



INSTITUTE *of*
HEALTH EQUITY



KENT MARMOT COASTAL REGION

A DEEP DIVE INTO THE RELATIONSHIP BETWEEN WORK, INCOME AND HEALTH

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Kent County Council

Kent Housing Group

Medway and Swale Health and Care Partnership

Swale Borough Council

Thanet District Council

GLOSSARY

DfE - Department for Education

DWP - Department for Work and Pensions

ESG - Environmental, Social and Governance

EU - European Union

FSM - Free School Meals

GP - General Practitioner

HSE - Health and Safety Executive

IAPT - Improving Access to Psychological Therapies

ICS - Integrated Care System

IDACI - Income Deprivation Affecting Children Index

IHE - Institute of Health Equity

IMD - Index of Multiple Deprivation

IPS - Individual Placement Support

KAE - Kent Adult Education

L&W - Learning and Work institute

MHCLG - Ministry of Housing, Communities & Local Government

MIHL - Minimum Income for Healthy Living

MIS - Minimum Income Standard

MSOA - Middle-layer Super Output Area

NEET - Not in Education, Employment or Training

NHS - National Health Service

OECD - Organisation for Economic Co-operation and Development

OHID - Office for Health Improvement and Disparities

ONS - Office for National Statistics

PHE - Public Health England

PIP - Personal Independence Payment

SEN - Special Educational Needs

SME - Small and Medium-sized Enterprises

SSP - Statutory Sick Pay

UCL - University College London

UK - United Kingdom

VCFSE - Voluntary, Care, Faith and Social Enterprise organisations

WCA - Work Capability Assessment

EXECUTIVE SUMMARY

Across the country, health is deteriorating and health inequalities are widening. In more deprived communities, people live shorter lives and spend a greater proportion of those years in poor health. Everyone below the highest socioeconomic group live shorter lives and experience worse health. This entrenched pattern – known as the social gradient – is evident nationally, regionally, and within Kent itself.

Most of the factors shaping health and these inequalities are outside the healthcare system and have their origins in the conditions in which people are born, grow, live, work and age. These ‘social determinants of health’ drive unfair and avoidable differences in life chances and a range of outcomes, including health throughout life. While there is no overarching national strategy focused on reducing health inequalities, there remains much that can be done at a local level. The University College London (UCL) Institute of Health Equity (IHE) works with places across the United Kingdom to identify where progress is needed to achieve health equity and to develop a system that prioritises and embeds this goal locally and sustainably.

In 2024, Kent commissioned the UCL IHE to support in becoming the first Marmot Coastal Region. This programme takes a proactive approach to tackling health inequalities by embedding multi-level system change. This encompasses decision-making at the top level, aligning systems for work and skills at the middle level, and operationalising change via ‘Marmot Accelerator’ programmes on the ground.

Achieving meaningful improvements in outcomes on health and its determinants, such as employment and education, requires a multifaceted approach. This will include the use of data and evidence to inform prioritisation, the development of appropriate interventions, long-term investment and a shared commitment to collaborations for equity across stakeholders in Kent.

This report summarises the literature on the relationship between work, income, and health, and applies this to Kent using local data. Analysis on a broader range of indicators across the social determinants of health can be found in the accompanying data-led report.

Ill health, worklessness and poverty can create a vicious cycle, especially in areas of entrenched deprivation. Growing up in poverty can contribute to worse mental and physical health; this can interfere with educational attainment and skills development; this in turn can reduce employment opportunities; worklessness can then exacerbate existing health issues, and so on. The interactions between the social determinants of health can form a seemingly inescapable net of overlapping disadvantage. However, the hidden upside of this is the realisation that if you seek to break a cycle, you can break it anywhere.

CHAPTER 1

INTRODUCTION

1A. WHAT IS HEALTH EQUITY?

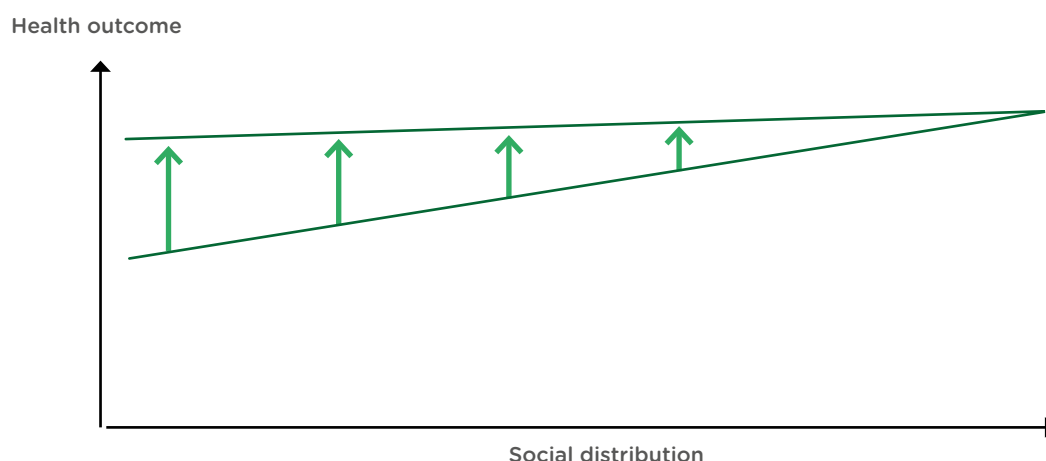
When people think about health, their minds tend to go first to healthcare: doctors and nurses, General Practitioners (GPs) and hospitals, medication and surgery, and above all, the National Health Service (NHS). While this is important, most of our health is shaped by the conditions in which we are born, grow, live, work and age rather than healthcare. These ‘social determinants of health’ include experiences during the early years, education, employment and work conditions, wealth and income, homes and neighbourhoods, discrimination and racism, all related to the social and economic systems and dominating cultures that lie behind these.

The causes of ill health, physical and mental, include pathogens like bacteria and viruses; behavioural risk factors like diet, exercise, smoking and alcohol use; as well as stress, accidents and injury. The social determinants of health affect exposure to these pathogens and risk factors, but also susceptibility to them, and the consequences that might ensue. For example, people in lower-paying jobs are more likely to be exposed to dangerous substances at work but are also more likely to struggle to afford the necessities for a healthy life, like nutritious food, good quality housing, and safe neighbourhoods with opportunities for exercising safely. In other words, these factors mostly determine how healthy a life we can live.

Inequalities in access to social determinants such as education and good work translate to inequalities in health, including an individual’s chance of developing many diseases, leading to a ‘social gradient’ in health. This means the higher your socioeconomic position, the better health is likely to be. This is not a simple two-way split into rich and poor, advantaged and disadvantaged, but instead a closely graded relationship between socioeconomic position and health from the best-off to the worst-off.

There are clear social gradients in both life expectancy – how long you might expect to live – and healthy life expectancy – how long you might be expected to live in good health. Poorer people, people living in more deprived areas, and some ethnic groups, are dying earlier and spending more of their lives in poor health than wealthier more advantaged groups. The evidence of clear and predictable social gradients in health show that these are not simply the result of individuals making decisions which harm their health. Instead, action to reduce inequalities in the social determinants is needed to support opportunities to live healthier and longer lives. Action for greater health equity leads to reduction of these unfair and avoidable inequalities in health between population groups. Because there is a gradient in health, reducing inequalities requires an approach that goes beyond just targeting help for the most disadvantaged, but supports everyone in a way which is proportionate to the scale of disadvantage. At the Institute of Health Equity (IHE), we advocate for proportionate universalism: services and support which is universal and open to all but with intensity of effort and resources proportionate to need. This is how we flatten the social gradient, as shown in Figure 1.

