The Great Retirement or the Great Sickness?

Understanding the rise in economic inactivity

February 2023

Executive Summary

In his 2022 Autumn Statement, the Chancellor highlighted an increase of 630,000 since the start of the pandemic in the number of people of working age who are 'economically inactive'. Various explanations have been put forward for this trend, with some dubbing it a 'Great Retirement' and most discussion focusing on getting the over 50s 'back to work'.

Given that the forthcoming Budget is expected to come up with a range of initiatives to tackle this problem, the purpose of this paper is to look at the data on what has been happening in the labour market, in the benefits system and in the NHS to see if we can better understand the problem and identify where any interventions are likely to be most effective.

Our key findings are:

- The rise in working age inactivity is not purely amongst those over 50; at the time of the Autumn Statement, nearly half the increase had come from the under 50s, with a big rise in the number of students a major factor;

- According to the latest data, the rise in working age inactivity now stands at 516,000; however, there are actually fewer working age retired people than there were at the start of the pandemic; by contrast, well over half (+353,000) comes from a growth in the long-term sick;

- Data on *flows* into and out of long-term sickness show that persistently high inflows into long-term sickness are a key problem; one growing group is those who flowed into long-term sickness having been previously categorised as 'short-term sick'; this suggests that failure to address short-term sickness, including through clinical intervention, could have contributed to the increase in long-term sickness;

- Benefits data shows a remorseless increase in the numbers on the key sickness-related benefits which began before the pandemic;

- Benefits data also reveals a 'hard core' of over 1 million people who have been on Employment Support Allowance for five years or more; over half of these are categorised as having 'mental or behavioural' disorders.

- Amongst the entire economically inactive population of working age, very few of those who are retired say they 'want a job', whereas over 600,000 of the long-term sick say they would like to work if they could; this suggests that policies designed to help the long-term sick are 'pushing at an open door' in terms of supporting people who would actually go back to work given the right opportunities and treatment;

- Pressure on the NHS is likely to be a contributory factor in the rise in long-term sickness. Whilst this could in part be due to delays in accessing elective surgery, pressures on primary care and on mental health services are likely to be important factors. Examples include:

    - Growing numbers of older people of working age are living with two or more chronic conditions; these are typically managed primarily by GP practices rather than in hospitals;
    - Chronic disease management has been disrupted during the pandemic; for example, around 500,000 have 'missed' starting treatment for high blood pressure;
    - A big drop off in people being diagnosed with, for example, type 2 diabetes means that many will subsequently be diagnosed in a 'sicker' state

In the final section of the paper, we explore whether there is any obvious correlation between data on NHS pressures and the rise in the number of sickness benefits in any given local area. However, we find that the type of NHS data that we have – for example, numbers of people on waiting lists for elective treatment – are unlikely to help explain much of the rise in working age inactivity. As noted above, the key for many people may well be access to primary care rather than elective care. Furthermore, waiting list data will include people of all ages, including pensioners, and may not therefore be a good guide to the capacity issues facing those of working age with the particular conditions that they face.

More detailed data on NHS pressures, including in primary care and for mental health care, might well help to identify areas where these pressures are linked with a rise in sickness benefit receipt. We believe that additional resources in these geographical areas and in these parts of the NHS system could well do more to address rising economic inactivity than measures focused on reducing or reversing 'early retirement'.

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Introduction

In his Autumn Statement on 17th November 2022, the Chancellor said:

> *"[we are] concerned that we have seen a sharp increase in economically inactive working age adults of 630,000 since the start of the pandemic…so the PM has asked the Work and Pensions Secretary to thoroughly review issues holding back workforce participation due to conclude early in the new year."*

At a time when claimant unemployment is relatively low and vacancies relatively high, the Government is understandably keen to understand why a growing group of people of working age have apparently dropped out of the labour market.

Initial comment on this phenomenon dubbed it 'the Great Retirement' with the suggestion that it was mainly driven by people opting to drop out of paid work to live off their pensions, perhaps having enjoyed a slower pace of life whilst working from home during Lockdown.

In response, there have been some calls for rules on 'Pension Freedoms' to be tightened up, to discourage people from using early pension access to support early retirement. And the Government is rumoured to be planning to expand 'mid-life MOTs' where people would take a realistic look at their finances and think again about whether their pension could really support such a long retirement.

But in this paper we argue that early retirement is not the key to the surge in economic activity. Instead, we identify a sharp growth in the number of people self-identifying as long-term sick – accompanied by a steady growth in the number of people on long-term sickness benefits – as explaining far more of this phenomenon.

To try to understand what is going on, we bring together a wide range of source data:

- The Labour Force Survey, which is the source for the Chancellor's 630,000 figure; in particular, we use the 'panel' aspect of the survey where the same people are re-interviewed over a period of time; this enables us to look at the transitions which individuals make into, and out of, economic inactivity;
- DWP benefit data; in particular, as we identify long-term sickness as a key source of the reason for the growth in inactivity, we look at DWP data for two key benefits – Employment Support Allowance (ESA), and Universal Credit (for those with 'Limited Capacity for Work'); this data is publicly available at local level;

- NHS data on 'incomplete pathways' (or 'waiting lists' in common parlance) which might provide a measure of the pressure on the NHS in different parts of the country; in principle, bringing this data together with benefit data for the same local geographic area might allow us to see how far NHS capacity issues are correlated with higher rates of sickness-related benefit receipt.

By bringing together official data from the benefits system and from the health system, we hope to shed new light on this important issue.

In some cases, we believe existing data enables us to understand more about this matter and in such cases we have marked "key findings" throughout the report. But we also believe that refinements to existing data, particularly on NHS waiting lists and primary care management of chronic conditions, would help us to understand these issues better, and we explore potential data improvements at the end of this paper.

01 Who are the 630,000 and what happened next?

The focus of this report is on what statisticians refer to as 'economic inactivity'. The definition of inactivity is based on answers given by survey respondents in the Labour Force Survey.

- The economically active are, broadly speaking, those who are employed or self-employed, or those who are unemployed (on the internationally standard definition) or on a government training scheme.
- The economically inactive includes those who are:
    - Unable to work because of sickness or injury
    - In full-time education
    - Retired
    - Looking after family or home
    - Or who give other reasons (or no reason) for being inactive

To produce the estimate of 630,000 more economically inactive people of working age, the Chancellor has compared quarterly Labour Force Survey data for December 2019 - February 2020 (the final three months before the first Lockdown) with quarterly LFS data for July 2022 – September 2022 (the most recent figures available at the time of his speech). The seasonally adjusted figures show an increase over the period from 8.37 million to 9.00 million.

The age breakdown of the 630,000 increase is shown in Table 1:

Table 1. Increase in economic inactivity since start of pandemic by age (seasonally adjusted, thousands) as at the time of the Autumn Statement 2022

Age Group	Dec 19 – Feb 20	Jul 22 – Sep 22	Change
16-24	2,544	2,746	+202
25-34	1,063	1,118	+55
35-49	1,534	1,562	+29
50-64	3,229	3,572	+343
All	**8,370**	**8,999**	**+629**

Although the over 50s show the largest absolute increase in economic inactivity, it is perhaps surprising to see that 286,000 out of the 629,000 increase (or 45%) is amongst those under 50, with much of this coming amongst the under 25s. Further data analysis suggests that this is primarily driven by rising numbers categorising themselves as students.

KEY FINDING1. The rise in economic inactivity is not simply to do with the over fifties. Nearly half of the increase at the time of the Autumn Statement was amongst those under fifty, partly due to a rise in the numbers in education since the start of the pandemic.

Chart 1 shows how the number of economically inactive people has changed over the period, this time broken down by the reason for their economic inactivity and up to July-September 2022.

