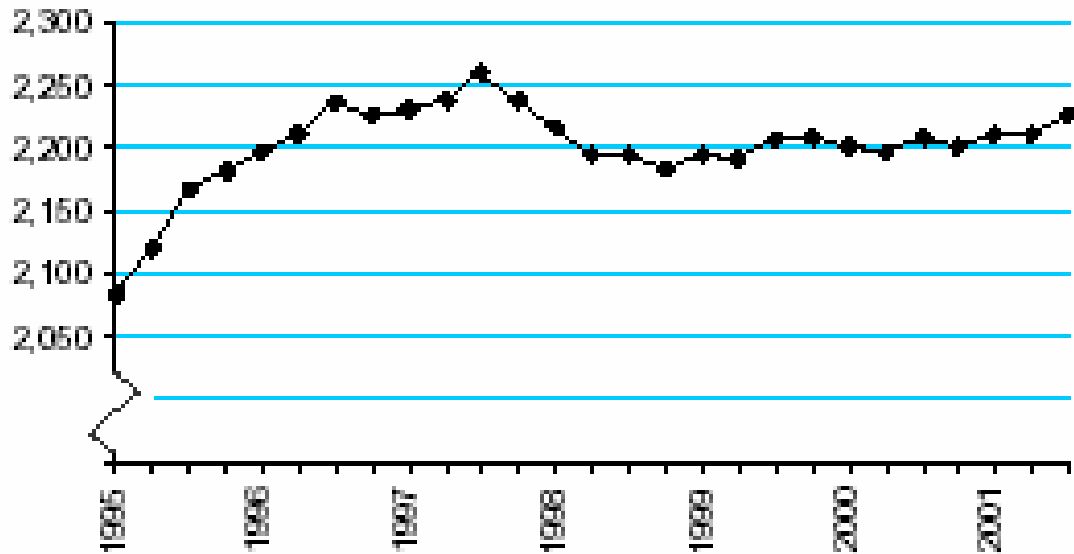
Figure 10 Working Age Benefit Claimants by gender, 1995-2001



Source: Analytical Services Division, Department of Work and Pensions, 2002

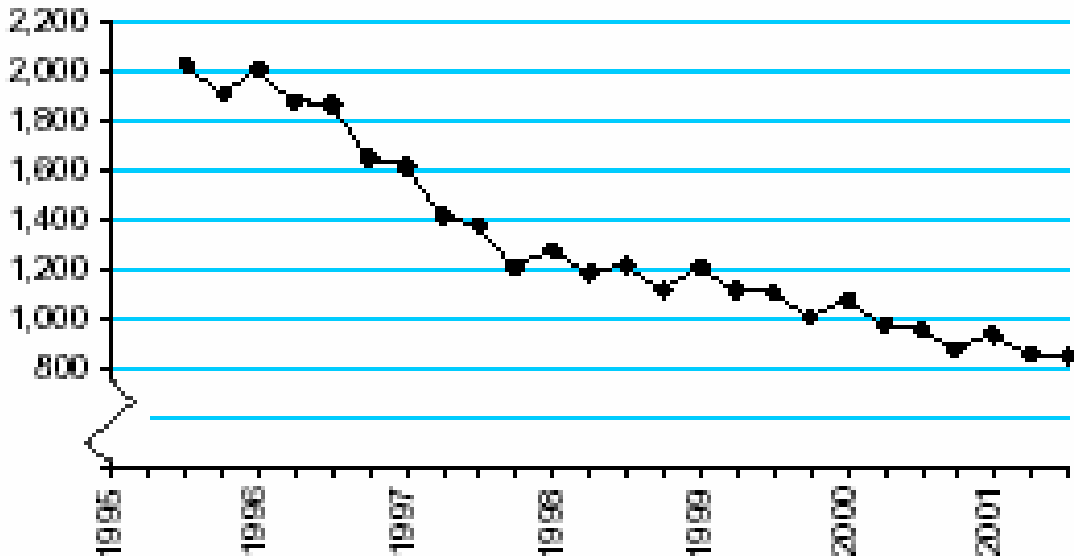
Income Support (IS) - a benefit for people on low incomes, generally people who are not working or who are working less than 16 hours a week - is received by over 2.2 million claimants (Figure 11). Lone parents (excluding the disabled) represent 23%; disabled people 26% and nearly two-thirds of claimants are women. Disabled claimants are on the increase.

**Figure 11 Number of IS recipients aged under 60/(000s)**



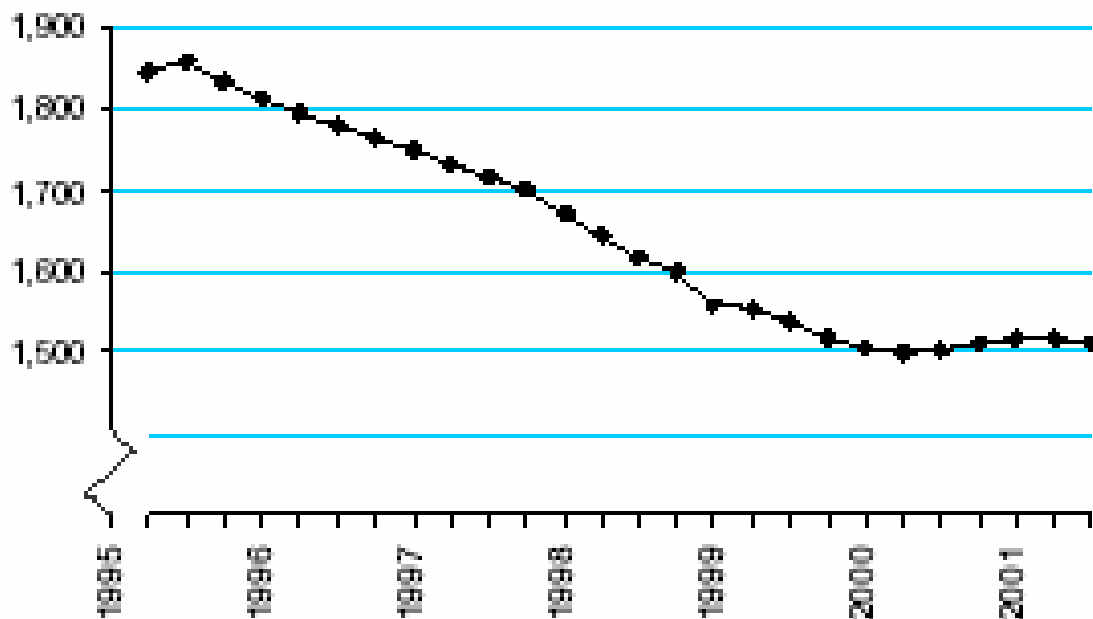
Reflecting the fall in unemployment, the number of jobseekers allowance claimants has fallen dramatically since 1995 (Figure 12).

**Figure 12 Number of Jobseekers allowance recipients (not seasonally adjusted)(000s)**



Incapacity Benefit (IB) is generally available to people who have been unable to work for 28 weeks or more. As indicated in Figure 13 there has been a steady fall in IB recipients since 1995; however this trend is flattening off.

**Figure 13 Number of Incapacity Benefit recipients/ (000s)**



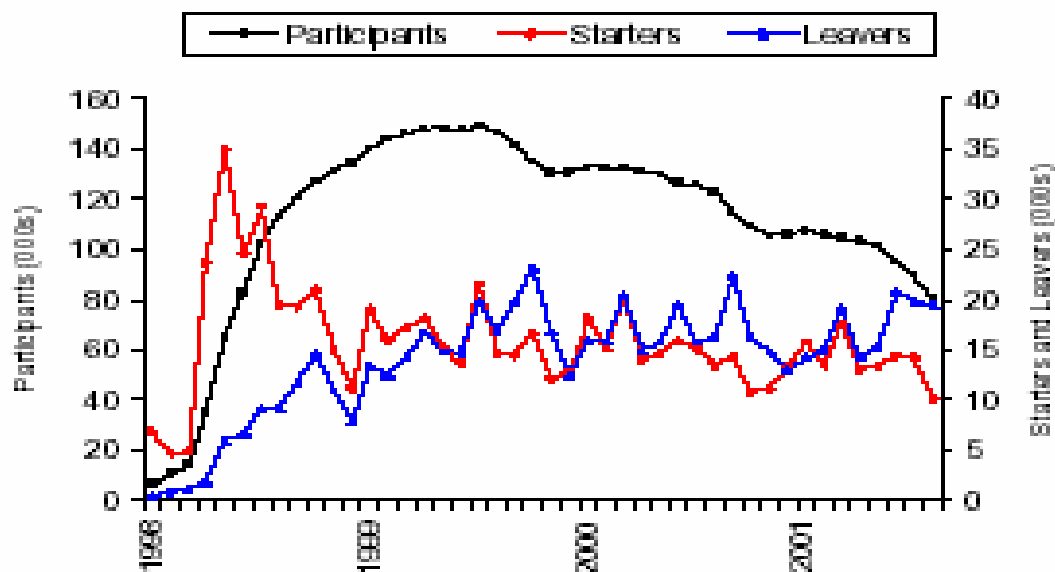
#### □ 6 **Employment programmes**

As part of the Government's Welfare to Work strategy, New Deal (ND) helps unemployed people into work, e.g. by providing training and personal support. There are 8 types of ND targeting different population groups:

- Young People - 18-24 year olds
- 25+
- 50+
- Disabled people
- Lone parents
- Partners of people on benefit
- Musicians
- Self employed

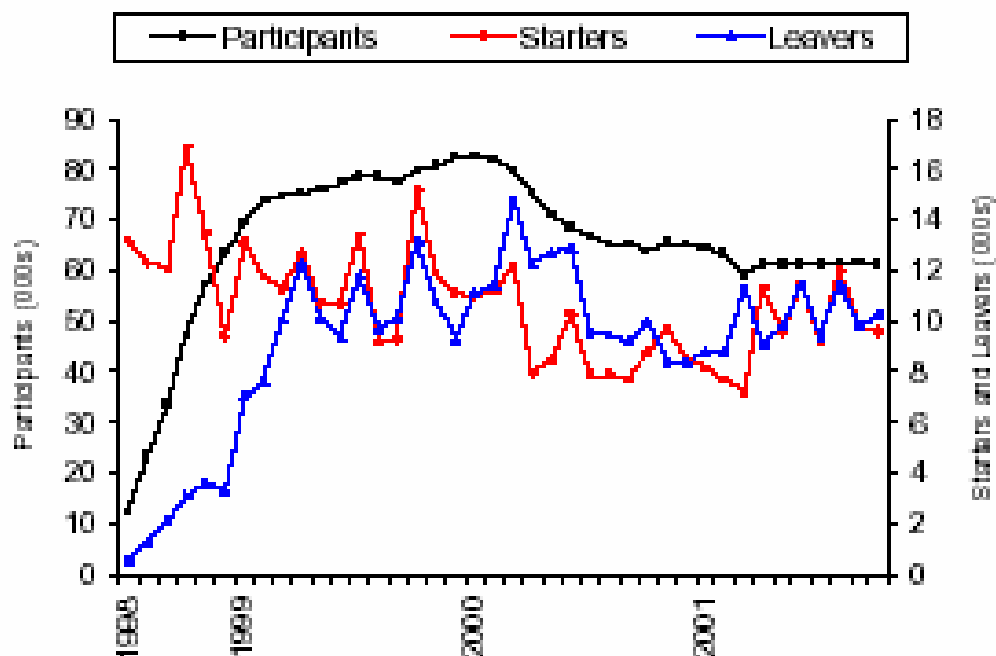
For 2001, 339,000 young people were in employment following a ND programme; 266,000 were sustained jobs, and 73,000 were jobs lasting less than 13 weeks (Figure 14). For the period 1998-2001, there have been 719,000 ND starters 639,000 leavers and 80,000 remaining participants. In addition to the 40% of leavers who have entered sustained unsubsidised jobs, 11% have transferred to other benefits, 20% have left for other known reasons, and 28% for unknown reasons.

**Figure 14 Number of participants in New Deal for Young People**



Similarly for people over 25, 75,000 people are in jobs following a ND programme in 2001; of these 62,000 are sustained jobs and 13,000 are for jobs lasting less than 13 weeks. Between 1998 and 2001, there were 427,000 ND starters 366,000 leavers and 61,000 remaining participants.

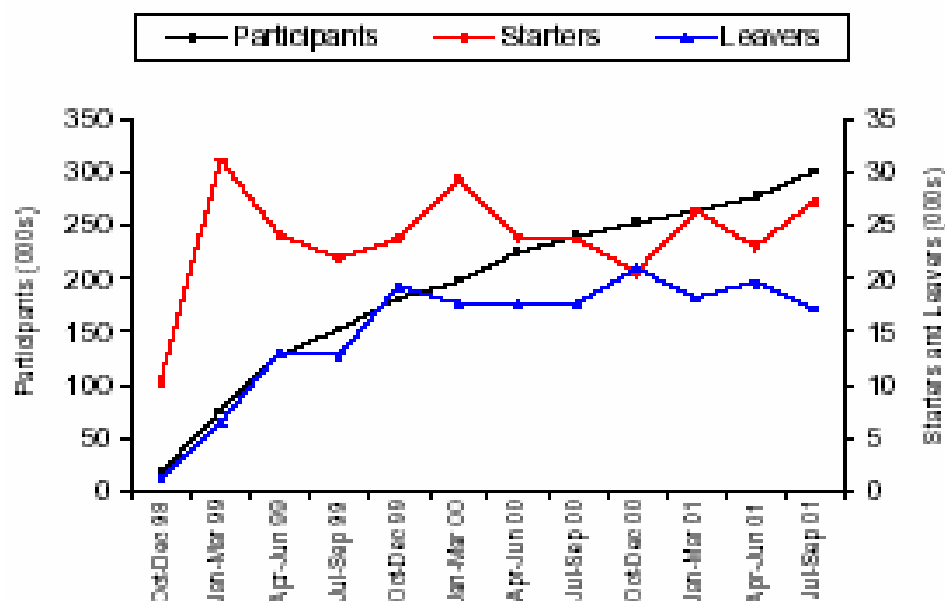
**Figure 15 Number of participants in New Deal for Long Term Unemployed People aged 25+**



Starts on the ND for lone parents (NDLP) had reached 294,000 since 1998 (Figure 16). A total of 188 thousand lone parents had left NDLP by end of October 2001 with 106,000 lone parents still participating. 329,000 lone parents had attended an initial interview by the end of October – 12,000 more than at the end of September 2001.



**Figure 16 New Deal for Lone Parents**



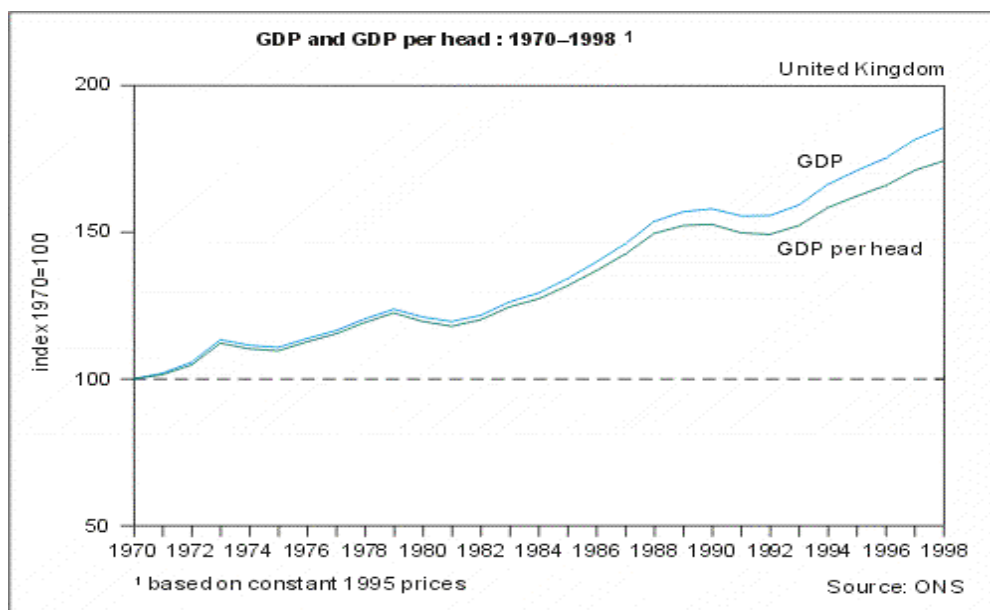
**7 Economic trends**

The UK is a trading nation and in order to prosper in rapidly changing world markets we need to produce goods and services more economically and efficiently than other countries. Also, if we can produce more with less, then spare resources can be transferred to other activities, helping to stimulate growth in the economy. This has clear implications for both short and longer term employment strategy: current and future labour supply needs to be in able match business capacity demands e.g. type and level of skills, volume of the workforce in different skill areas, which in turn reflect the demands for goods and services.

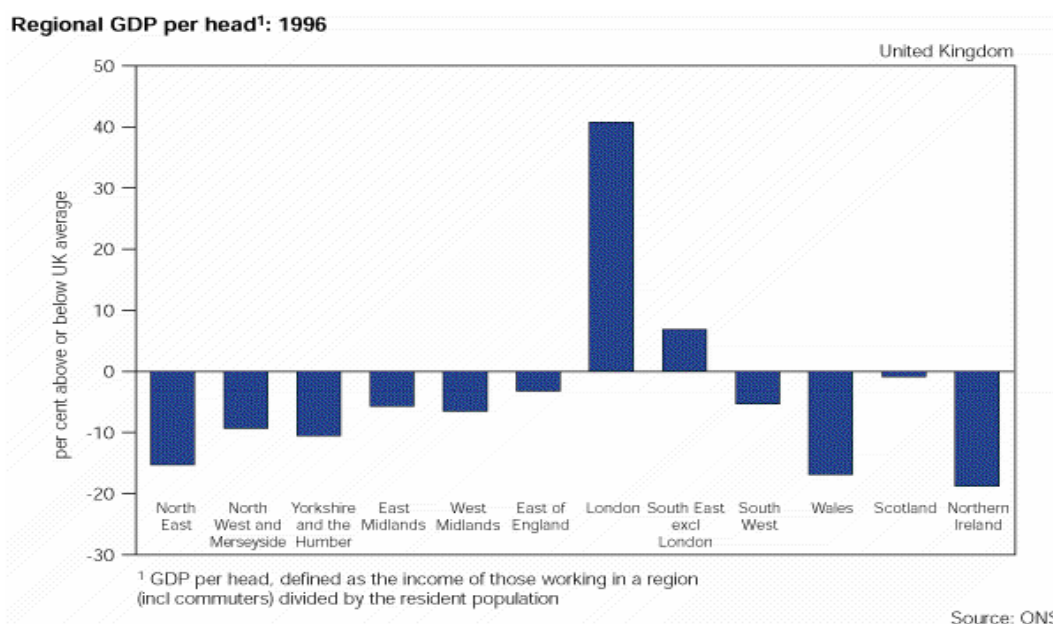
The economy has continued to grow; between 1970 and 1998 with Gross Domestic Product (GDP) output increasing overall by 86 per cent in real terms (that is after taking account of inflation). There have been three major recessions during this period. Output per person has grown at a slightly lower rate, by 74%, reflecting the fact that the population has also increased. In 1997, labour productivity in Germany, France and the US, based on output per hour worked, was around 20 per cent higher than in the UK. The shortfall in productivity occurred in both manufacturing and service sectors.

Productivity levels are expected to converge amongst industrialised countries in the long run although there is considerable debate about the speed at which this will happen. Over the last few years the productivity gap between the UK and the US has been closing but the UK is losing ground to Germany and France. Productivity in Japan has been catching up with the UK. Exports and imports have almost doubled over the last 20 years or so, with a negative trade balance (imports are greater than exports).

**Figure 17 GDP and GDP per head: 1970-1998**



**Figure 18 Regional GDP per head (1996)**



The UK needs to develop strong regional economies, to provide high living standards for everyone, and to address localised problems of high unemployment, low investment, poor productivity and urban decay. Regional GDP per head (income of those working in the region divided by the resident population) shows the relative prosperity of UK regions. Since 1970, GDP per head in traditional manufacturing regions like the West Midlands and the North West has fallen relative to the UK average and GDP per head has risen in the South East, East of England and Scotland. Since 1990 GDP per head relative to the UK average has been increasing in the South East, East of England, Scotland and the West Midlands but decreasing in the North East, Merseyside, East Midlands and Wales.