Figure 1. Social gradients and proportionate universalism



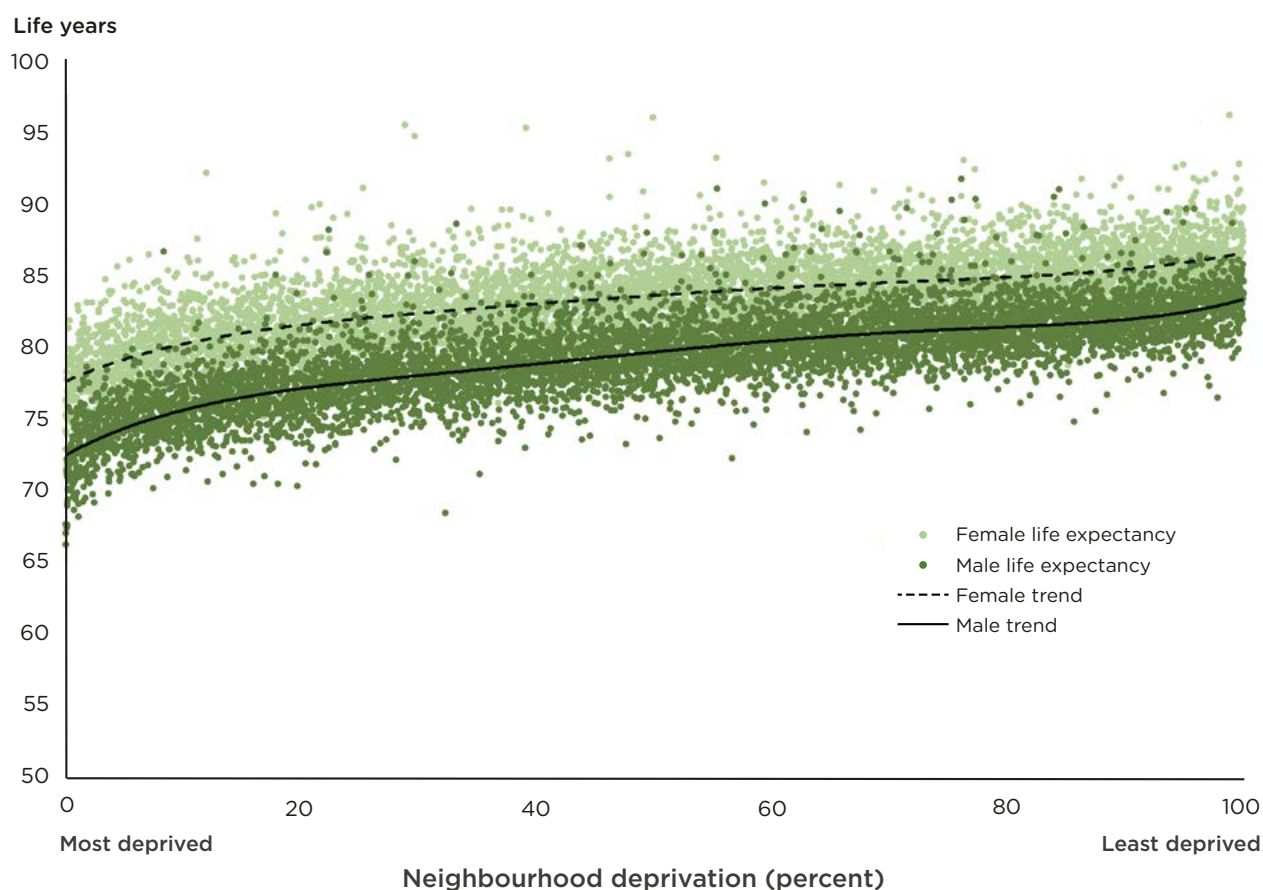
1B. INEQUALITIES IN HEALTH

Across England health is deteriorating and health inequalities are widening. These trends are largely the result of worsening social, economic, environmental conditions – the social determinants of health – due to funding cuts and the reduced capacity of services and voluntary sector organisations to provide the needed support. Across England, many people lose years of life due to this inequality.

Women in the most deprived 10 percent of neighbourhoods in England can expect to live about eight years fewer than those in the least deprived. Similarly, a man in one of the most deprived neighbourhoods can expect to live a decade less than a man in one of the least deprived (Office for Health Improvement and Disparities (OHID), 2024).

Figure 2 shows life expectancy at birth for every neighbourhood in England, plotted against the level of deprivation. The social gradient is clear – the more deprived the neighbourhood you live in, the shorter the life expectancy is.

Figure 2. Life expectancy at birth for neighbourhoods in England, by sex and deprivation, 2016-20

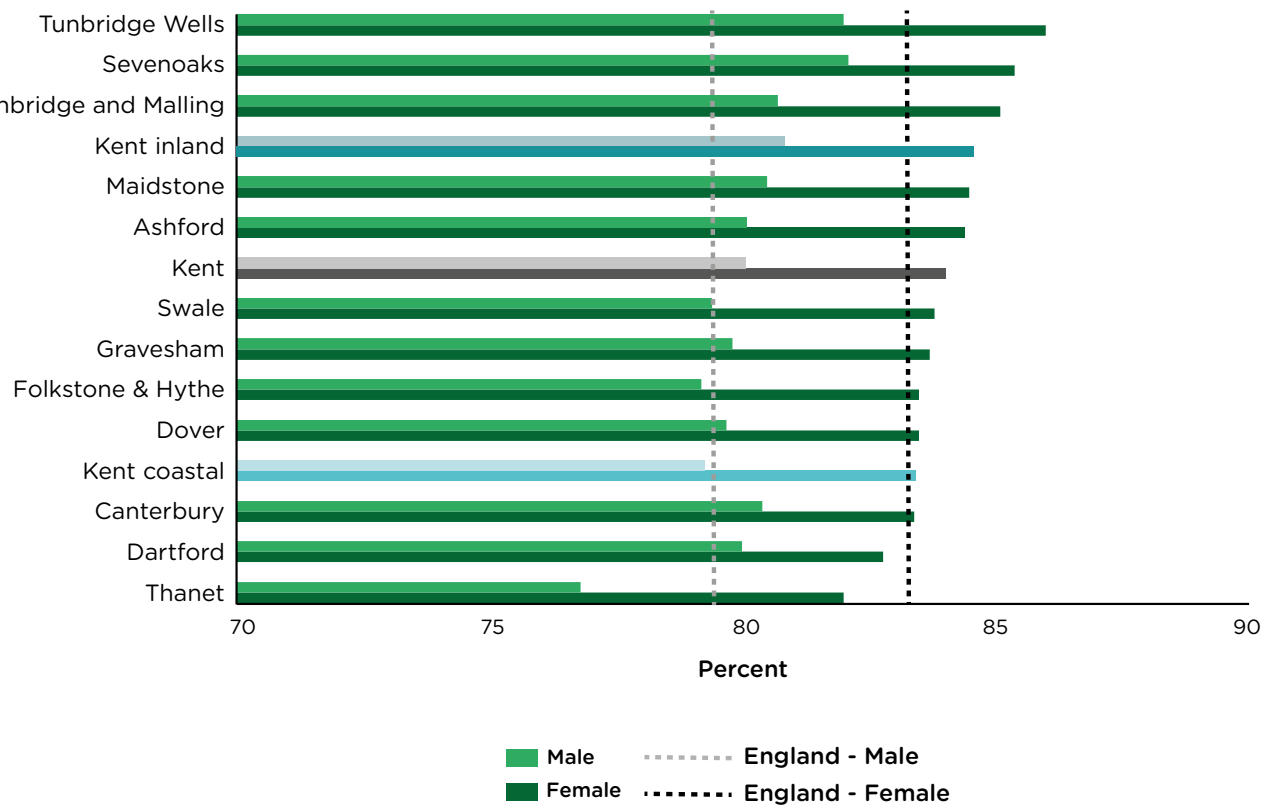


Source: Office for National Statistics (ONS), 2024

Between 2011 and 2019, over one million people in England died earlier than they would have done had everyone in the country experienced the same death rates as those living in the least deprived 10 percent of areas (Goldblatt, 2024). There are also clear inequalities

in health within Kent, and between Kent and other parts of England. Figure 3 below shows differences in male and female life expectancy across Kent's districts, indicating a clear gradient from wealthier to poorer areas.