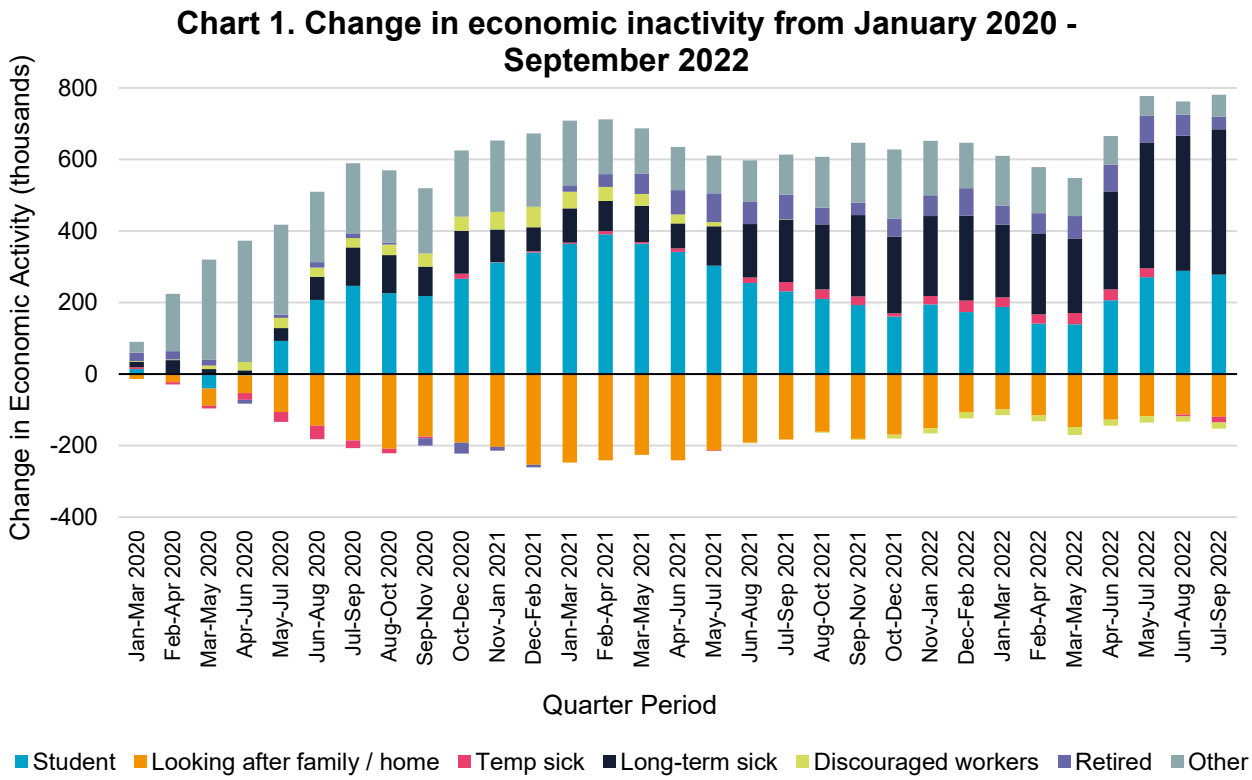


Chart 1: Stacked bar chart showing change in economic activity by reason for their economic activity by quarter for the period January 2020 – September 2022 (thousands).

Chart 1 shows that the main groups where inactivity has risen are the long-term sick and students. The number of working age retired was up only slight at the time of the Autumn Statement. There are also relatively falls in inactivity amongst some groups including those caring for family / home (-120,000).

However, we now have the benefit of data for a further three months, taking us up to the quarter from October to December 2022. The table below shows the baseline pre-Pandemic data (December 19 to February 20), the figures as at the Autumn Statement (July 22 to September 22) and the latest figures (October 22 to December 22), broken down by type of inactivity.

Table 2. Economic inactivity amongst people of working age (thousands) – a) at start of Pandemic, b) at time of Autumn Statement and c) latest data

	Start of Pandemic (Dec19-Feb20)	Autumn Statement (Jul22-Sep22)	Latest (Oct22-Dec22)	Change
Student	2130	2408	2274	+144
Carer	1840	1720	1702	-138
Short-Term Sick	177	161	200	+23
Long-Term Sick	2112	2519	2465	+353
Retired	1122	1157	1107	-15
Other	989	1034	1139	+150
TOTAL	**8370**	**8999**	**8886**	**516**

Source: Authors' calculations based on ONS data for seasonally adjusted economic inactivity. Note: 'Discouraged workers' have been included in 'other'.

The latest data shows a net increase of 516,000 in working age inactivity since the start of the pandemic (compared with the 630,000 figure when the Chancellor made his speech). Long-term sick are now +353,000, students +144,000, retired actually down 15,000. This reinforces the view that the growth in economic inactivity really is not about a 'great retirement'.

KEY FINDING 2. The rise in economic inactivity has very little to do with 'early retirement'. Even at the time of the Autumn Statement, the majority of the 630,000 increase in inactivity was due to a growth in long-term sickness. New data available since then shows that there are actually fewer working age people who are retired than there were at the start of the Pandemic.

As has been pointed out by the Institute for Fiscal Studies amongst others, this data shows the net impact of a whole series of transitions – some people are moving into economic inactivity, some are moving out, and some are changing category within the total (eg going from short-term sick to long-term sick). We may gain more insights into what is going on by looking at the Labour Force Survey micro data on which these published statistics are based, and in particular by focusing on *transitions* between different groups. We do this in the next section[1].

[1] In June 2022, the IFS published research (The rise in economic inactivity among people in their 50s and 60s | Institute for Fiscal Studies (ifs.org.uk)) on economic inactivity suggesting that early retirement was a key factor. This was based on data up to Q1 2022. However, since then, the number of economically inactive people working age who are 'retired' has fallen by 69,000 whilst the number of long-term sick has risen by 151,000. Our analysis, which covers a longer time period, therefore points much more to sickness as a central factor.

02 *Rising economic inactivity 2020-22 – Labour Force Survey panel data*

The published statistics shown in the previous section are based on a huge sample survey of the population – the Labour Force Survey (LFS). When people take part in the survey they give detailed answers about their labour market status which provides more granular detail than shown in the summary statistics.

For example, amongst those categorised as economically inactive there are no fewer than 28 different categories. In particular, for each of the categories shown in Chart 1 (eg students, family carers, short-term sick, long-term sick etc) we also know:

- Who is currently actively seeking work and who is not
- For those not currently seeking work, who would (at some point) like work and those who would not

In this paper we look at this more granular detail to see if we can better understand the rise in the numbers categorised as long-term sick, which seem to be the main group which has increased in size since start of the pandemic.

We also use the 'panel' element of the LFS. The LFS has a rolling 'panel' element where people are interviewed once a quarter over a five quarter period before dropping out of the sample. In theory this would allow us to track individuals as they move between different labour market states over a period of more than a year. Indeed, Phoenix Insights have recently published analysis based on this five-quarter panel[2].

Unfortunately, trying to interview the same people every quarter for five quarters leads to a lot of people dropping out. This panel 'attrition' means that the final sample size of the five-quarter data set is far smaller than the original sample[3]. Given that we want to look in fine detail at the composition of the long-term sick, if we use the five quarter panel we will be at risk of very small samples and high levels of sampling variability.

[2] See: "What is driving the great retirement", published by Phoenix Insights in November 2022. https://www.thephoenixgroup.com/sites/phoenix-group/files/phoenix-group/Phoenix%20Insights/Publications/Phoenix%20Insights%20What%20is%20driving%20the%20Great%20Retirement.pdf

[3] For example, the complete LFS dataset for the quarter running July-September 2022 includes over 72,000 observations, of whom 43,000 are of working age. By contrast, a single five quarter panel for January 2021 – July 2022 inclusive has just under 4,000 observations of whom barely 3,000 are of working age.