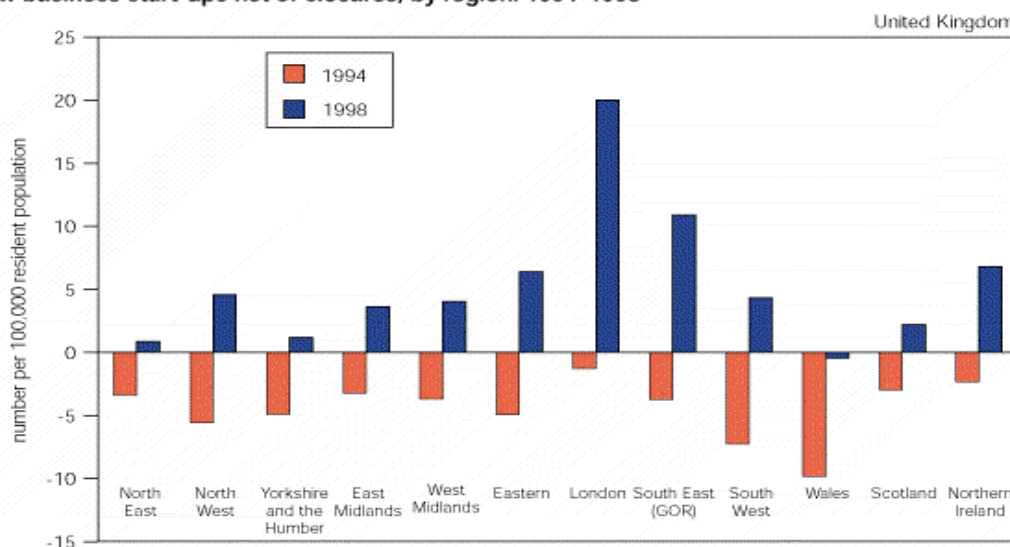
The number of businesses registering and de-registering, i.e. start-ups and closures is provided in Figure 19 below. The UK wide figures show (over the 2 years to 2002)

both a reduction in the number of business start-ups and an increase in the number of business closures.

Enterprise and the support of the small business community is key for job and wealth creation in the UK. Barriers to business start-ups and support to enable small businesses to thrive are important considerations of a multi-sectoral employment strategy.

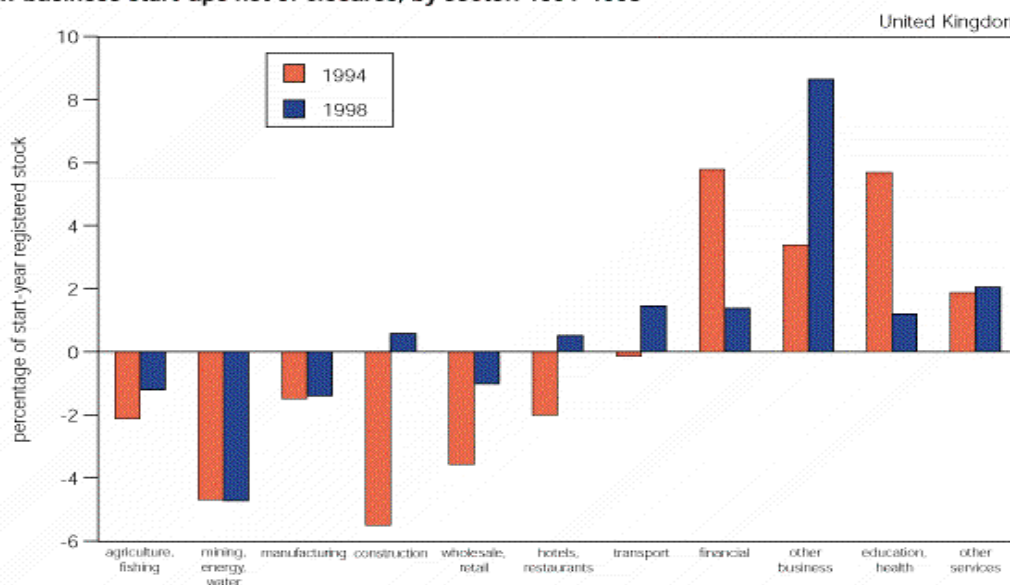
**Figure 1 □ Business Start-Ups and Closures - by region and sector**

**New business start-ups net of closures, by region: 1994–1998**



Source: DTI

**New business start-ups net of closures, by sector: 1994–1998**



Source: DTI

### □.8 Socio-economic working conditions

Socio-economic and physical working conditions are known to influence the motivation, performance and retention of the workforce. The proportion of people working over 45 hours a week increased, with cyclical fluctuations, from 21 per cent in 1984 to 26 per cent in 1998. The proportion of people working over 50 hours per week also increased from 11 to 14 per cent over the same period. The proportion of those working over 60 hours a week remained relatively constant, at around 4 to 5

per cent. However more recently, working hours have begun to fall. For example, total hours worked per week fell 7.1 million hours to 899.7 million hours (ONS, 2004). This is largely attributed to the introduction of the Working Time Directive in 1998.

In addition to the working hours falling, the annual rate of growth in average earnings (including bonuses) for the three months to November 2003 was 3.5 per cent, down from the October rate of 3.6 per cent. However, pay growth in the private sector was unchanged at 3.2 per cent, compared with the public sector where it fell to 4.8 per cent from 5.4 per cent last month (ONS, 2004). There are however gaps in the increase in earnings for manual and non-manual employees and between men and women (women earn 75% the average hourly gross pay of men). In addition workers in small businesses tended to have lower rates of pay. In addition the rates of workers under the National Minimum Wage (NMW) is significantly and consistently higher for part-time workers and is overwhelmingly a private sector phenomenon. (Table 19). It should be noted that the 1998 WERS showed a relationship of low productivity with employee earnings.

**Table 1 □ Number of jobs/Percentage paid at less than NMW (£3.60 per hour (aged 18-21) or £4.20 per hour (aged 22 and over) for 2003)**

	2001		2002		2003	
	Numbers	%	Numbers	%	Numbers	%
All full-time	60	0.3%	100	0.5%	80	0.4%
All part-time	190	2.8%	230	3.5%	180	2.7%

Management practices are important indicators of psychosocial working conditions as well as organisational performance. High performing organisations have been shown to have 16 essential characteristics. 50 % of UK organisations had 5 of these 16 and 25% had 8 (appendix).

In order to compete with international markets it is important to invest in the development of the workforce, research and development as well as premises, equipment and machinery. Public sector investment is also important, e.g. to ensure there is an adequate transport infrastructure for the distribution of goods. Over the most recent international economic cycles 1973-79, 1979-89 and 1989-96 UK business has consistently invested less per worker than most other G7 countries. There has been a general decline both in total investment relative to GDP over the period 1970 to 1998, and in social investment over the period 1970 to 1992, but with cyclical variations reflecting the economic cycle. Total investment declined from 20 per cent of GDP in 1970 to 17 per cent in 1998.

'Investors in People' is the National Standard that sets a level of good practice for improving an organisation's performance through its people. As discussed above, organisational performance can be improved through linking the training and development of employees to an organisation's business objectives. The numbers of organisations recognised as Investors in People have increased over the past few years, particularly among larger organisations. In England in March 1999, 22 per cent of organisations with 50 or more employees, and 3463 organisations (2%) with between 10 and 49 employees, were recognised as Investors in People.

Positive relationships have tended to be reflected in low levels of formal industrial action (2% of workplaces) and also industrial tribunals (1.9 per 1000 employees).

## □.9 **Educational attainment**

To achieve stable and sustainable growth, we need a well-educated, well-equipped and adaptable labour force. There has been a steady improvement in the proportion of young people gaining formal educational qualifications. The proportion of 19 year olds gaining level 2 qualifications, in the UK has risen from 45 per cent in 1984 to 74 per cent in 1999 (LFS, 2000). Level 2 is defined as 5 or more GCSEs at grade C or above, intermediate level GNVQ, and NVQ level 2 or any other equivalent. 2002 DfES estimates from LFS data indicates that the proportion of the working age population who have level 2 or above qualifications is 67%.

The percentage of school leavers at 16 who leave with no qualifications is decreasing: in 1988 this was 7.5% and in 1998 this had fallen to 6.1%. Girls have consistently out performed boys and this gap remains.

Over a fifth of all adults of working age in the UK were estimated to have low literacy and numeracy skills in 1996 (IALS, 1996). Those people performing at the lowest level (level 1) were predominantly older people with low levels of education. They were more likely than people with higher levels of these skills to be unemployed, to belong to the manual rather than the non-manual social class groups, and to be on a low income. They were also more likely to say they needed help with various literacy tasks, particularly filling out forms and reading information from government, businesses and other institutions (almost half 'sometimes' or 'often' needed help with one or more tasks). Relative to some other countries, the skill distributions in Britain appear more polarised; large proportions of the population were at the either the lowest or highest literacy levels. Significant skills shortages have been identified particularly at the intermediate level. It has been estimated that at least half of the productivity gap between Germany and the UK can be explained by skills differences.

Developing a culture of life long learning in the UK is important for the labour force to be able to adapt in both existing and new jobs. This needs attention from the supply and demand sides of the labour market (HMT, 2003). In the first year of the National Adult Learning Survey, (DfEE, 1997), 27% of respondents in England and Wales (equating to about 8.5 million people) said they had done no learning in the previous three years, or since leaving full-time education if that was more recent. Groups least likely to have undertaken learning in the past three years included:

- people aged 50 or over,
- those looking after the home or family,
- the retired,
- those unable to work because of long-term sickness,
- those leaving school aged 16 or younger and
- those leaving school without qualifications.

The definition of learning used includes all types of taught, classroom-based learning and non-taught learning of a deliberate nature, including self-study. Both vocational and non-vocational learning are included regardless of whether they lead to qualifications.

## □.10 **Travelling to work**

Barriers to employment including access - physical and social - need to be considered in the context of employment strategy. Data on transportation to work and the travelling times are useful indicators to consider. The dominance of cars, vans and other forms of private motor transport in England are clear. Public transport usage is a relatively small proportion of all journeys in the UK. Compared to mainland

Europe, the use of non-vehicular transport in the UK is very low; walking and cycling make up a very small proportion of all journeys.

**Table 20 Percentage of people travelling to work by mode of transport**

□.11 Area	Percentage aged 16-74: drive a car/van	Percentage aged 16-74: passenger in a car or van	Percentage aged 16-74: travel on foot	Percentage aged 16-74: bicycle
		54.9	6.1	10.0
England	Percentage aged 16-74: working at home	Percentage aged 16-74: underground / tram	Percentage aged 16-74: train	Percentage aged 16-74: bus / minibus / coach
		9.2	3.2	4.2

This is associated with travelling times. The data indicates that most journeys to work take 10 minutes or less with less than 5% taking an hour or more. From this it would suggest that most people work close to where they live.

### □.11 Child and elder care

Childcare is another issue to consider in relation to employment: the lack of access to quality childcare facilities has been an obstacle for some parents in returning to work. Table 20 shows the recent increase in child day care places. In total, the number of day-care places for children in England, Wales & Northern Ireland rose by nearly 100% per cent between 1987 and 2000.

**Table 21 Day-care places for children**

England, Wales & Northern Ireland	Thousands				
	1987	1992	1998	2000	2000
All day nursery places	62	123	236	262	281
All childminder places	161	277	407	369	353
All playgroup places	444	455	426	389	394
Out of school clubs	..	..	97	119	153

Source: Department for Education and Skills; National Assembly for Wales; Department of Health, Social Services and Public Safety, Northern Ireland

Elder care will undoubtedly need to be considered in the future.

### □.12 Health services

Changes in employment conditions have implications for health services, particularly primary care services. For example, demands for a more flexible workforce have capacity implications for services such as out of hours. Analysis of out of hours services (Salisbury et al, 2000) indicates a call rate of 159 per 1,000 patients per year. Patients living in deprived areas made 70% more calls than less deprived areas. 45% were managed by telephone advice, 24% by home visit and 30% by attendance at a centre.

Similarly there are implications for the management of chronic conditions such as asthma to enable people to take up, return or stay in work. Speedier access to diagnostics, and a greater uptake of day-case procedures for elective surgery are other potential benefits to the labour market.

Health surveillance of the effects of workplace hazards are currently reported through THOR and RIDDOR and collated by the HSE. In addition to a decline in certain industries in the UK, the changing nature of work will also have implications for the scope of this surveillance. Doctors' certification may be another aspect of current health care delivery that is impacted on.

Finally, there are implications for how occupational health services are provided to employees of small businesses which are typically underserved in this area and are a growing sector. A confederation approach may be one option.

## 5 Documentary Analysis

### □.1 **Introduction**

This documentary analysis section describes the methods, procedures and findings from the analysis of the policy, audit and analysis of associated official documents and review of literature relevant to the policy. The primary purpose of the documentary analysis in a HIA is:

- To assess the process by which policies are initiated, formulated and implemented
- To consider the policy components, including the potential outputs (intended and unintended), and their potential impacts on health outcomes and key health determinants
- To examine evidence from the literature of the policy's relationship with health determinants and health and well being outcomes

In addition the documentary analysis also contributes to the generation of the data set for the profile, the question guides for the stakeholder and key informant (KI) interviews and the topics for the literature search.

### □.2 **Methods and process**

The documentary analysis involved a number of steps and associated outputs:

#### **Step 1: with HIA terms of reference**

- Developing a policy summary (precis of policy document) including background/rationale, aims, objectives, explicit values, actions, targets/outputs, funding,
- Identifying population affected and stakeholder groups,
- Identifying associated official documents from departmental websites and stakeholders,
- Undertaking an initial analysis of EES/UKEAP (initiation, formulation and implementation),
- Outlining the data set for profiling,
- Defining topics and search terms for the literature search,
- Developing stakeholder/KI question guides

#### **Step 2: after HIA terms of reference**

- Undertaking a secondary analysis of EES/UKEAP (relationship to other policies/strategies, implicit values, political context),
- Undertaking literature searches and reviews, eg collecting evidence from electronic databases (Health Development Agency, Health Evidence Network, Centre for Reviews and Dissemination)

#### **Step 3: concurrently with profiling, interviews, literature reviews**

- Undertaking a tertiary analysis of EES/UKEAP (unintended outputs, risks to implementation, policy's considerations of health) and defining the relationship with key health determinants/health,
- Defining priorities for refining the scope of the HIA
- The policy audit involved searching Government department publication electronic databases. The analysis of these focused on four criteria: policy development, policy content, policy implementation and health in policy planning. These in turn were sub-divided into key questions.



### □.3 **Policy Audit and Analysis**

#### **Context**

Evidence from a range of sources indicates there have been significant improvements in employment rates with a corresponding decrease in unemployment over the last 10 years; similarly in terms of GDP the UK has become more prosperous with low levels of inflation. However a number of employment and employment-related challenges still remain. These include:

#### **Demographics**

- ageing population and shrinking labour supply

#### **Unemployment and inactivity issues**

- unwavering levels of economic inactivity, particularly inactivity due to disability or ill health

#### **Employment and industrial issues**

- comparatively low employment rates of BME groups, women, people with disabilities, lone parents, people with low qualifications, and older people (60+ years),
- regional and also neighbourhood variations in employment rates,
- the gender 'pay gap' (e.g. women have approximately 75% of men's average gross hourly earnings) and low proportion of women in senior executive positions compared to men (e.g. 52% of teachers are women, but only 25% are head teachers),
- relatively low productivity levels of the UK workforce compared with the US, France and Germany,
- changes in employment by industrial sector (e.g. shrink in proportion employed in manufacturing and agriculture) with associated occupational changes,
- demand to increase the skills-base of the labour force,
- demands for more flexible labour (e.g. non-standard employment) from employers,
- demands for more flexible working conditions from employees,

#### **Entrepreneurial activity and self-employment**

- low rates of business start ups

#### **Factors that may contribute to these issues include:**

- 'consumerism', demands for improving living standards/quality of life and public services,
- information mis-match, e.g. about available jobs, benefits of information technology,
- lack of confidence, e.g. applying for jobs,
- low skills base at basic and intermediate skills level,
- low levels of investment in human capital by employers, but also in physical capital, innovation and technology
- management and leadership influencing performance,
- discrimination, e.g. on the basis of race, gender, age, disability, 'post code'
- occupational gender stereotyping,
- cultural and attitudinal barriers e.g. recruitment and management practices, 'no one around here works',
- 'risk averse', e.g. poor at adapting and changing,
- available and affordable child care provision,
- available and affordable housing in areas of high employment,
- occupational immobility,

- physical access to employment, e.g. transport infrastructure

Many of these employment issues also have direct or indirect effects on health:

#### **Unemployment**

- differential distribution of employment/unemployment, especially for those population sub-groups who already experience worse health than the population at large

#### **Socio-economic working environment**

- lower income for women in employment
- management practices, e.g. through high demand, low control working conditions ('Job strain/stress' model)
- non-standard employment status, e.g. through job insecurity

#### **Physical working environment**

- non-standard employment status, e.g. by working with hazardous products, repetitive tasks
- workplace hazards

#### **Social mobility and life chances**

- occupational changes

#### **Policy context**

The policy audit identified over 40 relevant policy documents for analysis. Table 21 provides a summary of key UK employment and economic policies that relate to these issues and give context to the UK EAP.

**Table 22 Summary of key UK law and policies relevant to the UK EAP**

<b>Law/Policy/Strategy</b>	<b>Author/ Date</b>	<b>Objectives/Key features</b>
1. 'Equal Pay Act'	HMSO, 1970	Prohibits employers discriminating on the basis of sex in relation to pay.
2. 'Health & Safety at Work Act'	HMSO, 1974	Places a duty on employers to ensure, so far as is reasonably practical, the health, safety and welfare at work of all their employees.
3. 'Sex Discrimination Act' (SDA)	HMSO, 1975	Prohibits employers discriminating in employment on the basis of sex, marital status or gender reassignment. This applies to recruitment, terms & conditions of employment, promotion and training, and dismissal or redundancy.
4. 'Race Relations Act'	HMSO, 1976	Prohibits discrimination on racial grounds in the areas of employment, education and the provision of goods, facilities and services, and premises.
5. 'Statutory Maternity Pay Regulations'	HMSO, 1986	Provides for paid maternity leave entitlement for women employees, and a right to return to work, providing employed for a minimum period.
6. 'Employment Act'	HMSO, 1989	Provided an exemption from the SDA for certain acts relating to the protection of women at work.
7. 'Disability Discrimination Act' (DDA)	HMSO, 1995	Prohibits discrimination against disabled people in the areas of employment, the provision of goods, facilities and services and premises, education and public transport.
8. 'Pensions Act'	HMSO, 1995	Requires occupational pension schemes to observe the principle of equal treatment between men and women
9. 'Employment Rights Act' (ERA)	HMSO, 1996	Extended maternity rights, the rights of carers and generic employment rights, e.g. requirement of a statement of employment particulars, itemised pay statement, minimum period of notice on termination of employment, written statement of reasons for dismissal and a redundancy payment.
10. 'Working Time Regulations'	TSO, 1998a	Contains provisions regulating working time, including a limit of 48 hours per week (with exceptions), daily and weekly rest entitlements and breaks, 4 weeks paid leave per year, special provisions relating to night work.
11. 'National Minimum Wage Act'	TSO, 1998b	Provides that workers shall not be paid less than a designated minimum rate per hour.
12. 'Fairness at work'	DTI, 1998	Aims to provide a minimum infrastructure of decency and fairness around people in the workplace.
13. 'Our Competitive Future: Building the Knowledge Driven Economy'	DTI, 1998	Aims to set out the competitive challenge facing the UK; a new model for how public policy can help business; and flagship programmes to promote entrepreneurship.
14. 'Maternity & Parental Leave Regulations'	TSO, 1999a	Details the rights to maternity and parental leave contained in the ERA. Also prescribes circumstances where dismissal is automatically unfair, including pregnancy, childbirth, maternity leave, parental leave or time off for dependants.
15. 'Opportunity for All - tackling poverty and social exclusion'	DSS, 1999 (now DWP responsibility - updated annually)	Aims to <ul style="list-style-type: none"> <li>♦ Tackle the causes of poverty and social exclusion</li> <li>♦ Create a fairer society where everyone can reach their potential</li> <li>♦ Invest in individuals and communities to take control of their lives</li> <li>♦ For children &amp; young people, people of working age, pensioners, and communities.</li> </ul>

16. 'Jobs for All'	DfEE, 1999	Defines inequalities in the labour market and attributable causes, e.g. skill differentials, racial discrimination in the labour market, lack of support to most vulnerable people, and targets with interventions to overcome these, e.g. targeting the most vulnerable, tackling racial discrimination, building bridges to employers, making work pay and involving local and ethnic minority organisations in the delivery of labour market services
17. 'Productivity in the UK'	HMT, 2000	Defines and analyses causes for the UK's lower productivity rate compared with other EU countries and the US: attributes this to poor investment in physical and human capital, as well as lower innovation rates (including ICT investment). Aims to create macroeconomic stability to allow firms to plan/invest and to reform the microeconomic environment - product, capital and labour markets.
18. 'Race Relations (Amendment) Act'	TSO, 2000a	Duty placed on public authorities to eliminate unlawful discrimination and promote equality of opportunity.
19. 'Part-time workers Regulations'	TSO, 2000b	Provides part-time workers with the same rights as full time workers, unless objectively justifiable.
20. 'Opportunity for All in a World of Change'	DTI, DfEE, 2001	A White Paper defining measures to increase individual skills particularly basic and ICT skills, regional innovation and development through e.g., RDA, universities, Manufacturing Advice Service, research, development and market promotion, a regulatory and financial climate to foster enterprise and growth, and increasing global competitiveness
21. 'Full and Fulfilling Employment: Creating the labour market of the future'	DTI, 2002	Aims to achieve full employment with social inclusion, a dynamic, skilled labour market matched with flexible employment, high productivity by strengthening competition, promoting enterprise and innovation, increasing investment and increasing public sector productivity.
22. 'Pathways to Work: Helping People into Employment'	DWP, 2002	Aims to help people on incapacity benefit back to work by piloting an enhanced Job Centre Plus Work Force Interview system linked with the Personal Capacity Assessment process in 7 areas over the next 2.5 years (60,000 people, 9% of IB claimants involved)
23. 'Employment Act' (Flexible working regulations)	TSO, 2002	From April 2003, section 47 introduces the right for employees to request flexible working. Makes a change to maternity, paternity and adoption rights in the ERA.
24. 'Employment Equality (Religion or Belief) Regulations'	TSO, 2003a	Prohibits discrimination in employment on the grounds of religion or belief from December 2003. Amended before enacted (Employment Equality (Religion or Belief) (Amendment) Regulations 2003) to cover discrimination in occupational pension schemes.
25. 'Employment Equality (Sexual Orientation) Regulations'	TSO, 2003b	Prohibits discrimination in employment on the grounds of sexual orientation from December 2003. Amended before enacted (Employment Equality (Sexual Orientation) (Amendment) Regulations 2003) to cover discrimination in occupational pension schemes.