Figure 3. Life expectancy at birth, by sex, years, Kent districts, Kent coastal and inland districts, Kent, and England, 2024



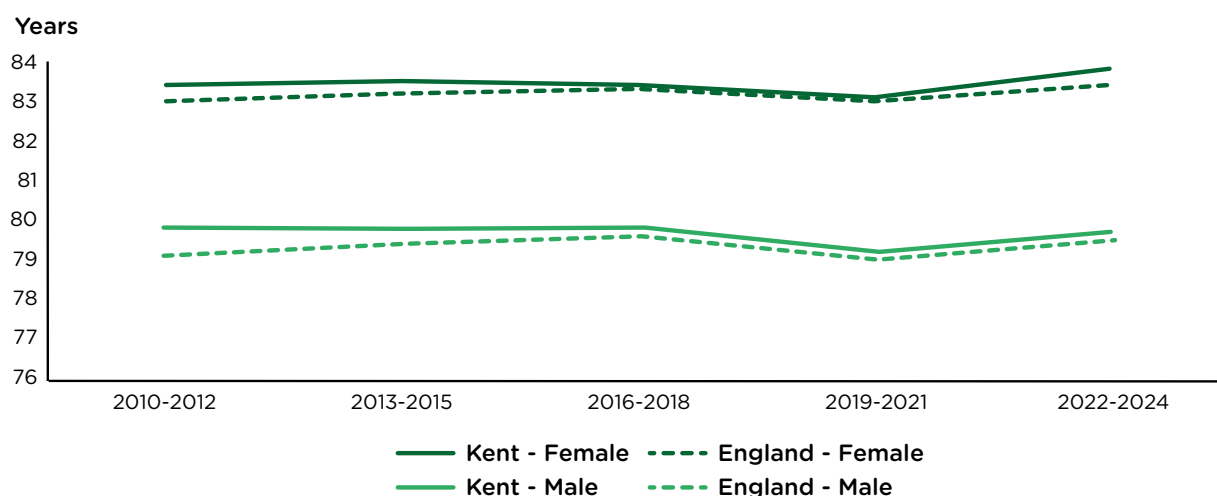
Source: Fingertips, OHID, 2026



In Kent as a whole, Figure 4 shows that life expectancy for both men and women has decreased since the start of the pandemic in 2019, and for males since

the early 2010s, a result of cuts associated with policies of austerity and worse conditions in the social determinants of health.

Figure 4. Life expectancy at birth, by sex, years, Kent, and England, 2010-12 to 2022-24

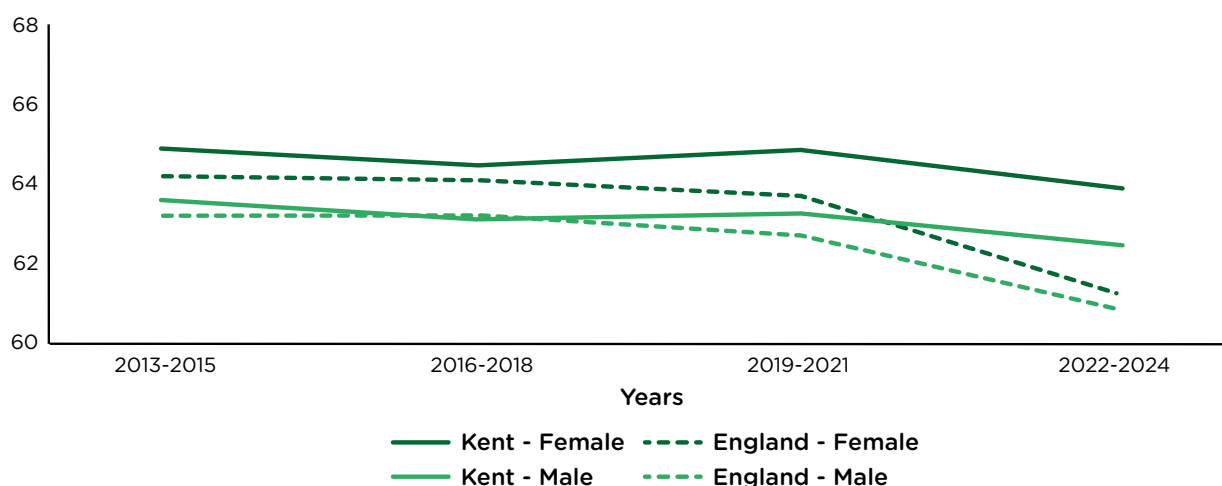


Source: Fingertips, OHID, 2026

Figure 5 shows trends in healthy life expectancy in Kent and England (how long you can expect to live in good health). Before the pandemic, healthy life expectancy in Kent was higher than England for both females and

males. Since 2018-2020, the trend has been clearly declining in Kent, but less steeply than in England. This data is not available for lower geographic areas.

Figure 5. Trends in healthy life expectancy, by sex, Kent and England, 2013-15 to 2022-24



Source: ONS, 2026

1C. MARMOT PLACE APPROACH

The UCL IHE was established by Professor Sir Michael Marmot to support greater health equity in England and around the world and is based on evidence showing that action in the social determinants of health is effective for improving health and reducing inequalities. With stakeholders, IHE identifies opportunities to drive progress towards health equity.

In the 2010 and 2020 Marmot Reviews, 8 principles for action on the social determinants of health were set out, based on a strong evidence base. These principles

are known as the Marmot 8 Principles and have been adopted by the more than 60 places that IHE have collaborated with to tackle health inequalities.

The principles are:

- 1 → Give every child the best start in life
- 2 → Enable all children, young people and adults to maximise their capabilities and have control over their lives
- 3 → Create fair employment and good work for all
- 4 → Ensure a healthy standard of living for all
- 5 → Create and develop healthy and sustainable places and communities
- 6 → Strengthen the role and impact of ill-health prevention
- 7 → Tackle racism, discrimination and their outcomes
- 8 → Pursue environmental sustainability and health equity together

An important part of work in Marmot places involves collation of evidence and analysis of the 8 principles in a place. While the approaches differ in each Marmot place there are common elements:

- Recognition that health and health inequities are mostly shaped by the social determinants of health
- Assessment of local inequalities in health and the social determinants of health
- Identification of actions that are already happening, gaps in existing approaches and development and delivery of steps to go further to reduce inequalities
- Evaluation of efforts and how partners can work together more effectively
- Strengthening the health equity system and collaborating with the national system

Becoming a Marmot place is not a question of any particular workstream, initiative or intervention. It does not come with a budget. It is not owned by the public health team, or even by the local authority, although they are often the ones who start the process. The Marmot

approach has been most effective where it has brought in partners beyond local government, from healthcare, from the community and voluntary sector, from other public services, from the private sector and across the system to take action to support better, and more equitable health. The Marmot approach aims to achieve lasting change, embedding health equity into a collaboration of partners across the system across the many sectors that shape the social determinants of health. This includes employment, education, skills building, early years and later life, housing, place shaping, transport, community services and all the services which shape peoples' experiences in these areas.