To try to strike a balance between benefiting from the panel element of the LFS but avoiding very small sample sizes, we have chosen to use the *two* quarter panel datasets made available every three months. This gives us a sample of around 20,000 people each quarter who are successfully followed up the following quarter and enables us to see how their economic status changes over that period. The earliest data that we use is for those interviewed between January and March 2020, and followed up between April and June 2020. (This is labelled in our graphs by reference to the starting quarter – in this case 'Jan-Mar 2020'). The most recent micro data we have is those interviewed in April and June 2022, followed up between July and September 2022. In all, we therefore have ten sets of quarterly panel data, covering information about nearly 200,000 working age individuals.

We use our rolling quarterly panel data to investigate a number of questions:

a) Is the growth in working age 'long-term sickness' due to a rise in inflow rates (more people becoming sick), a fall in outflow rates (fewer people ending a spell of sickness) or both?

b) For people who 'enter' long-term sickness, what were they doing before? Has this changed?

c) For people who 'leave' long-term sickness, what do they do next? Has this changed?

Results

Is the growth in working age 'long-term sickness' due to a rise in inflow rates (more people becoming sick), a fall in outflow rates (fewer people ending a spell of sickness) or both?

Chart 2 shows the rate at which people flow into and out of long-term sickness in each of our ten quarterly datasets.

Chart 2: Inflow and outflow rates for working age long-term sickness

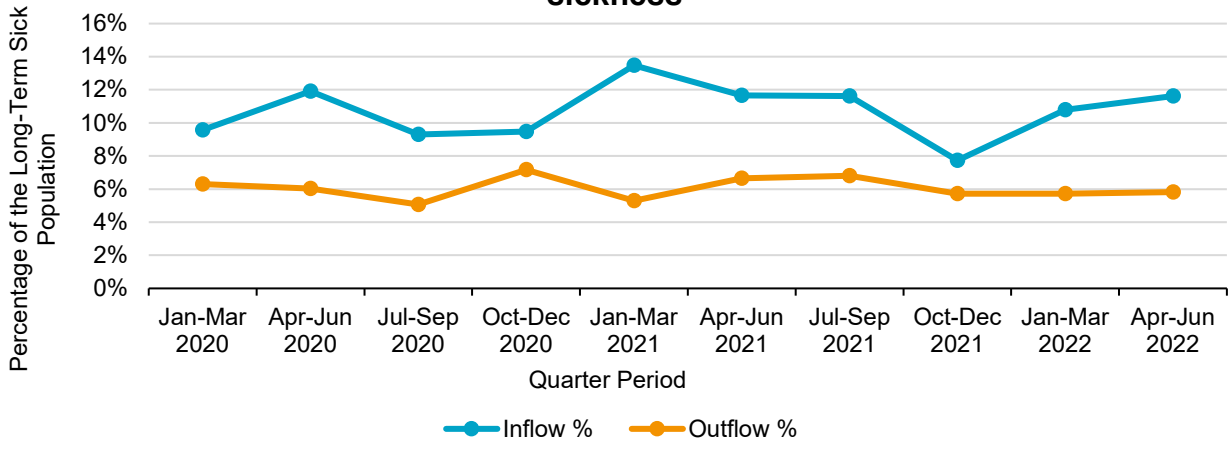


Chart 2: Line graph showing inflow and outflow rates for working age, long term sickness, as a percentage of the long-term sick population size.

A number of results can be seen in our data:

- For each of our samples, the size of the 'long-term sick' population grows in the three months after they are first interviewed; this can be seen from the fact that the 'inflow' rate is always above the 'outflow' rate;
- Although there are fluctuations from quarter to quarter (which will partly reflect sampling variations but may also reflect seasonal factors, which we cannot strip out at this micro level), the outflow rate is broadly stable at around 6%; this means that in any given three month period, around 6 in 100 of those who were previously self-described as long-term sick will have moved into another category; this almost feels like a 'steady state' outflow rate as some people from this group will inevitably reach pension age, retire, get better or (in a minority of cases) die over any given 3 month period;
- Inflow rates are somewhat volatile, but there does appear to have been a noticeable increase in the rate at which people are becoming long-term sick in the most recent data;

Key finding 3: The growth in the number of long-term sick is not primarily driven by a drop-off in the rate at which people 'leave' sickness; rather, rates of inflow into long-term sickness are relatively high and seem to be on an upward trend;

In the next section we look at where people who are now long-term sick have 'come from' in terms of their previous economic status.

For people who 'enter' long-term sickness, what were they doing before? Has this changed?

Using the panel element of our survey, we can 'look back' at those who have just become long-term sick to find out their prior economic status[4]. This data is summarised in Chart 3.

[4] It is important to note that Labour Force Survey in this two-quarter panel data series is 're-weighted' so that the high level employment status totals are held constant between the first and second wave. Whilst this does not prevent us from using this data to look at the inflow and outflow into long-term sickness to / from different categories, it does mean that the aggregate totals should be treated with particular caution.

Chart 3 Prior economic Status of those entering Long-Term sickness

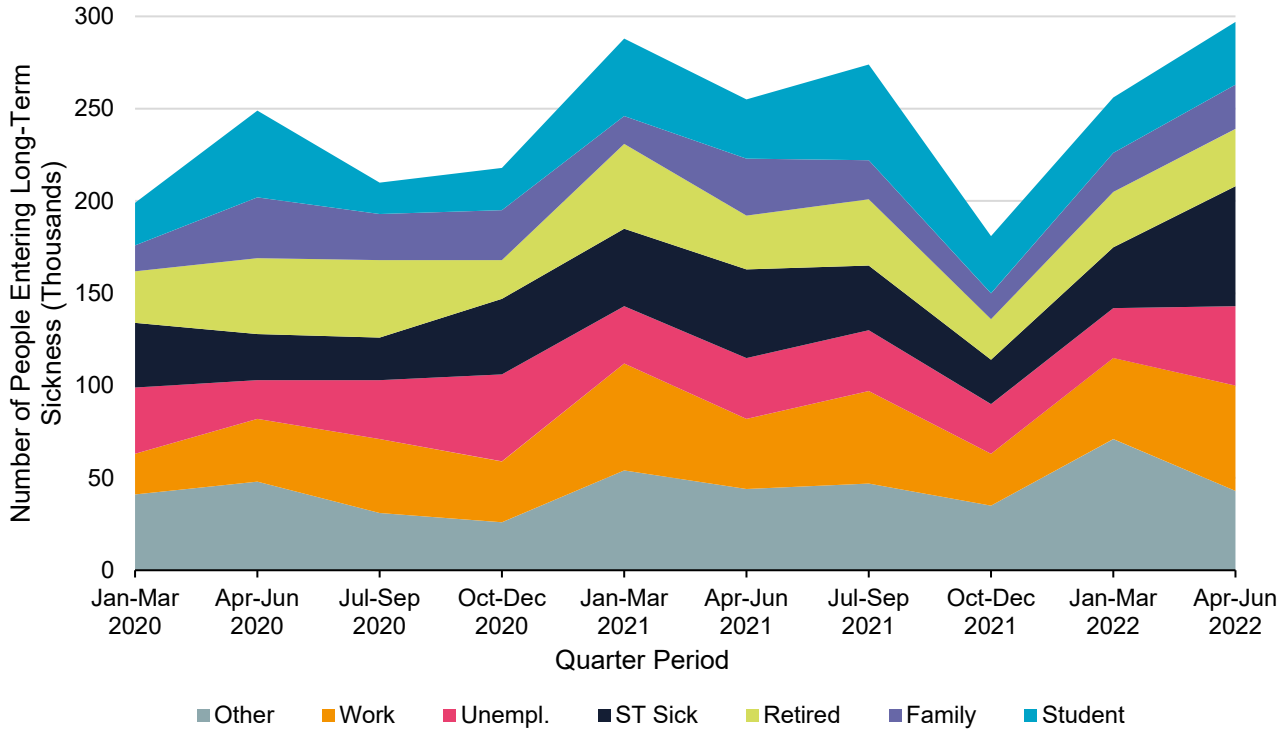


Chart 3: Prior economic status of people who have newly transitioned into Long-Term Sickness. Unempl.: Unemployed, ST Sick: Short-Term Sick

A number of features of this chart are worthy of note:

- The routes *into* long-term sickness are many and varied – particularly at the start of the period there were quite similar numbers of people coming into long-term sickness direct from employment, from unemployment, from 'short-term' sickness, from retirement, from family responsibilities and from studying.

