



Public Health
England



UCL Institute of Health Equity

Protecting and improving the nation's health

Local action on health inequalities

Promoting good quality jobs to reduce health inequalities

Practice resource: September 2015



About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. It does this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. PHE is an operationally autonomous executive agency of the Department of Health.

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About the UCL Institute of Health Equity

The UCL Institute of Health Equity (IHE) is led by Professor Sir Michael Marmot and seeks to increase health equity through action on the social determinants of health, specifically in four areas: influencing global, national and local policies; advising on and learning from practice; building the evidence base; and capacity building. The institute builds on previous work to tackle inequalities in health led by Professor Sir Michael Marmot and his team, including the Commission on Social Determinants of Health, Fair Society Healthy Lives (The Marmot Review) and the Review of Social Determinants of Health and the Health Divide for the WHO European Region (www.instituteoftheequity.org).

About this practice resource

This practice resource was commissioned by PHE and produced by IHE. The document is intended to help local authorities, health and wellbeing boards, and health and social care professionals when devising local programmes and strategies to reduce health inequalities. A shorter summary document supports this more detailed practice resource.

This practice resource was written for IHE by Dan Durcan.

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Key messages

1. There are four ways in which the nature of work can adversely affect health: through adverse physical conditions of work; adverse psychosocial conditions at work; poor pay or insufficient hours; and temporary work, insecurity, and the risk of redundancy or job loss. In 2014, an estimated 1.2m working people in Great Britain had an illness or health condition believed to be caused, or exacerbated by, their current or previous work placement.
2. Musculoskeletal disorders (MSDs) and work-related stress, depression and anxiety were the most common work-related illnesses in 2013-14.
3. There is no generally accepted definition of good work but there are a range of features commonly associated with good jobs: adequate pay; protection from physical hazards; job security and skills training with potential for progression; a good work-life balance and the ability for workers to participate in organisational decision-making. Skilled work typically has more protective elements and less health-adverse conditions.
4. There is evidence of an increase in high-paid and low-paid jobs at the expense of middle-ranking jobs. Lower-skilled, lower-paid work is also disproportionately concentrated in the north of England. Increasing the quantity of jobs in England without consideration of job quality is likely to exacerbate social and health inequalities and create unequal economic growth.
5. To develop better jobs for local populations, local partnerships can draw on what is known about the features of good and poor quality work, and can learn from emerging strategies that promote good quality jobs with employers. A range of strategies should be used to focus on improving the quality of new and existing low-skilled jobs.
6. Local authorities have the opportunity to create jobs through a range of partnerships and initiatives, including working through local enterprise partnerships, employment services providers, and with third sector organisations to devise job creation strategies that could reduce health inequalities. Local partners should encourage jobs where workers are valued, receive a living wage at minimum, have opportunities for promotion, and are protected from adverse conditions, like shift work, when possible.
7. Working to improve the skills base of people in local and regional labour markets may help to attract more skilled employment to the area, and contribute to improving the quality of work. This is particularly important in more economically deprived regions such as the north of England, where a skills deficit already exists and sits side by side with greater health inequalities.

1. Introduction

The conditions in which we work have a large impact on our health:¹ good quality jobs can be protective of health, whereas poor quality work can be adverse for health. Poor quality jobs are an issue for health inequalities as they are concentrated at the lower end of the social gradient.² Unemployment rates increased from 5% before the 2008 economic crisis to 8.4% in the third quarter of 2011, and have been generally falling since, to 5.6% for the period between March and May 2015.³ However, this has arguably been associated with more part-time employment, increased use of zero-hours contracts^{4, 5, 6} and higher levels of in-work poverty.⁷ With many of the jobs created being insufficient to support a healthy lifestyle, job growth post-2010 is likely to be driving health inequalities. It is therefore important that good quality jobs are encouraged to help tackle health inequalities.

The UCL Institute of Health Equity (IHE) was commissioned by Public Health England (PHE) in 2014 to produce a report that would illustrate how to reduce health inequalities through creating and promoting more employment opportunities in good work. It builds on a previous collaboration between PHE and IHE culminating in the report 'Local action on health inequalities: Increasing employment opportunities and improving workplace health'.⁸ Section 2 looks at how job quality impacts on health. In Section 3, we turn to trends in job quality and document how work can be health-protective in Section 4. Section 5 considers how local authorities can create jobs to reduce health inequalities. It pays particular attention to local enterprise partnerships (LEPs), a key tool for local authorities to influence job creation. LEPs bring together local authorities, employers, academics and employee representatives to direct local economic strategies. The way in which LEPs can shape job growth to take into account health inequalities, and how they can use job creation to help reduce these inequalities, are presented.

This practice resource is designed to help local public health partnerships (public health teams, health and wellbeing boards and LEPs), to influence job creation, given the current context of economic regeneration activity.

Method

There is a substantial body of work on the relationship between work and health, which is used to inform this practice resource. IHE, in partnership with PHE, identified and consulted with leading stakeholders and experts on employment and health, as well as with the wider public.

This practice resource was informed by the following processes and research methods:

- attending public health advisory meetings to better understand the current policy focus of employment and health
- desk-based research, focusing on case studies, reports and research studies, using peer-reviewed and 'grey' (unpublished) literature, complemented by policy documents and Office for National Statistics (ONS) data. The bibliography of this practice resource lists these. Analysis was also made of available data from the Labour Force Survey and the Health and Safety Executive to better understand which types of jobs are better and worse for health
- input from an expert steering group
- consultation with experts, policy-makers and practitioners

2. Job quality and health impacts

Work can have a considerable impact on health. Between 2013 and 2014, 1.2 million working people in Great Britain had an illness or condition believed to be caused, or exacerbated by, their current or previous work placement. Half a million of these were new conditions that started during the year. Over 629,000 injuries occurred at work in 2013-14, of which 148,000 led to more than seven days' absence.⁹ Ill-health and injuries result in considerable costs to society, estimated at £14.9bn to the British economy in 2012-13¹⁰ with 23.5 million days lost due to work-related ill health and 4.7 million days due to workplace injury in 2013-14.⁹

The nature of work affects health inequalities because health-adverse work conditions are concentrated in more disadvantaged social groups.¹ One of the Marmot Review's policy objectives to tackle inequalities in the social determinants of health is to create fair employment and good work for all.¹ Two other related Marmot Review policies are: ensuring a healthy standard of living and creating and developing healthy and sustainable places and communities. The former is closely related to pay, while the latter is closely related to skills basis and regional equalities. These relationships will be examined in this practice resource.

The Marmot Review recommendation to improve the quality of work was based on a growing literature about aspects of work that are protective or damaging to health, and evidence that more skilled and more highly paid work is associated with better health outcomes.¹ For example, the first Whitehall Study compared the mortality of staff in the highly stratified environment of the British civil service, showing life expectancy increases with seniority. This is particularly interesting given that the civil service excludes the richest and poorest members of society.² A social gradient was observed for a range of different diseases: heart disease, some cancers, chronic lung disease, gastrointestinal disease, depression, suicide, sickness absence, back pain and general feelings of ill-health.²

Studies in Europe and Australasia also show a clear relationship between position in the social hierarchy and mortality.² In addition, within the EU there are strong and persistent social inequalities in exposure to health-adverse work environments, resulting in unfair employment conditions.¹¹ Patterns of employment therefore both reflect and reinforce the social gradient of health, and there is inequality of access to labour market opportunities.¹

There is also evidence that adverse work conditions are more common among ethnic minority groups and disabled people. For example, low pay is more common among Pakistani and Bangladeshi groups, with almost half being paid less than £7 per hour, whereas a quarter of white British workers were paid at this rate. People

with a longstanding illness or disability are more likely to earn a below average income. In Great Britain in 2010, two-fifths of all adults aged 45-64 on below-average incomes had a limiting longstanding illness or disability, this was one-and-a-half times the rate for those on average incomes and three times the rate for those on high incomes.¹²

Work can adversely impact an individual's health in five main ways (box A), each of which is discussed in the remainder of this section.

Box A. The nature of work can adversely affect health through:

1. Adverse physical conditions of work.
 - exposure to physical and chemical hazards
 - long hours
 - shift work
2. Adverse psychosocial conditions at work.
 - conflict
 - lack of autonomy
 - lack of control
3. Poor pay or insufficient hours.
4. Temporary work, job insecurity and risk of redundancy.
5. Job satisfaction and wellbeing.

2.1. Adverse physical conditions at work

a. Physical hazards

Physical hazards include, for example, unhealthy or restricted posture at work, engaging in repetitive movements and heavy lifting. These features of work can lead to unsafe conditions that cause large volumes of injury, illness and death.¹³ There were 133 fatal injuries in Great Britain in 2013-14, a rate of 0.44 deaths per 100,000 workers.¹⁴ Common work related illnesses include musculoskeletal disorders (MSDs) (in 2013-14, 42% of all work-related illnesses or 526,000 MSD cases were reported),¹⁵ hearing loss (in 2013 there were 17,000 work-related hearing problems)¹⁶ and vibration white finger (there were 515 recorded incidents of vibration white finger in 2013).¹⁶

Table 1 highlights professions that have the highest rates of musculoskeletal disorders. It is evident that those professions that include lifting and bending have the worst outcomes in this area.

Table 1: Musculoskeletal disorders and profession

Type of musculoskeletal disorder	Highest prevalence rates
Back disorders ¹⁵	Health professionals Skilled trade, in particular skilled construction trades Service and leisure occupations, in particular caring personal services Agriculture and associated trades
Upper limb disorders ¹⁵	Skilled construction and building trades Health and social care professions

Source:¹⁵

Further statistics on injuries in the workplace can be found in appendix 2. Process, plant and machine operatives are almost five times more likely to have an injury than the average across all occupations.¹⁷ Administrative and secretarial occupations on the other hand see the lowest injury incident rate.¹⁷

b. Chemical hazards

Working with chemicals can irritate the skin, causing illness and skin disease. Most occupational skin disease cases are contact dermatitis and similar numbers of these are caused by exposures to allergens and irritants.¹⁸ Working with wet hands, and contact with soaps and cleaning materials are the most common causes of occupational contact dermatitis. There are an estimated 5,000 new cases of work-related skin disease a year,¹⁸ with a downward trend of occupational contact dermatitis since the late 1990s.¹⁸ These are easily avoidable conditions that can be prevented by, for example, wearing gloves.¹⁸

c. Long hours

Working 48 hours or more per week increases the risk of fatigue and accidents.¹⁹ While the average figure across the EU is one in twenty,²⁰ in the UK approximately one in eight workers work more than 48 hours per week, rising to one in six in London.²¹ There is some evidence that working long hours can lead to stress, depression or mental ill health.^{19 22} In a self-report survey of UK workers working more than 48 hours a week, over half of respondents reported “mental exhaustion” as a health problem, and around 40% reported feeling unable to cope at work. Around 20% said they were anxious, depressed or had “bad nerves”.²²

Working long hours can increase accident risk. For the first eight or nine hours in a shift, the accident risk is constant, but after 12 hours the risk approximately doubles, trebling after 16 hours.¹⁹ Accidents related to long hours are most associated with medical and driving occupations.¹⁹

ONS data indicate the occupations most likely to work over 45 hours per week as being managers and senior officials and the sector most likely to do so is agriculture and fishing (figures 9 and 10, appendix 2).²⁰

d. Shift work

There is no specific definition of shift work in law, but it usually means a work activity scheduled outside standard daytime hours, where there may be a handover of duty from one individual or work group to another; or a pattern of work where one employee replaces another on the same job within a 24-hour period.²³

There are well-established adverse health effects of shift work,^{1 24 25} mainly a reduction in quality and quantity of sleep, widespread complaints of fatigue, anxiety, depression, and increased neuroticism, increasing evidence of adverse cardiovascular effects, a possible increase in gastrointestinal disorders, increased risk of spontaneous abortion, and giving birth to low birth weight babies and prematurely,²⁶ Approximately 17.3% of UK workers worked shifts in 2010, an increase from 15.4% in 2005.²⁷

The sector with the greatest proportion of shift work (37.2%) is transport and communication workers followed by workers in public administration, education and health (Figure 11, Appendix 2).²⁸ Shift work is more concentrated in lower-skilled occupations²⁷ and therefore the negative impacts will add to health inequalities. However shift patterns among some workers are essential to provide round-the-clock care for the population. Therefore, such workers require specific measures to limit any adverse health effects of shift working where shifts cannot be avoided.

2.2. Adverse psychosocial conditions at work

There are a number of adverse psychological conditions at work that are related to increases in stress as discussed below. The number of cases of work-related stress, depression and anxiety in 2013/14 was 487,000, 39% of all work-related illness. The sectors most affected were health and social work, education and public administration and defence.²⁹

a. Conflict

Conflicts within workplace hierarchies and power relations can restrict employee participation in decision-making and drive discriminatory activities. These types of psychosocial stresses in work places can cause ill health and have become more

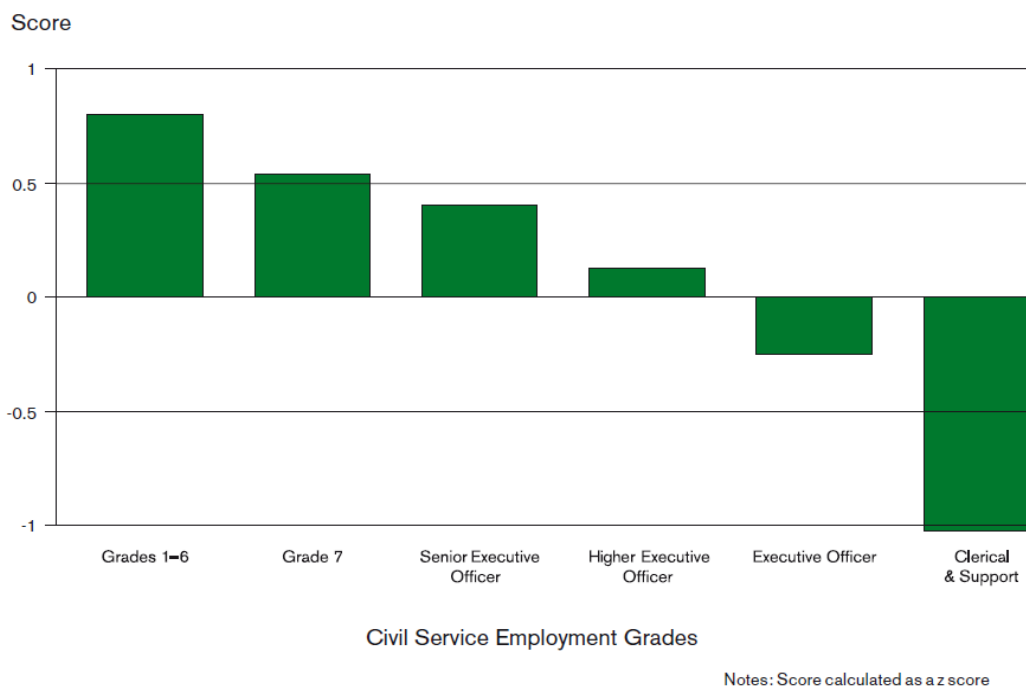
widespread.¹³ Commonly, a consequence of workplace conflict is stress,¹³ which can affect mental and physical health.

b. Lack of autonomy and control

In demanding jobs, concurrent low control and low reward may increase the probability of ill health – above and beyond the health effects of either factor.¹³ Work conditions where people experience low control, autonomy and reward can be particularly negative for workers who do not perceive themselves to be paid sufficiently.³⁰ These conditions elicit negative emotions and enhanced stress responses with adverse long-term health consequences.

Job control is associated with lower socioeconomic position.² As can be seen in Figure 1 below, a clear gradient was seen in job control and civil service grade in the Whitehall studies. Investigators concluded that much of the difference in coronary heart disease morbidity and mortality observed between job grades could be explained by stress induced by job control.³¹ This suggests that there is a social gradient of stress at work and those at the lower end of the social gradient are most affected.³²

Figure 1: The association of civil service grade with job control, Whitehall study, 1985-88¹



2.3 Low pay and insufficient hours

The relationship between low income and poor health is well established. Income effects health through different broad pathways:

- material: through the ability to afford a healthy lifestyle
- psychosocial: through the impact that having insufficient income has on stress levels
- behavioural: the material and psychosocial impact of income can lead to maladaptive coping strategies such as drinking and smoking.