Achieving such system and cultural change is complex. Without practical examples and tools, it can become too diffuse an ambition. This is why it needs to be supported by tangible action on the Marmot Principles, while acting to embody and demonstrate new ways of working together. Transformational processes and tools help operationalise health equity into ways of working, including through funding allocations, contracting and tendering, and service design and delivery and empowering individuals on the front line of services and within communities.

1D. KENT'S PRIORITIES

In 2024, the IHE was commissioned by Kent County Council to support the development of a Kent Marmot Coastal Region. By focussing initially on Kent's more deprived coastal fringe, the intention is to maximise impact on reducing health inequalities. Work with the Coastal Region can inform and inspire work across Kent, and other places in England, with the ambition to improve health and health equity for all Kent's residents.

It is fundamental to the Marmot Places approach that local place-based solutions emerge through the programme, being co-created by local partners and communities and relevant to the local context. This is important to ensure actions are locally owned and relevant for local contexts and strategic directions.

Early in the Marmot Place process, Kent established their priorities as supporting good work and skills for work. These priorities align with three of the Marmot principles:

- **Principle 2:** 'Enable all children, young people and adults to maximise their capabilities and have control over their lives'
- **Principle 3:** 'Create fair employment and good work for all'
- **Principle 4:** 'Ensure a healthy standard of living for all'.

Good quality employment and development of relevant and rewarding skills are directly related to health and equity. Making this case can help galvanise support for action. Health and health equity must be at centre of issues of employment and skills building. The interests of health, justice and the economy are not to be traded off against each other but are complementary – good health supports better productivity, retention and recruitment, while good quality works supports better health and reduces demands on healthcare and welfare spending.

In Kent, following on from the 2021 Annual Public Health report, the Marmot Place work is to focus initially on the coastal region, where much deprivation is concentrated and evidence suggests an increased burden of disease (Duggal *et al.*, 2021). In relation to work and skills in particular, coastal areas often face issues with connectivity due to their peripheral nature, resulting in reduced access to jobs and training. While this will be the focus of the Marmot work initially, it is hoped that insights will be shared across all of Kent, and that the commitment to health equity will expand to include all of Kent, as well as all of the Marmot Principles, as the project goes on.

This report contains a deep dive on the literature on work and skills how they influence and impact health. The accompanying data-led report contains an overview of inequalities in health in Kent and inequalities in key social determinants. It also outlines more detail around the governance structures and levers for change involved in the Kent Marmot Coastal Programme.

CHAPTER 2

POVERTY, INCOME AND HEALTH

2A. INCOME AND HEALTH

Among the most important ways in which work influences health is through pay. While a high income cannot guarantee good health, an insufficient income leads to poor health. The Marmot reviews summarise robust evidence linking lower incomes, and experience of poverty, to worse health and shorter lives (Marmot *et al.*, 2010; Marmot *et al.*, 2020).

Lower income damages health, and poorer health can reduce the chance of being in employment and having sufficient income (Marmot *et al.*, 2010). The cycle can even perpetuate into the next generation: forced to take multiple jobs and work unsociable hours to make ends meet, workers in precarious employment will spend less time with their families and experiencing poverty as a child can damage prospects for health. Poverty is stressful and also affects household relationships with greater risks for poor mental health.

Being in poverty can also be time-consuming. For example, through time taken to source the cheapest food, or slower, more affordable forms of transport. Children who receive less attention at home from absent or exhausted and preoccupied parents are likely to have reduced cognitive development compared with their peers even before their formal education begins (Marmot, 2015).

The IHE has previously advocated for a Minimum Income for Healthy Living (MIHL) (Marmot *et al.*, 2010). This is the income necessary to support a healthy lifestyle and includes money for necessities whose absence harms health – like food and housing – but also income that can support full participation in society and allow for peace of mind and freedom from the constant stress of poverty. The Joseph Rowntree Foundation's calculation of a similar minimum income standard (MIS) also takes into account what is needed to achieve security and stability in an unstable labour market and sufficient income for a healthy life (Davis *et al.*, 2024). One scientific paper, by Benzeval *et al.* (2014), identified four broad theories linking money (or its lack) on health. These are **materialist theories; psychosocial mechanisms; behavioural factors; and reverse influence**. It is likely that all of these play a part.

Materialist theories relate to the effects of material deprivation on health. In other words, the inability to afford the things you need for health. These can be necessities like food and shelter, or more complex things that allow for healthy lifestyles in a modern world, like membership of a gym, or a decent home in a safe area with good air quality and access to green spaces. In addition, money affects access to important services like education and healthcare. While healthcare is free in this country, there are still costs and barriers to accessing

healthcare, from levels of funding and provision of healthcare in poorer areas (the 'inverse care law'), to the costs associated with travel to appointments, time off work, or the costs of managing long-term health conditions (Fisher *et al.*, 2024; Fisher *et al.*, 2022; Tudor Hart, 1971; Mallorie, 2024).

Food and fuel poverty have both attracted a great deal of attention in recent years. To afford the Government-recommended, 'healthy' diet, the most deprived fifth of the country's population would need to spend 45 percent of their disposable income on food, and this rises to 70 percent for households with children (Food Foundation, 2025). Fuel poverty forces many lower income households to choose between 'heating or eating'. The IHE has published several reports into the negative effects of cold homes, linked to a range of physical and mental health problems (Donkin and Marmot, 2024).

Psychosocial mechanisms are more related to the stress caused by poverty and deprivation. Financial hardship causes stress, and stress has direct effects on the body, increasing susceptibility to a range of physical and mental health problems. The adaptations the body makes to the experience of chronic stress is called **allostatic load**. The experience of poverty, including the experience of childhood poverty, is linked via this concept of **allostatic load** to increased risks of death from a range of conditions, including cardiovascular disease and some cancers, as well as shorter lives overall (Parker *et al.*, 2022; Guidi *et al.*, 2021; Kelly-Irving, 2019; Beckie, 2012).

Psychosocial stress is one reason why relative poverty can be damaging to health as well as absolute poverty. The experience of being unable to afford the things that your society considers 'normal' for yourself and your family, can cause stress even if you are not at immediate risk from starvation or lack of shelter. This contributes to the social gradient in disease and partly explains why there is a relationship between money and health from the poorest to the richest. There is a wide body of research on the psychosocial effects of socioeconomic status on health, going back to the Whitehall studies in the 1960s and 80s (Marmot, 2004; Marmot *et al.*, 1991).

Behavioural factors include diet and exercise, smoking, and alcohol intake. These are all highly socially patterned in the UK and internationally. Income and wealth affect people's behaviour, which then affects their health. Smoking, for example, is much more common amongst those on lower incomes and in lower-status occupations. There are several reasons why this may be, including as coping mechanisms for stress (linked to the psychosocial mechanisms mentioned above) or that healthier lifestyles are less accessible for those poor in money, time, and resulting lower mental bandwidth to make difficult changes to behaviours. There is also a theory, derived from the economic phenomenon of 'discounting', which suggests that people with present difficulties, fewer prospects for the future, and expectation of shorter lives, might value present pleasures over hypothetical future benefits from better health.