Key Finding 4: The majority of those newly classed as long-term sick were not in work three months earlier. This means that initiatives targeting employers (with a view to reducing flows from work into sickness) are unlikely to have a quick impact on the level of long-term sickness.

- Although the numbers flowing in to long-term sickness fluctuate from quarter to quarter, the most recent growth appears to have come primarily from those who were previously short-term sick; this might provide some evidence for the theory that NHS capacity issues have contributed to the rise in economic inactivity; this could be because those who might otherwise have been treated (and moved from short-term sickness to employment) went untreated (and moved from short-term sickness to long-term sickness);

Key Finding 5: A key contributor to the growth in long-term sickness appears to be an increased inflow from short-term sickness, perhaps in part reflecting NHS capacity constraints;

For people who 'leave' long-term sickness, what do they do next? Has this changed?

As well as looking at where the long-term sick have come from, we can also look at the routes 'out of' long-term sickness. Chart 4 shows the destinations of those in our series of panels who moved out of long-term sickness three months after they were first interviewed.

Chart 4: Destinations of those exiting Long-Term sickness

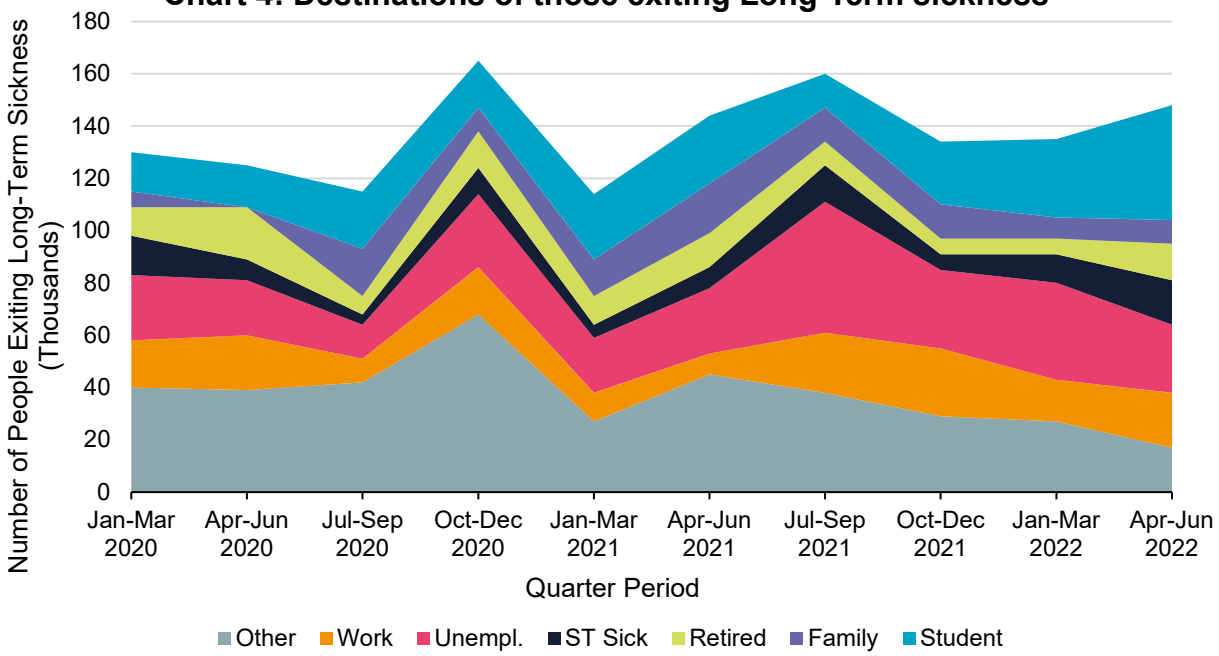


Chart 4: Economic status of those who have transitioned out of long-term sickness within 3 months of being interviewed. Unempl.: Unemployed, ST Sick: Short-Term Sick

The absolute numbers leaving long-term sickness are somewhat volatile, but Chart 4 shows that there is clearly some diversity in what happens to people who move out of this group. Key destinations include:

- Unemployment (ie actively seeking work) – this might suggest that their health condition has improved enough for them to go out and look for work;
- Retirement – although all of these people are of working age, some may simply now think of themselves primarily as retired; it may be that their health has improved but that they no longer want to work or that they have a chronic health condition which they are living with, but as a result they no longer expect to work again and predominantly self-identify as retired;
- Students – there may be some seasonal element to the data, but it is worth noting that for some people a route out of long-term sickness may be a course of study; one

possibility could be people who are no longer able to do their previous job because of a health condition but who might be able to do other work with suitable retraining.

03 Rising economic inactivity 2020-22 – DWP benefits data

The advantage of the Labour Force Survey data (used in the previous section) is that it is based on tens of thousands of individuals giving relatively detailed accounts of their individual circumstances and goals. But the downside is that it is simply a sample of the population and this makes it difficult to draw detailed conclusions about population subgroups, particularly if we are interested in looking at granular trends at a local level. We therefore now turn to government data on benefits to see what clues this may give us to recent trends in economic inactivity.

The largest data source on those of working age who are out of work because of sickness comes from the benefits administration data provided by the Department for Work and Pensions (DWP). One advantage of this data is that it is publicly available at a very localised level.

Drawing conclusions about trends in long-term sickness from DWP benefits data is made more complex by the major reform to the benefits system which we have seen in recent years. The key points are:

- A new income-related benefit – Universal Credit – is being phased in, to combine six existing benefits (including tax credits, Job Seekers Allowance and Employment Support Allowance); the roll out of this benefit started with particular groups of the population (single people with no dependants) and in particular parts of the country (certain JobCentre districts implemented the new benefit before others);

- Many people continue to receive 'legacy' benefits; in the case of those off work sick, the main benefit is Employment Support Allowance (ESA); in the most recent Autumn Statement, the Chancellor announced a further four-year delay in 'migrating' people from ESA to Universal Credit; however, in general terms, the majority of those starting to make a claim for benefit on grounds of sickness will either go directly on to Universal Credit or will have a limited time period on ESA before moving to UC; the exception to this is those in poorest health (known as the 'support group') who may qualify for ESA on an open-ended basis.

To track numbers of working age people off work sick via DWP benefit data, we have concluded that the best approach is to track the *combined* total of people on ESA and

those of Universal Credit on the basis of 'limited capacity for work'.[5] Because we will then be comparing this data with information from NHS England, we look purely at DWP benefit recipients in England.

Chart 5 shows how the combined numbers on ESA and UC (for sickness reasons) have moved since the start of the pandemic.