There may also be a vicious circle whereby poor health leads to a reduced income.³³

Two common standards of sufficient income are the minimum income standard (MIS) and the living wage. Annually, the Joseph Rowntree Foundation publishes the MIS, defined as the income that people need in order to reach a minimum socially acceptable standard of living in the UK today, based on expert and public opinion. It is calculated by specifying baskets of goods and services required by different types of household in order to meet an acceptable standard of living and to participate in society.³⁴ The MIS varies according to the different household types.³⁴ The living wage is an hourly rate that considers the cost of living and MIS data,³⁵ and is useful for determining whether a job reaches a certain standard of pay quality.

The proportion of employees earning below the living wage in 2014 was 22%, up from 21% in 2013 – a real-terms rise of 147,000 people to 5.28 million.³⁶ Analysis by the Trades Union Congress (TUC) of the Labour Force Survey suggests that 77% of the net rise in employee jobs from June 2010 to June 2013 was in low-paid industries such as retail, waitressing and residential care.³⁷ The increase in temporary workers may also be of concern as 36% of temporary/casual workers are low paid, compared with 20% permanent employees.³⁸

Insufficient working hours refers to workers not having the desired hours for work. Fewer work hours impact on take home pay and therefore have the health effects associated with low pay. In 2012, 10.5% of adult workers in the UK (3.05 million people) wanted to work more hours, rising to around a quarter for part-time workers.³⁹ In 2008 to 2012 the number of all workers who wanted to work more hours increased by 1 million (or 47.3%).³⁹

2.4. Temporary work, insecurity and the risk of redundancy

A job may be regarded as temporary if it is understood by both employer and the employee that the termination of the job is determined by objective conditions, such as reaching a certain date, completion of an assignment or the return of an employee who has been temporarily replaced.⁴⁰ Job security refers to the discrepancy between the level of security experienced and the preferred level.¹³ In the EU, precarious work (poorly paid, insecure, unprotected, and cannot support a household) is more prevalent for those with low education and skill levels and those who are in lower socioeconomic positions.³²

Studies show that workers reporting insecurity in their jobs have higher self-reported ill-health relative to workers in secure employment.⁴¹ Workers exposed to chronic job insecurity had the highest self-reported morbidity, indicating that job security might act as a chronic stressor.⁴¹ Temporary workers are often exposed to strenuous and tiring positions, intense noise and repetitive movements, have less freedom to choose when to take personal leave and are rarely represented in health and safety committees.^{41 42} Between Quarter (Q) 1 2010 and Q1 2014, the number of temporary workers rose from 6 to 6.4% – from 1,477,000 to 1,648,000 of the total number of employees.³⁷

A form of temporary and insecure employment that has received a lot of media attention is the zero-hours contract. The term “zero-hours” is not defined in legislation but is generally understood to be an employment contract between an employer and a worker whereby the employer is not obliged to provide the worker with a minimum number of working hours, and the worker is not obliged to accept any of the hours offered.⁴³

There is mixed information about whether zero-hours contracts benefit workers. For example, the Chartered Institute of Personnel and Development found zero-hours workers were just as satisfied with their job as the average UK employee (60% and 59% respectively), and more likely to be happy with their work-life balance than other workers (65% versus 58%).⁴⁴ However, TUC research found that the average hourly wage for a worker on a zero-hours contract was £8.83 an hour – a third less than the average for staff on permanent contracts (£13.39).⁴⁵ Further, the TUC research found that the majority (57.6%) of workers on zero-hours contracts outside London earned less than the living wage of £7.65 an hour, while more than three-quarters of those working in the capital earned less than the London living wage of £8.80 an hour.⁴⁵

Redundancy risk is another threat to health that is widespread in the current economy. In 2012, 52% of employees reported anxiety about loss of job status, while 11% were very insecure, believing their chances of losing their job were “evens or worse”, and this proportion had risen from 7% in 2006; 31% of employees were anxious about unfair treatment at work and this had increased since 2000, particularly in relation to fear of arbitrary dismissal.⁴⁶ (See Figures a1 & a2 in Appendix 3 for a breakdown of job insecurity by occupation and sector). Health-adverse conditions at work often form “toxic combinations”: for example, a job with low security will often have lower job satisfaction and pay.¹³ This reflects and reinforces the social gradient in health.

2.5. Job satisfaction and wellbeing

The sections above have looked at the pathways through which work can have a negative impact on health. Another way to approach the issue is to consider what

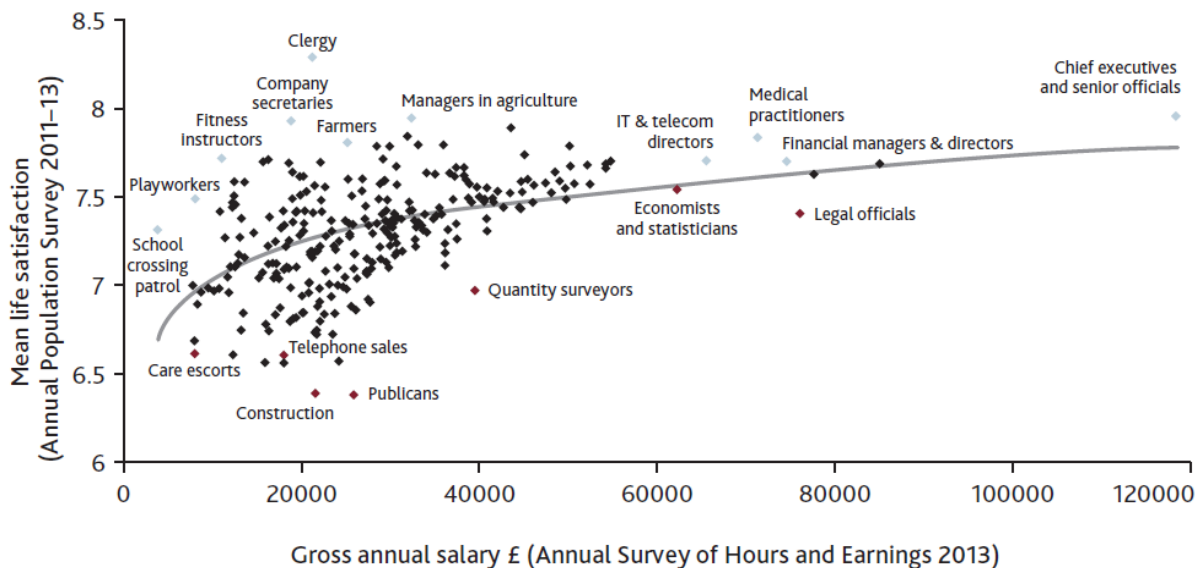
people think about their jobs; their level of satisfaction with work. Job satisfaction is declining in most advanced countries.^{47 48 49}

The link between job satisfaction, wellbeing and productivity

Positive job and life satisfaction has been found to increase productivity and creativity, as well as reduce sickness absence.⁴⁹⁻⁵¹

Figure 2 shows life satisfaction by occupation for mid-career age groups (35-50). It shows there are clear differences in wellbeing by occupation and while there is a link between good pay and job satisfaction, this is not always the case. Occupations with high life satisfaction, such as fitness instructors and company secretaries, often have relatively low median incomes. Yet some jobs with comparatively low mean income are associated with low life satisfaction – so there must be other factors at play. Similarly, some high-paying jobs are associated with low levels of wellbeing – such as IT engineers and quantity surveyors.

Figure 2: Life satisfaction by employee group⁵²



Box B. Jobs associated with the highest and lowest life satisfaction^{53 †}

Jobs associated with the highest life satisfaction include:

- clergy
- chief executives and senior officials
- company secretaries
- health care practice managers
- fitness instructors
- farm workers and managers in agriculture and horticulture

Jobs associated with the lowest life satisfaction include:

- publicans
- bar staff
- rent collectors
- leisure assistants
- tilers
- telephone salespersons

[†]ONS defines life satisfaction as the average score reported by UK adults (aged 16 and over) who gave a rating on a 0 to 10 scale (where zero was "not at all" and ten "completely") when asked "Overall, how satisfied are you with your life nowadays?".

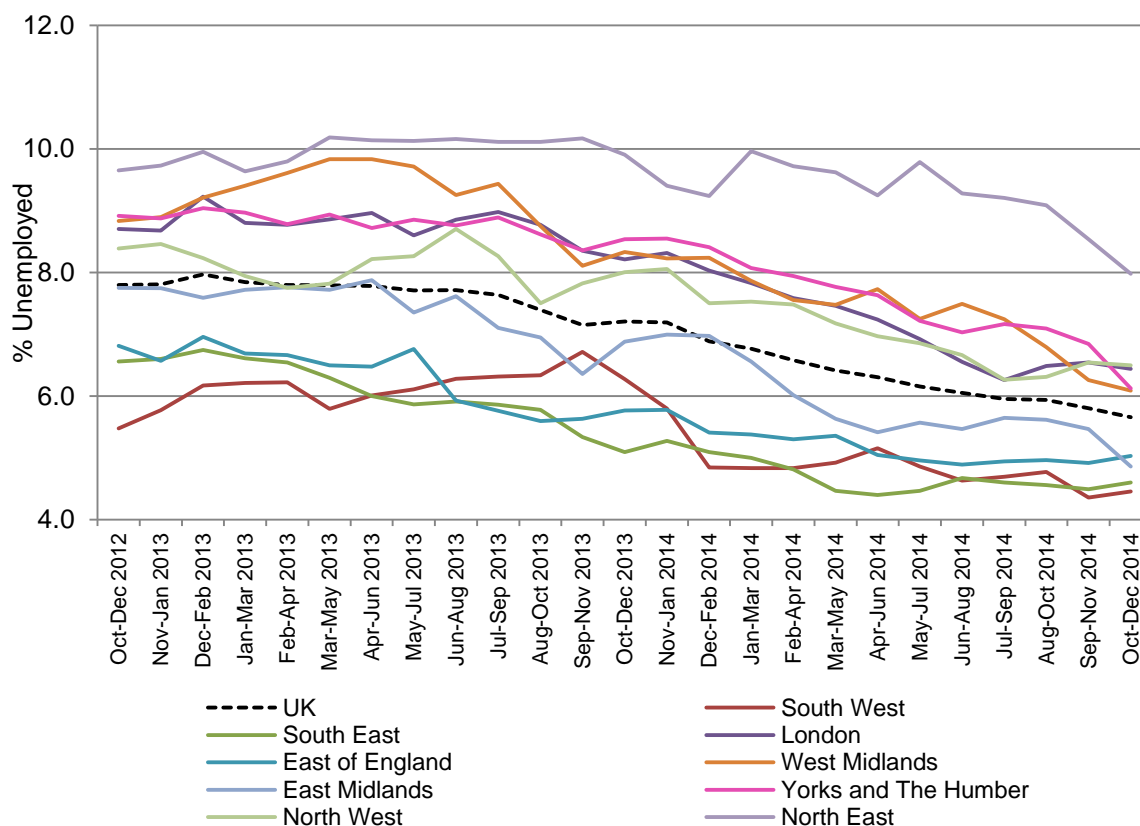
3. Recent trends related to work quality

3.1. Regional inequalities in poor quality work

The North represents 30% of England’s population but has 50% of the poorest neighbourhoods.⁵⁴ Furthermore, poor neighbourhoods in the North tend to have worse health than places with similar levels of poverty in the rest of England. This north-south divide means the UK now has the largest difference in economic output between regions of any country in Europe.⁵⁴

The UK’s GDP overtook its pre-recession peak in the third quarter of 2013 but growth has been concentrated in the South.⁵⁵ Across the three most prosperous regions – London, the South East, and the East – 1.2 million jobs were created or 70% of the total. London led the way with an increase in employment of just over 700,000 or 15%, followed by the East at just under 8%, and the South East at just under 7%.⁵⁶

Figure 3: Regional differences in unemployment in the UK, 2012-2014⁵⁷



In contrast, across the three regions of north England – the North East, the North West, and Yorkshire and Humberside – total job creation was just 145,000 or just

over 2% of the total. Nine of the 10 best cities to find a job were in the South of England, while eight of the worst were in the North.⁵⁸ There were some contrasts – the North West demonstrated a performance growth of nearly 5%, Yorkshire and Humberside grew by a modest 2%, but in the North East employment decreased by just over 5%.⁵⁶ This trend is illustrated in Figure 3. The data highlights the need to focus efforts on creating good quality across regions of England, particularly in the north of England.

Regional equity goes beyond the number of jobs: it includes skills and pay. In the North a lower proportion of the population is qualified to degree level or above (NVQ level 4) compared with the rest of the UK.⁵⁹ The northern city-regions generally have a higher proportion of people with their highest qualification at other levels – level 1, 2, 3 and skilled trade apprenticeships.⁵⁹ This reflects the nature of the northern labour market, where employment in sectors including manufacturing and occupations that require intermediate and lower skills is more prevalent than in other parts of the country.⁵⁹

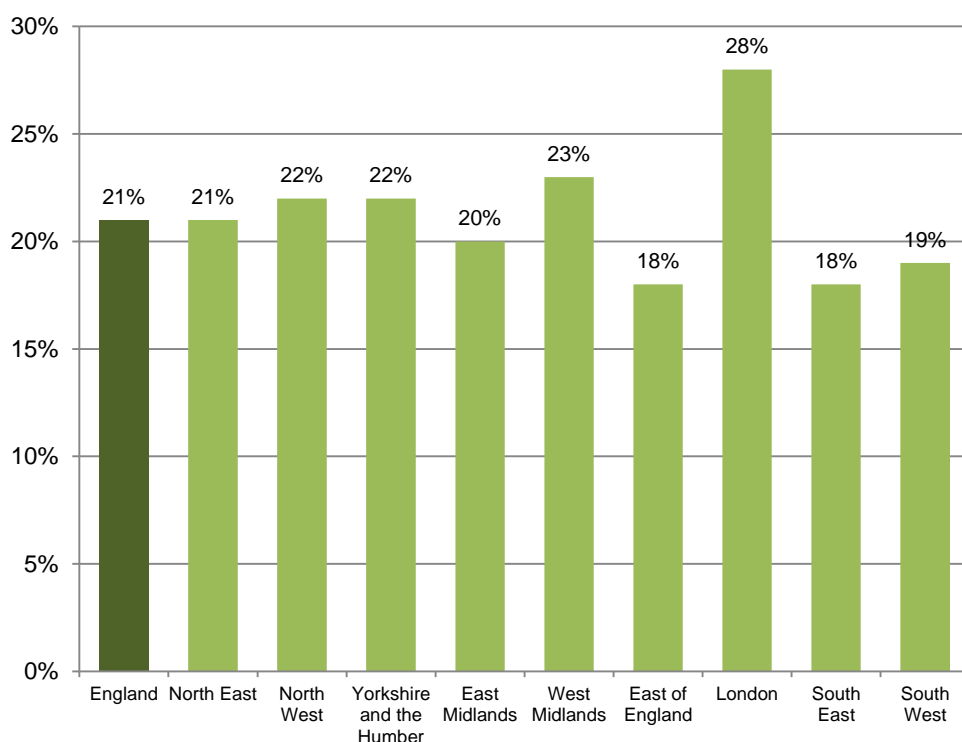
The North faces distinctive skills challenges on both the supply and demand side. On the demand side, few northern employers are working towards improving the regional skills base.⁵⁹ On the supply side, a smaller proportion of the northern workforce has a degree and a larger proportion has no qualifications. In some areas this results in a vicious circle of low skills and low productivity termed the low-skills equilibrium.⁵⁹

However, while the northern regions typically perform worse in terms of skills and jobs, other factors such as housing make the relationship between regional, work and health inequalities more nuanced. Figure 4 illustrates the regional differences in the proportion of households earning below average income across England after housing costs are considered.

While this clearly shows northern regions typically perform worse than average it also illustrates that London households fare the worst. This is probably explained by the higher cost of living in London. The West Midlands also performs worse than northern regions.

This section illustrates that lower skilled, lower paid work is disproportionately concentrated in the northern regions, reinforcing existing inequalities. Local authorities therefore have the opportunity to tackle health inequalities through attracting more skilled work and developing skills in the North: in encouraging a high-skilled economy there.