26. 'Building a Britain of economic strength and social justice' (Budget 2003)	HMT, 2003a	Describes assessments and forecasts of the economy and public finances, reports on progress towards long-term goals and further steps and investment to advance these goals. Includes measures to increase flexibility in the labour market, raise skills, spread employment opportunity to disadvantaged groups and to increase productivity and enterprise by reducing regulatory burdens, boost research and development, financial help to small businesses
27. 'Full Employment in Every Region'	HMT & DWP, 2003	Summarises progress in increasing UK employment rates and the reasons for this. Identifies those population groups, regions and local authority areas that are not as 'engaged in the labour market' and defines existing and new action to remove barriers to employment so that the 'labour market works for the many, not the few', ensuring social justice. New action includes Job Retention & Rehabilitation pilots, Access to Work and Work Preparation pilots, Working Neighbourhood pilots, Housing Allowances for some Pathfinder areas, Ethnic Minority Employment Task Force.
28. 'A Full Employment Strategy for Europe'	HMT, 2003b	Provides a UK analysis of key issues facing Member States in meeting the Lisbon targets: regulatory and institutional frameworks to increase flexible working opportunities and job creation for all, benefit regimes linked to training and moving into jobs, incentives to making work pay, supporting individuals and businesses in developing the skills base
29. '21 <sup>st</sup> Century Skills - Realising our potential: individuals, employers, nation'	DfES, DTI, DWP, HMT, 2003	Aims to develop skills needed by employers, now and in the future, and to give individuals the skills for employability and personal fulfilment. Describes issues at basic and intermediate skill levels, as well as at management levels, contributing to lower productivity compared with UK competitors. Defines action including: for employers and employees - management and leadership training, advice/business support on training, unions involvement; for individuals - financial and training incentives for basic, intermediate skills development; Sector Skills Councils.
30. 'Ethnic Minorities and the Labour Market'	Cabinet Office, 2003	Defines key issues for ethnic minorities in the labour market, including lower employment rates, levels of pay for some groups. Identifies underlying causes including cultural, educational, living in deprived areas, infrastructure, and discrimination. Outlines action in education, employment, promoting equal opportunities in the workplace and through reform of Government structures.
31. 'Balancing Work and Family Life: Enhancing Choice and Support for Parents'	HMT and DTI, 2003	Describes measures to support parents and families with their caring responsibilities whilst facilitating flexible working, and promotes the benefits of flexible working to businesses and the take up of best practice.

In addition to these there are a number of related strategies that indirectly contribute to employment and economic objectives, including:

- Transport - providing access to jobs, e.g. 'A New Deal for Transport' (DETR, 1998) and 'Transport 2010, the 10 year Plan' (DETR, 2000)
- Housing - providing affordable housing close to employment, e.g. 'Sustainable Communities: building for the future' (ODPM, 2003)
- Sustainable development - high and stable economic growth and employment that protects the environment, uses resources efficiently and supports social progress for all, e.g. 'A Better Quality of Life: a sustainable development strategy for the United Kingdom' (TSO, 1999b)
- Health - improving health in the population, including people of working age with chronic illnesses and disability, e.g. 'The NHS Plan' (DoH, 2000), 'Saving Lives: Our Healthier Nation (DoH, 1998); 'Tackling health inequalities' (DoH, 2003); improve workplace health and safety, e.g. 'A strategy for workplace health and safety in Great Britain to 2010 and beyond' (HSE, 2004)

### **Political Context**

Political and macro-economic drivers provide an important context regarding the priority issues for employment and interventions to address to them. 'Third way' economic systems reflecting 'third way' political ideologies have not been realised in the UK. Enterprise capitalism is the dominant economic system in the UK, as well as the USA. The key feature of this is the belief in the workings of a 'free' market, which is itself a self-regulating mechanism. Social capitalism is the dominant form of capitalism in central and Western Europe. The key theme with this form of capitalism is to marry the disciplines of market competition with the need for social cohesion and solidarity (Heywood, 2002). Anglo-American and Alpine capitalism are often contrasted as 'shareholder' and 'stakeholder' capitalism (Hutton, 1995). These economic systems have been reflected in different emphases in employment strategy and labour market reforms. As an EU member state the UK supports the twin objectives of the EES of high employment and social inclusion; however the UK is also an advocate of US approaches to increase employment and improve economic performance (Daguerre & Taylor-Gooby, 2004; DTI, 2002). Whilst it is indeed not helpful to see US and EU as opposing approaches to labour market reform, it is important to consider the potential effects of different underpinning ideologies in their implementation.

### **Analysis**

The analysis is in three parts: firstly it considers the UK policy context against the policy analysis criteria, followed by an analysis of the 2003 Guidelines and the UK EAP, and finally it reflects on the added value of the EES in the UK. It must be noted that this is an analysis of official documents only at this stage.

#### *Current policy context: Development and content*

The current UK policy measures incorporate:

- Increasing employment of unemployed and inactive
- Stimulating job creation
- Developing a flexible workforce and flexible working
- Increasing productivity and innovation
- Lifelong learning and skills development
- Making work pay
- Promoting fairness at work and in gaining work

Collectively these policies have defined key barriers to high and stable levels of economic growth and employment in the UK, and have identified action to address them. There is synergy and coherence between the different policy elements of the economic/employment agenda reflecting collaboration between the ministries with

lead responsibilities for these different elements. The policy analysis did not reveal, however the extension of these policy networks, that is who else was involved in the policy development process beyond Government departments. In addition although there is a clear rationale for the interventions, with defined overarching aims, objectives and targets the associated investments are not as well defined. For example, the Public Sector Agreement (PSA) target 3 for DWP is to increase employment and reduce unemployment and target 4 is to increase employment rates of disadvantaged areas and groups; specific targets are not associated with all of them. Similarly whilst for example US economic and labour market models are often described (e.g., HMT, 2003; DTI, 2002; HMT, 2000), there is no explicit acknowledgement of the theoretical model underpinning UK policy direction or the evidence-base of associated interventions, although this may be reflected elsewhere.

*Current policy context: Implementation*

There have been different degrees of measurable success in the implementation of these measures. For example the DWP's PSA target 3 is making good progress, however fairness in the workplace or in obtaining work (PSA target 4) still remains a particular challenge. Disparities in employment rates for women, people who are sick or disabled or from minority ethnic groups, pay and occupation for women and BME groups. In spite of the challenging targets and comprehensive recommendations in 'Jobs for All' (1999) it took 4 years to agree action and investment for example focussed at reducing labour market inequalities (LMI) (Cabinet Office, 2003; HMT/DWP, 2003). For women in work the gender pay gap still remains nearly 25 years after the Equal Pay Act and 20 years after the Sex Discrimination Act. In the UK women have 75% the average gross hourly earnings compared with men, the lowest in the EU-15 in spite of having one of the highest levels of female employment (Eurostat, 2000). This may have contributed to the perception that the UK is less focussed on issues related to fairness (The Guardian, 2004). Having said this the recent policy developments and the various pilots and other initiatives underway to address these LMI are welcomed.

*Current policy context: Health in policy planning*

There were some explicit links made between health and particular employment strategies. Probably the most striking were 'New Deal for Disabled People' and 'Pathways to Work' (DWP, 2003) targeted at helping people with a chronic illness or disability, back to work; within this working with local Primary Care Trusts and GPs was emphasised. References to reducing worklessness, poverty and social exclusion were common, which links to the wider public health agenda and reducing health inequalities. In a work context work-life balance considerations have been promoted, but no explicit links have been made between, for example flexibility, job insecurity and health or work environment conditions, health and productivity. There is, of course, the link described in the 'Securing Health Together' occupational health strategy (HSE, 2001) which recognises the importance of a healthy workforce for economic success. However there is an inherent conflict in promoting deregulated labour markets, whilst protecting the health - physical and psychological - and safety of the workforce.

*2003 Guidelines and UK EAP: Development and content*

The UK EAP is a response to the EES 2003 Guidelines and country-specific recommendations from the European Council. Using the open method of co-ordination, Member States agree the guidelines and targets and then draw up their NAPs describing how their action plan accords with these commitments. These are then exposed to peer review by their partners and are scrutinised by the Commission. Thus, as with some other NAPs, the UK EAP involved no new action in responding to the Guidelines; it provided information on current UK strategies and work plans, which contribute to the Guidelines and targets. As with any process

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involving building consensus between members of a group with different local challenges, historical and cultural contexts, and structures there is the potential for members to have different levels of commitment to the group agreement. The development process is obviously important in assuring maximum 'buy-in' from members. The 2003 Guidelines and the employment/economic policy agenda in the UK have remarkable resonance. Notable differences include the setting of clear objectives with measurable targets for the population as a whole and for groups disadvantaged in the labour market, such as older people and women.

There also appears to be a greater emphasis to social justice in the Guidelines as reflected in the key targets, as well as stronger role given to social partnerships.

#### *2003 Guidelines and UK EAP: Implementation*

In some respects the UK EAP seems somewhat unchallenged by the targets. For example, the UK has already met the Lisbon and Stockholm 2005 and 2010 targets for overall employment rate, employment for women and older people. Similarly under Guideline 3, the UK response in the UK EAP leads the Community by, for example, setting health and safety targets. This is not the case for all Guidelines though, particularly concerning social justice issues. For example, whilst under Guideline 6 the issue concerning the gender pay gap was readily acknowledged the action to address this was primarily geared to facilitate equal pay reviews and speed up equal pay tribunal cases. The PSA target to bring about measurable improvements in gender and race equality is acknowledged however. Action identified in the 'Ethnic Minorities and the Labour Market' report (Cabinet Office, 2003) was put forward under Guideline 7, but it was not clear whether this was confined to UK nationals or included migrant workers (EC or third country nationals), refugees and asylum seekers.

#### *2003 Guidelines and UK EAP: Health in policy planning*

In relation to the health implications of the UK EAP, this was not explicit other than through the effects of improved health and safety at work. Whilst this is acknowledged, there was no evidence of a more comprehensive consideration of the health effects of the UK EAP during the development process. This is contrary to the recommendation in 'Securing Good Health for the Whole Population', 'that the Cabinet assesses the impact on the future of the population of any major policy development' (Wanless, 2004), but this may reflect issues of timing. Similarly whilst the EC Directorate of Employment and Social Affairs has commissioned and published work considering the health effects of unemployment (Commission of the European Communities, 2003), it is unclear the extent to which article 152 was applied to the development of the Guidelines.

#### *EES 'added value'*

The EES and UK employment agenda are very similar as indicated above. It appears that the 'added value' of the EES is the positive influence it has on the UK's social agenda. The attention drawn to the inequities experienced by some groups in employment and the action to address these may contribute to more effective performance in reducing these inequalities, which as indicated above is a risk area.

#### **□□ Evidence from the Literature**

This section reviews evidence from the literature on the effects of unemployment, low income and employment on health with particular attention being paid to trends in employment and labour markets; where possible it draws on evidence from systematic reviews. In addition it also looks at the effects of labour market interventions and practices, for example 'welfare to work' approaches and flexible working.

It involved searching key databases, collecting reports, articles of studies, and reviewing these (appendix 5). Over 200 documents were examined.



### *Unemployment, low income and health*

There is a well-defined evidence base showing the effects of unemployment on:

- Physical health
- Psychological (mental) health
- Mortality

Studies have shown that both men and women are affected, as well as family members. Unemployment is a key determinant of health inequalities in people of working age, with people further down the social scale being hit hardest (Lawless et al, 1998; Nickel & Bell, 1995; Payne & Payne, 1994).

Research indicates a higher prevalence of ill health (Daniel & Stilgoe, 1979; Moylan & Davies, 1980; Cook et al, 1982; Moylan et al, 1984) in men and women. Social instability, unemployment and job insecurity are associated with high blood pressure and raised mortality rates (Schnall & Landsbergis, 1994). Self-reported health is also more likely to be reported as fair or poor by people who are unemployed.

Unemployed people also suffer a range of psychological effects from symptoms of depression and anxiety to self-harm and suicide (Shortt, 1996; Bartley, 1994); this seems to be independent of pre-existing health conditions (Montgomery et al, 1999). Recent rather than the total amount of unemployment was when deterioration in mental health was steepest. Gershuny (1994) and Bartley et al (1999) showed that improvements in psychological health were not immediate after unemployed people returned to work.

The unemployed also suffer disproportionately from premature mortality. In England and Wales, all cause mortality was consistently higher than average among unemployed men. Among younger men mortality from injuries and poisonings, including suicide was particularly high. Unemployed women had higher rates of mortality from heart disease and from injuries and poisonings, including suicide (Bethune, 1997). The British Medical Association (1998) estimated that for every 2000 unemployed men, there were 3 excess deaths. More recently Brenner (2002) was able to show up to a 10-year lag in increased mortality in an analysis across the EU-15 and the US.

The wives of unemployed men have also been found to have an excess risk of death (Moser et al, 1990). In addition there is evidence indicating the effect of poverty, of which worklessness is the main cause, on the mental and physical health of children as well as infant mortality (ONS, 2001; ONS, 1999). The life chances and social mobility of children are also related to parents' income (Blanden et al, 2001; Dearden et al, 1997).

Various longitudinal studies (Bethune, 1997; Goldblatt et al, 1990; Martikainen, 1990; Iversen et al, 1987) have suggested that the relationship between unemployment and health is unlikely to be by 'direct health selection', that is that poorer health itself increases the risk of unemployment. However it has been shown that ill health is clearly a risk for initial job loss and subsequent re-employment (Clausen et al, 1993); this indicates a double disadvantage people who are chronically sick or disabled may face.

Explanations of the mechanisms by which unemployment leads to poorer health focus on the following factors:

- Poverty
- Unemployment as a stressful life event
- Social exclusion
- Health-related behaviour changes

- Disrupting future career development

Financial strain has been reported as a strong - in some studies the strongest - mediating factor. The proportional change in family income between employment and unemployment predicted subjects' score on the General Health Questionnaire (Jackson & Warr, 1984). Long-term unemployed people who had to borrow had a higher risk of depression than those who did not; similarly they were more likely to report deterioration in physical health (White, 1994). Deterioration in psychological well being appears to plateau after 12 to 18 months of unemployment with an adaptation to the social and financial circumstances, associated with lower self efficacy, alienation and cynicism (Jackson & Warr, 1985; 1987).

The concept of unemployment as a stressful life event is based on the non-financial benefits that work gives an individual: Jahoda's 'latent consequences' (Jahoda, 1942; 1979) or Warr's 'vitamin theory' (Warr, 1987). These benefits include self-esteem, social status, structure to the day, physical and mental activity, use of skills, interpersonal contact, purpose. Studies in Sweden (Isaakson, 1989) and Finland (Lahelma, 1992) have shown psychological health benefits from low paid work or work experience compared to unemployment. In the US, welfare recipients' psychological outlook was shown to change according to the length of time on public assistance (Popkin, 1990).

There is not overwhelming evidence of the associations between unemployment and changes in health-related behaviour; however there is an apparent relationship with long-term development of health behaviours (Wadsworth, 1991). Evidence from the NCDS cohort (Montgomery et al, 1998) at age 33 suggest men who have experience more unemployment tend to have lower body weight, were less likely to have given up smoking and were more likely to indicate they were 'problem drinkers'. In later years, data from NCDS indicate that unemployment may be associated with weight gain. It appears that periods in and out of employment result in stress-related alternations of weight loss and weight gain which has been reported to be a significant risk factor for cardiovascular disease (Bosello et al, 1992). Evidence from elsewhere shows an increase in illicit drug taking by young unemployed people but associates this with an adoption of an alternative culture rather than used to combat stress (Peck & Plant, 1986; Hammer, 1992). Suicide and parasuicide have shown to be higher in unemployed men particularly young men; however evidence indicates that this is because unemployment increases the likelihood of other adverse life events, such as relationship breakdowns and losing ones home, whilst lessening the psychological and social resources needed to cope with these events (Kessler et al, 1988).

#### *Labour market interventions and health*

There are a variety of schemes and fiscal measures aimed at enhancing the employment prospects of different groups of people who are unemployed or inactive. The following lists some of these labour market programmes, including:

- New Deal (ND) programmes - for young people, long term unemployed, 50+, Lone parents, disabled people, self-employed, partners, musicians
- Pathways to Work programme - for people who are incapacitated by illness or disability (pilot stage only)
- Employment Zones - for disadvantaged areas in Britain with persistent long term unemployment
- Tax credits - working tax credits, child tax credit, disabled person's tax credit
- National minimum wage - independently assessed, age-variable minimum hourly rate of pay
- Modernising the employment service - structural reforms to the employment service to improve services to jobseekers and employers

Table 21 provides a more comprehensive description of the policy and legislative framework and the measures associated with them. Many of these schemes have been evaluated since they have been introduced. Key impacts are presented in Table 22. In addition, there is evidence of a broader range of impacts on families from similar longer running 'welfare to work' programmes in the US, and more recent developments in Norway. The expected impacts of recently introduced welfare systems and programmes in the Netherlands and New Zealand are also considered.