Chart 5: Combined sickness-related benefits caseload (England)

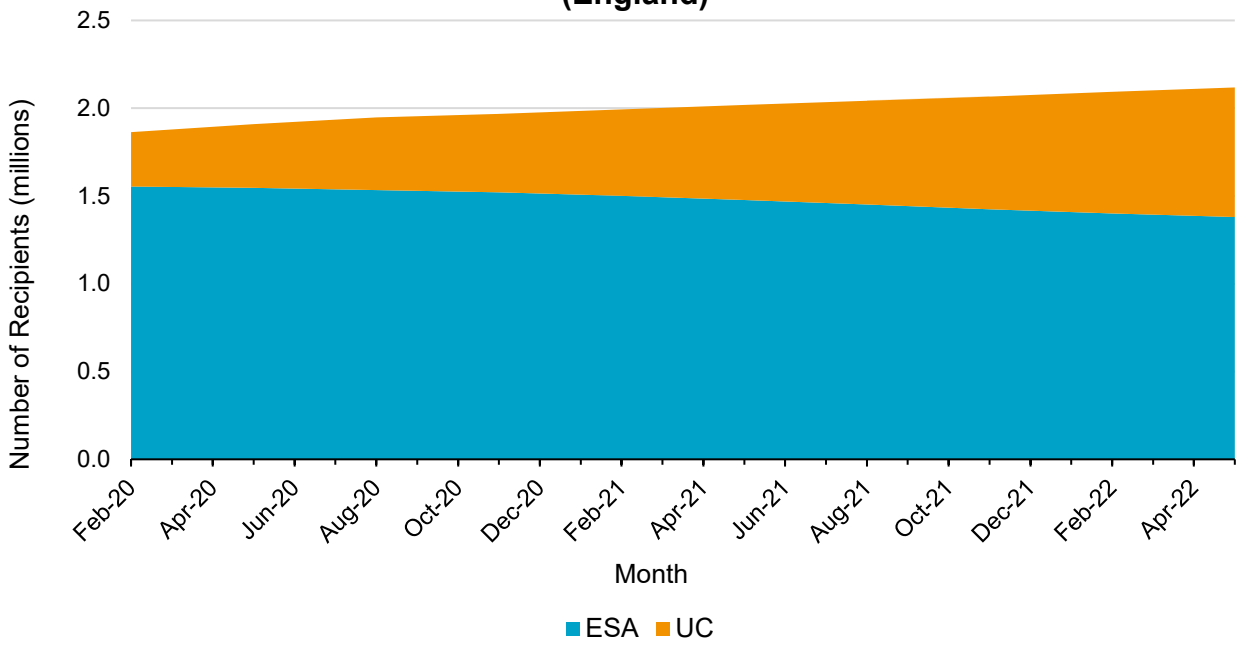


Chart 5: Chart detailing the total number of claimants of Employment Support Allowance (ESA) and Universal Credit (UC) by Month in England.

In terms of the total numbers shown in the chart, we see that between February 2020 and May 2022 (the latest date for which ESA data is available at time of writing) the number of people on sickness related benefits in England had risen from around 1.9m to just over 2.1m. This compares with the published Labour Force Survey data which suggests that across GB there were around 2.1m people of working age who were economically inactive because of long-term sickness in Q1 2020, and that this had risen to just under 2.4m by Q2 2020.

Although receipt of a sickness-related benefit is not the same as being economically inactive because of long-term sickness, it is reassuring to note that the two different definitions seem to be telling a broadly similar story, both in terms of the size of the group of interest (allowing for the England/GB difference) and the magnitude of the recent growth in that group.

In terms of the individual benefits, because relatively few new claims are being made for ESA, this group is relatively steady in size and increasingly represents a 'hard core' of long-term sick people of working age. For example, out of 1.38m people in England on

[5] To be more precise, the group we count are those on UC with 'limited capacity for work or work-related activity' – LCWRA.

ESA in May last year, just over one million had been in receipt of benefit for five years or more.

By contrast, because Universal Credit is a relatively new benefit, the caseload here is changing much more rapidly, and durations are typically shorter. We are only looking at people with "Limited Capability for Work or Work-Related Activity" (LCWRA). In early February 2020 (just before the first Lockdown), the UC caseload in this group amounted to just under 350,000 households but by May 2022 this had risen to around 770,000. As Chart 6 shows, a growth in claimant numbers across the two benefits was seen in all English regions[6].

Chart 6:Total recipients by region by half year

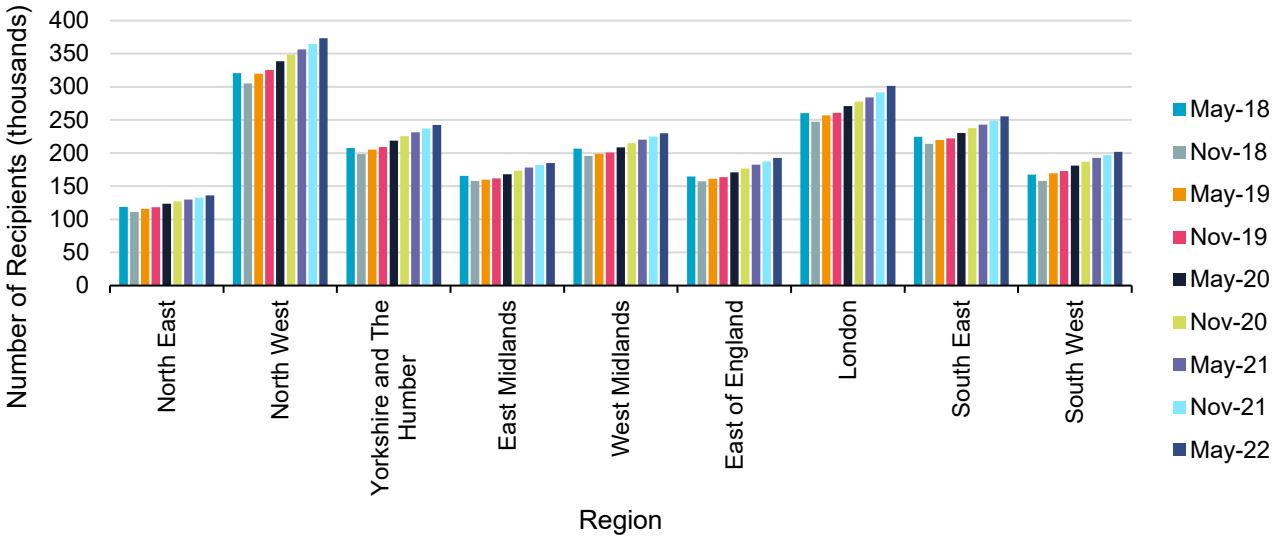


Chart 6: Bar Chart of the Change in the Total Number of Recipients of Sickness-Related Benefits by Region per 6-months period.

Aside from geographical area, the ESA and UC datasets provide different levels of detail about the other characteristics of claimants which makes it hard to describe the combined characteristics of the group as a whole. However, we do get some interesting insights by looking at the characteristics of those on ESA, where more detailed information is available.

Characteristics of those on ESA

As noted above, with limited exceptions[7], no new claims are being accepted for ESA. A gradual programme of 'migration' of people on ESA onto Universal Credit is being undertaken, though the Chancellor announced in his Autumn Statement that this would be paused for the next few years. As a result, those already on ESA can remain on it, unless there is a change of circumstances which could lead them to switch to Universal Credit, or

[6] Note that, for context, this chart starts in May 2018, and illustrates that claimant numbers were already starting to rise even before the pandemic.
[7] A 'new-style' ESA is available which is only for those who have the relevant record of National Insurance contributions. For those in the 'work-related activity group' benefit lasts for 12 months only, but is open ended for the more severely disabled in the 'support group'.

until they reach state pension age when they would generally switch onto retirement pension or move off benefit and into work.