Figure 4. Households below average income after housing costs⁶⁰



In addition, local authorities in the North should make efforts to improve the quality of this low-skilled work to mitigate against the negative impacts associated with it. A new wave of high-quality, low-skilled work is needed. Strategies of this nature could help to decrease the wage gap and tackle the wide-ranging problems created by the north–south divide.

3.2. Pay distribution in a knowledge- and service-based economy

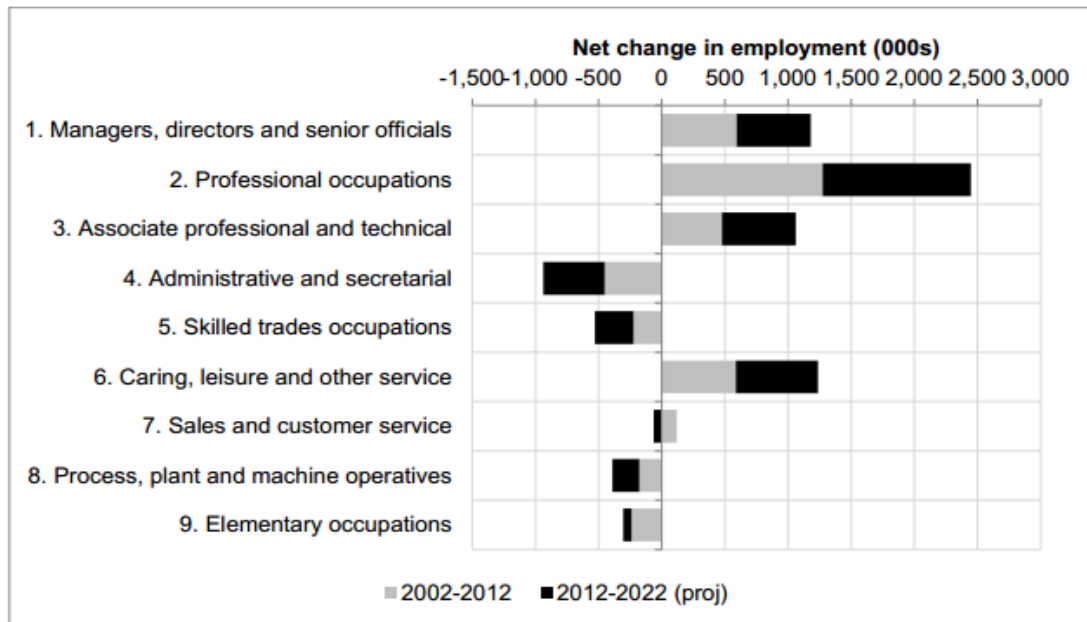
There is evidence of job polarisation, with increases in employment share at the top and bottom of the job spectrum according to their initial wage, with lost employment share (and actual numbers of jobs) over time in the middle of the distribution.⁶¹

Job creation figures for the UK showed that from 2002–2012:⁶²

- 2.3 million higher-skilled jobs were created “at the top”
- 2 million jobs were created “at the bottom”
- 1.2 million jobs were lost “from the middle”

Figure 5 gives a more detailed breakdown of where jobs have been created and lost. It shows that jobs have been created in the managerial and professional occupations (high-skilled) and the caring, leisure and other service occupations (low-skilled). However, they have been lost in skilled trades and administrative positions (medium-skilled).

Figure 5. Net change in employment⁶²



In the UK there is evidence of high polarisation in terms of the distribution of jobs by education requirements – there are many jobs with low educational requirements (primary education or less) and many with high educational requirements (tertiary education or more).⁶³ 22.7% of jobs in the UK require only primary education or less, whereas 33% of jobs in the UK require tertiary education or more. Only Spain has higher polarisation (25% primary, 37% tertiary). By contrast, Austria, Italy, the Czech Republic and the Slovak Republic have more jobs characterised by medium-level educational requirements.⁶³

In addition it has been found that it is more difficult to progress from low-paid work in the private sector than in the public or third sectors. Particularly, hospitality or sales roles are negatively linked to progressing from low-paid positions (although tips or commissions can bolster pay in these industries).⁶⁴

Working for a large employer (1,000 or more employees) is positively associated with moving out of low pay – most probably because they are often higher paying and have more senior positions to which staff can progress. Low-paying industries often have a higher proportion of employees “stuck” at a certain level, although some low-paying sectors are associated with better than average rates of employees progressing to higher-paid positions.⁶⁴

Linked with these trends there is regional variation in pay progression across England. People progressing from low paid jobs, are more likely to live in London and the east of England and less likely to live in the North East or the West Midlands.⁶⁴

Those working in healthcare are more likely to progress from low pay than workers in other sectors. For example, 41% of those working in public hospitals and 38% of those working in medical practice activities progress from low incomes. Initiatives such as the NHS Skills Escalator, which aims to promote progression among healthcare staff, may have contributed to these rates.⁶⁴

Conversely, many sectors have low levels of low pay progression. The hospitality sector is particularly poor for low pay progression, with just 11% of catering staff, 12% of workers in independent pubs, or takeaways, 13% of workers in licensed restaurants, and 14% of workers in hotels, progressing from low pay. In addition just 17% of social workers progress from low pay.⁶⁴ (For the full list, see Figure 12, Appendix 2).

4. Promoting health-protective work

The previous sections described those industries and aspects of work that are bad for health and their prevalence. There are therefore two avenues to consider for health enabling economic regeneration: the type and nature of the industry and the quality of the jobs within that industry.

Creating a strategy to avoid industries or sectors with poor health outcomes is largely unrealistic and potentially damaging. For example, it cannot be recommended that places avoid having healthcare jobs because of the risk of those staff developing musculoskeletal disorders, or that there are no process, plant and machine operatives because they have five times the national injury rate. We need healthcare and a manufacturing industry. However where those industries do exist, public health professionals should do all they can to help companies and their employees reduce the risks, through strong adherence to health and safety recommendations and healthy workplace initiatives.

The second avenue is to encourage the expansion of “good jobs” within those industries or sectors. As the previous section highlighted, there is a social gradient such that those who are in higher managerial professions have better health outcomes than those who are in less skilled positions. Some of the pathways by which such a gradient could exist have been highlighted: through insecurity, low pay and lack of control, for example. A key part of the work of health professionals therefore could be to highlight the aspects of good work – defined below – to those who are involved in making decisions regarding economic regeneration for growth.

4.1. Defining good work

Definitions of “good work”

There is no universally accepted definition of what constitutes good work. However, the different definitions available all share common features. Definitions of good work often perceive it to be something that both sustains the worker financially, providing security, but also enriches the worker’s life through a good work-life balance and promoting good physical and mental health.^{65 66 67} The Marmot Review summarised the features of good work, as illustrated in box C.¹

Box C. Features of good work¹

1. Free of core features of precariousness, such as lack of stability and high risk of job loss, lack of safety measures (exposure to toxic substances, elevated risks of accidents, and the absence of minimal standards of employment protection).
2. Enables the working person to exert some control through participatory decision-making on matters such as the place and the timing of work and the tasks to be accomplished.
3. Places appropriately high demands on the working person, both in terms of quantity and quality, without overtaxing their resources and capabilities and without doing harm to their physical and mental health.
4. Provides fair employment in terms of earnings reflecting productivity and in terms of employers' commitment towards guaranteeing job security.
5. Offers opportunities for skills training, learning and promotion prospects within a life course perspective, sustaining health and work ability and stimulating the growth of an individual's capabilities.
6. Prevents social isolation and any form of discrimination and violence.
7. Enables workers to share relevant information within the organisation, to participate in organisational decision-making and collective bargaining and to guarantee procedural justice in case of conflicts.
8. Aims at reconciling work and extra-work/family demands in ways that reduce the cumulative burden of multiple social roles.
9. Attempts to reintegrate sick and disabled people into full employment wherever possible.
10. Contributes to workers' wellbeing by meeting the basic psychological needs of self-efficacy, self-esteem, sense of belonging and meaningfulness.

These different definitions share the same broad theme: work ought not only to be free of health-adverse effects but it should also be beneficial to the worker, providing opportunities to improve health.

A previous IHE report, *Increasing employment opportunities and improving workplace health*,⁸ looked at interventions to improve workplace health. These interventions could be looked at with longitudinal studies to determine their long-term effects, and how they impact on health inequalities. Monitoring of this type would allow policy-makers to know when and where to intervene to tackle health inequalities.

4.3. Further information to help identify good quality jobs

One approach to promoting economic regeneration for health is to promote industries that already have a good reputation for good work. This section examines available data on good quality work, as well as the limitations of this information. The

data sources available for examining the quality of work come from the Office for National Statistics (ONS), the Health and Safety Executive (HSE), and the European Foundation for the Improvement of Living and Working Conditions (Eurofound).¹

a. Industry and occupations

In Section 2, data was presented to illustrate those jobs that are particularly bad for health and in some cases this was broken down by the nature of health condition. This data can be helpful to identify the worst offending jobs and to mitigate against the harmful outcomes they may cause. The ONS and HSE have limited information on elements of good work for specific industries and roles; their data collection focuses more on adverse conditions. However, Eurofound does provide information in this area. The data is limited in that it represents the EU as a whole and does not take into account how an industry or role might have different qualities in different countries. Table 2 compares Eurofound data on perceptions about job characteristics for managers and elementary workers and illustrates that managers are more likely to perceive that their job is characterised with features of good quality work, such as control over work, than those in elementary occupations – though clearly this is not universally the case. Figures a1–a16 in Appendix 3 illustrates the full Eurofound data gathered on different elements of job quality by sector and profession.

Table 2: Managers versus elementary workers: perceptions about job²⁷

Element of good work	Managers	Elementary workers
Might lose job	12.7%	23.8%
Wellbeing at risk	17.5%	24.2%
Control over work	79.5%	22.5%
Household very financially secure	44.8%	18.7%

Figures a1–a16 in Appendix 3 add to the evidence of the social gradient of health. Sectors and professions at the top end of the social gradient tend to have multiple elements of good work, whereas sectors and professions at the bottom end tend to have multiple elements of bad work. For example, the financial services sector scores positively in all elements examined, as do managers. Conversely, the agriculture sector and even skilled agricultural workers scored poorly in most measurements (though performed well in job security and having complex tasks).

The data highlights that in every sector and profession, a significant majority of people are satisfied with their working conditions. The agricultural sector has the

¹ Eurofound is a tripartite European Union Agency, whose role is to provide knowledge in the area of social and work-related policies.

highest amount of workers that are not satisfied (27.4%), and the professions with the highest amount of workers that are not satisfied are plant and machine operators, and assemblers (25.9%) followed by elementary occupations (23.9%). However a word of caution – farmers were found to have the *greatest* life satisfaction in the UK.²⁷ Those who call themselves farmers in the UK may of course be a great deal wealthier and have better working conditions than the majority of the agricultural workforce in the EU and this highlights the risks associated with utilising data on broad sectors from Europe.

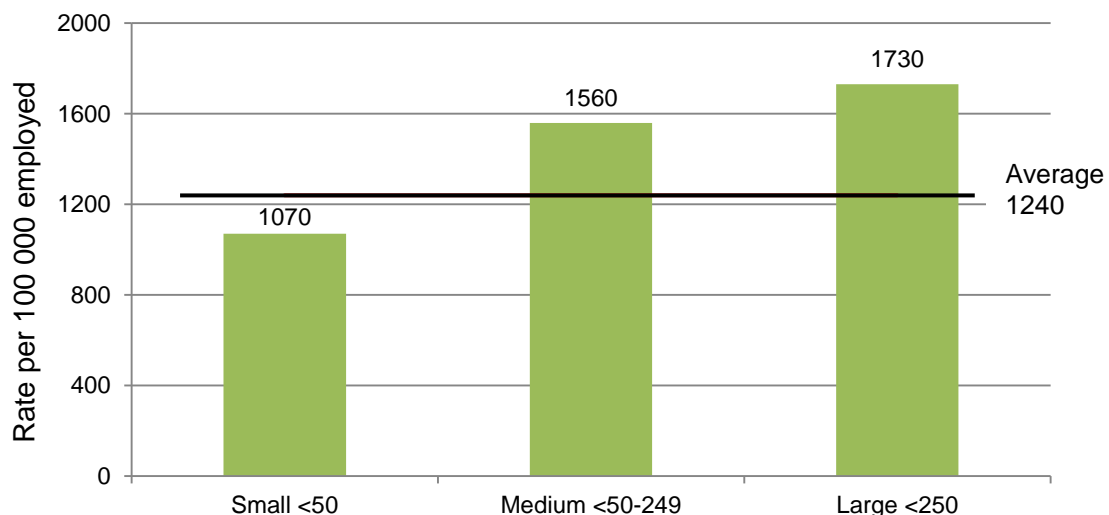
b. Workplace size

Size of firm is associated with job quality. Small firms pay lower wages than large ones, and they are also the least likely to have HR departments, to deploy formal employment policies, or to deal with trade unions.⁶⁸ These are dynamics associated with poor quality work.

On the other hand, small firms reveal a paradox of having more bad features than average while also displaying higher levels of job satisfaction and high scores on autonomy, and meeting “employee needs”.⁶⁸ Figure 6 examines the relationship between workplace size and stress (the biggest cause of workplace illness).

Figure 6. Workplace size and stress⁵⁷

Work related stress by workplace size



The link between workplace size and stress suggests that small local initiatives can create good quality jobs with the potential of tackling health inequalities. However, caution needs to be taken, as wages are likely to be lower and protection through employment policies is likely to be less (see above). Furthermore, stress management support in small workplaces is far less prevalent than in medium and

large workplaces,⁶⁹ which could mean that severity of stress is worse in small workplaces. There is scope for local authorities to provide support incentives for small businesses to adopt better practices when it comes to formal employment policies.

c. Employment contracts

Section 2 discussed the relationship between contract type and poor health. This relationship can simply be flipped to understand which contract types are more protective of health. This information should discourage local authorities from promoting employers offering temporary and zero-hours jobs to help reduce health inequalities, as these jobs lack elements that are protective of health such as investment in skills training and security.⁷⁰

According to Eurofound data, the sector that best promotes secure work (workers on indefinite contracts) is transport (88.1%), followed closely by financial services (88%).²⁷ The sector with the highest proportion of temporary or agency contracts was agriculture with 16.7%.²⁷ The profession with the highest proportion of indefinite contracts was managers (91.2%),²⁷ and the profession with the highest proportion of temporary or agency contracts was elementary occupations (15.2%). There is a social gradient of work quality, with skill being a factor in contract quality.²⁷ For the full data see figures 14 and 15 in Appendix 2.

d. Productivity and skills

Productivity is also an important factor in job quality. Jobs that can be defined as more productive lead to better health outcomes through higher pay.⁷¹ They are also associated with healthier workplace environments⁴¹, better contract types²⁷ and less health-adverse job roles.²⁷ Jobs that are more productive and profitable are more likely to be valued higher by the employer, which creates an incentive to provide health-protective working conditions to avoid injury and sick leave.⁴¹

The Gross Value Added (GVA) is a measure of the increase in the value of the economy due to the production of goods and services. It is measured at current basic prices, which include the effect of inflation, excluding taxes (less subsidies) on products (for example, Value Added Tax). GVA plus taxes (fewer subsidies) on products is equivalent to Gross Domestic Product (GDP).⁷² Using GVA enables the comparison of the productivity of different jobs, sectors, and regions. As seen in Box D below, the three lowest GVA-rated jobs are in manufacturing.

Box D. Worst five jobs using the Gross Value Added (GVA) productivity rating⁷³

1. Textiles and clothing manufacturing
2. Machinery and equipment manufacturing
3. Coke and petroleum manufacturing
4. Accommodation and food services
5. Real estate activities.

While the economy needs a range of jobs to support society, creating jobs which are more productive, with more highly skilled workers, could be of benefit, as discussed in Section 3 with reference to the north-south skills gap. Where there is a skills deficit, a strategy of increasing the skills base of more deprived regions would increase productivity. However, this would only work where there is a demand for skilled work. Where deprivation and low skills demand coexist, other strategies need to be pursued.