**Table 23 Impacts of UK welfare programmes**

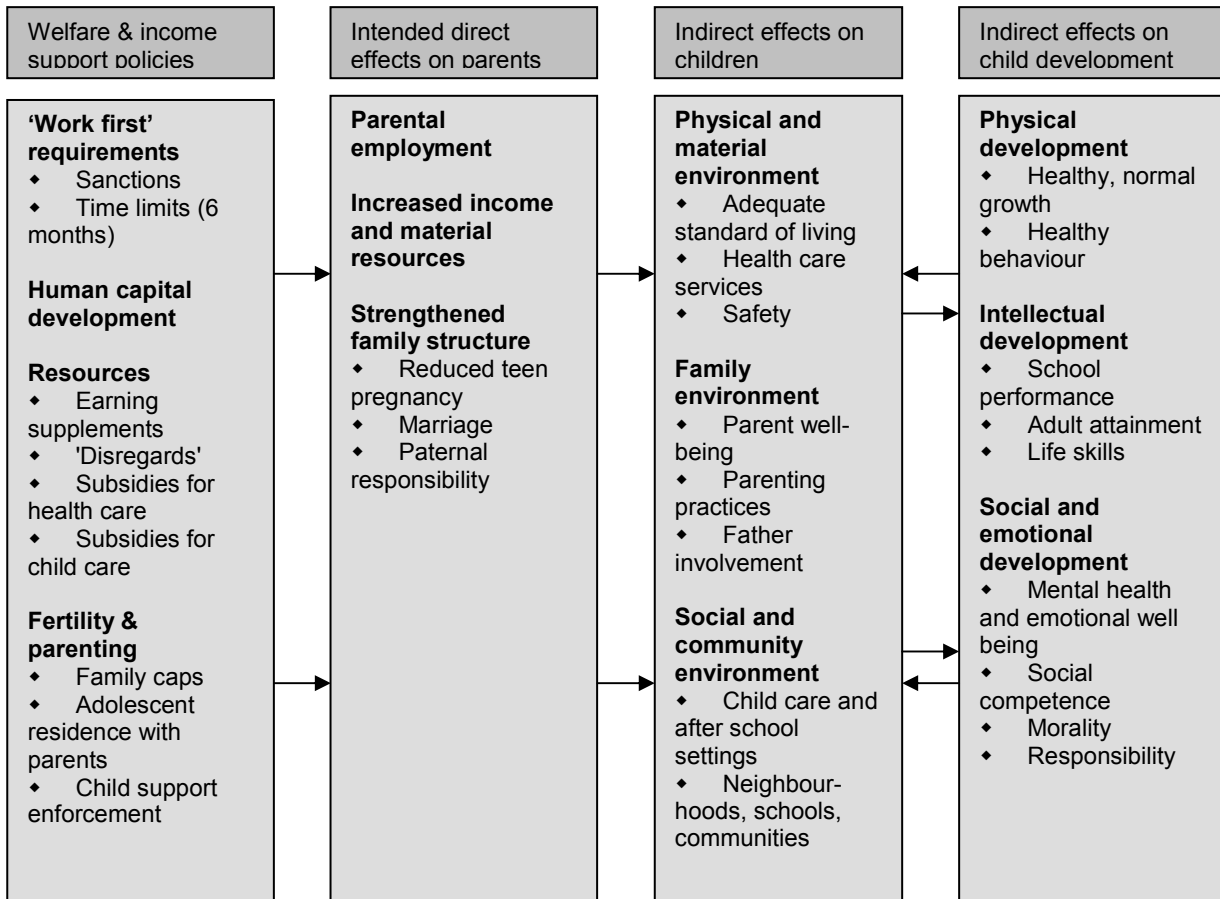
<b>Programme</b>	<b>Impacts</b>	<b>Most successful features</b>	<b>Least successful features/barriers to participation</b>	<b>Groups who benefited most</b>	<b>Groups who benefited least</b>
ND Lone Parents	<ul style="list-style-type: none"> <li>♦ 51% leavers off Income Support (41% employed 16+ hrs per work)</li> <li>♦ 52% leavers employed</li> <li>♦ 87% of leavers employed after 12 months</li> <li>♦ £1600 net saving to Exchequer per job</li> <li>♦ Increased confidence, motivated</li> <li>♦ Reduced isolation</li> </ul>	<ul style="list-style-type: none"> <li>♦ Personal adviser (PA) support</li> <li>♦ Flexible/part time work</li> <li>♦ Work placements/mentoring (Inn. Fund)</li> <li>♦ Manageable, enjoyable training (Innovation Fund)</li> <li>♦ Close employer engagement</li> </ul>	<ul style="list-style-type: none"> <li>♦ Outreach service - poor referral rates to PA</li> <li>♦ Poor employer engagement</li> <li>♦ Lack of local employment context - e.g. local skills gaps</li> <li>♦ Lack of local, affordable, quality child care</li> </ul>	<ul style="list-style-type: none"> <li>♦ 'Labour market ready'</li> <li>♦ Looking for work</li> </ul>	<ul style="list-style-type: none"> <li>♦ Lone fathers</li> <li>♦ Teenage &amp; older parents</li> <li>♦ People with health problems or disability</li> <li>♦ Ethnic minority groups</li> <li>♦ Live in deprived, urban areas</li> <li>♦ Live in inaccessible rural locations</li> <li>♦ Not 'job ready'</li> </ul>
ND 25+	<ul style="list-style-type: none"> <li>♦ 4% less likely to be unemployed (compared with non-ND 25+)</li> <li>♦ Negligible increase in employability</li> </ul>	<ul style="list-style-type: none"> <li>♦ Individually tailored package</li> <li>♦ Early entry</li> <li>♦ PA flexibility</li> <li>♦ Client choice in IAP</li> <li>♦ Work placements</li> <li>♦ Employers &amp; subsidies (pre-2001)</li> </ul>	<ul style="list-style-type: none"> <li>♦ Poorly organised, repetitive or irrelevant Intense Activity Periods (IAP)</li> </ul>	<ul style="list-style-type: none"> <li>♦ Men</li> </ul>	<ul style="list-style-type: none"> <li>♦ People unemployed for 5+ years</li> <li>♦ Women</li> <li>♦ Ethnic minority groups</li> <li>♦ People with health problems or disability</li> </ul>
ND 50+	<ul style="list-style-type: none"> <li>♦ 84% not claiming benefits at 12 months (job retention indicator)</li> </ul>	<ul style="list-style-type: none"> <li>♦ Employment credit</li> <li>♦ Flexible training - work-related and confidence building</li> <li>♦ PA/Job centre support</li> <li>♦ Work with employers to overcome discrimination</li> </ul>	<ul style="list-style-type: none"> <li>♦ Discrimination by employers</li> </ul>	<ul style="list-style-type: none"> <li>♦ White men</li> <li>♦ 'Active' JSA clients</li> </ul>	<ul style="list-style-type: none"> <li>♦ People with health problems</li> <li>♦ Ethnic minority groups</li> <li>♦ 'Inactive' clients</li> <li>♦ People with outdated skills</li> </ul>

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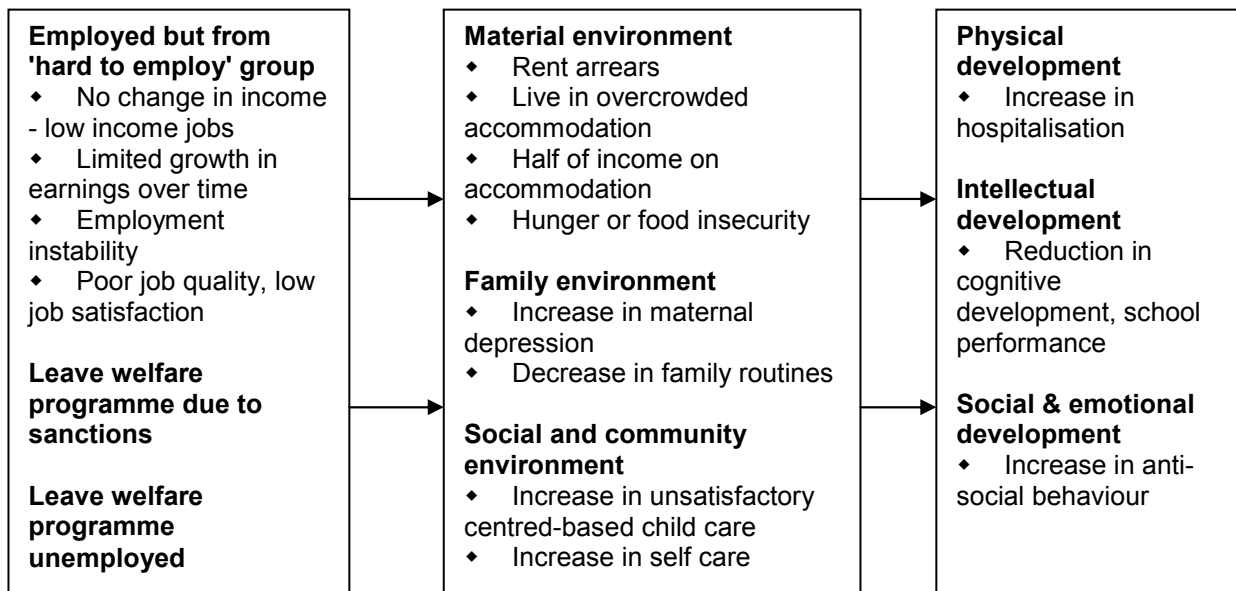
ND Disabled People	<ul style="list-style-type: none"> <li>♦ One third in paid work, five months after registration</li> <li>♦ Increased confidence</li> <li>♦ Less anxious about financial issues</li> </ul>	<ul style="list-style-type: none"> <li>♦ Job Broker support</li> <li>♦ Flexible/part time work</li> <li>♦ Work at home</li> </ul>	<ul style="list-style-type: none"> <li>♦ Job opportunities</li> <li>♦ Attitudes of employers</li> </ul>	<ul style="list-style-type: none"> <li>♦ Women</li> <li>♦ Access to a vehicle</li> <li>♦ Living with a partner</li> <li>♦ 'Labour market ready'</li> <li>♦ Want to work</li> </ul>	<ul style="list-style-type: none"> <li>♦ People with poor health</li> <li>♦ People without basic skills</li> <li>♦ Older people</li> </ul>
Employment zones	<ul style="list-style-type: none"> <li>♦ 34% were in work or had worked, 10 months from referral (cf 24% ND 25+)</li> <li>♦ 11% more employed 16+ hours per week 10 months from referral (cf 24% ND 25+)</li> <li>♦ 8% more employed 16+ hours per week 20 months from referral (cf 24% ND 25+)</li> </ul>	<ul style="list-style-type: none"> <li>♦ PAs support, flexibility</li> <li>♦ Discretionary fund for 'one-off' payments to participants, e.g. interview clothes</li> <li>♦ Provider innovation &amp; flexibility to meet participant needs</li> <li>♦ Individually tailored package</li> </ul>	<ul style="list-style-type: none"> <li>♦ Job instability</li> </ul>		<ul style="list-style-type: none"> <li>♦ People with health problems</li> <li>♦ People without basic skills</li> <li>♦ People without qualifications</li> <li>♦ People with criminal records</li> </ul>
Modernising the employment services	<ul style="list-style-type: none"> <li>♦ Increased effectiveness of Jobcentre plus (JP) for jobseekers</li> <li>♦ Decline in employer awareness, satisfaction of JP services</li> </ul>	<ul style="list-style-type: none"> <li>♦ JP staff</li> <li>♦ Physical refurbishment of JP offices</li> <li>♦ Jobseeker focus by JP</li> <li>♦ IT system developments</li> </ul>	<ul style="list-style-type: none"> <li>♦ Employer focus by Employer Direct</li> </ul>	<ul style="list-style-type: none"> <li>♦ Women</li> <li>♦ Younger people</li> </ul>	<ul style="list-style-type: none"> <li>♦ Least 'job ready', most disadvantaged in labour market</li> </ul>

In the United States similar welfare programmes were introduced under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA); this aimed to increase paid employment, reduce welfare dependence, and to influence family structure by encouraging marriage and two-parent families. Figure 20 provides a schematic representation of the conceptual model on which the policy has been based on and the intended effects. Figure 21 identifies additional actual impacts.

**Figure 20 Conceptual Model of PRWORA Policy Effects on Families (adapted from Hurston, 2002)**



**Figure 21 Actual Policy Impacts on Families**



Norwegian welfare policy reforms in 1998 (appendix) aimed to combine childcare, education and paid work, but with a shift in emphasis to a time limited provision of 3 years and towards paid work. Importantly they explicitly sought to improve the financial circumstances of lone parents. Evaluated impacts have included:

- Halving of the number of allowance claimants
- One in four lone parent families' income at comparable population income levels
- Increase in employment (difficult to show direct association)
- No impact on occupational stereotyping - occupational demands on employee flexibility, low, unsteady income
- No impact on gender inequality
- Reductions in long term education opportunities
- Low levels of involvement in BMO support programme
- Negative impacts on maternal well being, e.g. maternal distress
- Negative impacts on children's well being, e.g. normal healthy development

There may be something here about the context in which changes are introduced, e.g. Siegrist's effort-reward imbalance (1986a), as well as how that affects how changes are perceived.

The Netherlands has shifted to an 'active' welfare state over the last 20 years. This model aims to increase employment and employability, whilst reducing social assistance. The most recent reforms in 2003 introduced different levels of measures, e.g. training or work experience, according to the 'work readiness'. The 'work first' orientation is expected to have the following consequences:

- Reduced opportunities for parental care of children - increased formal care
- Limited impact on reducing poverty for lone parents - low skill levels
- Long term reductions in social assistance for lone parents

New Zealand provides an interesting comparator to the UK. It faces a similar policy dilemma to the UK over the issue of lone parents - high rates of economic inactivity and dependence upon state benefits - but in 2003 it took a very different course (Hutten in DWP, 2003). The emphasis has been on client-centred 'enhanced case management' and the early identification of welfare beneficiaries in need of support to overcome barriers to entering the labour market. Application for benefit is accompanied with an interview with annual follow-ups on re-application for benefit. Data on 8 specific areas are collected:

- financial issues
- accommodation
- health
- employment
- personal needs
- education and training
- social participation
- other

to identify employment barriers and an action plan is developed. Referrals are made to local agencies, e.g. health services, debt counsellors, for areas outside the labour service. This is seen as an approach with long-term sustainable outcomes. The expectations are that the level of benefit claimants will reduce over time, however maintaining levels in year 1 is seen as likely. In addition the rates of job readiness are anticipated to increase. But with this programme's holistic approach there are also expectations that it will contribute to health, social and economic outcomes, including greater involvement in communities. Client satisfaction surveys are already revealing enhanced levels of success.

### *Employment and health*

The impacts of work on health have traditionally focused on exposure to physical and chemical hazards associated with different occupations and their risks to health. This is the domain of occupational health of which there is a comprehensive evidence-base underpinned by extensive surveillance mechanisms (Drever, 1995).

However there is a growing literature on the relationship between work and health that transcends occupations; this relates to psychosocial factors at work. Karasek and Theorell (1990) put forward the job demand-control or job strain model to explain how high psychological demands and low control working conditions are associated with health related harm. Low control work has been associated with an increased risk of:

- coronary heart disease (CHD),
- musculoskeletal disorders, e.g. back pain,
- mental illness,
- sickness absence.

These risks have been shown to be independent of the psychological characteristics of the people studied. High demand, low control work is more common with lower socio-economic groups and it is believed that psychosocial factors at work may play an important part in the social gradient in ill health.

The Whitehall II study (Marmot et al, 1991), which showed a dramatic difference in mortality by grade of civil servants unaccountable by conventional risk factors, examined the characteristics of the demand-control model and suggested that the lower grade of employment in the civil service, the lower level of control over the job, the lower use of skills and the higher level of monotony. It was found that low levels of control, both self-reported and independently assessed, were at higher risk of new CHD within 5 years. High demand and low social support were not associated with increase risk of new CHD.

Psychosocial work characteristics associated with higher rates of sickness absence (short and long spells) for both men and women included low control, low variety and use of skills, reported low support at work and a slow pace at work (North et al, 1993). Low support from colleagues and supervisors, low variety and use of skills were particularly associated with absences for mental health issues. (Stansfield et al, 1997). Low control was consistently related to short and long spells of sickness absence for back pain for men and women (Marmot et al, 1997). However when other factors were standardised for, psychosocial work characteristics could only account for short spells of sickness absence and there was a stronger support for predicting sickness absence within lower employment grades where job strain was more prevalent (North et al, 1996). This is significant not only for health considerations but also in terms of organisational performance and productivity.

A review of 25 studies found that 17 had significant associations between job control and cardiovascular outcome, whereas job demand was significant in 8 out of 23 (Schnall & Landerbergis, 1994). More recently a review to identify the best available evidence identified a positive association between aspects of the job strain model and CHD in 6 out of 10 studies (Marmot et al, 1997). The SHEEP project in Sweden indicates that a loss of control is also associated with increased risk of myocardial infarction and there is a stronger association for manual workers and in men under 55 years (Hallqvist et al, 1998).

An alternative but related model focuses more on the links between work and labour market dynamics. The effort-reward imbalance model (Siegrist, 1986a; Siegrist, 1996b) links the needs of the individual, e.g. self-esteem, with the work environment and with wider social structure. Effort at work is part of a socially organised exchange process, to which society at large contributes. Rewards are financial, esteem, career opportunities and job security. The



model suggests a reciprocal relationship, which when it is out of balance, i.e. high effort, low reward, results in emotional distress or 'active coping'. 'Active coping' is characterised by feelings of irritation, anger, frustration and dissatisfaction. The associated neuro-hormonal responses are postulated to increase cardiovascular risk. Examples of effort-reward imbalances associated with current labour market trends for flexibility include fixed-term/temporary contracts, job instability/insecurity, fragmented career opportunities, and forced occupational mobility. It can also be used to explain the negative psychological health effects of welfare to work measures that result in no improvements in income, little prospects for improvement and poor job quality.

Compared with the demand-control model, fewer studies have been undertaken on the effort-reward imbalance. However, the evidence from six studies gives full or partial support of this model's basic assumptions. With regard to CHD incidence, effort-reward imbalance was associated with a two to six-fold increased relative risk compared with those who are free from chronic work stress (Siegrist et al, 1990; Bosma et al, 1998). Additional evidence indicates chronic work stress derived from effort-reward imbalance was associated with elevated risks of high blood pressure, and high concentrations of atherogenic lipids (LDL cholesterol). One study showed raised fibrinogen levels.

With high effort, low gain work conditions an increased relative risk of new psychiatric disorders has also been reported: 2.6 in men and 1.7 in women (Stansfeld et al, 1998b). Similarly effort-reward imbalances at work predicted for poor physical, psychological and social functioning after adjusting for confounding variables (Stansfeld et al, 1998a). Other reported health effects of effort-reward imbalances include:

- Musculoskeletal disorders
- Gastrointestinal symptoms) (Peter et al, 1998)
- Fatigu
- Sleep disturbances
- Sickness absence (short and long term) (Peter & Siegrist, 1998)
- Coronary restenosis (Joksimovic et al, 1998)

Job insecurity, whether through threatened unemployment, reduced working hours, temporary work or even fixed term contracts, is a particular form of effort-reward imbalance. Both physiological and psychological (Burchell, 1995; Ferrie, 1999; Robinson, 1986) health effects have been observed, as well as increases in the use of health care services (Beale & Nethercott, 1985; 1986). Ferrie (1998; 1995) showed that civil servants experienced a phased deterioration in health status when a department was privatised: an 'anticipation phase' saw an initial deterioration followed by significant increase in cardiovascular risk factors immediately before the transfer. Chronic job insecurity in civil servants transferred to an agency exhibited relatively higher blood pressure compare with those who remained in the civil service. One study has related these changes to the degree of financial uncertainty (Matthiason et al, 1990). Ferrie and colleagues (2001) observed an increase in smoking and reduced activity in women with both 'anticipation phase' and chronic job insecurity; there was also an increase in control, demand, and loss of skill discretion and support. Compared to full-time permanent workers, employees with temporary contracts were two times more likely to report job dissatisfaction (Benavides & Benach, 1999; Benavides et al, 2000). Other effects have also been reported including organisational commitment and performance (Sverke et al, 2002). Insecure jobs are also those that tend to involve greater exposure to physical and chemical hazards (Robinson, 1986); thus this group of workers have an additional health burden. An analysis of the third European employment and health survey (Benach et al, 2002) indicates that for all employment contract types, full-time workers report worse health than part-time workers.

In general, however, being in work is better for health than having no job. Across the EU-15 and the US, Brenner (2002) was able to demonstrate that increases in employment decrease mortality within 10 years. But there do seem to be exceptions to this rule. Earlier

examples have indicated that for welfare to work participants when there is no income improvement or when the job is insecure or unsatisfactory health scores are similar to the unemployed (Burchell, 1996). Similarly particularly hazardous forms of work pose considerable risks to health for some workers (Brenner, 2002).

#### *Employment interventions and health*

A recent systematic review of 121 studies on international workplace interventions indicates that an increase in workers' control, e.g. decision latitude, participation, can benefit physical and mental health, and mitigate against the harmful effects of job insecurity (Egan et al, forthcoming). Increasing job demands can have either no effect or harmful effects on health, although benefits can arise from lengthening working days to allow more days off. There was evidence that some well-intentioned interventions could have adverse health effects. This work supports an earlier review undertaken by Karasek (1992) which demonstrated that improvements in the psychosocial workplace environment can improve worker health. Although changes that were introduced needed to be specific to the particular workplace context, a number of common features for successful interventions were identified:

- Commitment and effort from management
- Support by management and the workforce
- Participation of the workforce in planning and implementation
- Development of trust
- Factors that inhibited health improvement in the workplace included:
  - Schemes which treated symptoms only, and not the causes of work-related ill-health
  - Technical solutions imposed from the top
  - Management-controlled communication

Successful interventions follow principles of good management practice (WHO, 1995). Effective leadership and management are also associated with enhanced performance (Collins & Porras, 1994; Karasek, 1992). Some studies have indicated that the costs of interventions to improve workplace health can be met by improvements in productivity (Wynn & Grundeman, 1999; Cooper et al, 1996). Evidence from Scandinavia also indicates that good practice may also be promoted by explicit commitment at the national level (Levi, 1992).

High levels of perceived co-worker, supervisor or trade union support have been shown to offset some negative aspects of job insecurity (Shaw et al, 1993). Increased perceived personal control and the provision of information about what is happening, the decision-making process and who is involved are key to minimising the harmful effects of organisational change. However from the 1996 European Survey on Working Conditions temporary workers tend to be less involved in consultations about organisational change, receive less training and have fewer discussions about work problems with colleagues or supervisors.

## 6 Stakeholder and key informant evidence

### 6.1 Introduction

This section presents evidence of health impacts identified from the data collected from 'stakeholders' and 'key informants'. 'Stakeholders' are defined as individuals or groups of people who have a stake or interest in the policy under investigation. For the UK EAP, stakeholders included the policy proponents, key health agencies, other government departments, business and trade unions, social partners, Non-Governmental Organisations, and regional government (see Section 4). 'Key informants' are experts or specialists in a specific policy field. For the purpose of this HIA, key informants in 'employment' and 'employment and health' were invited to be involved.

### 6.2 Methods and process

The methods and process consisted of:

- Stakeholder and Key Informant sampling
- Stakeholder and Key Informant engagement
- Development of question guides specific to different stakeholders and key informants
- Facilitation of in-depth face-to-face or telephone interviews
- Transcription and initial analysis of recorded interviews
- Observation notes and written submissions
- Email discussion group

The stakeholder and key informant engagement process involved:

- Once organisations had been identified from sampling, a 'fieldwork plan' was developed
- Initial contact was made by telephone
- Confirmation of the interview date/time/venue was made in writing
- Details of the HIA, a summary of the EES and UKEAP and the question themes for the interview were circulated with the confirmation letter
- Consent forms were completed by interviewees

The HIA team at IMPACT developed two question guides: one for employment stakeholders and key informants and one for stakeholders and key informants with a background in health and employment. Each was designed with a number of themes, which started with broad open questions and then focused down to more specific questions; all had supplementary questions and prompts. The schedules can be found in appendix 4. A health impact matrix was used to record the potential positive and negative impacts of the UKEAP.