Reverse influence is the theory that causation runs in the opposite direction: that poor health leads to lower incomes, by reducing education and employment opportunities. This would not account for the evidence that experience of poverty in childhood and adolescence is linked to health problems later in life. However, this reverse influence could contribute to a vicious cycle whereby poverty damages health and poorer health then further damages both learning and earning potential and the ability to improve one's situation.

As Munro, Allen and Marmot (2023) put it: "[I]ogic, social justice and evidence clearly indicate that where a problem is driven by people having insufficient income, then increasing their income will reduce the problem – and this is always the preferred option in providing people with the greatest dignity and choice and the least stigma."

A systematic review by Cooper and Stewart (2013) found that the effect of increased income on cognitive and educational outcomes for children in poor families was comparable with spending the same money directly on school or early learning programmes, and a update by the same authors found increasing evidence of benefit for children's physical health as well (2017).

In addition to its effects on health, there is evidence to suggest that financial distress has effects on productivity, absenteeism and presenteeism, providing an economic argument for decent wages that can support a healthy and relatively stress-free life. In 2023, financial distress-related absenteeism was estimated to cost UK employers £3.7 billion, up from £2.5 billion in 2021 (Cebr, 2023).

Despite this, financial security remains out of reach for a large proportion of people in the United Kingdom (UK). In 2022/23, 14.3 million people in the UK were living in poverty, over one fifth of the total population, and including 4.3 million children (Bokhari *et al.*, 2025). Poverty and its health damage affect both those in work and those out of work and more dependent on the benefits system. The threat of poverty is highest for those out of work (54 percent of adults in workless households are in poverty), but at a population level, work does not guarantee freedom from poverty. Around two-thirds of working-age adults in poverty live in a household where at least one person is in work. This is particularly pronounced for people who are exposed to the insecure 'gig' economy: nearly one quarter (23 percent) of self-employed part-time workers are in poverty (Bokhari *et al.*, 2025).

The National Living Wage is insufficient to support a healthy lifestyle for many, particularly in parts of the country with high costs of living. In 2024, a single working-age adult working full time on the National Living Wage would only reach 77 percent of the Joseph Rowntree Foundation's Minimum Income Standard (a standard which matches the IHE definition of a minimum income for healthy living) (Davis *et al.*, 2024). For those on benefits, the situation is predictably worse, as single people on out-of-work benefits would only reach 28 percent of the MIS, and couples on the same benefits only 27 percent (Davis *et al.*, 2024).

For both those in and out of work, families with dependent children are likely to fall well short of the MIS. A lone parent on out-of-work benefits with two children would only reach 44 percent of the MIS, rising to 69 percent if working full time on the National Living Wage. Even couples both working full-time on the National Living Wage would be unable to adequately support their own health and that of their two children, earning 82 percent of the MIS (Davis *et al.*, 2024). Another measure of the insufficiency of wages is the use of the benefits system to maintain the income of people in work. 39 percent of working-age adults in England in receipt of Universal Credit are in work (Work and Pensions Committee, 2024). This could be argued to represent in part a public subsidy to low-paying employers and providers of insecure work. Similarly, housing benefit represents a transfer of money from the public to private landlords, for the provision of homes that are often poor quality and fail to support health.

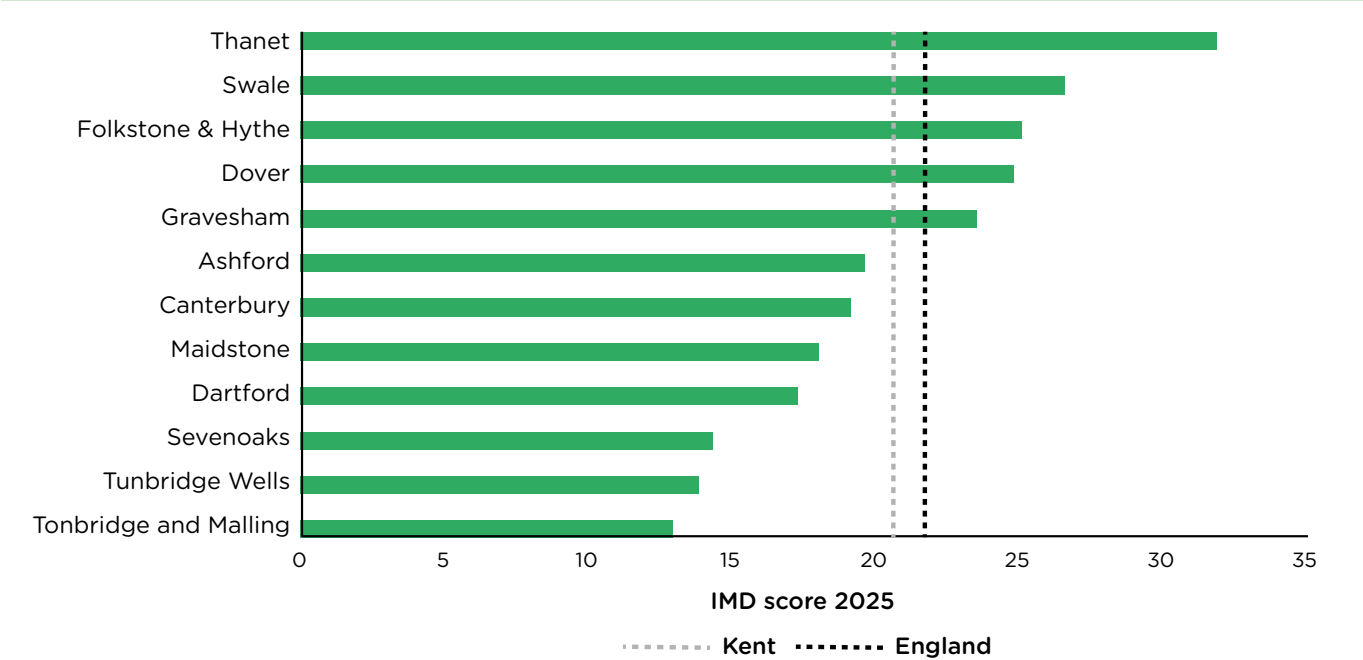
2B. POVERTY IN KENT

The English Index of Multiple Deprivation (IMD) estimates the population’s deprivation by combining seven dimensions: income, employment, education, health, crime, barriers to housing and services and living environment.

Figure 7 shows Kent’s population overall is less deprived than in England, with an IMD score of 20.7 compared to the national average of 21.8. However, Kent’s districts show substantial heterogeneity in levels of deprivation, with the IMD scores by district in 2025 ranging from 32 in the most deprived area (Thanet) to 13 in the least deprived district (Tonbridge and Malling). This gives particular emphasis to the

concept of embedding proportionate universalism into service design and delivery across Kent, with more deprived areas requiring considerably more support and appropriately designed services. However, it is important to note that support remains necessary even in the least deprived areas, where there are still many households experiencing deprivation.