However, productivity doesn't always lead to valued staff with health promoting work conditions for example retail services, which have a high GVA rating, are also associated with poorly paid staff. This suggests that it would be worthwhile to explore ways of increasing the perceived value of staff to employers.

4.5 The limitations of existing data

While the data on poor quality work was substantial, unfortunately this is not the case for good quality work. There is little detailed information on which physical and psychosocial characteristics of work are protective of health across different employment sectors.

Monitoring data plays a key role in supporting and driving action. It is difficult to know if the nature of work is improving if there is no baseline data or monitoring framework. Targets and performance management systems can also help to drive forward improvements. Some national surveys have attempted to measure the quality of work but these have been infrequent. Local authorities could benefit from better quality of information on job quality. Therefore they and central Government should consider the benefits of improving the measurement of job quality. In addition, further national investment into longitudinal work that tracks individuals through workplaces would be beneficial.

Surveys could include good aspects of work such as job satisfaction, whether or not jobs offer training, a good work-life balance and demanding but not overtaxing roles. This information would provide data on which jobs and positions are more likely to provide these health-protective aspects. This would empower policymakers to focus

on job creation schemes that produce better quality work, and are therefore protective of health.

5. Local job creation initiatives to address health inequalities

Public health professionals, now placed within local authorities, have an opportunity to influence wider agendas. In the case of good quality work, they can aim to influence job creation and economic regeneration decisions. This section aims to provide some practical guidelines, based on the evidence and examples of what could be done at a local area level.

Local public health professionals should familiarise themselves with the types of work available to local employees and help local employers to mitigate against health risks and create better work. A summary of the key messages (box E) provides some pointers regarding particular sectors to be aware of and the types of sectors and work that are currently doing well.

Box E. Key messages on distribution of poor and good quality work

Section 2 described the elements of poor quality work, and the sectors of work in which these elements are more common:

- the construction industry has the highest physical injury rate due to physical hazards
- health and social care workers are most susceptible to both stress and musculoskeletal disorders
- long hours (45 hours-plus per week) are most associated within the agricultural sector, and for managers
- shift work is most prevalent for health workers
- stress is most prevalent for welfare and housing professionals, followed by workers in teaching and education
- low-paid work is most associated with retail, waitressing, and residential care
- the worst work for poor stability and security is in elementary occupations and agriculture

For all health-adverse working conditions, a social gradient has been observed, with those at the lower end of the social gradient most affected.

While certain aspects of poor quality work have improved, for example injury rates, others such as low pay and job security, have got worse since the 2008 recession.

Good quality work is less well-monitored than health-adverse work. However, from what we do know:

- managers are the most likely to have permanent or fixed term contracts (96.7%), and the public administration and defence sector are most likely to issue such contracts
- stress was lower in small workplaces; however there are concerns about the resources available to small workplaces to tackle health-adverse conditions.
For example small workplaces are less likely to have HR departments
- there is a relationship between pay and life satisfaction. However, some of the highest scoring employee groups are company secretaries and fitness instructors, illustrating that good work isn't simply about high pay and seniority.
- healthcare workers, particularly in public hospitals and medical practice activities have high rights of progressing from low pay

5.1: How local policy-makers can reduce health inequalities

A typology of actions available to tackle health inequalities generally is shown in Table 3 and applied to tackling stress in the workplace.⁷⁴ Stress is a major consequence of health-adverse work. Table 3 helps locate possible actions for local authorities, and provides examples what has been done before to tackle stress.

Table 3: Typology of actions for reducing health inequalities⁷⁴

Action	Explanation	Application to stress in the workplace
Strengthening individuals	Aimed at strengthening individuals in disadvantaged circumstances, and using person-based agencies. Some build up self-confidence and skills in people, others address the relative powerlessness of the worst-off in society. Examples: health information campaigns, life skills groups, and one-to-one counselling/support.	Person-based approaches, offering counselling and education to increase a person's skill and capacity to cope with the stress produced by the work set-up.
Strengthening communities	Aimed at building social cohesion and mutual support. These interventions either encourage social interactions between members or groups of the same community, or they foster interactions on a society-wide basis, between different groups on the social scale.	Improvements in communication patterns and human relations, providing opportunities for making decisions, joint problem solving with workmates and constructive feedback on how the job is going.
Improving living and working conditions	These initiatives identify the critical cause of observed health inequalities to be greater exposure to health-damaging environments, both at home and at work, with declining social position. Historically improvements in day-to-day living and working conditions and access to services have been important in improving the health of populations. Examples: safer workplaces, better housing, and better access to health and social care.	There are changes in large-scale organisational issues – redesigning production processes and management strategies that influence the tasks individuals are asked to do.
Promoting Healthy macro-policies	This perspective first identifies the causes of health inequalities in the overarching macroeconomic, cultural and environmental conditions that influence the standard of living. Promoting healthy macro-policies entails looking at which policies reduce poverty. Following such policies subsequently reduces health inequalities. These policies tend to span several areas and work across the population as a whole, unlike some of those in the other categories.	There are entry points for interventions to influence the outside pressures imposed on workplace organisations. Market conditions and rules about competition, national labour relations programmes which influence employment rates, job security, wages, and national levels of unemployment and so on potentially have a huge impact on the psychosocial stress experienced in individual workplaces, even though these macro-policies are outside one organisation's control.

The previous sections have explored how work affects health, and which jobs and industries are most protective and most adverse to health. This information can be used by public health practitioners to mitigate against risks and encourage the creation of good work. Box F summarises what to focus on when aiming for good quality jobs is provided, based on the evidence.²⁰

Box F. Key elements for good work

- permanent contracts
- a minimum income standard to live a healthy life – for example, a living wage
- variation in tasks and roles and some autonomy in *how* to accomplish them
- avoidance of shift work/a reduction in the risks associated with shift work
- effective health and safety procedures
- effective management to avoid stress

Ensuring jobs have these key elements was the subject of IHE's previous report *Increasing employment opportunities and improving workplace health*,⁸ which examined interventions that improve these key elements for health and workers' resilience to adverse conditions. This practice resource builds on that work, but is focused on the attraction of new jobs with the key elements described above.

5.2. Strategies to improve skills

Skills have been described as, “the foundation for growth and prosperity”.⁷⁵ One strategy to encourage the growth of good quality jobs – those providing key elements for protecting health – is to encourage skilled jobs. Creation of skilled jobs relies on a range of factors, some of which (such as the condition of the global economy) are far beyond the reach of local partnerships. However, local partners can influence the skills base and matching between education, training and employment opportunities.

A better skills base could encourage better quality jobs, and therefore help reduce health inequalities. Policymakers should note that a better skills base cannot grow jobs alone, there are other macro-economic factors at work behind job creation. Still, developing skills is a necessary part. An OECD report provided recommendations for building local skills, shown in box G.⁷⁶

Box G. Designing local skills strategies – OECD recommendations for building local skills⁷⁶

1. Access to relevant information and data

Local actors – including the Jobcentre Plus, LEPs and health and wellbeing boards – need to develop evidence-based skills strategies from an understanding of the skills, supply and demand in a local labour force (sometimes referred to as the local “skills ecology”). One role is collecting data on skills demand and skills supply from the Labour Force Survey to ensure that training is being well targeted to local business needs. Jobcentre Plus currently helps identify skills demand by matching people with jobs, as well as recommending training programmes to help unemployed workers adapt to the local economy.

The partnerships defining the local skills supply and demand should include higher education institutions and work programmes such as Jobcentre Plus.⁷⁷ Jobcentre Plus is seen to be particularly effective, with 83% of employers reporting themselves satisfied with its services⁷⁸. Jobcentre Plus has also recently been praised by the National Audit Office for coping well with increasing numbers of claimants.⁷⁸

2. Look to the future and anticipate change

Localities should strike the right balance between attracting talent, integrating disadvantaged groups into the workforce development system and upgrading the skills of the low qualified. Developing a strong skills strategy may require providing incentives for local actors to work towards longer-term objectives and investment in sustainable growth of worker productivity.

3. Better mapping of skills provision

Joining up disparate education and training systems locally is crucial to helping people to build on their learning over time while in and out of employment. In New York, “career ladders” have proved a very good way of linking education and training provision into a coherent system in certain sectors, to provide workers with career and pay progression, so that people can, for example, see how a basic course in retail can ultimately lead to a management position in a local department store.

4. Building strong relationships with employers

The success of local skills strategies depends on the ability of local actors to foresee future growth and skills demands. Skills strategies need to be subject to regular review and adjustment as economies and industries evolve. In particular, localities need to develop “flexible specialisation”, building on specific local strengths and comparative advantage but adapting to new forms of market demand that emerge.

The report gives insight into what local authorities need to do to help improve their region's skills base. These recommendations illustrate the importance of information on current skills and future skills demands – information that will empower local authorities to plan where to promote job growth, in such a way that it will reflect their resources.

As well as appreciating which jobs are more and less protective of health – the subject of this resource – it is equally important for local authorities to examine their existing skills base and how these skills can be transformed into ones that bring jobs with more health-protective elements.

This practice resource has given attention to the north-south divide. The North suffers from worse health, and has a lower-level skills base than the southern regions. It has been estimated that the North needs half a million *skilled* jobs created to reduce the gap⁵⁹ – the case for this being reinforced by the existence of in-work poverty. Only a northern regeneration strategy based on the creation of good quality jobs can effectively reduce health inequalities.

Initiative: Michigan skills strategy⁵⁹

The Michigan strategy identified five key sectors in which future jobs and wages growth was possible, based on a wider economic strategy and labour market intelligence. This led to the formation of employer-led cluster partnerships, bringing together employers, training providers and state bodies to:

- identify industry skills shortages and long-term skills challenges
- work with training providers and welfare-to-work providers to fill these gaps
- develop career progression pathways so people can improve their earnings, opening up entry-level opportunities for new entrants
- stimulate employer demand for skills

Noteworthy lessons from this case study include:

- the important role played by dedicated and skilled intermediaries in facilitating and sustaining collaboration
- the start-up funding of around US \$100,000 (which was intended to be self-sustaining) needed to be supplemented on an on-going basis from grants and donations from charitable foundations and through further attraction of mainstream workforce development resources available from the state government

Internationally, strategies have been successfully employed to increase the skill level in areas described as having a skills deficit, such as Michigan in the United States.⁵⁹ The Michigan skills strategy suggests that the key step that needs to be taken is to identify skills and work in partnership with local employers:

The Sheffield City Deal Initiative gives an example of an initiative in England designed to increase skills and wages.

Initiative: Sheffield City Deal, 2015–2021⁷⁹

The City Deal secured £4m in skills funding from central government, with a further £23.8m of adult skills and apprenticeships budgets channelled from central government departments. Local co-funding includes £6m to £12m of local authority funding and a minimum of £37.5m of employer investment.

The City Deal has four main strands:

- skills for growth: including upskilling existing employees and creating apprenticeships
- financial tools for growth: establishing a regional investment fund which pools funding streams
- transport: increasing connectivity and bringing forward investment in key projects
- advanced manufacturing and procurement: developing a national centre for procurement in advanced manufacturing and nuclear research

The skills package agreed under the City Deal has two main strands to be achieved over a three-year period:

- to create an additional 4,000 apprenticeships, through an Apprenticeship Training Agency and Group Training Associations, to support small and medium-sized enterprises (SMEs) that are unable to meet the cost or risk of employing apprentices full time; using public procurement to maximise apprenticeship creation; and supporting young people who are not in education, employment or training (NEET) into apprenticeships
- to train 2,000 current employees with the skills needed by businesses locally, with employers shaping skills provision; financial incentives for providers to deliver training to meet employer demand; and developing bespoke commissions to meet the needs of local employers

As this work is on-going, an evaluation of this initiative is not available.

The key obstacle for the Sheffield City Deal was the demand for skills.⁷⁹

Policymakers need to recognise that improving supply of skills; while a necessary step, will not ensure that the overall quality of work improves. Effort needs to be given to encouraging skills demand on the employer side.

Increasing skills in deprived regions has the potential to increase productivity, pay, and the amount of good work. These benefits will make work more protective of

health, therefore tackling health inequalities through creating good quality work. Policymakers ought to look to similar examples when formulating their own jobs growth and skills strategies.

5.3. Local authorities and job creation

Key policies available to local authorities for job creation include LEPs and Enterprise Zones (EZs). Central Government policy supports these schemes and they have been further supported by Growth Deals, which provide further funding.⁸⁰

LEPs are partnerships between local authorities and businesses. They decide what the priorities should be for investment in roads, buildings and facilities in an area. So far, 39 have been created. LEPs can apply to have an Enterprise Zone, which is a geographical area within LEP boundaries that offers a range of incentives to encourage businesses to start up or expand there, such as tax incentives and simplified local planning regulations. All business rates growth generated within an Enterprise Zone will, for at least 25 years, be kept and used by the relevant LEP and local authorities to reinvest in local economic growth.

Box F. The Government's vision for Local Enterprise Partnerships⁷⁷

- articulate a clear long-term strategy for enterprise growth based on a realistic appraisal of the area's strengths and opportunities
- identify existing barriers to business growth, for example, in terms of land-use planning, infrastructure (in the broadest sense), skills/labour market, and the actions required to remove them
- gain buy-in from all sides to a small number of objectives and outcomes that can survive institutional/political changes over the long run, not least because the financing mechanisms used will likely pitch short-term risk against long-term gain
- "sell" the area by taking responsibility for bids for central government funding (for example, the Regional Growth Fund), leveraging private investment capital and influencing local funding streams (such as the Community Infrastructure Levy and retained business rates) and ensuring these deliver against locally-agreed priorities, without necessarily being the direct budget holders
- focus on improving the local business environment through strategic planning, transport networks, and matching training offers to labour market needs.

Within LEPs, funding from housing, infrastructure and other streams can be pooled and given directly to local authorities and businesses to spend. Projects beginning in 2015 to 2016 are expected to be matched by local investment worth around twice the contribution from central government. Across the country LEPs are expected to lead work on more than 150 roads, 150 housing developments and 20 train stations, as well as:

- providing small business support services in every part of England and significant investment in skills training
- working to improve educational attainment
- getting more people from welfare to work.

Not only do LEPs create business incentives, but they also give local authorities the opportunity to influence the type of industry and jobs created. This element of LEPs is of particular interest as it could enable a health inequalities focus on job creation. LEPs give local authorities the opportunity to implement job creation strategies and choose what type of jobs they promote. A local authority has the potential to focus a LEP on reducing health inequality through focusing on creating good quality work. Below is an example of the LEP for Humber – and its effect on health inequalities is examined, to better understand how job creation can tackle health inequalities.

Initiative: Humber Enterprise Zone Skills Plan and Local Enterprise Partnership

The 2014 Marmot indicators showed that there are relatively poorer health outcomes in the city of Hull than the England average across all indicators. The Marmot indicators are a set of indicators released annually for each local authority on the social determinants of health, health outcomes and social inequality, broadly corresponding to the policy recommendations proposed in Fair Society, Healthy Lives. Table 4 shows outcomes in Hull on two key indicators – life expectancy and healthy life expectancy.

Table 4. 2014 Marmot indicators for Hull⁸¹

	Males		Females	
	Hull	England	Hull	England
Life expectancy	76.6	79.2	80.5	83.0
Healthy life expectancy	57.8	63.4	56.5	64.1

Note: Figures for 2010–12.