Table 3 shows the age distribution of those on ESA and how it has changed since February 2020[8]:

Table 3. ESA recipients by age – February 2020 and May 2022, England only

Quarter	Feb-20	May-22
Age (bands and single year)		
Under 18	149	92
18-24	62,534	24,519
25-34	204,159	170,728
35-44	254,039	225,095
45-49	187,517	149,038
50-54	242,638	213,644
55-59	277,410	262,200
60-64	283,547	276,525
65 and over	42,187	58,239
Unknown	..	..
Total	1,554,184	1,380,074

Source: DWP 'stat xplore' tool, England only, recipients of ESA

Because of the lack of new claims to ESA, and the gradual migration onto UC, the total number of people on ESA has fallen by around 170,000 over the period. However, although the age profile of ESA is skewed towards older ages (as might be expected), what is striking is that a significant number of younger people are on ESA. Roughly 30% of the ESA caseload is in under 45 age bracket, and this percentage has only fallen slightly in the last couple of years.

What is also very notable is the very long durations on benefit which many of the ESA caseload have experienced, as shown in Table 4.

[8] Note that the switch from ESA to Retirement Pension would generally occur at state pension age which was increasing gradually from 65 in Autumn 2018 to 66 in Autumn 2020. This would tend to lead to an increase in the '65 and over' group and a small reduction in ESA outflow.

Table 4. ESA recipients by duration of claim – February 2020 and May 2022, England only

Quarter		Feb-20	May-22
	Duration of current claim		
	Up to 3 months	20,485	24,262
	3 months up to 6 months	15,783	21,076
	6 months up to 1 year	24,512	32,879
	1 year and up to 2 years	83,221	49,088
	2 years and up to 5 years	444,853	182,414
	5 years and over	965,336	1,070,346
	Unknown duration	..	..
	Total	1,554,184	1,380,074

Although the total caseload on ESA has dropped, the number with very long durations – over five years – has actually gone up by over 100,000. This suggests a growing group of people who are long-term sick or disabled, many of whom may not have been in paid employment for five years and who are therefore probably some distance from being potential participants in the labour market.

There is also a small increase in the numbers on relatively short durations. These are likely to be claimants of 'new style' ESA. This is available only to those who satisfy the relevant National Insurance Contribution test (essentially those who have recently been in paid work). For those with the highest needs (the 'support group') payment is open-ended, but those required to do 'work-related activity' cease to be entitled after 12 months.

The DWP data on ESA recipients allows us to focus on those with the longest durations – those on benefit for five years or more – for information about their medical condition. This is summarised in Table 5.

Of the increase of just over 100,000 in the number of people in England on ESA for five years or more, Table 5 suggests that around two thirds is amongst those with 'mental and behavioural disorders'. It seems reasonable to suppose that this correlates to some extent with the growth in the number of younger people classified as 'economically inactive'. Beyond this, the increased numbers are quite widespread across medical conditions, though there is a near 10,000 increase in the numbers reporting diseases of the nervous system.

The ongoing transition from ESA to UC makes comparisons over time imperfect, the relative increases by condition in long-term ESA recipients is interesting. While the average increase was of 11% between February 2020 and May 2022, congenital conditions (55% increase), conditions of the ear (24%) and eye (15%), cancer ('neoplasms') (16%) along with mental health conditions (14%) were all notably higher than the average.

In the next section we look at whether the growing numbers of people on sickness-related benefits is correlated at local level with pressures on the local NHS, as reflected either in waiting lists or in the wider pool of people with an underlying health need who may not (yet) be included in the waiting list figures.

Table 5. Long-term ESA recipients by condition – February 2020 and May 2022, England only

England, 5 years and over	Feb-20	May-22
Certain Infectious and Parasitic diseases	5,405	5,726
Neoplasms	14,103	16,353
Diseases of the Blood and Blood forming organs and certain diseases involving the immune mechanism	2,065	2,361
Endocrine, Nutritional and Metabolic diseases	13,248	13,500
Mental and Behavioural disorders	495,333	563,297
Diseases of the Nervous System	82,783	92,491
Diseases of the Eye and Adnexa	9,478	10,911
Diseases of the Ear and Mastoid Process	4,434	5,485
Diseases of the Circulatory System	33,355	33,111
Diseases of the Respiratory System	20,439	21,943
Diseases of the Digestive System	13,738	14,413
Diseases of the Skin and Subcutaneous System	3,661	3,905
Disease of the Musculoskeletal System and Connective Tissue	124,983	127,180
Diseases of the Genito-urinary System	4,995	5,082
Pregnancy, Childbirth and the Puerperium	430	463
Certain conditions originating in the Perinatal period	9	5
Congenital Malformations, Deformations and Chromosomal Abnormalities	11,426	17,655
Symptoms, signs and abnormal Clinical and Laboratory findings, not elsewhere classified	80,014	88,928
Injury, poisoning and certain other consequences of external causes	19,656	20,428
External causes of morbidity and mortality	2,349	2,474
Factors influencing Health Status and contact with Health Services	23,428	24,637
Codes for special purposes	..	6
Unknown or claimants without diagnosis on the system	..	..
Not available	..	..
Total	965,336	1,070,346

04 NHS England data on waiting lists – is there a link between rising benefit claims and NHS pressures?

Given that the changing (self-reported) health of the population appears to the key to unlocking the puzzle around rising economic inactivity, it seems reasonable to look at whether pressures on the NHS could be part of the reason for growing levels of working age sickness.

One way to do this is to look at NHS data at a local level, and compare this with DWP benefit data for the same area. One hypothesis would be that those in areas with long waits for elective treatment – the nearly 7 million waiting for non-urgent appointments - might be more likely to get 'stuck' in long-term sickness or move from short-term to long-term sickness and that this would be reflected in benefits data (and levels of economic inactivity).

An important point to note however is that the readily available data on waiting lists is not broken down by age group. This means that we are attempting to explain (some of) the growth in inactivity amongst the working age population by reference to NHS pressures faced by the whole population. Whilst waiting lists for those over pension age are obviously important in their own right, they would not be relevant to our specific inquiry in this paper. To better test our hypothesis, we would therefore need local-level NHS data on waiting times which excluded those over pension age.

With that important caveat in mind, we look at some initial data plots.

First, we provide a simple plot between absolute numbers of people on waiting lists ('incomplete pathways') in each local authority area and the absolute numbers on sickness-related benefits. The result is shown in Chart 7.