As soon as possible after each interview the facilitator wrote down their broad impressions about how the interview went and any limitations or procedural variations they were aware of. Notes that were taken during the interviews were used to supplement the recorded transcripts. One-to-one interviews (face to face and telephone) were tape recorded and transcribed verbatim. Qualitative data was coded according to the themes generated, and analysed systematically for similarities and differences (Knodel, 1993; Silverman, 1993). Content analysis - the systematic identification and analysis of key words and phrases in documents, transcripts, field-notes and recordings - has been used to analyse qualitative data. A discussion group was facilitated via email to develop further commentary on the emerging themes.

### 6.3 **Presentation of evidence**

The findings are presented under the following headings:

- Perspectives on Unemployment
- Perspectives on Unemployment and Health
- Perspectives on Employment
- Perspectives on Employment and Health
- Potential impacts of the UK EAP

The themes that emerged from the interviews and focus groups are grouped under each heading. Contributions have been anonymised to preserve confidentiality. As described in section 4, the purpose of participatory, qualitative approaches is to gather evidence from stakeholders and key informants based on their experience, perceptions and beliefs. This provides a more in-depth understanding of the relationship between unemployment/employment and health, and the particular interventions of the UKEAP and how this might affect this relationship. It was not the purpose of the qualitative approaches used to attribute numerical values to different views. Fourteen interviews were undertaken, each lasting approximately an hour.

#### 6.□ **Perspectives of Unemployment and Inactivity**

There was general agreement that unemployment in the UK was at historically low levels, partly due to the strong and stable economy. There were concerns however that the focus to reduce unemployment in general masked underlying issues for particular groups of people; particularly the long term unemployed and the inactive.

*'A lot of that [unemployment] is likely to be short-term unemployment, people between jobs, but there is a stock of long-term unemployed people many of whom I think have a number of disadvantages in participating in the labour market.'*

The long-term unemployed were said to consist of older people, particular ethnic minority groups, people with disabilities and with learning difficulties. Interestingly comments from employers' perspectives were that long periods of unemployment were felt to indicate a lack of interest in working, making employers somewhat wary of people who are marked out as having been long-term unemployed.

The steady levels of economic inactivity were of concern to a number of stakeholders and key informants. Within this inactive group there was particular concern for nearly 3 million people who are on disability-related benefits. About 2.5 million of these were said to be over 50 but under State Pension Age.

Other population groups disadvantaged in the labour market and targeted by Government programmes included partners of people on benefit and lone parents. People with low skills were also mentioned. Some geographical areas, predominantly but not exclusively, inner cities were also said to have high rates of unemployment. There were particular issues in areas of multiple deprivation, where high unemployment is associated with, for example, poor public services, lack of quality affordable child care.

*'...there are high and difficult to explain concentrations of worklessness and unemployment, often cheek by jowl with very tight labour markets.'*

*'... if you are disabled and black, and live in Renfrewshire in Scotland and you are 58, the chances of you having a job are miniscule.'*

One key informant contrasted unemployment in the 1980s with unemployment today by; in the 1980s high levels of unemployment were spread across the social spectrum with increased risks for all but especially those who had always been more at risk. However the social security system in the 1980s meant there was a more detrimental impact on people reliant on them compared to the 1930s.

## 6. □ **Perspectives of Unemployment and Health**

There was awareness of the relationship between unemployment, poverty and health by several stakeholders. In particular there was reference to income levels on benefit and the effects on quality of life. Associated with this were the effects on family formation and breakdown. This upset and tension can also affect any children in the home. However, a few stakeholders were struck with how people re-adjusted possibly to cope.

*'...the lack of income ...relying on the dole and people think that you're possibly fiddling and all that [these] sorts of feelings go with being unemployed.'*

Unemployment was said to cause uncertainty; for many people it was said that not only was there a loss of social networks and personal contacts, but there was also a lack of role in life. Reference was made to the effects of unemployment on mental health, reducing self-esteem and inducing depression. Some stakeholders also said a small minority, drift into sub-cultures, whether drug-taking or other forms of anti-social behaviour were a consequence of unemployment.

For older people, there is a tendency once unemployed to stay out of work for longer. This was said to be impact on their self-esteem and motivation. The concept of face-saving behaviour was also mentioned; here a reason for not being in work, for example lack of time, is given but often masks the real reason.

Government employment policy was said to have twin objectives:

*'...to improve people's lives as much as to improve the economy through the better working of the labour market.'*

It was reported that there was a knock on effect of being out of work on health services. People who are not in work were said to visit the GP three times more often than those who were worked.

## 6.6 **Perspectives on Employment**

The unemployment/employment transition and reducing the mismatch between labour supply and demand were seen as key challenges.

*'...There is a lot of talk about tight labour markets and vacancies being greater than the number of people able to fill them.'*

Although there was general acknowledgement of the developments in attaining near full employment - a feat that a few years ago was felt to be impossible - there were concerns about the associated creation of a lot of relatively low-paid jobs. There were particular concerns that this was actually being encouraged by Government subsidies. The impact of this was felt to be the creation of a new group of 'working poor'. The National Minimum

Wage, however, was said to be an important safeguard to low wages and a relative reduction in low pay was reported. In spite of the growth in the NMW above inflation, there was still a widening of earnings at the top and bottom, with the middle pulling away from the bottom. Within these types of jobs there was felt to be little scope for advancement and they were generally described as poor quality. The concept of 'quality of work' was raised as something the EC are trying to promote within the Social Policy Agenda and was felt to be an important way to encourage a better working environment.

One of the features of the UK labour market has been the growth in diverse patterns of employment. Some indicated that reported increases in flexible working, e.g. part-time work, were exaggerated. Others however suggested that increasing flexibility could be positive, e.g., encouraging and enabling people who may not be able to participate in full-time work, and negative, e.g. the increased trends in job insecurity associated with downsizing, redundancy and so forth. Women and older people were seen as the groups that benefit most from the availability of increased flexible working. It was indicated that there were anecdotal reports from some employers indicating that increasing flexible working for employees has increased productivity. Conversely it was argued that employee flexibility may compromise the overall flexibility of the business which may lead to loss in productivity and profitability. However there was said to be a resistance from employers to job share which may impact on the type of job available.

Flexible labour market practices were said to have been operating for some time in certain manufacturing sectors where order books had fallen in recent years in the face of international competition. This had often led to pay freezes. The shift from a manufacturing industrial base to a predominantly service employment base, as a result of global economic developments was also mentioned by some.

A number of stakeholders pointed to 'skills base problems' as affecting the employability of individuals and industrial competitiveness. Too many people were reported to have no qualifications or very low qualifications, i.e. below level 2. In addition the UK was said to have poor intermediate skills (levels 3 and 4) as well compared with say Germany and France. Evidence was said to show the proportion of the productivity gap with Germany and France (and to a lesser extent the US) is due to the skills deficit. The impact on business development was also said to be affected by this skills gap. However, some key informants expressed little sympathy for employers criticising the skills shortage when it was considered that insufficient was done by them to train and develop staff. This was even so in spite of the 'irrefutable evidence' that was said to exist showing the association between levels of investment in training and productivity.

*'I think that this constant bemoaning of the quality of the labour supply...from employers who are not really willing to train and develop workers is something of a non-starter.'*

*'The extent of workforce development and career development....[is] something limited to a minority of higher potential people.'*

This low-level investment in training has meant that the training 'system' in the UK is relatively poorly developed compared with, e.g. the Netherlands, France and Germany. The merits of the 'dual system' in Germany were mentioned. However it was generally felt that the development of the Learning and Skills Council and their agencies was a move in the right direction. Similarly the new 'Skills Strategy' places a lot of emphasis on better-qualified and skilled workers leading to greater productivity.

Poor skills were said to be associated with lower socio-economic groups and areas of high deprivation. Similarly people with low skills are more likely to be in low paid jobs, threatened by unemployment or unemployed.

*'...it's essentially the lowest socio-economic groups [with lower skills] and there's a clear correlation between the lack of qualifications and the lack of employment opportunities.'*

Other factors that were felt to be associated with productivity included the quality of management.

The implications of poor investment in training and development, but also in plant and machinery were held up by some to be key reasons for the UK's relatively poor productivity. In addition low morale and poor management were also said to affect productivity.

The UK was seen to be out of step with the rest of Europe concerning employment policy and employment protection. This was seen as largely historical, e.g. the weakening of trade unions and the reduction in social security benefits, but with implications for how the labour market operates in the UK today.

Some stakeholders recounted that some industries, especially those with manual workers, worked long hours and were routinely seeking exemptions from the Working Time Directive to work over a 48-hour week. Employees who could only earn reasonable incomes by working long hours agreed this to. It was believed though that although across all sectors these hours are stabilising, part-timers hide the true picture.

Issues around the involvement of staff in decision-making were discussed. Some stakeholders expressed hope for improving employee/employer relations with the new EC Directive on Information and Consultation, although there were concerns that putting it into practice would be difficult.

*'...laws can sound good but often don't work in practice because employers find loopholes...consultation is one thing, negotiation is another - even if you are consulted you may be ignored.'*

There was reported to have been a dramatic decline in the participation of the over 50s in the workforce between the mid 1970s and the end of the twentieth century. This was stemmed in the late 1990s in part due to Government policy but also due to economic factors. Employment for people over 50 grew faster than for any other group, but this was predominantly women and part-time work. It was also reported that over 50s were more likely to be self employed; it was partly thought that this was due to the lack of available quality jobs for managers and other white collar workers recently unemployed.

## **6.7 Perspectives on Employment and Health**

With the shift in the UK industrial base towards the service sector, as well as changes in occupations some key informants reported changes in the type of health conditions workers were suffering from. Related to this was the multi-causal nature of these conditions and the different employment context they were working in, e.g. no more jobs for life, more occupational mobility.

*'When you're dealing with things like lead poisoning from working on lead batteries it is very clear who is in charge, but when you are dealing with work-related stress which is very close to other forms of stress it is not quite the same thing.'*

It was also suggested that agencies were not making a lot of progress in improving the health of people at work. This was said to have prompted the occupational health strategy,

'Securing Health Together' which is setting up a national occupational support system and is a partnership between various agencies.

Musculoskeletal disorders (1.25 million) and work-related stress (0.5 million) are the two most common work-related illnesses, but whereas the incidence of musculoskeletal disorders (MSD) is plateauing, stress was said to still be on the increase. Programmes to reduce MSD and stress were described as risk assessment approaches - carrying out an audit using guidelines and introducing evidence-based interventions to meet any identified shortfalls.

'Securing Health Together' was also seen as a strategy complementing initiatives to reduce economic inactivity from ill health; the strategy is about preventing short-term sickness developing into a more chronic condition with long-term incapacity issues. However it was said that if this were to work effectively, organisations and managers would need to develop new cultures and practices, e.g. support rehabilitation of workers back into the workforce after long periods of sickness. Similarly General Practitioners and Primary Care Practitioners also need to adopt new approaches to treating work-related ill health.

Another key informant described the impacts on health of the separation of executive functions, e.g. child benefit payment, in the UK civil service into executive agencies during the 1980s. This was seen as the first step to privatisation. Managers and employees had to put in a bid in open competition with the private sector. Prior to this a civil service job had been seen as a 'job for life' however this introduced a whole new way of working and new working conditions. Fortunately, data on pre-existing morbidity had been collected before the changes were introduced so it was possible to plot the changes in health status with the changes in working conditions. The 'anticipation phase' was described as when you know something is going to happen but don't know what; although this phase was protracted in this case, there were other examples mentioned where it could be very quick. Self-reported health measures at this phase showed a significant increase in physical morbidity compared with 19 control departments, but less so for psychological morbidity. This was followed by a 'pre-termination phase', where termination corresponds to redundancy, retirement or transfer to the private sector, which showed adverse effects on physiological measures as well. After privatisation, comparisons of the health status of people in perceived secure jobs were made with those who judged that they were in insecure jobs or who were unemployed. The unemployed and those in insecure jobs had the worst health.

*'...One of the most interesting findings for us was that insecure employment was as bad for somebody's health as unemployment.'*

Qualitative data from interviews with these civil servants also revealed that South Asian employees felt that when jobs were under threat, racial discrimination surfaced.

*'...every single person I interviewed from an ethnic minority found this. Everything was fine when the going was good, when the going got tough then discrimination came out of the woodwork.'*

Definitions of job insecurity were also considered; two examples include actual levels of job security against perceived levels of security, and the loss of valued features of a job. In relation to this, issues associated with the transferability of these results to the 'secondary' labour market were discussed. This work is characterised as already being insecure, poorly remunerated, poor leave entitlements, few or no benefits, and is largely restricted to women, ethnic minority groups and people who cannot get employment in the 'primary' labour market.



The experience of job insecurity in relation to organisational downsizing in the Finnish public sector in the 1990s was a case in point. Here the effects of downsizing were examined in relation to contract type: permanent or temporary. Temporary employees were shown to have less physical ill health, less sickness absence but poorer mental health. Data on the impacts on mortality are currently being examined.

The particular work environment characteristics associated with feelings of job insecurity were discussed. In the UK example there were increases in demand and control that resulted in poor health outcomes, contrary to job strain models. In the Finnish example there was an increase in demand, but loss of control and social support. Thus it was suggested that during periods of organisational change, the relationship of work environment characteristics to health differs from a stable organisational state.

The importance of management practice in improving workplace health was mentioned by several stakeholders and key informants. Afro-Caribbean people were said to suffer the most from work-related stress. A holistic approach was said to be important, with an emphasis on tackling the cause of sickness absence. This needs better 'managing attendance' processes so that issues could be addressed but also so patterns of absence could be monitored. Management Standards for Handling Stress was promoted as an approach to improve workplace health. The standards are being piloted and cover six areas, including job demands, social support, control, organisational change and roles and relationships. A survey is being administered to employees to assess these areas. The results from this will then be modelled for their potential health effects. From the pilot a set of indicators is to be developed that will be then be monitored.

Other work characteristics influencing health included personal autonomy and status. Respect was also mentioned in the context of older workers. Stakeholders were aware of evidence linking improved qualifications with enhanced wellbeing and general health outcomes, although less was said about the mechanism of action.

*'...people with a certain level of qualifications tend to feel more content, their mental health improves, their physical well being also improves...'*

The impact of new forms of work organisation were discussed by some. For example with the advent of information technology more remote working was being undertaken. Some believed this was on the increase, but others thought it was not on a large scale. The impacts of this are on social well being, from personal contact and also team working, had been observed.

Long working hours and low paid work were also identified as important socio-economic work factors that affect health. Long working hours were said to be potentially associated with an increase in work-related accidents and a reduction in healthier lifestyles, as well as impacting on family life. It was suggested that there was often an association with low pay and a poor employer; in these cases this usually meant poor health and safety practices. Low paid work tends to be more repetitive and routine. Low income whether in work or unemployed affected how people live.

## **6.8 Impacts of the UK Employment Action Plan**

There was a consistent view that the Guidelines were highly applicable to the UK. It was suggested, though, that this open method of policy co-ordination across the EU is more targeted at poor performers within the EU, and since the UK had already met the key objectives, the Guidelines were less challenging. A key stakeholder confirmed that the UK had developed no new action in response to the Guidelines. It was indicated that the UK

had actively been involved in setting the EES agenda and as such UK employment policy was in harmony with the Guidelines.

However, not everyone shared the view that the UK was influencing the agenda.

*'...I don't know how much of what Minister's do is influenced either directly or indirectly ...through the Commission, the Lisbon Agenda and others.'*

There were some Guideline areas where the UK was clearly underperforming, and also paying less attention to. In response to questions concerning the UK inequalities in labour market outcomes and the Guidelines that attempt to address these, it was said that the targeting of disadvantaged groups in the labour market, the implementation of interventions and the associated investment is a dynamic process. This process is becoming more comprehensive and sophisticated with time. When prompted many agreed that the Guidelines did provide some challenges for the UK, e.g. integrating the long-term unemployed into the labour market, supporting the economically inactive back into the labour market, labour market inequalities, language learning, the gender pay gap. 'Making work pay' was seen as another challenge for the UK in view of the creation of predominantly low pay, low skill jobs. It was suggested that attention needs to focus on how we can drive up the skill content of jobs and so pay. Another important feature of the Guidelines to the UK was the emphasis on reducing inactivity.

The interventions within the UK EAP associated with specific Guidelines were discussed.

#### *Guideline 1*

Several stakeholders and key informants expressed positive views about New Deal programmes and the increase in employment that these have produced. Particularly positive aspects of New Deal programmes were said to be the guidance and support process, and the emphasis of the personal relationship between the personal adviser and the client. This was said to lead to increased confidence and overcoming barriers to work. Another important element was a change in culture:

*'...the 'something for something' regime...is at the heart of its success.'*

Also smaller programmes seem to have been more successful than larger one. The EC's involvement was also mentioned in the context of localised support through New Deal for Communities. Although New Deal has seen successful for a number population groups there were some concerns that they may not be as effective for some ethnic minority groups. However the complexity of the issue surrounding poor labour outcomes for BME groups was recognised and it was indicated that inter-ministry attention to address this issue was underway.

The New Deal 50+ with the Employment Credit was seen as very effective. There was believed to be less success with people on incapacity benefits; this was seen as a more sensitive area which risks being very unpopular politically. However some concerns about the rate of participants who do not stay in employment because of lack of support structures, both inside work and outside.

#### *Guideline 2*

There has been less impact on women becoming self-employed and more on people over 50.

### *Guideline 3*

It was suggested that the increase in work-life balance arrangements were generally a positive influence on health. However job insecurity was mentioned as making people more fearful for the future; this was particularly so for older workers. There were differing views on impacts of work-life balance arrangements. Some suggesting positive impacts; more disturbingly others indicated that they were 'a fashion thing' not taken seriously by employers. Between these two extremes was the view that some employers see work-life balance as relevant to working mothers with dependent children and not for the workforce as a whole.

### *Guideline 4*

Interventions to improve skills start within the compulsory education period. It was reported that there was a lot being undertaken with 14-19 year olds. This is really trying to increase the motivation of young people at school, preventing 'drop-out' and the associated risk of leaving school with low skills and qualifications. The UK has one of the worst drop out rates at 17 in OECD countries. Other interventions mentioned included financial incentives - Education Maintenance Grants - to encourage young people to stay in full time education or training. The basic skills programme, 'Skills for Life', with a target of 1.5 million adults to improve their skills level was also referred to; again stakeholders saw this as key to building employability and also tackling social exclusion. The 'Skills Strategy for England' was another important mechanism for improving skills, entitling every adult to a level 2 qualification. Government will fund all these interventions. Level 3 and above skills development is expected to be funded by individuals and business. It was suggested that Government might support initiatives to reduce some regional skills shortages, though the Sector Skills Council.

### *Guideline 5*

Comments were made on the enormous strain of caring for two generations for people over 50, growing up children and elderly parents. Whilst the developments associated with the Childcare strategy were applauded, it was felt that there was a huge gap in elder care support.

### *Guideline 6*

The parity of the EU target for adult employment and the UK target for lone parent employment, both at 70%, was commented on. Concerns were expressed about the 'culture of discrimination against lone parents'.

### *Guideline 8*

There were concerns expressed about workless households and whether benefit reform proposals dealt with the issues of total family income.

*'One person has to work so much to compensate for the benefit loss of the other that then there is a huge disincentive for people to work.'*

It was mooted that different groups of people may have different thresholds at which they believe it is worth going out to work. This is likely to go up with age. Current measures are not reducing the population income differential.

## 7 Impact analysis

### 7.1 Introduction

Data from the profiling, documentary analysis and from the fieldwork have been collated and analysed to identify evidence of the potential health impacts of the EES on the UK population. Since the UK EAP represents how the EES will be implemented nationally, and this reflects Government policy, these impacts will be discussed first. This will be followed by a brief examination of how the EES affects Government policy. The matrices below define the *Potential Health Impacts* of the scheme on different health determinants and their subsequent effect on health outcomes (the impacts on health status are described after the impacts on health determinants and follow the arrow symbol ). The *Direction* indicates whether this impact is a health gain (+) or loss (-). *Scale* is a measure of the severity of the impact (in terms of effects on mortality, morbidity and well being) and the size/proportion of the population affected. The number of symbols represents this as follows:

Severity/population proportion	High	Medium	Low
Death	---- or +++++	--- or +++	-- or ++
Illness/injury	--- or +++	-- or ++	- or +
Well being	-- or ++	- or +	negligible

The *Likelihood* of impact describes the probability that the impact will occur. The likelihood can be definite (in the case of retrospective HIAs), probable, possible or speculative - which in turn relates to the strength of the evidence. Where there is a close correlation between evidence from all data sets (which includes published literature and information from stakeholders/key informants), this is regarded as strong evidence. In addition to the analysis of the potential health impacts on the population as a whole, the potential impacts on health inequalities are also discussed.