Further, Hull has an unemployment rate of 13.9% compared with 7.4% in England as a whole and is the worst performing local authority in England for long-term unemployment, with 32.6 per 1,000 long-term unemployed compared with 9.9 per 1,000 for England as a whole. Finally, Hull's rate of work-related illness in 2011-12 was 3,900 per 100,000, higher than England's 3,640.⁸¹

The Humber Enterprise Zone job creation scheme could inform initiatives for creating good quality jobs to reduce health inequalities by improving the quantity of good quality work in the region. For more information see box below:

Initiative: Jobs in the Humber Local Enterprise Partnership^{82 83}

The Hull Enterprise Zone aims to develop a renewable energy super cluster specifically as a hub for the offshore wind energy sector. This project is expected to create 3,500–8,500 new jobs by 2023 in:

- manufacturing, components assembly, and pre-installation of wind turbines. These require engineering skills at NVQ level 3
- vessel-related activity such as stevedoring (manual work involving loading and unloading of ships)
- jobs related to wind farm maintenance including electrical and mechanical technicians. Maintenance will continue for a period of at least 25 years, encouraging long-term jobs
- onshore construction jobs including: general labourers, scaffolders, bricklayers and electrical, plumbing and heating trades
- jobs in the supply chain such as construction and logistics of wind turbine development
- potential for other jobs in the service sector

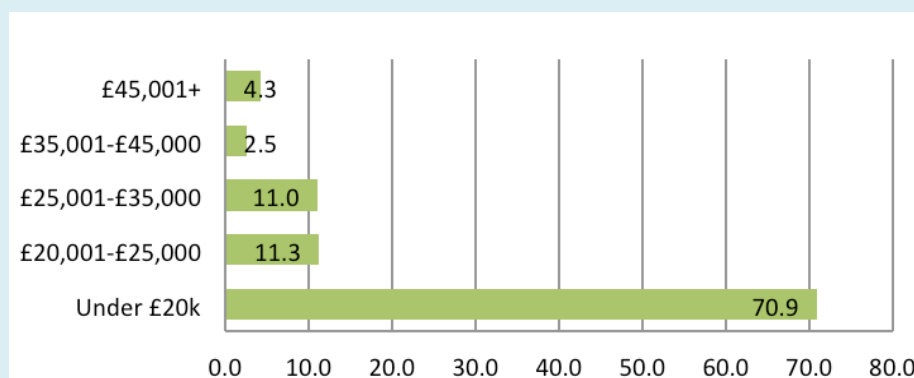
The Humber LEP estimates that many of these jobs could be filled by currently unemployed people as initially these jobs are at the lower end of skill level (see Figure 7 below). However over time the aim is increase the number of people with qualifications in the region aligned to the local economy needs, leading to growth in higher-level skills work.

The achievements as of the 2013–14 review are:

- 1,200-plus jobs created
- £1.5m UK government skills training funding received
- £3.7m EU skills training funding received.

The graph below illustrates the distribution of jobs by pay bands, as at January 2015.

New jobs by pay band (%)⁸⁴



The graph shows that the vast majority of the jobs sit in the lowest pay grade. While at first glance this information implies the Humber LEP is creating poor quality jobs, this information does not show prospects for progression. As such, it is difficult to say how this strategy will impact on health inequalities. This emphasises the need to monitor job creation to ensure that the impact on equity can be assessed.

The job creation by Humber LEP is a positive development in tackling the region's problems in unemployment. The new jobs will help reduce the region's high unemployment levels and the alignment with skills development to fit the local needs will make these jobs more likely to be better paid, reducing the problem of in-work poverty. This has the potential to bring more health-protective elements and tackle regional health inequalities. It is important to note that construction jobs are likely to come with adverse health conditions, although more protective than some occupations (e.g. agriculture and elementary occupations). While job creation schemes should match the skill base in the region, efforts should be made that these jobs are offset with health protective elements. The sector, industry and jobs an LEP creates will affect health inequalities in that region and should be taken into consideration. Overall, the Humber LEP and Enterprise Zone are likely to help reduce health inequalities through job creation. Further efforts should be taken to maximise this opportunity, such as ensuring that as many jobs as possible are high skilled, secure, and with stress avoiding conditions such as autonomy.

5.4. European Social Fund

The European Social Fund (ESF) gives support to employment programmes across the EU. In the UK one of the main focus regions of the ESF has been Cornwall, an economically deprived area.

Initiative: European Social Fund – Cornwall, 2007–13^{85 86}

The ESF in Cornwall aimed to contribute to sustainable economic growth and social inclusion by extending employment opportunities and by developing a skilled and adaptable workforce. The programme had two broad objectives:

- to increase employment by providing training and support to unemployed and disadvantaged groups
- to provide targeted support to build a better and more competitive workforce.

It also has two crosscutting themes: gender equality and equal opportunities; and sustainable development.

The funding was allocated as follows:

- tackling worklessness by reducing or removing the barriers to employment (€75m)
- improving local workforce skills (€118m)

The project worked with local employers, further education facilities and local trade unions to improve the skills base and competitiveness of the county.

A survey was conducted to help determine the effectiveness of the initiative. It asked employees and employers if they had found an improvement in a number of areas, including skills. Analysis of their responses is given below.

Survey responses on benefits of the scheme reported by employees and employers⁸⁶

	Employee	Employer
Improved participant skills	89% agreed	94% agreed
Increased job satisfaction	56% agreed	-
Increased interest in job	58% agreed	-
Increased productivity	-	57% agreed

The evaluation found that as well as increasing skills in the region, the project was successful in getting the long-term unemployed into work (shown below – figures for 2013).

Long-term employment targets

	Target	Achieved	% of target achieved
Total no. receiving self-employment help	2,080	2,400	119.2
Total no. achieving qualifications	30,520	32,675	107.1
No. of beneficiaries into employment	8,690	8,029	92.39

More research on the long-term impacts of this project is needed to understand whether or not the increased skills base increased the number of good quality jobs and reduced the number of poor quality jobs.

The Cornwall European Social Fund example illustrates the success that can result from service provision. The immediate project goals of increasing skills were met and

in some cases exceeded. There also appear to be benefits to quality of work already being felt: 56% of employees reached by the scheme noted increased job satisfaction. The long-term effects of this initiative need to be closely monitored to determine how increasing the region's skills base has effected overall economic performance and health inequalities. Positive elements should be copied by local authorities, particularly in deprived Northern regions.

5.5. Other example of initiatives

Other examples of initiatives to help tackle health inequalities through job promotion exist. These schemes, as with LEPs and the ESF, do not specifically look to tackle health inequalities; however, they have elements within their strategies that promote health-protective conditions. It is important for policy-makers to observe when strategies have had the knock-on effect of helping to tackle health inequalities. Such observations can help inform future strategies.

Initiative: YTKO's Outset programme⁸⁷

Outset is a social enterprise delivering start-up support services (run by YTKO Group, a private sector business based in Cambridge). It aims to promote social and economic inclusion through the creation of new enterprises across the UK. The service offers enterprise coaching, personal development and business start-up training to help unemployed and disadvantaged people from a range of backgrounds to become economically active through self-employment.

The Outset programme has seen multiple benefits. On the one hand it has seen measurable outputs – more jobs created, more and better businesses built, and quantifiable increases in GVA (Gross Value Added, a measure of productivity). An independent review estimated that the Social Return On Investment (SROI) (which evaluates all impacts made by a programme, including those that are often considered intangible or hard to measure, like client wellbeing and quality of life) to be over £38.5m of value created throughout the South West.

Evidence of success and impact includes:

- 4,009 businesses created
- 4,436 jobs created
- 20,727 people helped, of which
 - 2% were ex-offenders
 - 14% had a physical or mental illness
 - 14% were lone parent or carers
 - 47% had no or entry level qualification
 - 74% were unemployed.

The YTKO's Outset programme is a good example of an active labour market programme. These seek to provide people who are at risk of unemployment (those with physical or mental illnesses) with employment. They are useful for tackling health inequalities as they aim to support those most at risk of health-adverse conditions. This particular example has created new jobs, not simply provided existing jobs to those at risk.

Initiative: Leeds local authority and Joseph Rowntree Foundation – More Jobs, Better Jobs⁸⁸

The More Jobs, Better Jobs partnership between the Joseph Rowntree Foundation (JRF) and Leeds city region is an example of a partnerships between local authorities and organisations dedicated to tackling poverty. The concern driving the project is that economic growth does not necessarily result in everyone being better off. The JRF-Leeds partnership aims to understand the issue of unequal growth and what can be done to change this. JRF will commission and manage practical research to shape policy and services in the Leeds area⁸⁸ and the initiative will bring together local employers, local authorities and local and regional politicians and other leaders to design and deliver new policy initiatives and approaches with the aim that “growth is felt by everyone in the region”. JRF supports the city’s agenda, which aims to develop skills that lead to greater access to jobs. This partnership aims to influence the national agenda on skills and create more and better jobs. Although in an early stage, the strategy is an example of the type of approach that might help reduce health inequalities. It also illustrates the possibilities for bringing in outside organisations with expertise local authorities might not have, to help devise job creation strategies.

Strategies that explicitly worked to reduce health inequalities through job creation could not be found by this research. However, it has been possible to identify job creation strategies that could help to reduce health inequalities. The examples of initiatives in this section give insight into what a job creation strategy to tackle health inequalities could look like. It would be helpful to monitor these examples in the future, following up to determine whether or not they have impacted on health inequalities. The following box summarises some of the key points from the examples above that could be beneficial for reducing inequalities.

Box G. Features of a job creation strategy to help reduce health inequalities

A successful strategy should:

- work collaboratively with central and local government; secure funding for skills mapping and skills development
- build links between relevant actors, specifically: employers, employees groups, universities and other further education establishments, and groups committed to tackling poverty and social exclusion
- prioritise the creation of jobs that have health-protective elements – skilled jobs and those with access to training and progression – which in turn will bring more health-protective elements including better pay
- use active labour market policies to help those most at risk from health-adverse conditions (those at the lower end of the social gradient) to attain work that protects their health

6. What else needs to be done?

Creating good quality, skilled jobs is an important way of reducing health inequalities. However, not all jobs can be good quality. Job creation is inevitably going to bring jobs of varying quality, some of which will contain some health-adverse features.

Public health officials should take into consideration that increasing skills bases and encouraging growth of skilled jobs is not a magic bullet for reducing health inequalities. As mentioned earlier, creating good quality work is within the scope of macro-economic policy. Therefore some of the factors determining the range of quality of work are far beyond the control of public health officials.

Reducing health inequalities rooted in the workplace requires that actions have to be taken beyond upskilling a workforce. Where low-skill work persists, working with companies to ensure that pay, safety, contracts and progression measures are in place will help to promote good quality job.

These strategies were looked at in the previous IHE report that this practice resource builds on 'Increasing employment opportunities and improving workplace health which provides more detail on workplace interventions'.⁸

6.1 The health sector: leading by example

Section 2 showed that health sector workers are particularly prone to multiple health-adverse working conditions, including: musculoskeletal disorders, low pay and shift work. Given the UK's ageing population and an increase in the demand for healthcare services, it is likely that the number of jobs in the healthcare sector could continue to expand. The health sector is already the largest employers in the UK, employing 3,858,300 people⁸⁹ Healthcare services are increasingly being provided outside normal working hours and there will be a movement to more shift work, so there is a need to ensure that new jobs created in the health sector are themselves health-promoting.

This entails the health sector taking action against the main causes of poor health in the workplace, including shift work, stress and musculoskeletal disorders, as well as paying the living wage at minimum and providing opportunities for promotion. By setting an example, the health sector can encourage other employers, particularly those that are expanding, to reduce the health risks of their employees.

There are already effective resources available for tackling specific health-adverse conditions at the workplace. The HSE produces guidance and information on health

at work, for both employers and employees. Managers of health services should utilise these resources to ensure that existing and new work is of good quality.

Boxes H-K in Appendix 1 give a brief overview of actions available for employers to help manage the specific health-adverse aspects of work, as well as links to further information. However, the effects of poor quality work are felt beyond these specific health conditions. Improved management of the elements of poor quality work is important but efforts need to go beyond this to give employees autonomy over what impacts their health. The Trades Union Congress (TUC) Healthy Workplaces Project did this well.

Initiative: TUC Healthy Workplaces Project⁹⁰

The TUC northern region ran a Healthy Workplaces Project as a way of using the workplace to involve employees in health improvement activities. It was a partnership between employers, unions and the NHS. Employee-led health initiatives were conducted at the workplace and subsequently audited. Depending on the success of the scheme, workplaces were awarded a gold, silver or bronze award.

- 200 employers were involved
- 40% of employers reported a fall in sickness and absence as a result of the project
- 70% of employers and 90% of employees felt the workplace was a better place to work
- 50% of employers and employees felt relationships between management and staff had improved

Successful examples of interventions to improve workplace health such as the TUC's should be more widely implemented. The role of public health officials is to help encourage businesses to adopt similar strategies. Given the benefit to businesses through reduced sickness and absence and improved relationships between management and staff, there is a clear argument for implementing such schemes. A further incentive is that they would reduce the burden on the NHS.

7. Conclusion

The UK's economic recovery is creating new jobs but many of these are of poor quality. As technology replaces middle-ranking jobs involving routine tasks, for example in production and administration, job creation is being redistributed to the extremes of the skill and wage spectrum especially towards the lower-skilled end with growing wage inequality. Most of the low-level jobs being created have been in social care, leisure and retail – the sectors most associated with low pay and a lack of guaranteed hours, training and job security. There has also been a fall in the amount of progression from entry-level jobs over time, with difficulty in escaping low-paid positions in hospitality and sales roles. Millions of people are thus finding themselves trapped in poor quality jobs, or cycling between poor quality jobs and unemployment, and are consequently struggling to pay their rent or mortgage, heat their homes and afford a healthy lifestyle.

Increasing the quantity of jobs in England without consideration of the quality of these jobs may therefore exacerbate social inequalities and disrupt economic growth.

This practice resource has identified the common aspects of both good and poor quality work. It has also highlighted how different features of work are strongly associated with each other. Part-time work, for instance, is negatively associated with moving out of low-paid positions. Where possible, the job types and sectors where the features of good and poor quality work are more common have been identified. For example, working for a large employer or in healthcare is known to be positively associated with moving out of low pay, whereas hospitality-linked sectors are have low rates of staff progression. Conversely, employees in the healthcare sector experience higher rates of stress and workplace injury.

However, an employee's position within the work hierarchy his one of the most important determinants of job quality. This means it is not simple case of encouraging or discouraging certain types of jobs or industries – good and poor quality work can occur right across the labour market. Therefore, a strategy to avoid industries or sectors with poor health outcomes is largely unrealistic and potentially damaging. Clearly, it cannot be recommended that areas avoid having healthcare-related jobs because of the risk of musculoskeletal disorders, or that there are no process, plant and machine operatives because they have five times the national injury rate. We need healthcare and a manufacturing industry. However, where those industries exist or are encouraged into an area public health professionals should do all they can to help companies and their employees reduce the risks, through strong adherence to health and safety recommendations and healthy workplace initiatives working in partnership with businesses.

Job creation strategies will also need to be developed and implemented in partnerships with relevant bodies and groups for example, LEPs, business leaders and universities. The inclusion of an anti-poverty organisation – the Joseph Rowntree Foundation – in Leeds' More Jobs, Better Jobs strategy is likely to be of particular interest for other local area.

7.1. Areas for further research

a) Developing skills

Future research should focus on how local authorities can effectively match skills to local employment needs. Research should look in particular at how local authorities can build upon an existing skill base to improve the quality of work. The scope of this research should include working with local businesses and universities.

b) Combining job creation with active labour market policies and interventions

Much of the existing work on employment and health inequalities has looked at active labour market policies and interventions to improve work entry. Further research should be done on how to combine labour market policies and interventions to ensure the maximum effect of all strategies – that is to get people into good jobs, not just any work.

c) Improved monitoring of job quality

For all policymakers, more information on job quality in the UK would enable more informed job creation policies. Such datasets would help enable policy-makers to encourage skills that are associated with jobs with health-protective elements.

d) Regional differences

More research might be done on how northern local authorities can narrow the health gap, alongside the wealth gap, with the South. Consideration also needs to be given to the West Midlands and London, which also both suffer from in-work poverty. For London, the solution may relate to reducing housing costs; for the West Midlands, more research needs to be conducted to examine the specific challenges this region faces.

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Appendix 1: Links to further information

Local skills strategies in the UK:

- Sheffield City Deal: <http://sheffieldcityregion.org.uk/city-deal/>
- Dorset Skills Strategy: www.dorsetlep.co.uk/talented-dorset/dorset-skills-strategy/
- Nottingham LEP: www.d2n2lep.org/
- Humber LEP: www.humberlep.org/priority/a-skilled-and-productive-workforce/
- Job Growth Wales: <http://gov.wales/statistics-and-research/jobs-growth-wales/?lang=en>

Other useful links:

OECD – Employment and Skills Strategies in England: www.oecd-ilibrary.org/employment/employment-and-skills-strategies-in-england-united-kingdom_9789264228078-en

OECD – Designing local skills strategies: www.delni.gov.uk/francesca_froy-2.ppt

Joseph Rowntree Foundation – How can local skills strategies help low earners?
www.jrf.org.uk/publications/local-skills-strategies-help-low-earners

The Work Foundation – Improving the health and wellbeing of the working age population locally: www.theworkfoundation.com/Reports/381/Healthy-Working-Economies

Box H. HSE advice to mitigate health-adverse effects of shift work

Permanent night shifts should be avoided in favour of rotating night shifts. Rotating shifts every two to three days is preferable as the internal body clock does not adapt and sleep loss can be quickly recovered, reducing the risk of fatigue and ill health.