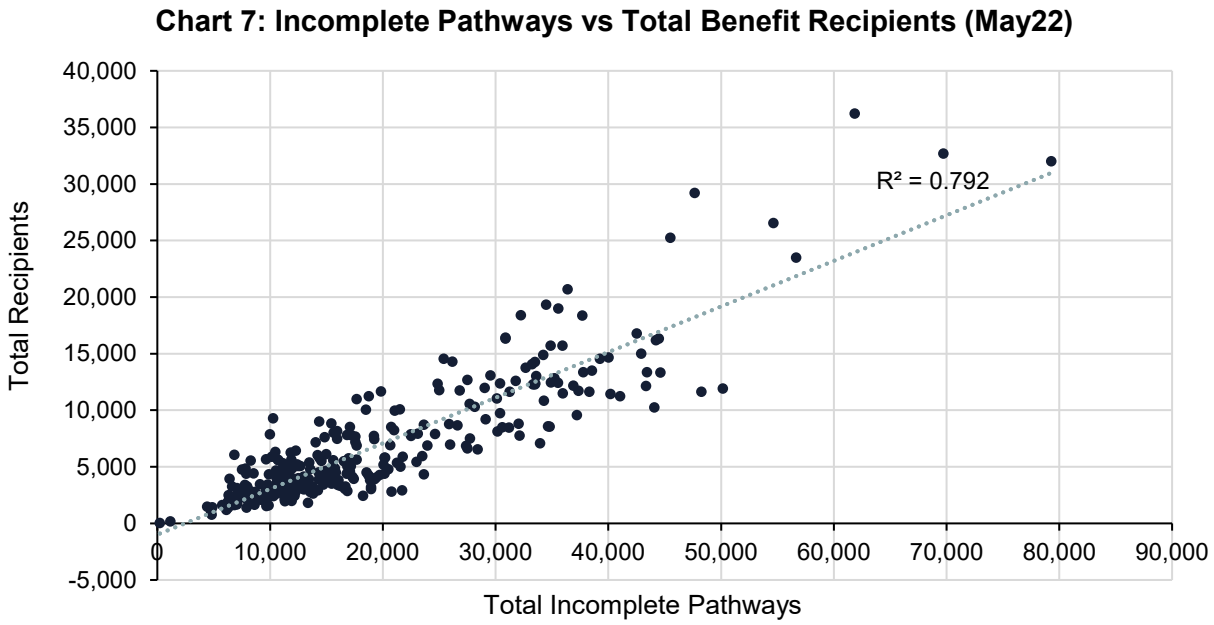


Chart 7: Scatter Plot Highlighting the Relationship between the absolute number of recipients of sickness-related benefits and the absolute number of people on the NHS waiting list.

On the face of it, the chart seems to suggest quite a strong positive correlation between numbers on waiting lists and numbers on benefit in any given area. However, given that local authorities vary considerably in size, it would not be surprising if large local authorities had both large numbers of people on benefit and large numbers of people waiting for NHS treatment, and this does not necessarily imply any causal link.

Perhaps a better approach would be to control for population size by looking at *rates* of sickness benefit receipt and *rates* of being on an NHS waiting list per 100,000 of population. This is shown in Chart 8:

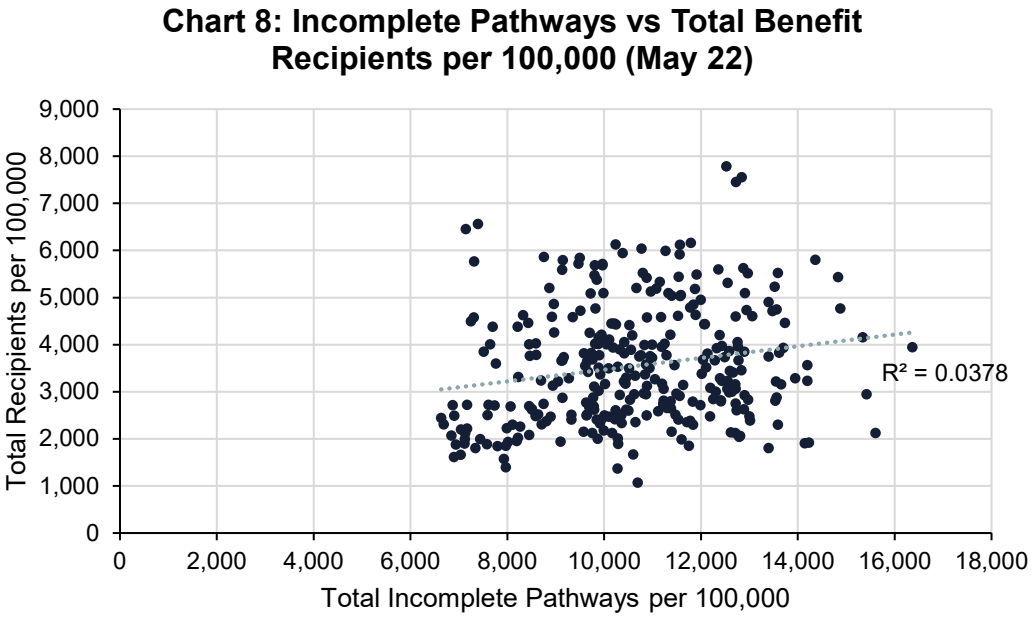


Chart 8: A scatterplot highlighting the relationship between the number of sickness-related benefit recipients per 100,000 and the number of people on the NHS waiting list per 100,000.

At first glance, this chart appears to show no obvious relationship between the proportion of people in any given area who are waiting for NHS treatment and the proportion who are on sickness-related benefits. However, as noted above, our waiting list data is likely to be dominated by those over pension age and this could mask any correlation between working-age waits and working-age benefit receipt.

We might also think that as we are trying to explain the *growth* in the number of people on sickness-related benefits we should also look at how these numbers have changed over time in different local areas and how that relates to local NHS pressures. In other words, whilst absolute levels of sickness benefit receipt in a given area might be affected by a range of other factors (eg the rate of unemployment), the change in benefit receipt might be expected to reflect things that have changed in that area, such as lengthening NHS waits. We explore any possible linkage of this sort in Chart 9, which plots, for each English region, the increase in total sickness benefit numbers against the increase in people with long (one year or more) waits.

Chart 9: Growth in Total Claims vs Growth in Waitlist >52 weeks by Region (Post March 2020)

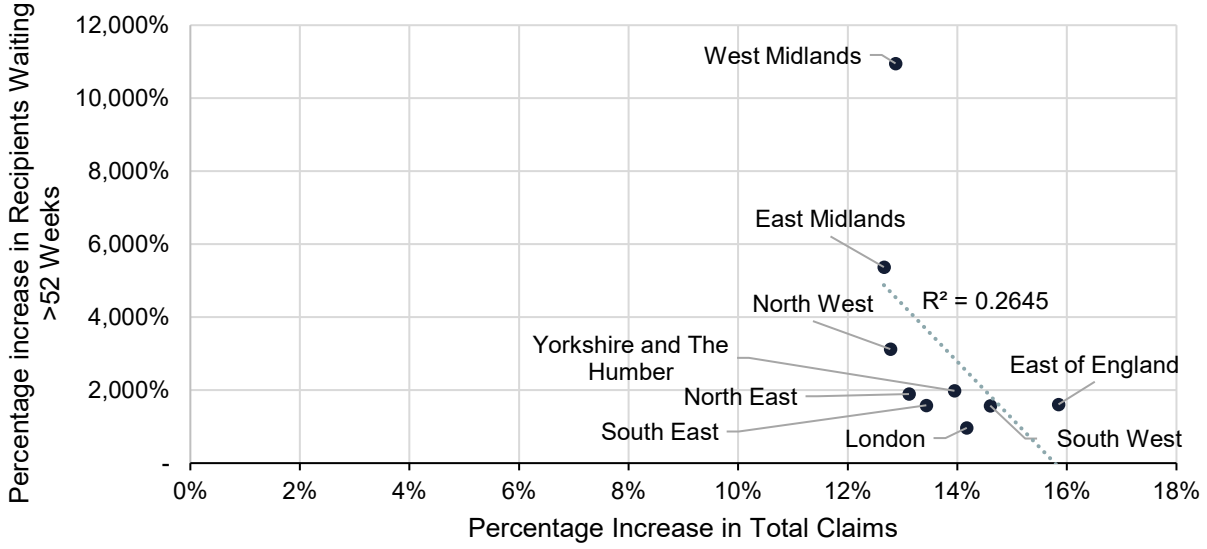


Chart 9: A scatterplot of the relationship between the growth in the number of sickness-related benefits recipients and growth in the number of people on the NHS waiting list by region.