## 7.2 Impacts of the UK Employment Action Plan

### 7.2.1 Increasing Employment and Reducing Unemployment

The potential health impacts of the UK EAP are summarised in the matrix below

Potential Health Impacts of the UK Employment Action Plan		
Potential Health Impacts	Direction/ Scale	Likelihood
<b>Working age population</b>		
<ul style="list-style-type: none"> <li>♦ Increase in employment</li> </ul> UK EAP will contribute to a marginal increase in employment rate reduction in all cause mortality (2-14 year lag); short/long-term health benefits for children in employed households	++	Probable
<b>Population sub-groups disadvantaged in the labour market</b>		
<ul style="list-style-type: none"> <li>♦ Increase in employment</li> </ul> UKEAP will contribute to marginal increases in employment rates for some groups but will not significantly reduce the inequalities gap with the working age population as a whole some improvements in health for the employed and their families	+	Probable
Groups disadvantaged in the labour market <b>and</b> have poorer health than the population as a whole include Pakistanis, Bangladeshis, people who are chronically sick or disabled		
Groups disadvantaged in the labour market include other ethnic minority groups, lone parents, people with no qualifications, older people, women		

There is evidence indicating the potential positive impact of UK EAP measures on reducing unemployment and increasing employment in the UK. Employment rates already exceed EES 2010 targets for the population as a whole (70%), women (60%), and older workers (50%). Although it is difficult to isolate the contribution of, for example, 'welfare to work' programmes from the influence of the strong economy on these employment changes, these and other UK EAP measures will probably contribute to potential employment gains in the future. However, the overall increase in employment during 2003 may be small, and the trend has been for a decline in the rate of increase.

Any increase in employment will have positive effects on the health of the population as a whole. Brenner (2002) has forecast a reduction in all cause mortality in the UK using an unemployment-GDP model with a lag of 2 to 14 years after the increase in GDP and employment. It is believed that this is primarily due to the increase in per capita income resulting from GDP growth. There is also likely to be short and long-term health benefits to the children of families where employment increases the household income and enhances the family environment. But there is evidence that not all employment is beneficial for health, and that some work characteristics can be as damaging to health as unemployment; this will be examined later.

However this increase in employment has not been uniformly shared across the UK. Certain population sub-groups have consistently had less favourable labour market outcomes, although this has improved for most groups since the mid-1990s. The groups and their relative disadvantage in employment outcome terms are described in Table 24.

**Table 24 Employment Rates (%)**

Population Groups	2001	2002	Difference (2002-2001)	Variance from 2002 average
working age (16-SPA)	74.7	74.8	0.1	0
people with disabilities (and chronic health conditions)	47.4	48.6	1.1	-26.2
ethnic minority groups (all groups)	58.1	58.4	0.3	-16.3
ethnic minority groups (Bangladeshis)	-	42	N/A	-32.8
ethnic minority groups (Pakistanis)	-	46	N/A	-28.8
lone parents	49.8	50.1	0.3	-24.7
people with no qualifications	50.9	50.3	-0.6	-24.4
older people (50-SPA)	70.3	70.5	0.3	-4.2
women	69.7	69.6	-0.1	-5.2

There are also regional differences in employment, with the south east and south west in particular having above average rates of employment and the north east, Northern Ireland, London and Wales having below average rates.

There are complex sets of factors associated with each of these inequalities in employment. For many of these there appeared to be a sound analysis of the issues contributing to these inequalities, with resourced policy measures underway and a clear political commitment to address them, for example, action to redress employment inequalities for people with no qualifications or with disabilities. For others, whilst developments by the Policy Action Team on 'Jobs For All' (1999) and more recently by the Cabinet Office on 'Ethnic minorities and the Labour Market' (2003) and the Treasury and DWP on 'Full Employment in Every Region' (2003), are acknowledged, the priority for this action was less clear. As such it is anticipated that whilst the positive changes in employment rates for disadvantaged groups may continue, there may be positive changes in employment rates for disadvantaged groups, these will be very small and will only marginally reduce the inequality gap. This will be discussed in more detail later.

There are likely to be small improvements in health for these groups associated with these slight increases in employment if they result in more income per capita. Many of these groups, for example, Pakistanis, Bangladeshis, people who are chronically sick or disabled, have poorer health than the population as a whole according to a number of health measures. Although 'direct health selection' is unlikely, that is, poor health itself increasing the risk of unemployment, it has been shown to be a risk for initial job loss and then subsequent re-employment. There is therefore a double disadvantage to people who have poorer health. In addition there are implications for the health of the children in these disadvantaged families. However, if the rate of increase in employment for these disadvantaged groups was to be greater than the working population as a whole, this may contribute to a reduction in the existing health inequalities.

It is recommended that:

- ♦ the reduction of labour market inequalities (LMI) for all disadvantaged groups (and their sub groups) is a more explicit priority for the Government
- ♦ there is a comprehensive analysis of the underlying causes of these LMI is built on
- ♦ action to reduce LMI is focused at the underlying causes
- ♦ PSA targets are set for year on year reductions in LMI for all disadvantaged groups relative to the working age population as a whole

## 7.2.2 The Unemployment/Inactivity to Employment Transition

The potential health impacts arising from the transition from unemployment or inactivity to employment as a result of active labour market policies are summarised in below:

**Table 25** Potential Health Impacts of the UK Employment Action Plan

<i>Potential Health Impacts</i>	<i>Direction/ Scale</i>	<i>Likelihood</i>
<b>'Job ready' unemployed/inactive population</b>		
♦ Increase in participation in 'welfare to work' programmes		
Active labour market policies (Guideline 1) will contribute to:		
• Work placements and employment short/medium term improvements in mental well being	+	Probable
• Increase in household income, reduction in benefits medium/long term physical and mental health and well being benefits to employed and their families	+	Possible
<b>Not 'job ready' unemployed/inactive population</b>		
♦ Increase in participation in 'welfare to work' programmes		
Active labour market policies (Guideline 1) will contribute to:		
• Skills development & training increased employability	Negligible	Probable
• Placements in low paid, poor quality jobs poor mental health of employed; poor physical, emotional and cognitive development of children in these families	-	Speculative
<b>Unemployed/inactive population who leave programmes &amp; benefit</b>		
♦ Adverse living conditions including overcrowded accommodation, food insecurity increased infectious illnesses, hospitalisation		

It is probable that the 'welfare to work' measures advocated in the UK EAP (Guideline 1) will contribute to the growth in the economy in increasing the employment of 'job ready' participants. In addition, if similar processes are used to recruit participants to programmes as have been recently used it is probable that there will also be a number of associated positive effects. The evaluations of the various 'welfare to work' programmes have shown these positive impacts on participants to include:

- Increased confidence
- Increased motivation
- Reduced isolation
- Reduced anxiety
- Gaining and retaining employment
- Participants moving off benefit

A key positive feature across all the programmes has been the value attached to the one-to-one relationship established between the participants and the Personal Advisors (PA) or their equivalents. Other important aspects of these programmes included flexible working arrangements, for example, part-time work or working at home, choice in training and work placements and positive relationships between the various employment or programme

agencies and employers. The evaluation of the New Deal for Lone Parents impacts also showed a net saving of £1600 per participant to the Exchequer.

This evidence suggests that for people who are 'job ready', 'work first' approaches advocated in the UK EAP will potentially have short-term benefits to participants' mental health as a result of 'welfare to work' programmes. However, it is recognised that the proportion of 'job ready' within the unemployed or inactive population is shrinking, and that a 'core' long term unemployed or inactive group with, for example, skills and/or health problems remains. Evidence from similar 'work first'/'welfare to work' programmes in the US suggests the positive health effects, for example enhanced well being, are most likely to occur when there is an increase in household income compared with the benefit position. There is also evidence indicating that there may be associated benefits for the health and development of children in households where parents move into employment. This is primarily as a result of enhanced parenting practices, as well as improvements in standards of living. For families with young children ensuring good quality childcare could potentially maximise the cognitive, social and emotional benefits even further.

However the evaluations of New Deal and the other programmes also revealed that these 'work first' approaches were less successful with people who were most disadvantaged in the labour market (Guideline 7). People with health problems, ethnic minority groups and people without basic skills or with outdated skills benefited least from such approaches, potentially being further disadvantaged in the labour market by interventions that did not meet their needs. Associated with this were some less successful features and potential barriers to participation, for example, employer attitudes, including discrimination, poor organisation and quality of some training. However, the recently introduced pilots such as Pathways to Work, Job Retention & Rehabilitation and Action Teams for Jobs may address many of these issues. Employment Zones (EZ) interventions seemed to have a greater success for longer term unemployed people compared to ND 25 plus, the latter having negligible impacts on employability. Working Neighbourhood pilots are hoping to build on the EZ successes, whilst taking account of the local context. Evidence from the US has shown that the most 'hard to employ' quintile were more likely to be placed in low paid jobs. When the income from work was less than the income on benefit, there were poor prospects and the job was of poor quality, the mental health of participants deteriorated. There were also negative impacts on children, including a reduction in cognitive development and school performance and an increase in anti-social behaviour. These are obviously pitfalls to avoid in the UK.

It is difficult to separate out the impact of fiscal measures such as the National Minimum Wage and working tax credits designed to help reduce poverty and 'make work pay' (Guideline 8) from the total 'welfare to work' package. The US 'welfare to work' programme differs from the UK's in that financial assistance is time limited and there are sanctions if participants fail to comply with requirements, for example, refusing a job. In addition to people who leave the programme due to sanctions there are also people who become unemployed at the end of the programme, but who are not entitled to further financial assistance. The impacts of being without social protection on the health and well being of these people and their families are severe:

- Hunger
- Food insecurity
- Rent arrears
- Living in overcrowded accommodation
- Increased incidence of hospitalisation of children

Although the US and UK schemes are different it was not clear what proportion of UK 'welfare to work' participants who come off benefit may also be unemployed and potentially living in extreme poverty, such as reported in the US.



Other potential health impacts from the move from unemployment or inactivity to employment could be changes in health-related behaviour and health service use. The changes in health-related behaviour could be either positive or negative; there was insufficient evidence to predict these with any reliability. Similarly it is not possible to predict the change in health service activity, however it is probable that the frequency of use will change, which has implications for out of hours provision. In addition the focus on reducing inactivity due to ill health will undoubtedly impact on primary care professionals from the GPs' initial certification to chronic disease management with practice nurses and rehabilitation with occupational therapists. The 'unemployment/inactivity to employment transition' may also have a number of stages in terms of the effects on mental and physical health; for example there may be an 'Anticipation Phase' for participants waiting to start a programme or be seen by a Personal Advisor. Analysis of other international welfare reforms suggest contextual factors appear to influence the impacts of interventions on participants, for example, when the changes are perceived as a net loss (financial, education, choice, esteem) or are introduced relatively quickly, the impacts on participants are more negative. This is reminiscent of the effort-reward imbalance model that has been used to explain the effects of psychosocial work characteristics on health outcomes. It is clear that more work needs to be done to construct a model explaining the relationship between different 'employment transition' factors and their impact on health.

It is recommended that:

- ♦ The differential access to 'welfare to work' programmes is addressed by, for example, introducing an interview with a PA as soon as the unemployed or inactive register for benefits (as New Zealand model)
- ♦ Programme outcomes are enhanced by, for example:
  - identifying each participant's labour market barriers (including health) and action plans to address with PAs (New Zealand and Iceland models)
  - working with employers to overcome barriers identified
  - working with Local Strategic Partnerships to overcome other barriers
  - referral into the programme from primary care professionals, voluntary sector
- ♦ Differential programme outcomes are reduced by, for example, developing specialist PAs to provide support and guidance to those groups most disadvantaged in the labour market (people with health problems, from ethnic minority groups, or without basic skills)
- ♦ Differential programme outcomes are reduced by, for example, building on the 'Pathways to Work' pilots and developing/testing holistic approaches to action planning (New Zealand model) for participants who are not 'job ready' including:
  - referrals to mixed programmes (training/work placement)
  - referrals to 'Expert Patient Programmes' (disease management programmes run by the local Primary Care Trusts) for participants with chronic conditions
  - referrals to Sure Start or Sure Start Plus
- ♦ Prospective research is undertaken to consider the short and long term health effects of 'welfare to work' programmes, including mixed programmes
- ♦ Data on the short and long term effects of 'welfare to work' programmes on household income is collected
- ♦ Follow-up data on unemployed programme 'leavers' who do not re-register for benefits is collected
- ♦ The potential health impacts of 'welfare to work' programmes are considered during programme planning

### 7.2.3 Employment flexibility

The potential health impacts resulting from increasing employment flexibility are summarised in Table 26.

**Table 26** Potential Health Impacts of increasing employment flexibility

<i>Potential Health Impacts</i>	<i>Direction/ Scale</i>	<i>Likelihood</i>
<b>Working age population</b>		
♦ Increases in labour market flexibilities (Guideline 3) will contribute to:		
• Increase in part-time employment increase in job satisfaction, reduction in health-related absenteeism, stress, fatigue, muscular skeletal disorders	++	Probable
• Part-time employment associated with lower income, 'poor quality' jobs, job isolation, less career development/training opportunities	-	Possible
♦ Increase in flexible working arrangements (Guideline 3) may contribute to :	+	Speculative
• Work-life balance improvements and associated mental health benefits		
<b>Working age population moving from secure to insecure jobs</b>		
♦ Increases in labour market flexibilities (Guideline 3) involving, e.g. threatened unemployment, changes in contract type will contribute to:	--	Probable
• Increase in job dissatisfaction	-	Probable
• Changes in health-related behaviour, e.g. increase in smoking, reduction in physical activity	-	Probable
• Psychological health effects, e.g. increase in depression, anxiety	--	Probable
• Physical health effects, e.g. increase in cardiovascular risk factors	-	Probable
• Increase in use of health services		
<b>Working age population in insecure jobs</b>		
♦ Increases in labour market flexibilities (Guideline 3) involving increases in insecure jobs associated with low pay, 'poor quality' jobs will contribute to:	-	Probable
• Increased risk of exposure to hazardous working conditions, e.g. high noise levels, painful/tiring working conditions, repetitive tasks	Negligible	Possible
♦ Increases in labour market flexibilities (Guideline 3) involving further insecurity to already insecure jobs will have marginal negative health effects		

There is strong evidence that points to an increase in flexibility in the workplace which the UK EAP (Guideline 3) will contribute to. There are potentially both positive and negative health impacts associated with this increase in labour market flexibility. Employment trends have shown an increased demand for labour market flexibility, for example, in 'non-standard' employment contract types, such as part-time and temporary contracts. This is in response

to globalisation and economic pressures, which have companies trying to adapt to seasonal fluctuations in demand for goods and other peak production times, whilst controlling labour costs. There have also been developments in flexible production processes, for example, 'just in time' production. Other forms of labour market flexibility include 'numerical' - adjusting the size of the workforce - and 'functional' flexibility - adapting the tasks of workers - have also increased in the UK recent years.

#### *Health impacts of part-time working*

The Third European Working Conditions Survey (2002) showed that part-time workers were more likely to report better health outcomes for six health indicators:

- Job dissatisfaction
- Health-related absenteeism
- Stress
- Fatigue
- Backache
- Muscular pains

This was regardless of the contract type, compared to full-time workers. Findings from the UK Workplace Employee Relations Survey (1998) also showed part-time employees were more satisfied with their job. However, potential issues associated with part-time work are employees feeling isolated or not as involved in the organisation, and receiving the same career development or training opportunities. Also part-time work is often unskilled work with poor working conditions.

#### *Health impacts of insecure jobs: secure to insecure transition*

However, there is strong evidence of the negative health effects of being in an insecure job, whether through threatened unemployment, reduced working hours, temporary work or fixed term contracts, for flexibility purposes. The following health effects have been reported when jobs changed from being secure to insecure:

- Changes in health-related behaviour, e.g. increase in smoking, reduction in physical activity in women (Ferrie, 2001)
- Psychological effects, e.g. increase in depression, anxiety
- Physiological effects, e.g. increase in cardiovascular risk factors (hypertension) (Ferrie, 1999)
- Increase in the use of health services (Beale & Nethercott, 1986)
- Increase in job dissatisfaction, e.g. twice as prevalent compared to permanent workers (Benavides et al, 2000)

Other reported negative effects include reduced organisational commitment and performance. There is also some evidence suggesting that ethnic minority groups experienced more negative effects as a result of discrimination. Some studies (Burchell, 1996) have shown equivalent health scores for people in insecure jobs and unemployed people.

Evidence from UK studies suggests that the psychosocial work factors associated with changes in job security and possible mediators for the health effects were:

- Increase in control
- Increase in demand
- Loss of skill discretion
- Loss of support

This is contrary to earlier job strain models where the level of control was seen as the key psychosocial work characteristic that could predict cardiovascular and other health outcomes of employees (Marmot et al, 1997). However, evidence from Finland was that there was an increase in demand, but reduction in control and a loss of support. It has been suggested that during organisational change, the relationship between psychosocial

work environment characteristics to health differ from a stable organisational state. Further research needs to be undertaken to explore this relationship.

*Health impacts of insecure jobs: precarious or secondary labour market jobs*

There appear to be different responses to job insecurity depending again on contextual factors. If, for example, job insecurity has been introduced into previously secure jobs, so that there is a change in perceived security or a loss in valued aspects of previous jobs, the impact on health is more severe. However, workers in secondary labour markets, that is, labour markets that are already insecure, tend to be jobs that are low skilled and of poor quality, are often women and people from ethnic minority groups do not appear to have such severe health impacts. What is clear though is that workers in insecure secondary labour markets are more likely to be exposed to physical and chemical hazards in the work environments, such as working in painful or tiring positions, high noise levels, and work involving repetitive tasks and movements (Robinson, 1986). Compared with permanent workers, they tend to have less opportunity to develop skills at work and have less access to training. Safety concerns have been raised in some industries, for example, the petrochemical industry, where contingent workers were less experienced and skilled than direct-hire workers and yet received less health and safety training than direct-hire workers (EASHW, 2002). They have less autonomy over their work and time and less opportunity to be involved in workplace decisions. The health effects of these psychosocial work conditions include musculoskeletal disorders and fatigue.

*Ameliorating the negative impacts of job insecurity*

There is strong evidence that increasing workers' control, for example, decision latitude and participation, can benefit both physical and mental health, and mitigate against the harmful effects of job insecurity (Egan et al, forthcoming; Karasek, 1992). Having information and co-worker, supervisor or trade union support were also identified as valuable buffers to the negative effects of job insecurity during organisational change.

The measures included under Guideline 3 - regulatory reform, promoting diversity of working arrangements, managing change and restructuring, and health and safety at work - are intended to develop a climate that enables labour market flexibility, whilst compensating for this with rights to flexible working arrangements for employees. The measures are also designed to protect against and limit the negative effects of labour market flexibility. It was beyond the scope of this assessment to examine each of these measures in detail.

However based on the current evidence (above) of the:

- growth in labour market flexibility with its associated negative health impacts,
- embryonic developments in flexible working arrangements for employees
- early developments in mitigating measures, for example, following redundancies, but not necessarily other issues associated with job security
- health and safety targets that may not meet the needs of the most vulnerable workers (contract type rather than occupation)

It is possible that in the short-term these measures will have net negative health effects on the labour market as a whole. The impacts will be most severe on workers who move from secure to insecure jobs; the health impacts could be similar to those described above. In the most severe cases these health effects could be as detrimental as being unemployed. However although workers already in insecure jobs may not experience such negative health impacts when they are subjected to organisational change, they are more likely to be already exposed to more adverse physical and social working environments than permanent workers. As indicated above, secondary labour markets tend to be low paid, low skilled, poor jobs and are over-represented by women and people from ethnic minority groups.

In the longer term, the development of flexible working arrangements for employees will possibly encourage more inactive people, for example, women, older people and people with disabilities into the work place. For those people in work, it may also help to reduce work-life imbalances with possible positive health effects; this will again most probably help

parents with children and older workers. Finally those organisations supporting flexible working arrangements may find it acts as a useful employment retention measure.

It is recommended that:

- ♦ Evidence-based interventions to improve the psycho-social work environment are actively promoted in order to buffer the negative health effects of increasing labour market flexibilities, for example:
  - Demonstrate management commitment to improve working conditions and worker health
  - Provide support from managers and co-workers
  - Develop participation of the workforce in planning and implementation
- ♦ The HSE pilot of Management Standards for Reducing Stress in the workplace is 'fast-tracked'
- ♦ The UK's performance against the 'Quality Jobs' indicators are published and action plans developed
- ♦ Research is undertaken into the health effects of :
  - different dimensions of labour market flexibility
  - labour market flexibility/organisational change on different workers
  - improving work-life balance
- ♦ The potential health impacts of employment policy are considered during policy planning
- ♦ Regulatory Impact Assessment includes the impacts on health of the working age population as a whole and on groups disadvantaged in the labour market
- ♦ Public sector procurement regulations are introduced that require contractors to submit evidence of their employment policies, for example, equality and diversity

#### 7.2.4 Employment to Unemployment Transition

The Jobcentre Plus measures (Guideline 3) to mitigate against job losses will potentially reduce the extent of negative health effects associated with redundancy and unemployment.

As defined earlier, unemployment has a range of short and long-term negative health effects. The steepest decline in mental health is following recent unemployment. As such it is recommended that:

- ♦ To reduce the negative health effects of recent unemployment, early health care interventions are planned as part of the package of Jobcentre Plus 'managing change and restructuring' measures

#### 7.2.5 Preventing Unemployment

Measures to develop the human capital of the population (Guideline 4) are likely to have long-term positive health effects for the population as a whole and for individuals. This relates to the increase in GDP and global competitiveness, from enhanced performance. Improving skills level increases performance. Skills and qualifications influence an individual's labour market position, their income, housing and other material resources.