Try to avoid permanent night shifts and try to have morning shifts start at 7am at the earliest. Shifts longer than 12 hours should also be avoided.

www.hse.gov.uk/pubns/priced/hsg256.pdf

Box I. HSE advice to mitigate health-adverse effects of musculoskeletal disorders

Upper limb

- reducing repetition
- finding the right position
- reducing the amount of force
- reducing duration.

www.hse.gov.uk/msd/uld/employers/howtoreducerisk.htm

Lower limb

- providing mechanical aids
- using staff rotation to lessen the time spent carrying out “risky” tasks
- using regular breaks
- providing seating, where possible.

www.hse.gov.uk/msd/lld/employers.htm

Box J. HSE advice to mitigate health-adverse effects of back pain

- think about how you can make jobs physically easier, e.g. by moving loads on wheels, providing better handles on loads, adjusting heights of worktops, etc.
- consult regularly with the employees on their health and wellbeing to help you identify concerns and developing trends
- take actions to address any outcomes from these discussions
- respond promptly when an individual worker reports back pain
- do risk assessments – and make changes where needed.

www.hse.gov.uk/msd/backpain/employers/industryguidance.htm

Box K. HSE advice to mitigate health-adverse effects of stress

- stress: management standards
- [demands](#) – this includes issues such as workload, work patterns and the work environment
- control – how much say the person has in the way they do their work

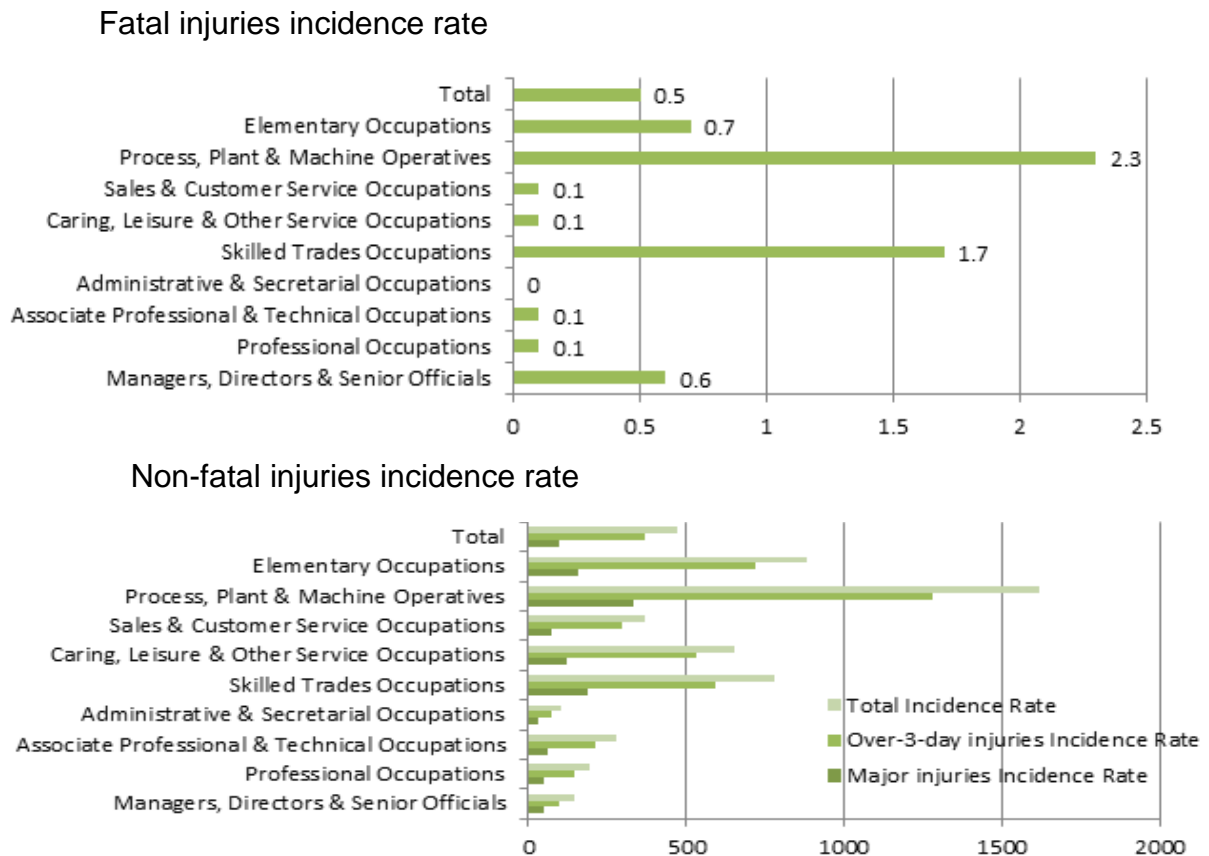
- [support](#) – this includes the encouragement, sponsorship and resources provided by the organisation, line management and colleagues
- [relationships](#) – this includes promoting positive working to avoid conflict and dealing with unacceptable behaviour
- [role](#) – whether people understand their role within the organisation and whether the organisation ensures that they do not have conflicting roles
- [change](#) – how organisational change (large or small) is managed and communicated in the organisation.

www.hse.gov.uk/pubns/indg430.pdf More resources:

www.hse.gov.uk/stress/resources.htm

Appendix 2: Further data on work and health inequalities

Figure 8: Injury incidence rates¹⁷



Incident rate = per 100,000. Note: Where rates of injury are available and shown they have been calculated using the Annual Population Survey (APS) as the source of employment data.

Figure 9. Working hours by occupation²⁰

% working 45 hours or more hours a week

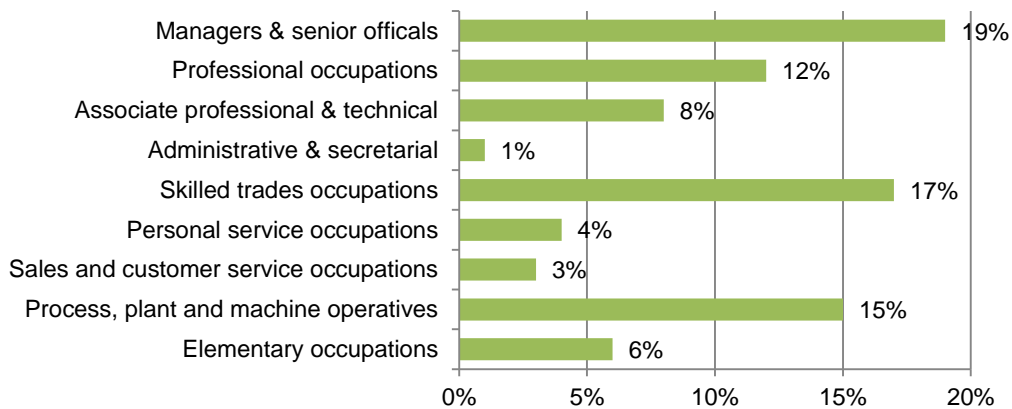


Figure 10. Long working hours by sector²⁰

% working 45 or more hours per week

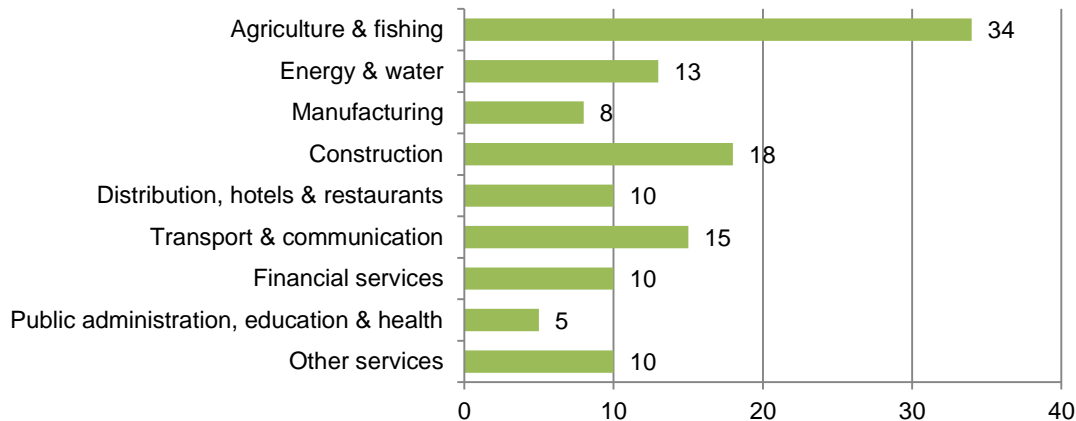
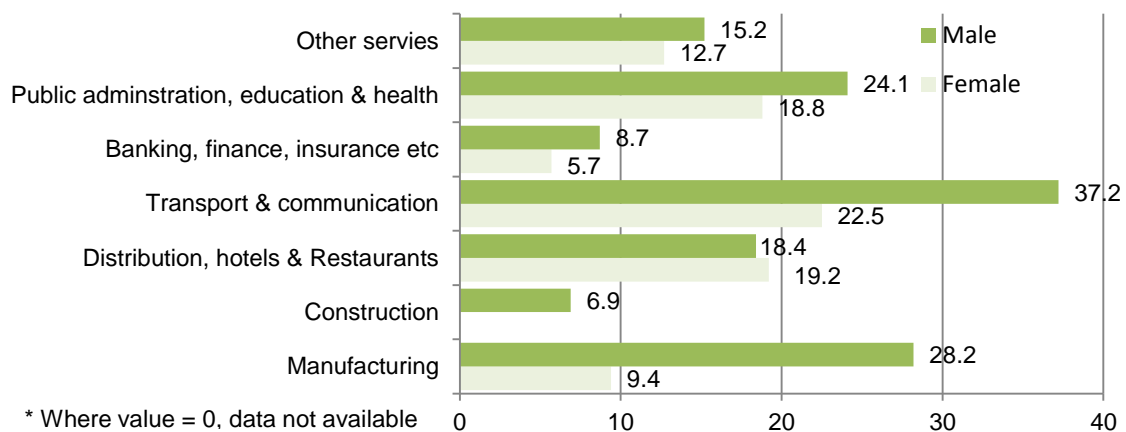


Figure 11. Shift work by sector, UK(%)²⁸



Note: Data was not available for agriculture and fishing, or energy and water, and construction for females due to disclosive base numbers.

Figure 12. Proportion of low-paid employees who progress to higher pay by sector, 2003-2013⁶⁴