Figure 7. Index of Multiple Deprivation (IMD), Kent districts, Kent and England, 2025

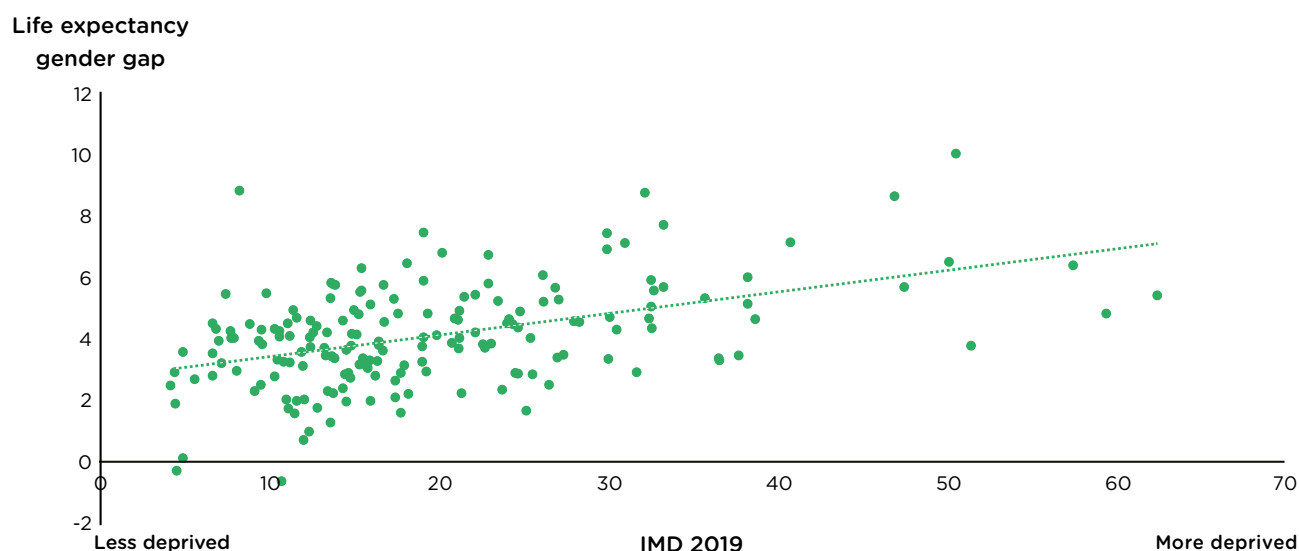


Source: OHID, Ministry of Housing, Communities and Local Government (MHCLG), 2026

Middle-layer Super Output Areas (MSOAs) are geographical areas which cover between 2,000 and 6,000 households and usually have a resident population between 5,000 and 15,000 persons. As observed nationally, life expectancy at birth by MSOA closely relates to the level of deprivation, also following a clear gradient in Kent. The higher the IMD score

and thus the greater the deprivation, the shorter the life expectancy at birth for males and females. The regression line is steeper for males, reflecting even greater inequality in life expectancy between the more deprived and less deprived areas than women. Figure 8 highlights major health and social inequalities between small areas in Kent.

Figure 8. Life expectancy gender gap (female-male) and deprivation (IMD score 2019), Kent MSOAs, 2019-2023

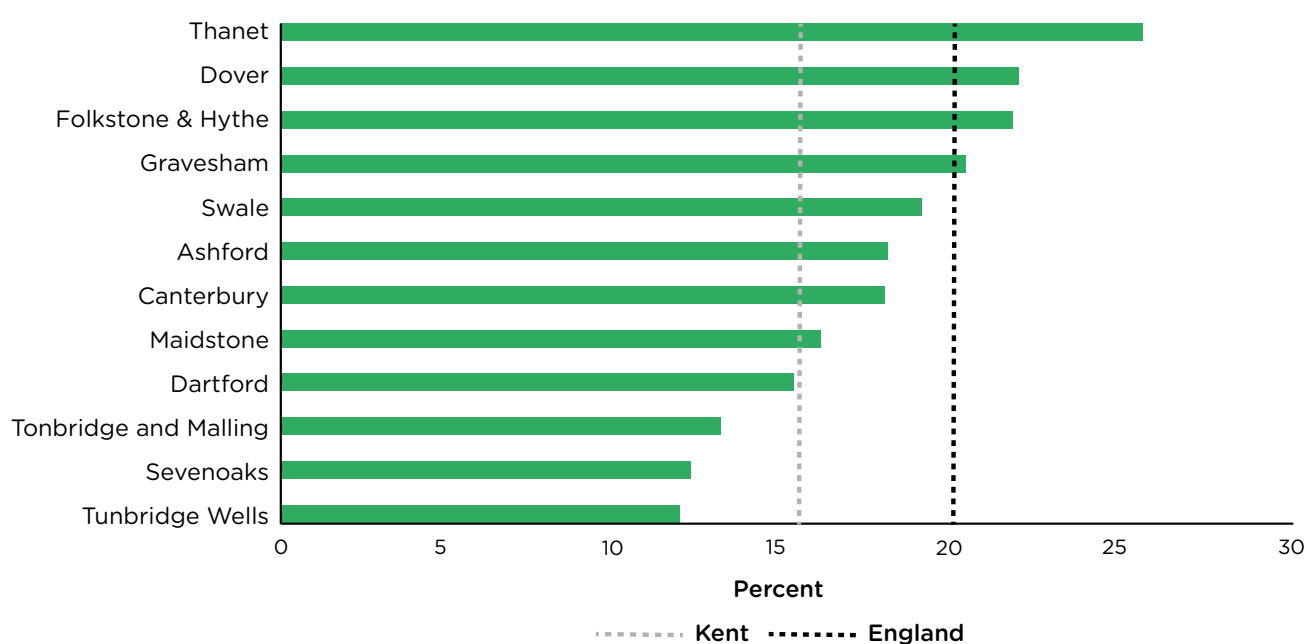


Source: ONS, MHCLG, 2026

The first few years of a child's life are critical to their physical and mental development, as well as being a determinant for their future health. Experiencing poverty as a child can be harmful for future health outcomes and even perpetuate across generations. Children in low-income homes may also receive less attention at home from exhausted or preoccupied parents, which can lead to reduced cognitive development compared with their peers, before formal education even begins (Marmot *et al*, 2015).

Across districts, the percentage of children living in a low-income family differs widely across Kent, ranging from 11.9 percent in Tunbridge Wells to 25.7 percent in Thanet (Figure 9). There is also a 5.8 percentage point difference between coastal and inland areas in Kent. While the average proportion of children living in relatively low-income families in Kent is lower than England, there are stark inequalities within Kent. It is essential to understand child poverty at a lower geographical level, which is planned in the next stages of the coastal indicators work.

Figure 9. Children in relative low-income families, percent, Kent's districts, Kent, and England, 2022



Source: Department for Work and Pensions (DWP), 2026

CHAPTER 3

ECONOMIC INACTIVITY, BENEFIT UPTAKE AND DISABILITY

3A. ECONOMIC INACTIVITY AND BENEFIT CLAIMANTS

There is real uncertainty around levels of economic inactivity in England. Evidence from the Labour Force Survey has been widely reported as indicating a significant rise in economic inactivity in England since the pandemic. However, the response rate to the Labour Force Survey (and other national surveys) has collapsed in recent years, rendering it unrepresentative of the population as a whole, and leading to the ONS downgrading its findings (Corlett, 2024; Burn-Murdoch, 2024; Alexander, 2025).

Despite this uncertainty, administrative data from the Department for Work and Pensions (DWP) indicates that there has been a sustained increase in working-age people claiming health-related benefits. More than half of this rise has been due to mental or behavioural conditions, and this aligns with evidence of rising levels of sickness absence, increasing demand on mental health services, and of rising mortality from 'deaths of despair (due to alcohol, drugs and suicide) (Latimer, Ray-Chaudhuri and Waters, 2024). This rise in benefits claims appears to be a specifically UK phenomenon, and is not reflected in other comparable countries' post-pandemic experiences (Latimer, Pflanz and Waters, 2024).