There were some concerns however that some measures to improve employability of the long termed are not proving effective, for example New Deal 25 plus. It is recommended that:

- ♦ To enhance skills and employability of groups disadvantaged in the labour market by designing programmes to meet their specific needs (see above)
- ♦ To assess the health effects of these programmes (see above)
- ♦ To actively promote investment by employers in the training and development of all employees

### **7.3 Impacts of the European Employment Strategy on the UK Employment Action Plan**

There were conflicting views from stakeholders and key informants on whether there was an impact of the EES on the UK EAP and, by association, national employment policy. The policy analysis indicated that the UK has a leaning towards US economic and employment policy. However, the value of the EES appears to be in balancing this policy direction by emphasising the 'European Social Model' and influencing the UK's social agenda. The importance of this influence cannot be underestimated; there are worrying trends in US employment policy resulting in severe negative health impacts on the health of vulnerable individuals and their families.

Having said this it is disappointing that there seems to be less influence from the EES; for example on equity issues such as action to reduce the gender pay gap. Similarly in the spirit of this open co-ordination method, the added value of the EES would be enhanced by encouraging more sharing of good practice from the UK with the rest of Europe, and vice versa. For example, the intermediate skills development programmes in Germany and the Netherlands.

It is recommended that:

- ♦ The EES enhance the impacts on UK employment policy particularly in relation to reducing inequalities in labour market outcomes for key disadvantaged groups, including access to employment, pay, training, 'quality jobs'
- ♦ The open method of policy co-ordination is used to share good practice between Member States

## 8 Conclusion and recommendations

### 8.1 Conclusion

Measures included in the UK Employment Action Plan, developed in response to the European Employment Strategy 2003 Guidelines, will probably contribute to UK employment gains during the year. This increase in employment is likely to be small. However it is difficult to isolate the relative contributions of the UK EAP measures on these employment changes from the impact of the strong economy.

There will be positive impacts on population health associated with these employment gains although it is estimated that there will a 2 to 14 year lag before these health gains materialise. There are also likely to be health benefits for the children of families where employment increases household income. But not all employment is beneficial to health; some work characteristics are as damaging to health as unemployment.

However there are certain population groups - certain ethnic minority groups, people with disabilities and poor health, people with no qualifications, lone parents, women and older people - who have consistently less favourable labour market outcomes than the working age population as a whole. There are complex reasons for these inequalities. Although there will be increases in employment for these disadvantaged groups, these will be small and will only marginally reduce the inequality gap.

There will be small improvements in health for these groups where these increases in employment result in increase in per capita income. However there are concerns that these groups also tend to be recruited to 'poor quality' jobs - jobs in the secondary labour market which are characterised by low pay, low skills, poor psychosocial and physical (hazardous) work environments, as well as being insecure. There are many negative health impacts associated with these 'poor quality' jobs, including depression and other mental health problems, musculoskeletal disorders, fatigue, job dissatisfaction. These groups have a tendency for poorer health than the population as a whole; having a poor quality job is a double disadvantage. There are also possible adverse health effects in children of these families.

The 'welfare to work' measures in the UK EAP (Guideline 1) will potentially benefit the unemployed or inactive who are 'job ready' in gaining employment. With an enhanced income they are likely to have improved long term health outcomes, in addition to short-term improvements in mental wellbeing. There are also possible developmental benefits to children. People who are not 'job ready' are less likely to benefit from 'work first' approaches; community-focused approaches such as Employment Zones are more likely to have positive impacts on employability. There are potential health impacts on, for example, health-related behaviour and health services, but these are speculative. Similarly there appear to be contextual factors that influence the impacts of interventions.

Measures to increase labour market flexibility (Guideline 3) may potentially have a combination of positive and negative health impacts. Positive health impacts are probable as a result of increases in flexible working arrangements such as part-time work and improvements in work-life balance, although there may be some negative impacts associated with psychosocial work factors such as increased isolation and reduced career opportunities. Negative health impacts are probable from changes in job security, including increases in cardiovascular risk factors, reductions in mental health and increases in health service use. In addition increases in poor quality precarious jobs will have negative health impacts as discussed above. It is possible that there will be net negative health effects on the working population as a whole as current measures to help manage the impacts of

labour market changes are not sufficiently well-developed to buffer these negative health impacts.

The impact of the European Employment Strategy on the UK EAP, and in turn national employment strategy is highly speculative. That is that it had a moderating effect on employment policy with a particular influence on the UK's social agenda. Nonetheless, this was felt to be highly important in protecting and improving the health of the working age population as a whole.

## 8.2 Recommendations

### **Reduce the negative health effects of labour market inequalities by:**

- Making the reduction of labour market inequalities (LMI) for all disadvantaged groups (and their sub groups) a more explicit, key priority of the Government
- Continuing the development of a comprehensive picture of the underlying causes of these LMI
- Ensuring action to reduce LMI focused at these underlying causes
- Setting PSA targets for year on year reductions in LMI relative to the working age population as a whole

### **Enhance the positive reduce the negative health effects of the unemployment/inactive to employment transition by:**

- Addressing differential access to 'welfare to work' programmes, for example, by introducing an interview with a PA as soon as the unemployed or inactive register for benefits (as New Zealand model)
- Enhancing programme outcomes, for example:
  - ♦ identifying each participant's labour market barriers (including health) and action plans to address with PAs (New Zealand and Iceland models)
  - ♦ working with employers to overcome barriers identified
  - ♦ working with Local Strategic Partnerships to overcome other barriers
  - ♦ referrals into these programmes by primary care health professionals, voluntary sector
- Reducing differential programme outcomes, for example, developing specialist PAs to provide support and guidance to those groups most disadvantaged in the labour market (people with health problems, from ethnic minority groups, or without basic skills)
- Reducing differential programme outcomes, for example, building on the 'Pathways to Work' pilots and developing/testing holistic approaches to action planning (New Zealand model) for participants who are not 'job ready' including:
  - ♦ referrals to mixed programmes (training/work placement)
  - ♦ referrals to 'Expert Patient Programmes' (disease management programmes run by the local Primary Care Trusts) for participants with chronic conditions
  - ♦ referrals to Sure Start or Sure Start Plus
- Undertaking prospective research to identify the short and long term health effects of 'welfare to work' programmes, including mixed programmes
- Collecting data on the short and long term effects of 'welfare to work' programmes on household income
- Collecting follow-up data on unemployed programme 'leavers' who do not re-register for benefits
- Considering the potential health impacts of 'welfare to work' programmes during programme planning



**Reduce the negative and enhance the positive health effects of employment flexibility by:**

- Improving the psychosocial work environment and employee health by actively promoted evidence-based approaches, for example:
  - ♦ demonstrating management commitment to improving working conditions and worker health
  - ♦ providing worker support from managers and co-workers
  - ♦ developing worker participation in the planning and implementation of individual business objectives
- Prioritising the widespread introduction of the Health and Safety Executive's Management Standards for Reducing Stress in the workplace, following the completion of the pilot
- Publishing the UK's performance against the EC's 'Quality Jobs' indicators and developing action plans to improve as necessary
- Undertaking more detailed research into the health effects of :
  - ♦ different dimensions of labour market flexibility
  - ♦ labour market flexibility/organisational change on different workers
  - ♦ improving work-life balance
- Considering the potential health impacts of employment policy during policy planning
- Adapting the Government's existing Regulatory Impact Assessment tool, which examines the impacts of all proposed legislation or policies on business, to include assessing the impacts on the health of the working age population as a whole and on groups disadvantaged in the labour market
- Introducing public sector procurement regulations that require contractors to submit evidence of their employment policies, for example, equality and diversity

**Reduce the negative health effects of the employment to unemployment transition by:**

- Introducing early health care interventions as part of the package of Jobcentre Plus 'managing change and restructuring' measures

**Enhance the positive health effects of preventing unemployment by:**

- Developing the skills and employability of groups disadvantaged in the labour market by designing programmes to meet their specific needs (see above)
- Assessing the health effects of these programmes (see above)
- Actively promoting the investment by employers in the training and development of all employees

**Enhance the impacts of the European Employment Strategy in the UK by:**

- Influencing UK employment policy in relation to reducing labour market inequalities for key disadvantaged groups, including access to employment, pay, training, 'quality jobs'
- Building on the open method of policy co-ordination to share good practice between Member States

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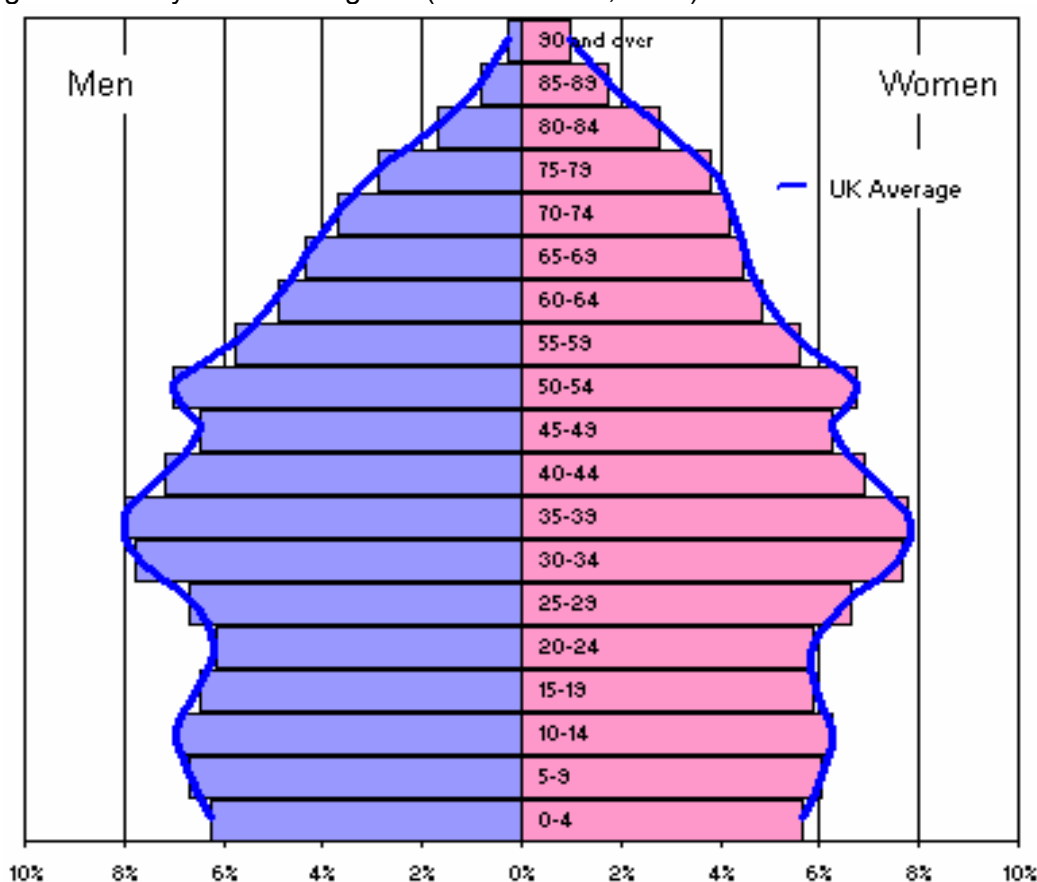
## Appendix

### Population data

#### England

The people of England make up 83.6 percent of the total (UK) population. The population of England has grown by 1,263,800 since 1991 and by 2,318,000 (5 percent) since 1981. There have, however, been large variations in the English regions. The North East and North West of England have shown a decline in population while the South West and South East of England have seen a population growth of 10 percent or more. This variation is often mirrored at the sub-regional level. For example, the cities of Manchester and Liverpool (in the North West region) have seen their populations fall by 9.1% and 7.6% respectively since the previous Census, by contrast, the City of London and the Local Authority area of East Cambridgeshire have seen increases in population of 34.0% and 20.3% respectively over the same period.

A.1 Age/Gender Pyramid for England (Source: ONS, 2001)



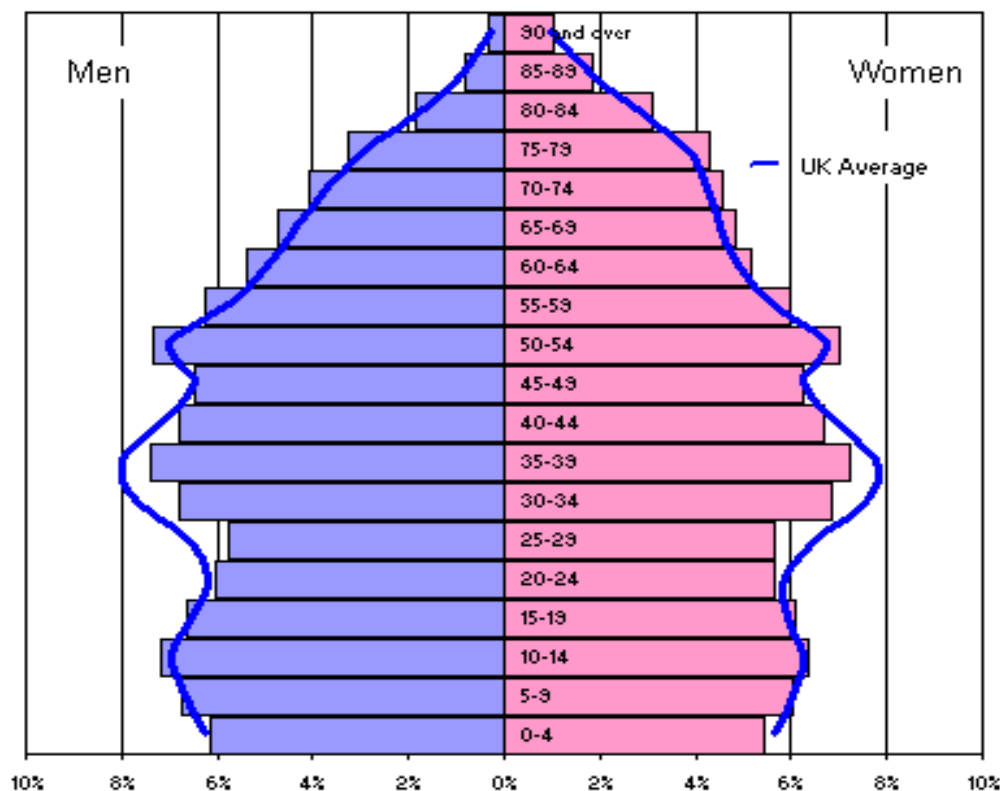
#### Wales

The people of Wales make up 4.9 percent of the total UK population. The population of Wales has grown by 30,100 since 1991 and by 89,600 (3%) since 2001. The population of Wales is getting older and growing slowly but steadily. Between 1951 and 2001 the population increased by over 300,000. In 2001 about two thirds of the population of Wales lived in the southern industrialised part of the country, with Cardiff, Swansea and Newport the largest urban areas. The remaining third lived in the mainly rural north and west. Wales is divided into 22 Unitary Authority areas of which Cardiff had the largest population (307,000), followed by Rhonda Cynon Taff (232,000) and Swansea (224,000). Merthyr Tydfil had the fewest residents, 56,000.

In 2001 the median age of the population in Wales was 38 years, up from 36 in 1991 and 34 in 1981. Three in five people were of working age (males 16 to 64, females 16 to 59), while one in five was over working age and one in five under 16 (ONS, 2003).

Between 1991 and 2001, the number of people over working age increased by nearly 2 per cent while the number of children under the age of 16 decreased by 0.5 per cent. The post-war trend of ageing among the overall population is particularly evident among the very elderly in Wales. The number of people aged 85 or over has grown five-fold over the last half century, reaching 59,000 in 2001 (ONS, 2003).

Figure A.2 Age/Gender Pyramid for Wales (Source: ONS, 2001)



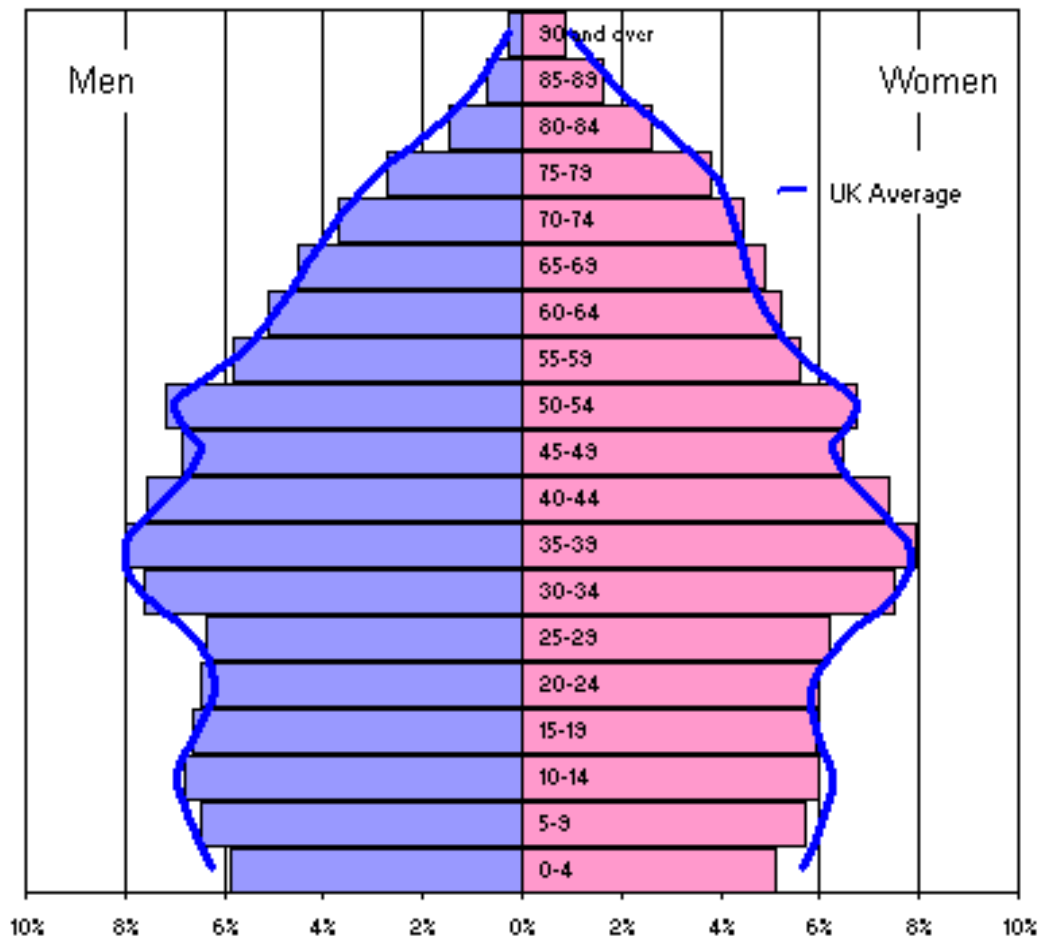
### Scotland

The people of Scotland make up 8.6 percent of the total (UK) population.

The population of Scotland declined by 2 percent between 1981 and 2001. The main factor leading to population decline was net emigration from Scotland; however, the level of net emigration fell during the latter part of this period. The biggest impact on population change in Scotland is now declining births (emigration has removed a percentage of the childbearing population). Deaths have fallen too but much more slowly. In 1981 there were 5,000 more births than deaths and 6,000 more in 1991, but by 2001 deaths exceeded births by nearly 4,800. The increase in longevity is resulting in an ageing population. The number of children has reached a new low and the population aged under 1 is now lower than for any other single age up to 60. In contrast the under 1 population in 1981 was higher than any other age up to 8 (ONS, 2003). The figure below demonstrates the constituents of change (natural change and net migration) over a longer period of time in Scotland.

It is predicted that the ageing of the population will continue even if the decline in births is reversed or levels off. The big increase in people of retirement age as a result of the 1960s baby boom is still 30 or so years away. Before then, there will be smaller increases in the more elderly age groups as those born in the post Second World War baby boom move into retirement in the next 10 to 15 years. The phased raising of pensionable age for women from 60 to 65 between 2010 and 2020 will mitigate the effect (ONS, 2003).