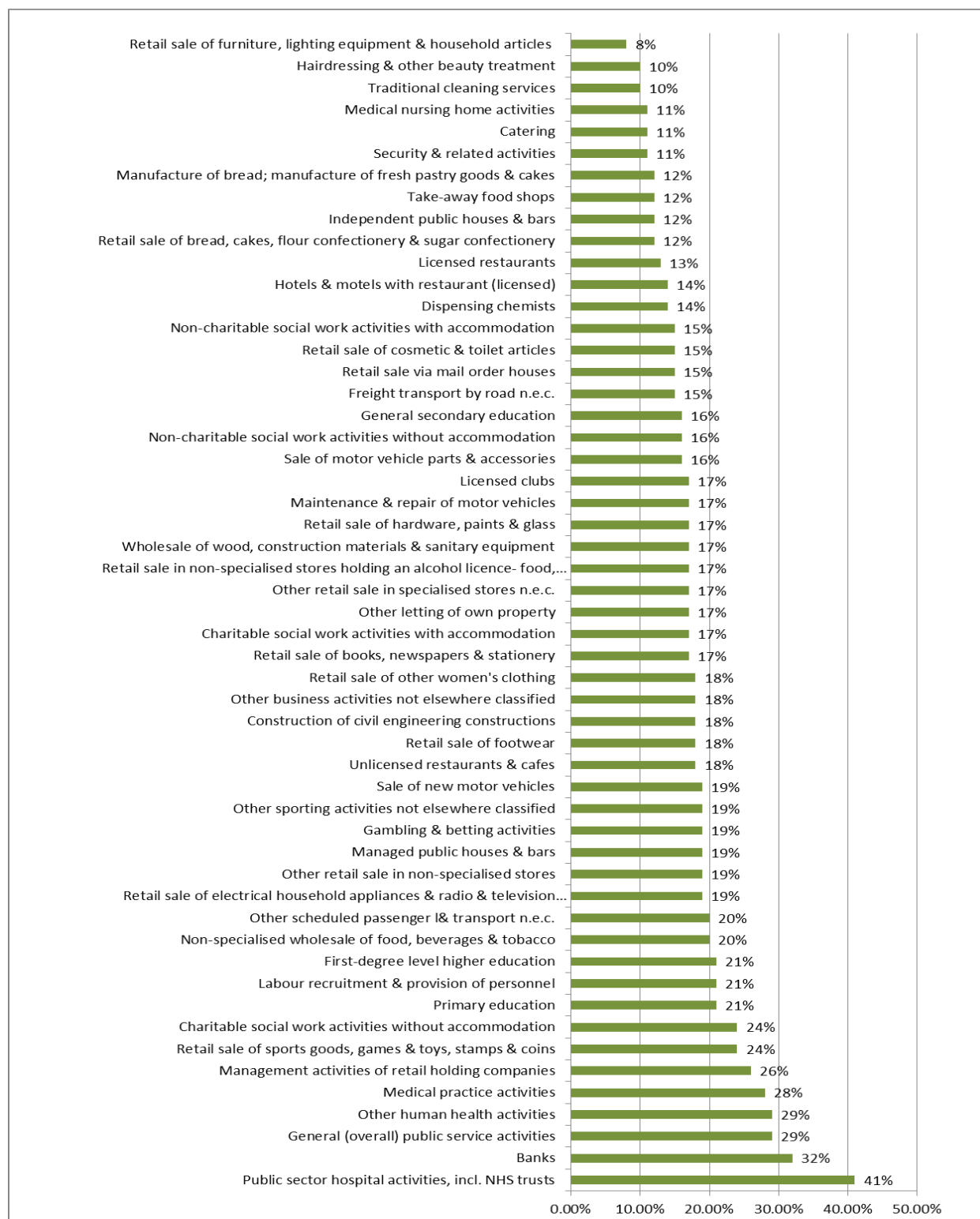


Figure 13. Stress and occupation¹⁷

Occupations with the highest work related stress

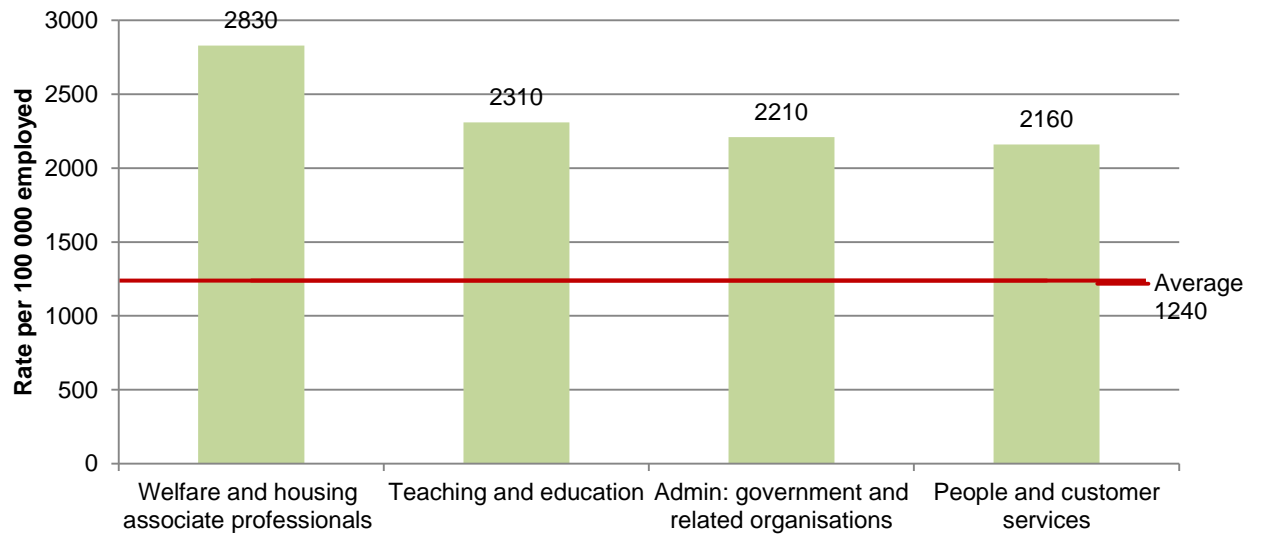


Figure 14. Insecure work by occupation

Temporary or no contract

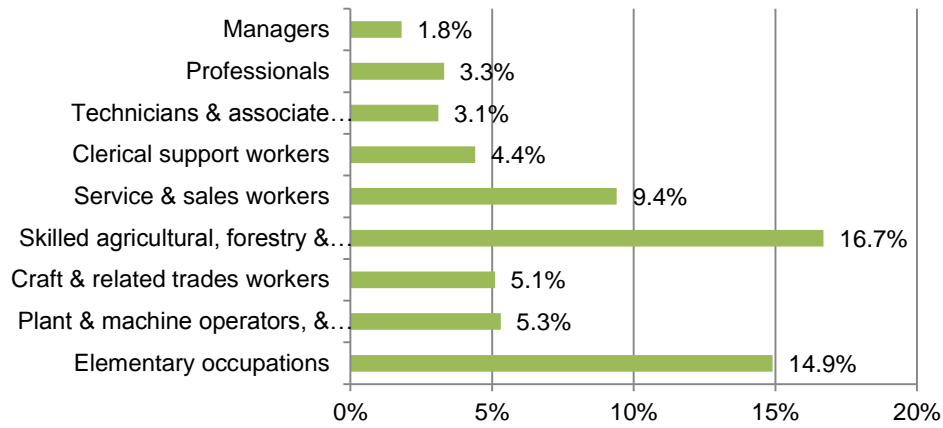


Figure 15. Insecure work by sector²⁷

Temporary or no contract

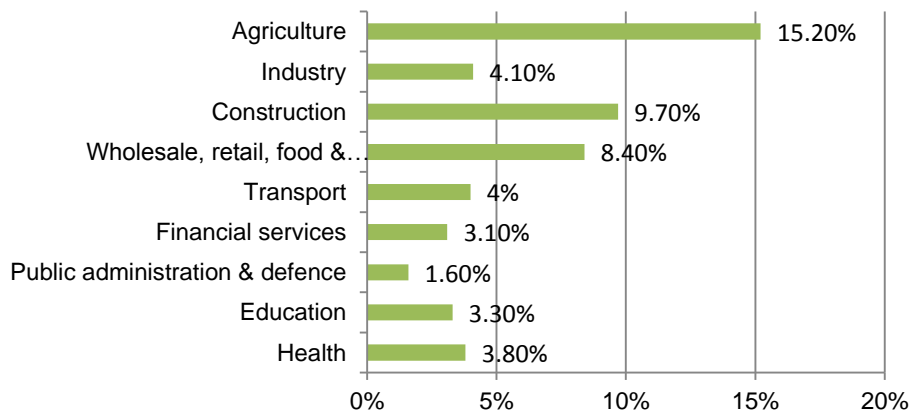


Figure 16. Workplace size and stress⁵⁷



Figure 17. Good quality contract by sector²⁷

Fixed term or indefinite contract

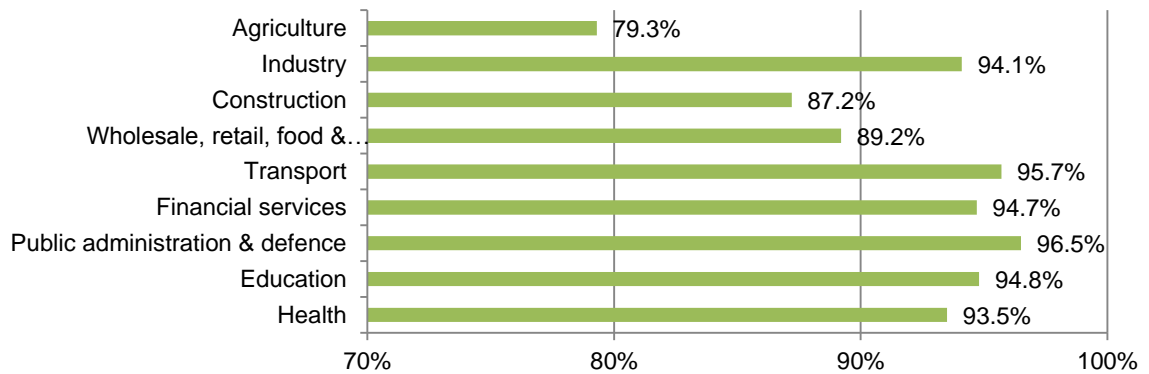
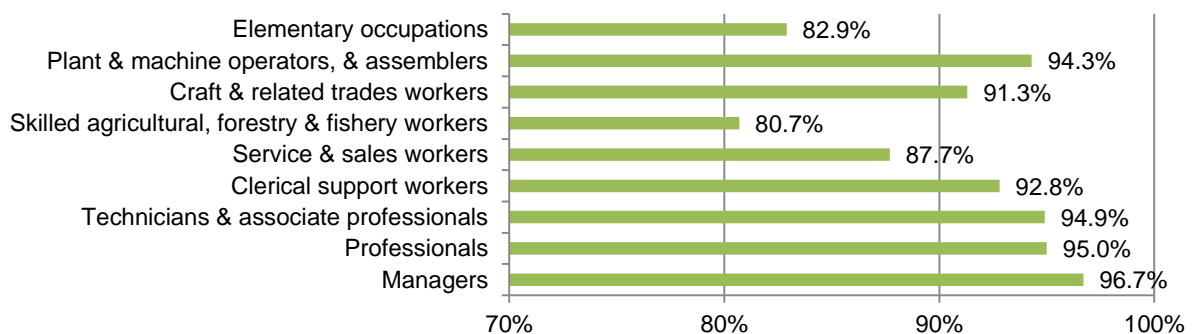


Figure 18. Good quality contract by profession²⁷

Fixed term or indefinite contract



Appendix 3. Eurofound data on job quality

This appendix sets out available data on work quality, as laid out by the Marmot Review. Data is provided by Eurofound. Data is available for sector and profession. This gives insights into which sectors best promote good quality health, as well as which jobs in those sectors. The data on professions also indicates the social gradient: at one end are managers, and at the other are elementary professions. Overall this data indicates that the better quality jobs are in more senior positions. It also indicates that jobs in the financial services tend to be the best quality, and jobs in industry and agriculture tend to be the poorest quality.

Free of core feature of precariousness: lack of stability and high risk of job loss

Figure a1: Might lose job in next six months, by sector

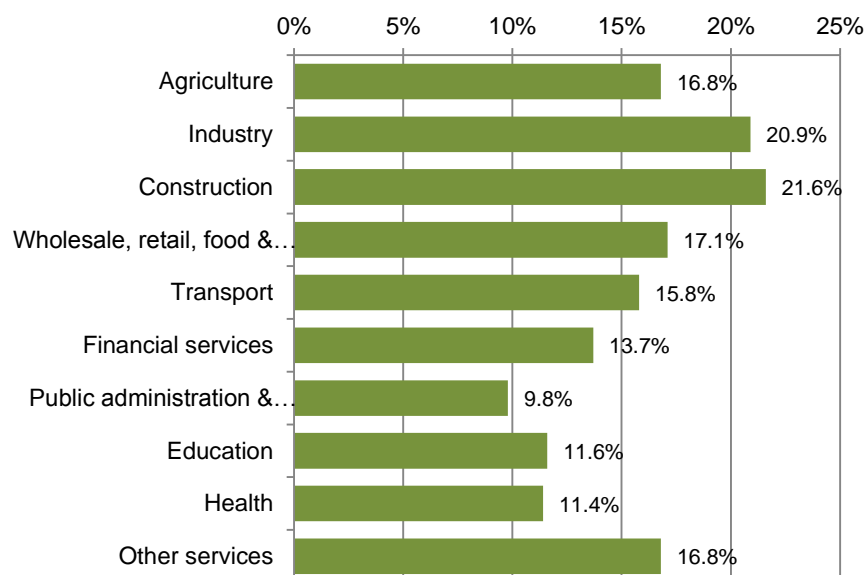
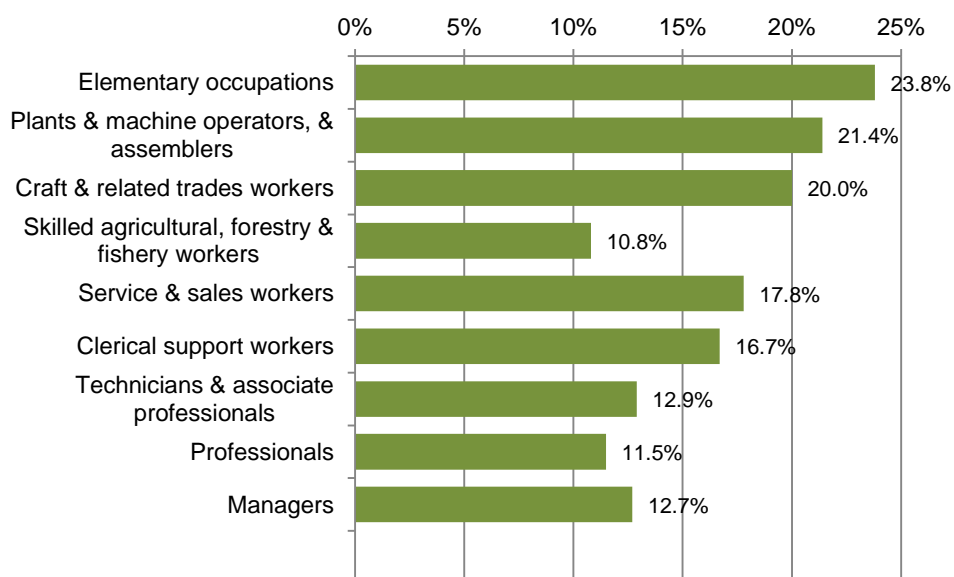


Figure a2: Might lose job in next six months, by profession



Free of core features of precariousness: lack of safety measures (exposure to toxic substances, elevated risks of accidents, and the absence of minimal standards of employment protection)

Figure a3: Wellbeing at risk at work, by sector

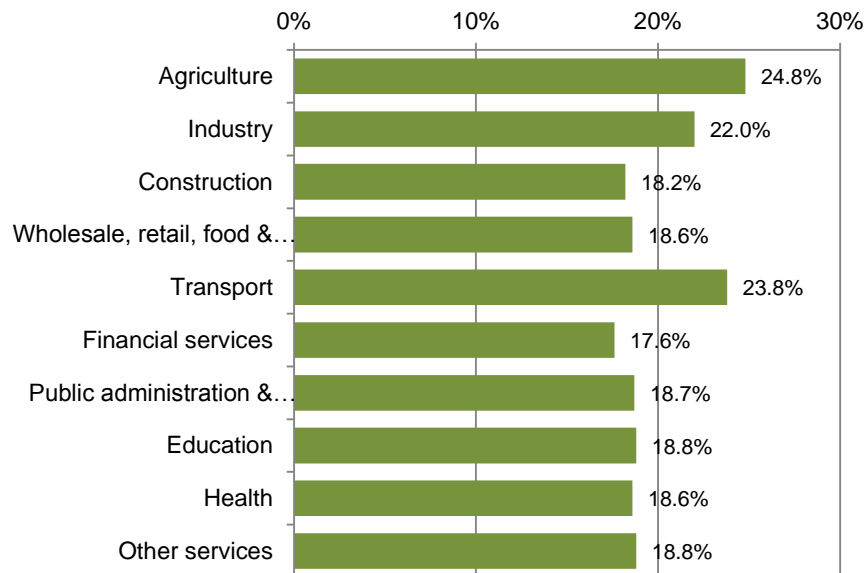
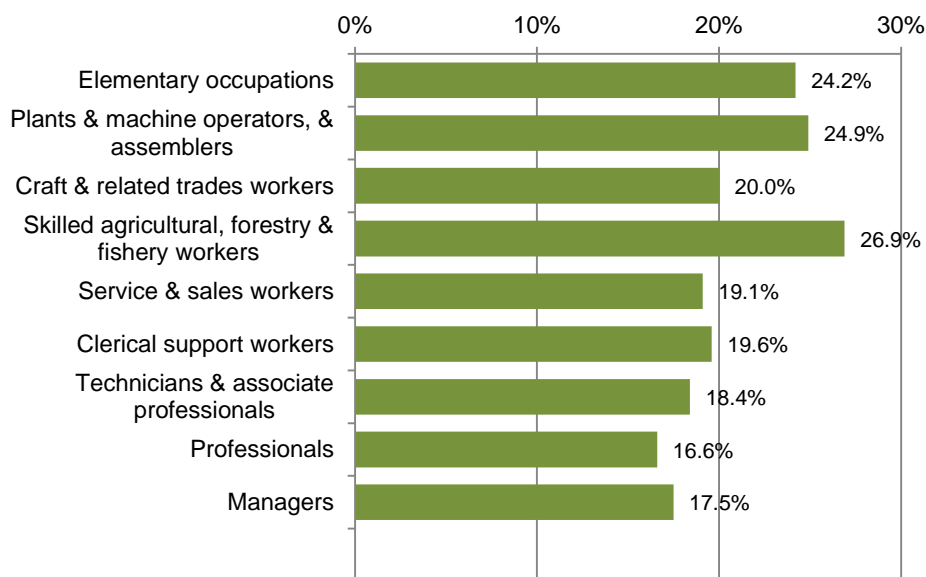


Figure a4: Wellbeing at risk at work, by profession



Enables the working person to exert some control through participatory decision-making on matters such as the place and the timing of work and the tasks to be accomplished