Broadly, the growth in sickness benefit claims has been driven by both new claimants and existing claimants remaining on benefits for longer. New claimants probably account for around two thirds of the rise and are on average younger and more likely to be claiming on the basis of mental or behavioural ill health. As was the case prior to the pandemic, around 70 percent of sickness benefit claimants are out of work, and most new claimants have been out of work for more than two years (Latimer, Pflanz and Waters, 2024).

Analysis of data from the European Union (EU) 15 (the countries that formed the EU from 1995 to 2004, including the UK) by Litsardopoulos *et al.* (2025) suggests that the UK performs relatively poorly when it comes to the employment outcomes of people with disabilities and health problems. This analysis is affected by some of the same difficulties with other datasets – in particular, it is not possible to accurately quantify the effect of differences in how ill health and disability are perceived and reported between countries.

Nevertheless, this analysis suggests that the UK has a relatively high burden of ill health compared to the EU15; that employment rates for people with health limitations have fallen faster in the UK than most of the other countries compared between 2018 and 2022; and that workers with health limitations are more likely to be out of work in the UK than they are in most of the comparator nations (Litsardopoulos *et al.*, 2025).

It is an open question as to how far apparently high levels of economic inactivity and low unemployment, as measured by the administrative data from the benefits system represent a primary health problem, and how far



this may relate to incentives within the benefits system. In other words, where sickness or incapacity benefits are, or are perceived to be, more generous or more easily accessible than unemployment benefits, claimants who are not in work and have some degree of health problem will be incentivised to seek those benefits. This does not require anyone to be misrepresenting or exaggerating their health problems and is arguably only a serious issue when the system then disincentivises people on sickness or incapacity benefits from taking up work through a loss of income.

The relevance of this is that it underscores the importance of taking a broad approach to work and health and that there is a complex relationship at play between health, work and benefits. Despite other countries seeing some of the same increases in ill health and disability post-pandemic, it is only in the UK that this appears to have translated into such a rise in sickness benefits and economic inactivity. It may be worth noting that, compared to other wealthy European countries, the UK provides less support for people with health problems who remain in the labour market, both in terms of direct state support beyond financial assistance, and in terms of obligations placed on employers by regulation (Litsardopoulos *et al.*, 2025).

The evidence of rising mental ill health, particularly among younger working-age people is concerning. It is important to maintain a social determinants perspective on this. Increasing access to mental health support is crucial but does not address the root causes of poor mental health. Improving opportunities for young people, through building skills, ensuring better quality work, resolving the housing crisis, and broadly restoring the confidence, aspirations and hope that previous generations had. Rising mental ill health among young people in coastal communities in Kent is of particular concern.

There are deteriorating employment opportunities for young adults in the UK and particularly among those with health limitations: in 2022 young people aged 16 to 24 years old with health problems were 13 percent more likely to be out of work than those without such health problems, a large increase from 2018, when they were 6 percent more likely to be out of work (Litsardopoulos *et al.*, 2025). Work by the Resolution Foundation on benefits claims also supports concerns around young people's health. Universal Credit claimants in their early twenties are more likely to report a work-limiting condition or disability than those in their thirties or early forties, and awards of health-related Universal Credit have risen fastest among young adults in recent years (Murphy, 2024). Similarly, in 2024 claims for Personal Independence Payments (PIP) rose by 77 percent for 18-24-year-olds, with a large 138 percent increase among those aged 16-17-years-old (Murphy, 2024).

The Government has made clear the intention to reduce expenditure on benefits while improving the quality of work through the Employment Rights Act, with the intention of 'making work pay' (Department for Business and Trade, 2025). This is coupled with the recognition that the current benefits system can disincentivise people with disabilities or other health problems from taking work by putting their current income from benefits at risk, and responding with a 'Right to Try Guarantee' (DWP, 2025a). This is still in development, however.

The government's proposed welfare and work policies are outlined in the Pathways to Work green paper (DWP, 2025c). Pathways to Work recognises many of the issues identified in this report, including the artificially simplistic binaries between can and can't work, jobseekers and those in receipt of health-related benefits, which can result in a lack of support for those with health conditions to find appropriate work, and perverse incentives whereby they lose benefits for trying. The green paper also recognises that the system moves too slowly and fails to intervene early to keep people in work, or limit time out of work.

The green paper proposes reforms to the benefits system, including scrapping the Work Capability Assessment (WCA) from 2028, and determining all health-related support via the PIP assessment (DWP, 2025c). This will have the result of decoupling access to health-related benefits from capacity to work, which alongside proposed legislation to prevent work triggering reassessments or award reviews, is intended to remove the disincentives to finding work that currently exist within the benefits system itself for those in receipt of health-related benefits. This is to be combined with a guarantee of personalised employment health and skills support made available to anyone on out-of-work benefits with a work-limiting condition or disability.

The 'Right to Try Guarantee' is a positive step, removing a barrier to work for those who want to try it; as is the development of the assessment system beyond a simple binary 'can or can't work', and the removal of reassessments for people with established life-long conditions or disabilities who will never be able to work.

While the long-term goal of supporting people with disabilities and long-term health problems into good quality appropriate work will have the effect of reducing the welfare bill, there is danger in cutting financial support prematurely if it is not accompanied by the necessary actions to help people into work. There are potential knock-on effects of losing PIP eligibility for other benefits, including losing priority status for housing under homelessness legislation, or eligibility for carer's allowance. For those PIP recipients out of work, a significant loss of income is likely to make managing

health conditions and moving toward work more difficult, as the Joseph Rowntree Foundation point out (Farnworth, 2025). For those in work, around one sixth of the total, that loss of income may even make it harder to stay in work, resulting in reduced employment.

People with disabilities already face a higher risk of poverty, due to the costs associated with disability and ill health, and barriers to work. 30 percent of people with disabilities are in poverty, compared with 20 percent of people without disabilities (also 27 percent of informal carers, and an enormous 50 percent of people with a long-term limiting mental health condition) (Bokhari *et al.*, 2025).

High levels of disability and ill health, especially in the context of poverty and deprivation, results in a high demand for unpaid carers. Unpaid carers can play a vital role in supporting people with long-term illness or disability, especially where formal services are insufficient, but face significant challenges themselves. High levels of unpaid caring can harm the local economy, as well as impacting the health and life chances of carers. However, with appropriate engagement and support from services and from employers, informal caring can be a positive experience and contribution to the community and the economy. Unpaid caring could also be a route to gaining skills and employment within the health and care sector. At a local level, the flagship programme to help people with disabilities and health conditions into work is Connect to Work, funded by the DWP but administered by local government. In Kent and

Medway this will be Kent County Council and Medway Council. This programme is now taking expressions of interest and offers an ongoing opportunity for input from Marmot partners to ensure that health and health equity are a consideration throughout.

In Kent and Medway, other groups also eligible for Connect to Work support include: 'offenders, ex-offenders, carers, ex-carers, homeless people, Armed Forces veterans or current Armed Forces personnel, people with drug or alcohol dependencies, care experienced young people or care leavers, refugees (resettled Afghans), people on the Ukrainian scheme, victims/survivors of domestic abuse, young people involved in or at risk of serious violence, victims of modern slavery' (Ratcliff, 2025).