Figure A.3 Age/Gender Pyramid for Scotland (Source: ONS, 2001)

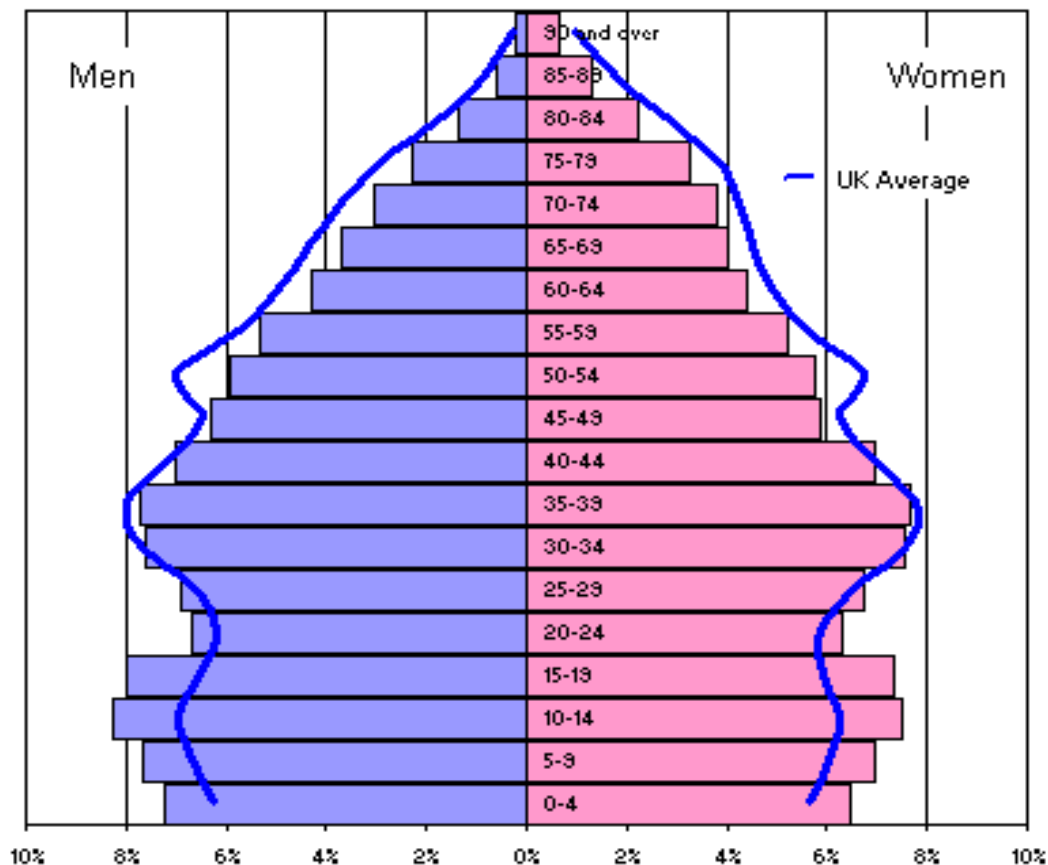




**Northern Ireland**

The people of Northern Ireland make up 2.9 percent of the total UK population. The population of Northern Ireland has shown the greatest growth (5 %) between 1991 and 2001 and 9 percent between 1981 and 2001. 24 percent of the population in Northern Ireland are children under 16 years of age – making Northern Ireland the youngest population within the UK. The figure below clearly illustrates the relative youth of the Northern Ireland population (relative to the UK average).

Figure A.4 Age/Gender Pyramid for Northern Ireland (Source: ONS, 2001)



**Workplace Employee Relations Survey Results (1998)**

Employee relations are clearly important if organisations are to perform well and continuously adapt and innovate. Management practices (Table A.1) are important indicators of employee relations and of high performing organisations (WERS, 1998). It was shown that high performing organisations were associated with a higher number of 'new' management practices. The clustering of these practices is particularly relevant: half of the workplaces have 5 or more of the 16 management practices and 20% had 8 or more. A clear grouping of certain practices is apparent, e.g. training, team working and problem solving, and single status had a strong association with team working and job security. Indirect employee involvement takes place in 75% of workplaces covering 67% of employees. The type of involvement mechanism varies according to workplace size: Joint Consultative Committees and workplace committees for smaller organisations and higher level Work Councils for larger multi national companies.

Table A.1 Use of 'new' management practices and employee involvement schemes

	<i>% of workplaces</i>
Most employees work in formally designated teams	65
Workplace operates a system of team briefing for groups of employees	61
Most non-managerial employees have performance formally appraised	56
Staff attitude survey conducted in the last 5 years	45
Problem-solving groups (e.g. quality circles)	42
'Single status' between managers and non-managerial employees	41
Regular meetings of entire workforce	37
Profit-sharing scheme operated for non-managerial employees	30
Workplace operates a just-in-time system of inventory control	29
Workplace level joint consultative committee	28
Most supervisors trained in employee relations skills	27
Attitudinal test used before making appointments	22
Employee share ownership scheme for non-managerial employees	15
Guaranteed job security or no compulsory redundancies policy	14
Most employees receive minimum of 5 days training per year	12
Individual performance-related pay scheme for non-managerial employees	11

The employees' survey of 1998 WERS considered the following areas:

- Commitment: loyalty, shared goals, pride in organisation
- Employee work-related and personal expectations/needs recognised and met: training, flexible/family friendly working, communication/involvement
- Job satisfaction

Other key findings from this survey were as follows:

#### *Commitment*

- 65% felt loyal to the organisation, 56% had pride in the organisation, 51% shared the organisation's goals
- Different occupations reported different levels of commitment: 81% of managers compared with 53% of plant machine operatives felt a greater sense of loyalty to the organisation
- Occupational differences were recorded in other aspects of employee attitudes which may reflect different employment experiences
- Employee work-related and personal needs
- Two thirds reported receiving some off the job training in the last year
- 19% had had 5 or more days training
- 62% of full-time workers compared with 43% of part-time workers underwent training
- One third of employees said flexi time was available to them
- 16% said they could job share
- 9% were able to work from home
- 25% were able to take parental leave
- 4% had help with child care, e.g. a subsidy or workplace nursery
- Nearly half of employees said none of these options were available to them
- More flexible working options were available to public sector workers and for women (it was queried whether this was the perception of male workers)
- 70% managers said they involved employees in discussing the implications of changes
- 30% employees said managers were good or very good at involving employees
- 45% of long serving employees (10+ years) said involvement was poor

#### *Job satisfaction*

- Approximately 60% of employees felt satisfied with the influence they had on their job, their sense of achievement and respect from their manager
- Approximately one third felt satisfied with their pay
- 25% remained uncommitted for all measures
- Overall 7% were very satisfied, 47% were satisfied, 27% were neither satisfied or dissatisfied and 19% were dissatisfied
- Different occupations reported different levels of satisfaction: managers were 71% satisfied compared to e.g. 40% for operatives
- Part-time workers were more satisfied (62%) compared to full-time workers (51%)

The analysis between job satisfaction and employee relations showed a clear causal relationship between the level of commitment and communication and job satisfaction: 90% who said they were consulted over job changes and 73% who felt highly committed, also expressed high levels of job satisfaction. Whilst this may seem intuitively obvious it provides strong evidence that policies building commitment and involvement will lead to more satisfied staff, and ultimately high performing organisations. This relationship also existed e.g. for flexible working and training, but less strongly.

The WERS survey (1998) defined flexibility as:

- Activities or services that are contracted out
- Non-standard employment (not full-time permanent work) - contractors ('freelancers', 'outworkers'), temporary agency staff (temps), fixed term contract (FTCs) employees
- 'Numerical' flexibility - to adjust the size of the workforce in line with requirements and demand
- 'Functional' flexibility - the ability to move workers from one task to another

Findings from the employers survey of the 1998 WERS showed that:

*Contracted out services/activities*

- 90% of organisations contracted out at least one service or activity
- one third of these workplaces would have provided these services directly 5 years earlier
- one third of these workplaces used contractors of whom at least some were former employees
- 11% of workplaces have transferred some employees to a different employer over the last 5 years (22% public sector and 6% private sector)

*Non-standard employment*

- Workplaces using non-standard employment: 13% freelancers, 6% outworkers, 28% temps and 44% fixed term contracts
- Use of non-standard employment varies with employment size: 20% of small workplaces compared with 75% of large organisations
- Non-traditional occupations, e.g. professional workers are now being used in non-standard employment: 5% of workplaces use professionals from temporary agencies and one third have professionals on FTCs

*'Numerical' flexibility*

- The increase in use of non-standard employment over the last 5 years outweighs the decrease: e.g. part-time employment - net increase of 33%, contractors - net increase of 23%

*'Functional' flexibility*

- The proportion of workplaces where employees are trained to be adaptable - do jobs other than their own: 50% negligible; 25% largest occupation trained to be adaptable
- Workplaces with a high use of non-standard employment were less likely to train employees to be functionally flexible

### **New Deal programmes**

New Deal for Lone Parents (NDLP) was a voluntary programme introduced in 1997, however mandatory meetings with Personal Advisers (PA) were introduced to increase uptake, following the Outreach service's limited success in referring large numbers to Jobcentre Plus (5% of contracted 20,000). NDLP is focussed on 'work first' rather than training. Overall since October 1998, 51% of all leavers from the programme and 41% of all participants have left IS and entered work of at least 16 hours per week; this compares with 13% from a comparable non-NDLP group. Overall rates of leaving the programme and entering work have increased from 47% to 52% of leavers from April 1999 to March 2002, despite changes in the composition of participants that suggests that they have become in aggregate more difficult to employ. This is an additional 26% success compared with lone parents not participating in NDLP. 23% of participants started work after the initial PA meeting with 87% of these were still in employment 12 months later. Similar impacts were found for job satisfaction. It has been estimated that there is a net saving to the Exchequer of £1,600 per additional job, with uncosted social benefits. However, lone fathers, teenage and older parents, people with health problems or a disability, as well as ethnic minorities have less positive employment outcomes. Interestingly the location also influenced the likelihood of successful job outcomes; participants from deprived urban areas or inaccessible rural locations were less likely to have positive job outcomes. More positive employment outcomes are associated with working under 16 hours.

NDLP Innovation Fund projects were designed for lone parents who were not yet 'job ready'. Evaluation of these showed less success in terms of increased employability and higher drop out rates; however more successful projects showed the value of work placements and mentoring, and manageable, enjoyable training. Work placements and mentoring were found to build participants' confidence. Close employer engagement was seen as the key. In particular training needed to reflect the local employment context, for example skills gaps. Employers who were more closely involved expressed more positive attitudes about recruitment from this group.

An evaluation of the impact of NDLP PA meetings on the attitudes and perceptions of lone parents involved 3,000 participants (DWP, 2003). This showed that the majority of participants found these positive experiences building confidence and breaking isolation, with a third saying they felt more hopeful for the future. This was more so for people who were 'closer to market' or were looking for work, and less so for people who had long-term health problems and or weren't looking for work. One in three said the meetings had motivated them to find a paid job.

In spite of the increase in provision through the national childcare strategy, access to local, affordable, quality childcare was another important barrier to lone parents participating in employment or training (DWP, 2003; Paull, et al, 2002).

Evaluation of job retention for New Deal for 50 plus (DWP, 2003) Employment credit claimants (75,000 by 2002) indicates that where data exists at the end of the 12-month entitlement period, 84% were not claiming benefits. The majority of participants were white (96%) males (69%). The New Deal for Disabled People (NDDP) is a voluntary programme for people claiming incapacity benefits. The evaluation involving over 3,000 participants (DWP, 2003) showed that five months after registration, a third were in paid work with a majority being expected to work in the future. Barriers preventing them from working included attitudes to their disability or health condition (47%) and the disability or health condition itself (45%). The most common main and secondary health conditions or disabilities were mental health conditions and problems with their neck or back. 93% reported their condition affected their ability to participate in activities, but only 38% said this was to a great extent. 50% said this restricted their ability to do paid work. Poor health was a limiting factor rather than disability. The relationship between the Job Broker and

Registrant was seen as important: 43% felt more confident concerning employment and less anxious about financial issues or benefits.

The macroeconomic assessment of New Deal for long term unemployed (ND25 plus) (DWP, 2003) which involved 500,000 participants between 1998 and 2002, found for men ND25 plus participants were 4% less likely to be unemployed. For women the impact was negligible. However, there was little evidence of an increase in employability. In the Intense Activity Period (IAP) participants felt dissatisfied when they were 'time-filling', had no choice over the training they undertook or were repeating course. Early entrants rather than regular entrants were more likely to go into sustained jobs. At the other end of the extreme, participants who have been unemployed for 5 years or more, were far less likely to go into jobs. There was little difference in progression through the scheme by gender or disability. Ethnic minorities eventually accessed the programme at similar levels to white participants, but entered very different options. There was no data found on people who left Jobseekers' Allowance without a job.

### **Welfare policy in the US**

Evidence from evaluations and other studies on the impacts of the PRWORA (Greenberg, in DWP, 2003) shows reductions in the number of families receiving welfare assistance and an increase in employment of lone parents. It has been difficult to estimate the direct impacts of the law and the different aspects of these welfare changes - expanded employment services, increased penalties and sanctions, time limits, 'make work pay' policies - as this period coincided with a very strong economy and other policy initiatives. Since 1996, there has been a large decline in welfare caseloads and a significant expansion in employment by lone-parent families. Studies consistently find that most of those who left assistance entered employment, typically in low-wage jobs. There is also evidence of limited earnings growth over time, of employment instability for a significant share of leavers, and of a group with multiple employment barriers that remains unemployed after leaving assistance. Although there have been reductions in absolute child poverty levels - a concern of the PRWORA - there is little evidence that the increased employment was associated with much, if any change in measures of child well being; this is especially so when there is an increase in employment without an increase in income (Box A.1).

Box A.1 Effects of US welfare programmes on child health and well being.

- ♦ Decrease in children living in poverty levels (against absolute US poverty standard) - 22% in 1994 to 16% in 2001 (Proctor and Dalacker, 2002), with the strongest effects in minority families
- ♦ Programmes that increased family income produced positive outcomes, eg school achievement (Morris et al, 2001); however welfare families from the very hardest to employ quartile or with adolescents or siblings showed less positive impacts, eg behaviour problems, poorer performance, grade repetition (Yoshikawa et al, 2003; Brooks et al, 2001).
- ♦ Changes in parenting explain selected impacts of the programme on children's cognitive function (McGroder et al, 2002) social and emotional development via impact of working conditions, eg job quality on parental behaviour, maternal depression and home environment (Fuller et al, 2002; Parcel & Menaghan, 1997). Negative effects, such as poor behaviour, were mediated by an increase in maternal depression, reductions in family routines and centre-based child care (Yoshikawa et al, 2003).
- ♦ Positive cognitive effects for children in high-quality centre-based care; stronger cognitive growth when caregivers are more sensitive and responsive, and stronger social development when caregivers have a post-High School education. Children in family child care homes show more behavioural problems but no cognitive differences (Loeb et al, 2004)
- ♦ More self care for older children and adolescents increase risks of inactive lifestyles, eg more TV, behavioural problems (Pettit et al, 1997)
- ♦ Youths who participate in structured activities approved by adults have better school performance and less deviant behaviour (Pettit et al, 1997)

Although there are many notable similarities to the NDLP programme, for example the 'work first' approach, essential differences with the US have been their funding mechanism (capped 'block' state grants, regardless of caseloads) and the ineligibility of legal immigrants to financial assistance. The former resulted in compulsion and penalties for those not working, as well as the time limit (6 months) to financial assistance. There have been significant difficulties in amending the law to strengthen employment retention and promote advancement for low-wage workers, and to develop more effective approaches for individuals with multiple employment barriers. It is recognised that if the associated aim of increasing employment of lone parents is to reduce child poverty, the US still has much to do to build skills, improve employment retention and advancement and to support low-income families. Key conclusions are that although there have been winners - individuals and the state - there have also been losers. The barriers preventing some welfare recipients becoming self-supporting were often beyond their control, resulting in extreme hardship for those who are unemployed and without financial support (Box A.2) and, even where support networks existed, less life satisfaction and reliance on subsistence coping strategies (Henly, 1995).

## Box A.2 Barriers and effects of US welfare programmes

*Barriers to work for unemployed leavers of US welfare programmes (Kubo & Richer, forthcoming).*

- ♦ Ill health - cancer, hepatitis, mental health problems, diabetes - or caring for disabled or ill children (20-30%)
- ♦ Transport issues (50%)
- ♦ Childcare (20-30%)

*Barriers to work for welfare leavers due to time limits (Taylor & Barusch, 2000)*

- ♦ Domestic abuse within last 12 months
- ♦ Post Traumatic Stress Disorder
- ♦ Language barrier
- ♦ Transportation

*Effects of leaving US welfare programmes on the health of unemployed leavers (Polit et al, 2001).*

- ♦ Hunger or food insecurity (25-33%)
- ♦ Rent arrears (25-50%)
- ♦ Live in overcrowded accommodation - less than one room per person (20%)
- ♦ Half of income for accommodation and utilities (35-50%)

*Effects of leaving welfare (due to sanctions) on children (Scalicky & Cook, 2000)*

- ♦ Increased likelihood of food insecurity (50%)
  - ♦ Increased likelihood of hospitalisation (90%)
- compared with families without sanctions

### **Welfare policy in Norway**

Norwegian welfare policies have been focused on employment but have presupposed that circumstances can make this difficult at times (Syltevik in DWP, 2003). The stigma associated with being a single parent in many countries, particularly a single mother, did not exist to the same extent in Norway. As such approaches for lone parents have reflected the 'Care-giving model' and 'Parent-worker model' (Lewis & Hobson, 1997) with financial support to enable parents to provide full or part-time care for their children. However recent reforms of the Lone Parent Strategy in 1998 have reduced the length of time of financial assistance available to 5 years. Although there is still the possibility of parents combining care, paid work and education, there is felt to be less choice and a duty towards paid employment. The aims of the reforms were to improve the economic situation of lone parents, to increase their capacity to make their own living through paid work and to improve the quality of public services for this group. With the changes there was an increase in the value of the financial support, the provision of child care expenses (70%) and the setting up of a self-help support group (BMO programme). It represents a shift in attitude and provision - parents will no longer be able to receive support from the state after their children are 3 years old - but a convergence with family policy.

Evaluation of the reforms shows the number of claimants of the transitional allowance has almost halved. However it has been more difficult to show a direct association with the reforms and the increase in employment of lone parents. In terms of a change in the economic situation only one in four had income levels comparable with the rest of the population (Fjaer & Syltevik, 2002). To gauge improvements in public services, participation in the BMO programme had been used as a success indicator and unfortunately numbers have been low, although the few participants who had taken part had found the support positive. The reforms had been originally seen as a way of reducing gender inequality, however role stereotyping - lone mothers work predominantly in health care and service sectors - has made this less successful. In addition education opportunities for longer-term education have been affected due to the time limit of assistance. The evaluation of the effects of working on lone parents and their children indicate the difficulties that this group



faces, comparable in many ways to that of US single parents. There may be something here about the context in which changes are introduced that affect how changes are perceived. There is an additional financial safety net for those people who are not 'self sufficient'; reasons for this were predominantly personal or child's health problems (19%) and the lack of education (34%).

### **Welfare policy in the Netherlands**

The Netherlands has seen a shift to an 'active' welfare state over the last two decades. During this time the objectives underpinning this have changed from social protection to prevention. This 'participation paradigm' is an important feature of the European Social Model and has influenced changes in welfare systems across Europe. Key objectives of this active welfare include promoting or enforcing employment and employability through employment programmes, reducing the dependence on social assistance by decentralising local employment services, and the marketisation and privatisation of activation services. In May 2003, the Jobseekers' Employment Act introduced the following measures:

- Training and education;
- Work experience placements: an employer from the public or private sector hires an unemployed person for a period of at least half a year, and receives a wage subsidy in return;
- JEA job: the municipality hires an unemployed person and sends him or her on secondment to a regular employer;
- Social activation: in order to promote employability and avoid social isolation, long-term unemployed people may be involved in unpaid activities (such as voluntary work), for which they may receive a small allowance for expenses.

In addition each unemployed person is classified according to his or her level of work 'readiness' or 'labour-market distance'; assistance with activation will be dependent on how they are classified. In line with the EES lone parents are not distinguished in the labour market, but additional support is provided to stimulate activation. These include additional financial support beyond 12 months and allowances/wage entitlements, no obligation to work for lone parents with children under 5, childcare provision and support.

For lone parents on Social Assistance, this 'labourist' or 'work first' orientation of Dutch activation has had several consequences. Their work obligations have been sharpened and the opportunities to care for their own children have been reduced. At the same time, escaping from poverty through employment is hard to realise, since many lone parents are poorly qualified and prefer part-time work in order to be able to combine paid work and child care. There are concerns from critics that the national government's aim is to increase the outflow from Social Assistance of lone parents to the level of the outflow for all Social Assistance recipients (Knijn & Berkel in DWP, 2003).

### **Welfare policy in New Zealand**

New Zealand provides an interesting comparator to the UK. It faces a similar policy dilemma to the UK over the issue of lone parents - their high rate of economic inactivity and dependence upon state benefits - but has taken a very different course (Hutten in DWP, 2003). This system is 'client-centred' and focuses more on getting the right solution for the individual regardless of the children's ages; there has been a shift from 'work tests' to 'enhanced case management'.

The 'work test' and associated 'work first' approach was disbanded in 2002 in reflection of the shift in ethos by the new Government to social development and enhanced well being of all New Zealanders. The emphasis has been on the early identification of welfare beneficiaries in need of support to overcome barriers to entering the labour market.

Application for benefit is accompanied with an interview with annual follow-ups on re-application for benefit. Other features include the development of personal development and employment plans (PDEP), support until in sustained employment, individuals decide about share of work or caring, and mentoring. Data on 8 specific areas are collected:

- financial issues
- accommodation
- health
- employment
- personal needs
- education and training
- social participation
- other

A journal is also developed identifying goals, objectives and actions for the PDEP. Referral to local agencies, e.g. health services, debt counsellors, for areas that cannot be resolved by the case manager is an important part of the process. There is no time limit to the programme and there are no expectations for 'quick wins'.

This is seen as an approach with long-term sustainable outcomes. The expectations are that the level of benefit claimants will reduce over time, however maintaining levels in year 1 is seen as likely. In addition the rates of job readiness are anticipated to increase. But with this programme's holistic approach there are also expectations that it will contribute to health, social and economic outcomes, including greater involvement in communities. Client satisfaction surveys are already revealing enhanced levels of success.

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