It would be fair to say that this data on its own does not show a clear correlation between areas where long-term waits for elective NHS treatment have risen the most and areas where sickness benefit numbers have risen the most. There is actually relatively little variation between regions in the rate at which benefit claims have increased and rather greater variation in the increase in long NHS waits so it is perhaps not surprising that there is not an obvious correlation at this high level.

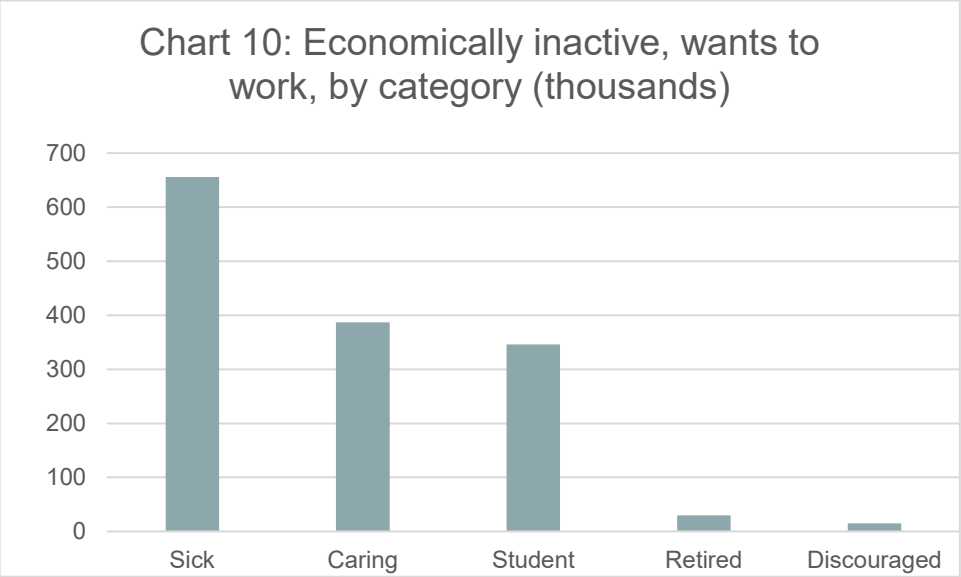
As will be apparent, at this stage we do not have clear evidence of a link between local NHS pressures and local rates of benefit receipt (or the growth rates of each). And clearly

changes in sickness benefit rates will be affected by a whole range of other factors, so we would not expect NHS issues to fully explain any regional variations. But it does seem reasonable to think that the growth in long-term sickness could in part reflect difficulties in accessing NHS treatment. In addition, our earlier findings from the Labour Force Survey showing a rising 'inflow' into long-term sickness from short-term sickness would be consistent with this theory. We will therefore be exploring if we can find NHS data for the working age population in order to explore the potential size of any such relationship.

05 Which group(s) should be targeted for policy interventions

Another way of approaching the issue of economic inactivity would be to look at the stock of people who are economically inactive and look at "how far" they are from the labour market. The survey data not only tells us about people's current economic status but also whether they are currently actively looking for work or, if not, they would like to back to work at some stage. It seems reasonable to suppose that policy interventions are likely to have most effect if they are targeted on those who are already positively inclined towards returning to the jobs market.

The chart below shows, for each group of working age economically inactive people in the latest data, how many 'would like a job' at some point.



Source: Labour Force Survey quarterly data Oct-Dec 2022

As the chart shows very clearly, amongst the economically inactive who would like paid work, by far the largest group – again – is those who are currently inactive because of sickness. By contrast, only a very small number of those who are inactive because they describe themselves as retired would like to work again.

This data suggests strongly that policy interventions designed to help overcome the barriers faced by those who are currently off sick will be 'pushing at an open door' in terms of getting them to return to paid work.

By contrast, very few of those who have chosen to retire are currently interested in returning to paid work. One consequence of this is that measures specifically designed to incentivise retirees to return (such as relaxing rules on tax free pension build up) could have a high deadweight cost, being enjoyed by existing older workers, but doing little to drive those who have already retired to return to work.

Looking at those who are sick but want to work, we find that the median person in this group is in the 50-54 age group. This suggests that successful intervention to help such people find work will potentially reap a rich fiscal reward as they have the potential to be

economically inactive for more than a decade before reaching state pension age. By contrast, the working age 'retired' population tend to be closer to state pension age so even getting them back to work may only result in a few years of extra economic inactivity.

Clearly, a range of policy initiatives will be required to tackle economic inactivity, and these will include measures to reduce the 'inflow' into inactivity (eg people currently in work retiring or going off sick), but in terms of measures designed to increase the 'outflow' from inactivity, doing more for the long-term sick is likely to be far more effective than concentrating on those people who have already retired.

06 Conclusions and next steps

The evidence is clear that a rise in long-term sickness is a key reason for the rise in economic inactivity. We see this both in the changing composition of the economically inactive population, in the high levels of 'inflows' into long-term sickness and in the remorseless rise in the numbers on sickness-related benefits.

In terms of the nation's health, we also see that while life expectancy improvements outstripped gains in healthy life expectancy during the decade preceding the pandemic, healthy life expectancy showed no increase from 2015 to 2018.

Healthy life expectancy is not published at small geography but the life expectancy gap between small areas increased to 21-years for women and 27-years for men across England, and this is likely to have worsened since March 2020. This is to say that even before the Covid-19 pandemic, people were living in ill-health for longer and this varied from community to community more than ever. The pandemic is likely to only have worsened this.

While our initial analysis did not find associations between either the relative (rate) size of elective waiting lists and sickness benefits there are several reasons why our initial approach is imperfect. The elective waiting list data, as outlined, is not broken down by age group and waiting list trends in working age groups may be masked by trends in the broader (and older) population. Secondly, this analysis, and waiting list data, is available at sub-ICB (previously clinical commissioning group) level which covers approximately 200-300k people. Health needs, and sickness benefits, are likely to vary substantially; analysing these trends at smaller geography may capture trends hidden in the aggregated data.

Thirdly, the link between (ill)health and employment is likely to be stronger with chronic diseases and corresponding adequate control of chronic diseases, much of which is not captured in elective waiting list numbers.

For example, more than 50% of adults in England live with two or more chronic conditions, with the rate being higher in more deprived compared to the more affluent areas. The average onset of this state of living with multiple conditions reduced from 56 in 2004 to 46 in 2019, where many would have more than 20-years of working life remaining. Many of these chronic conditions such as back pain, depression or diabetes, are generally managed by primary care teams including GPs rather than in hospitals via elective waiting lists.

It was a known phenomenon before the Covid-19 pandemic that while populations were generally sicker in poorer areas, primary care (GP) capacity was not proportionately higher. Recent work has identified substantial disruption to chronic disease management in primary care since the pandemic began with 500k people 'missed' starting blood

pressure tablets during this period; this is likely to reflect a cohort of people having less regular checks for their chronic condition and living in poorer health.

A big drop off in people being diagnosed with, for example, type 2 diabetes means that many will subsequently be diagnosed in a 'sicker' state – causing time off work with the initial presenting illness, a longer period to stabilise the condition or in the worst situations a first diagnosis via an emergency visit to hospital with a diabetes-complication; each resulting in a larger impact on one's ability to work than would have previously been the case.

Analysis of primary care data to identify disruption of chronic disease control at small geographies would enable addressing the leading hypothesis that the rise in sickness benefits is linked to a deterioration of the stock of health of individuals and communities and that this is socially patterned. These trends are likely to have been in place before the Covid-19 pandemic but, as with many health and illness outcomes, have been exacerbated by the pandemic. If our hypothesis holds true, detailed analysis would be able to identify who is at high risk of falling into sickness benefits with sufficient warning to put in place efforts to prevent it, reducing both NHS pressures and boosting the workforce.

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