Figure a5: Control at work, by sector

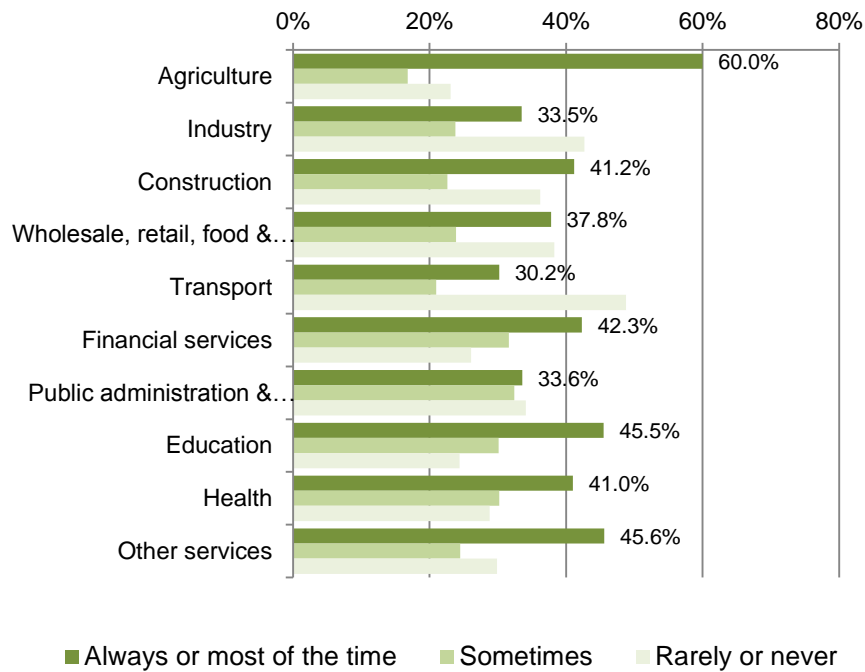
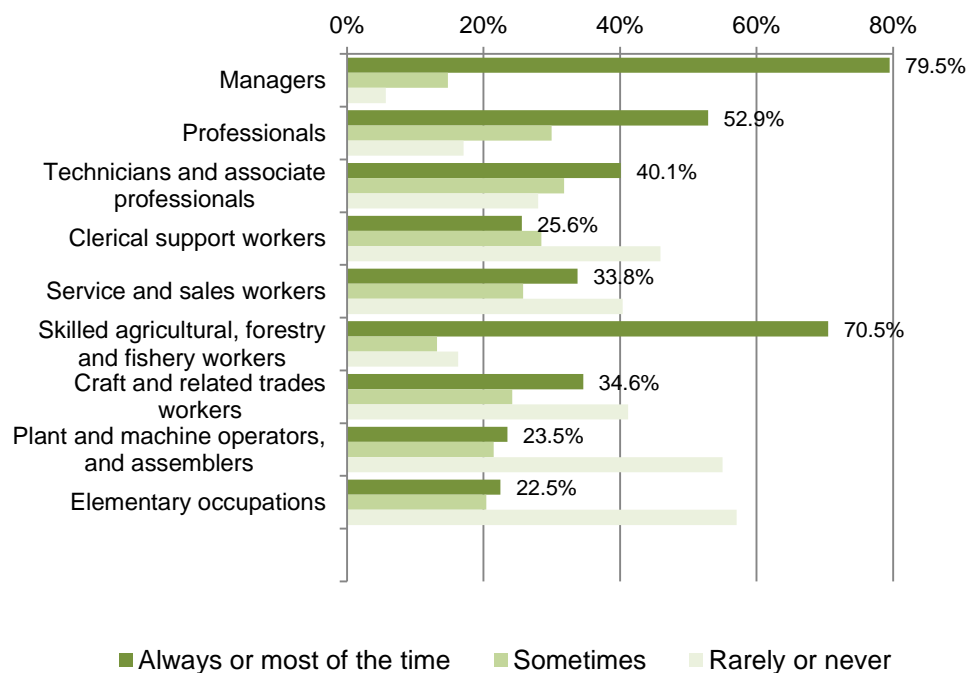


Figure a6: Control at work, by profession



Places appropriately high demands on the working person, both in terms of quantity and quality, without overtaxing their resources and capabilities and without doing harm to their physical and mental health

Figure a7: Job involves complex task, by sector

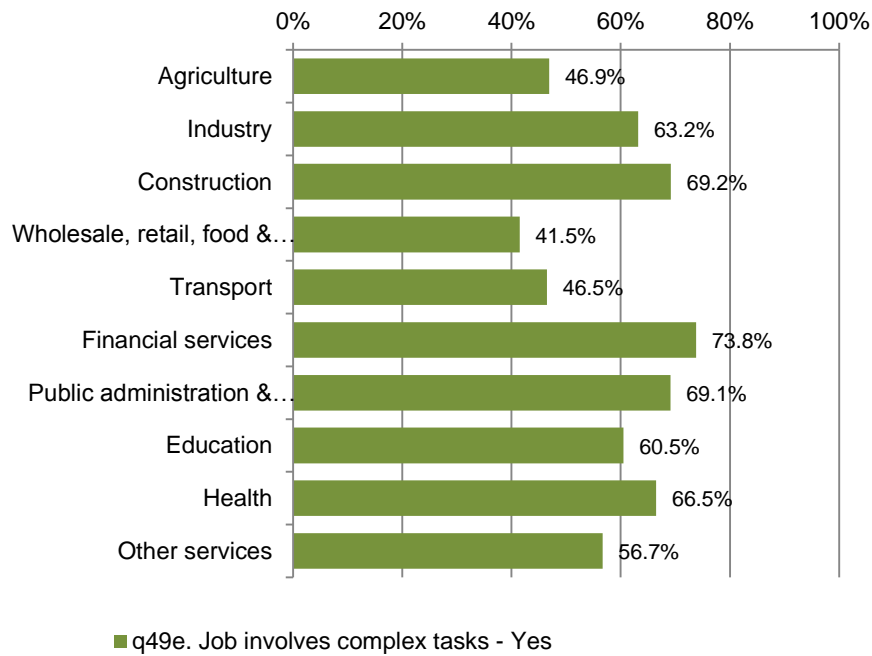
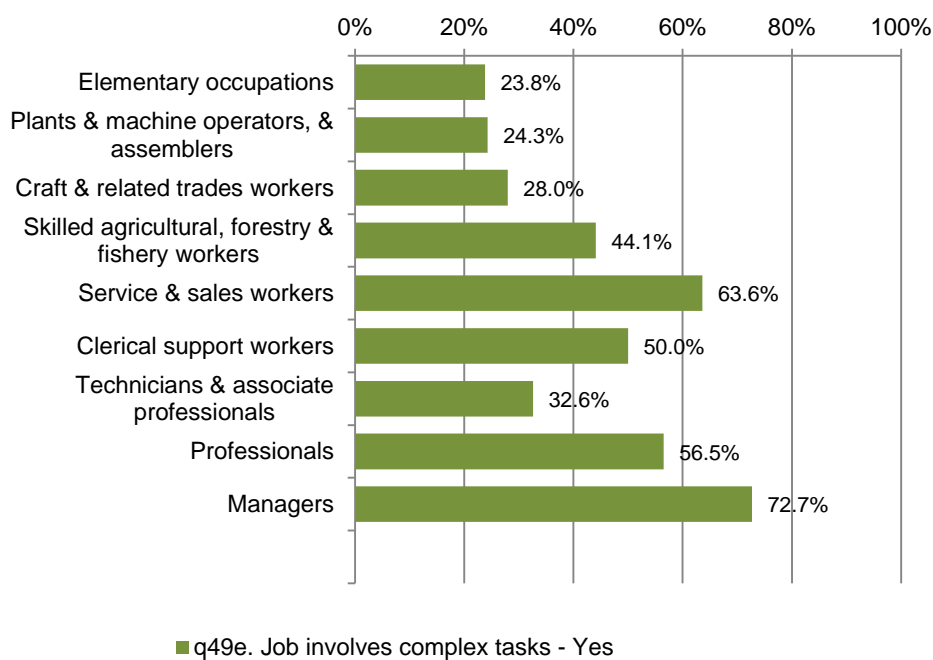


Figure a8: Job involves complex tasks, by profession



Provides fair employment in terms of earnings reflecting productivity and in terms of employer's commitment towards guaranteeing job security

Figure a9: Financial security, by sector

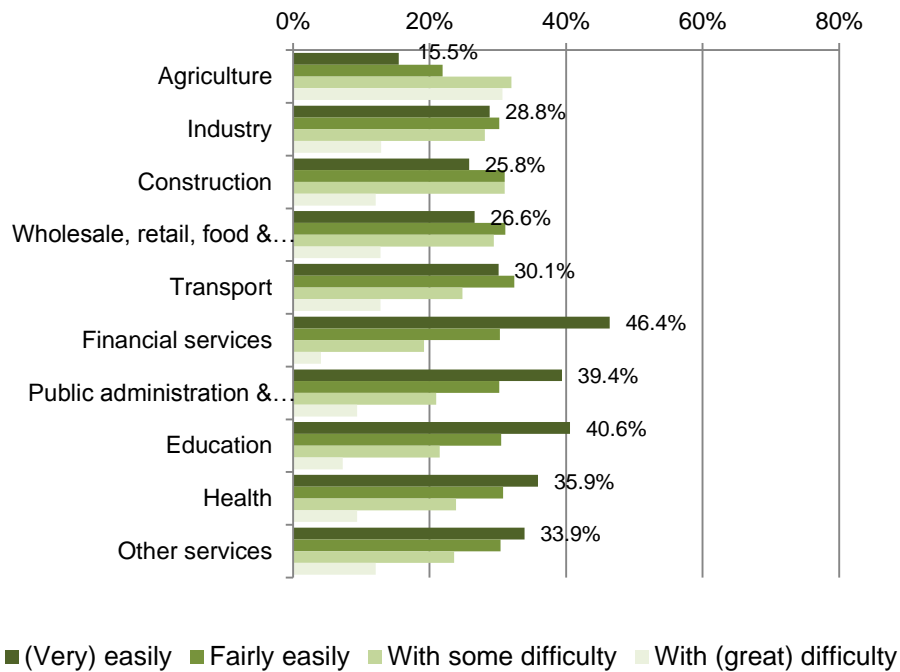


Figure a10: Financial security, by profession



Offers opportunities for skill training, learning and promotion prospects within a life course perspective, sustaining health and work ability and stimulating the growth of an individual's capabilities

Figure a11: Satisfaction with working conditions by sector

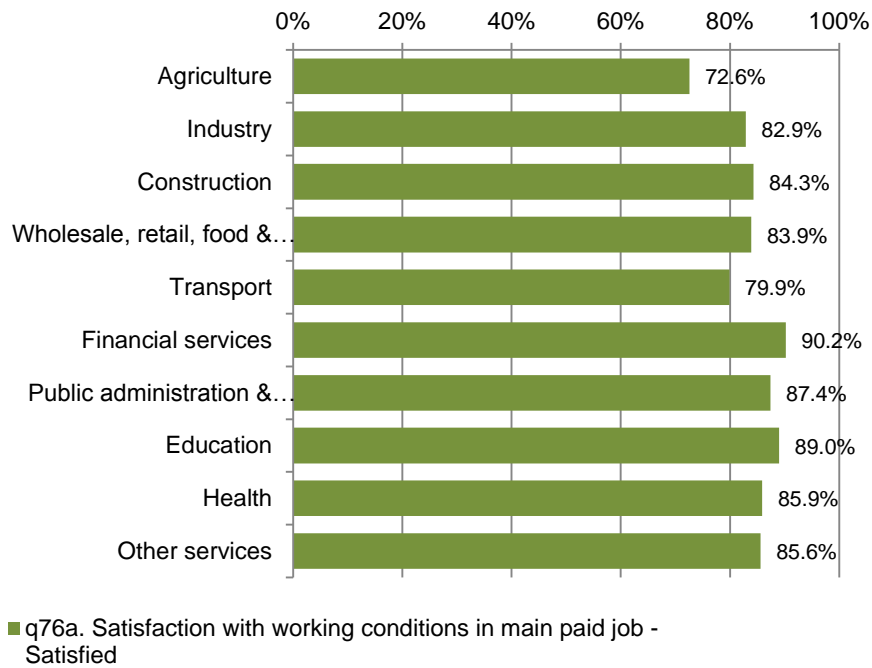


Figure a12: Satisfaction with working conditions by profession

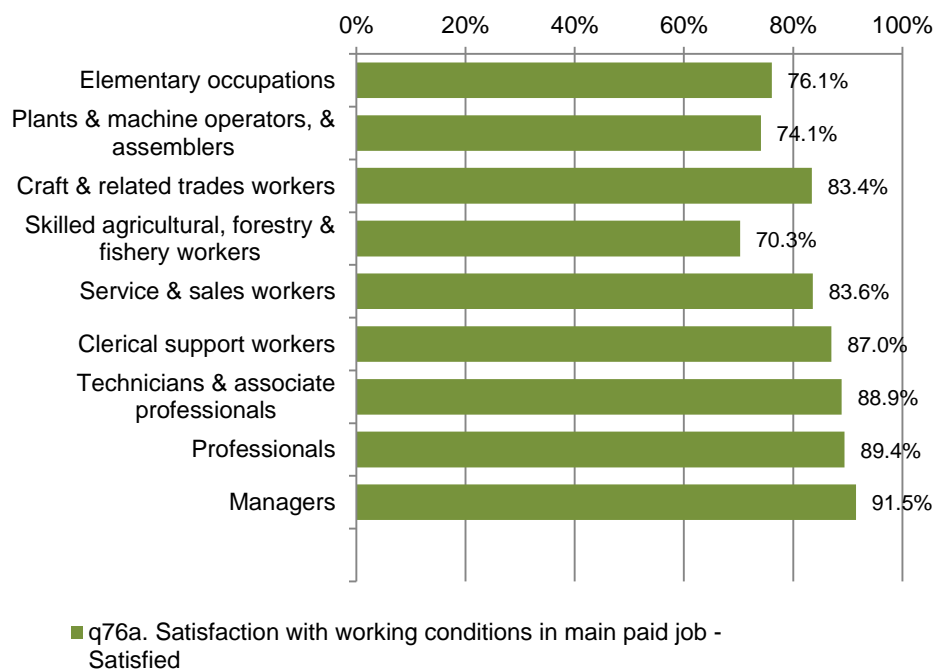
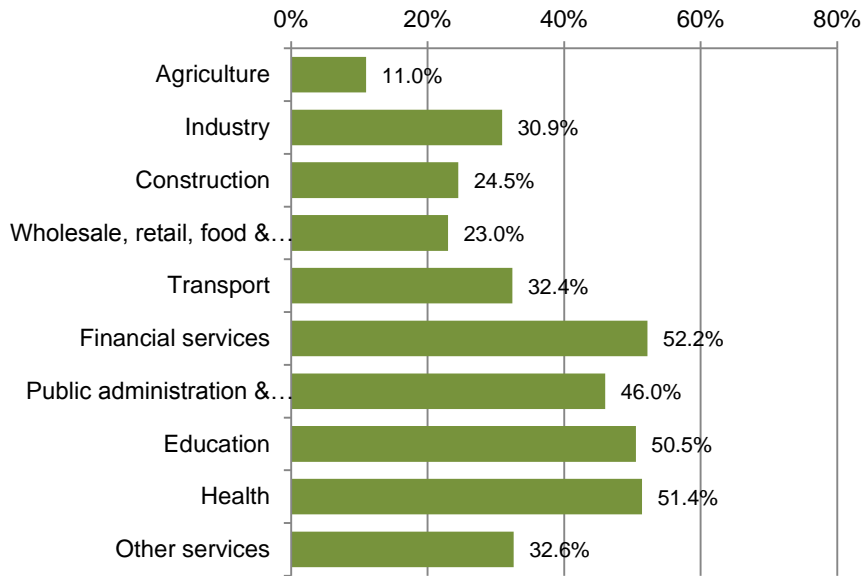


Figure a13: Opportunities for training, by sector



■ q61a. Having undergone training paid-for in the past year - Yes

Figure a14: Opportunities for training, by profession



■ q61a. Having undergone training paid-for in the past year - Yes

Figure a15: Job prospects, by sector

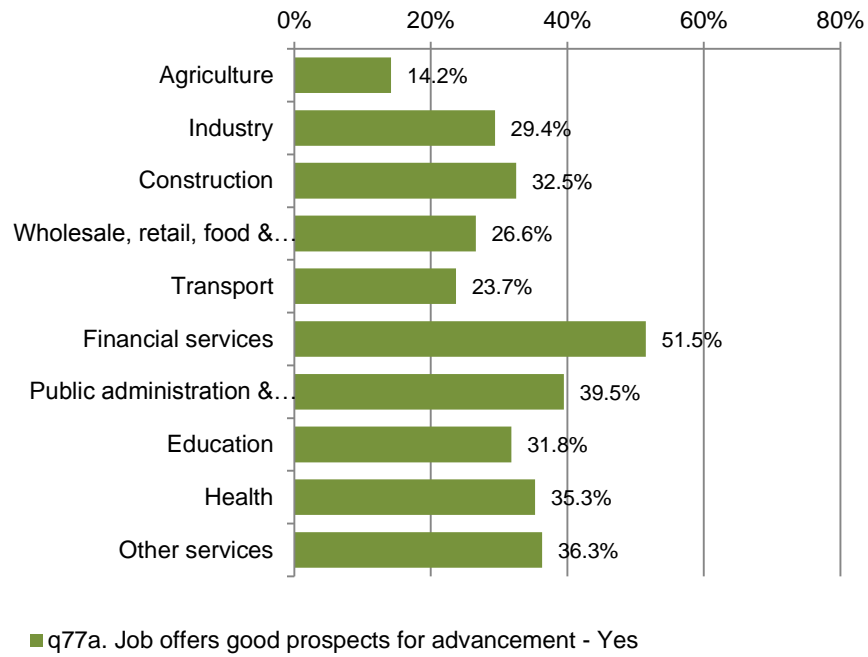


Figure a16: Job prospects, by profession