The increase in ill health among young people may relate to the increasing numbers of 16-24-year-olds not in education, employment or training (NEET). Numbers of NEETS have been rising since the pandemic, and it is difficult to compare to pre-pandemic changes, both because of issues around the Labour Force Survey, and because of legislative changes that have kept more young people in education. In data, for 2024, an estimated 837,000 young people between 16 and 24 are NEET, an increase of 103,600 from 2023. This constitutes 13.6 percent of the age range, or close to 1 in 7 (DfE, 2025). Previous work from the IHE and Public Health England (PHE) has detailed how being NEET can have a detrimental effect on both physical and mental health, greater when the time spent NEET is at a younger age or lasts longer (Allen, 2014c; Allen, 2014b).



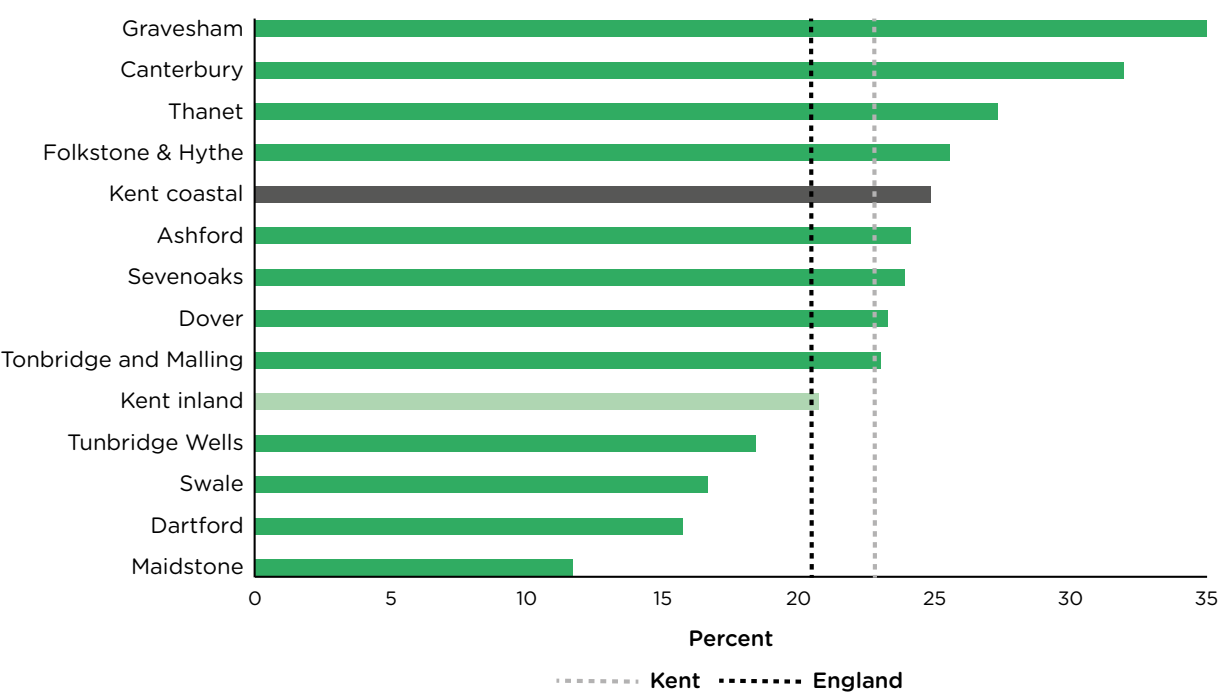
3B. ECONOMIC INACTIVITY AND BENEFIT UPTAKE IN KENT

The proportion of residents in Kent who are economically inactive is higher than in England (22.8 vs 20.5 percent), as illustrated in Figure 10. However, there are marked differences between districts.

11.7 percent of residents are economically inactive in Dartford, the lowest rate of all districts, compared to Gravesham (35.9 percent) with more than a third and Canterbury (31.9 percent) of residents of working age who are economically inactive. Overall, the percentage

of residents between 16 and 64 years old who are economically inactive is higher in Kent Coastal districts (24.8 percent) than in Kent inland districts (20.7 percent).

Figure 10. Economically inactive residents, 16- to 64-years old, percent, Kent districts, Kent coastal and inland, Kent, and England, 2025



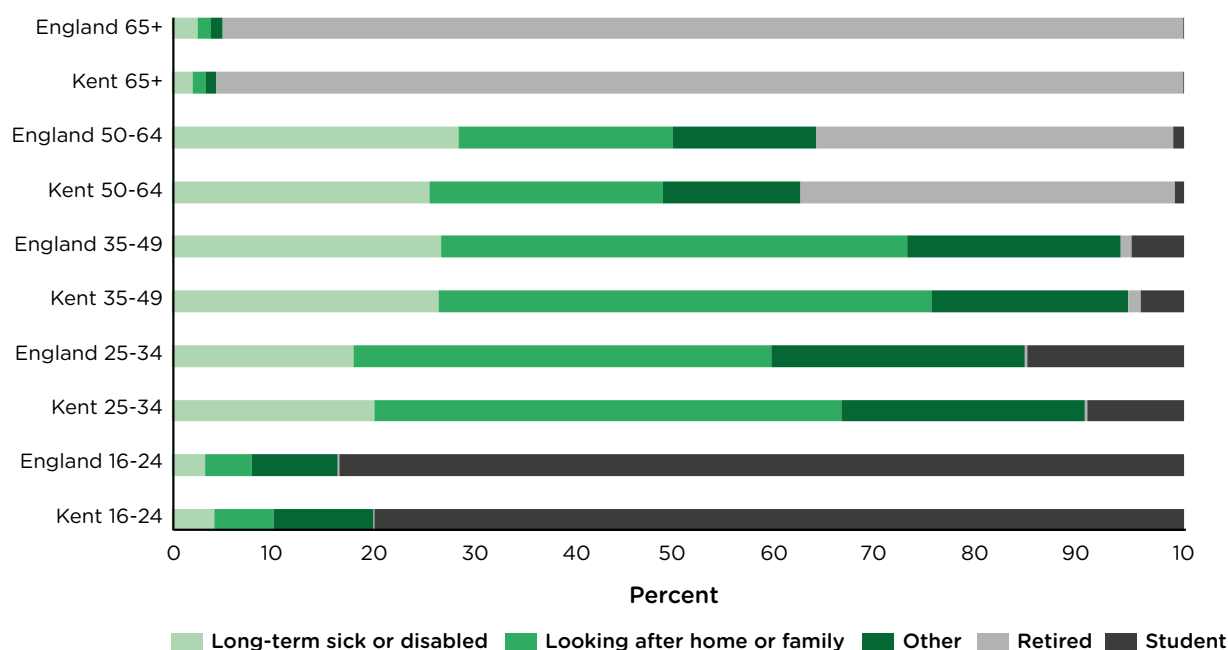
Source: Nomis, Annual Population Survey, 2026
Note: The data comes from the Annual Population Survey, a representative sample of the population.

Figure 11 shows the proportion of residents in Kent who are economically inactive by age categories and by reasons.

Among people aged 16- to 24-year-olds, the proportion of people who are economically inactive and students is lower in Kent (80 percent) than in England (83.5 percent). In Kent, 46.1 percent of economically inactive residents

from 25- to 34-years-old are looking after home or family members, a higher proportion than in England (41.3 percent). The proportion is also higher for residents aged 35- to 49-years-old. The residents who are economically inactive because of a long-term sickness or are disabled, account for 20 percent economically inactive residents from 25- to 34-years-old in Kent, the lowest proportion, compared to 17.9 percent in England on average.

Figure 11. Economically inactive residents, by age and reasons, percent, Kent and England, 2021



Source: ONS, CENSUS 2021

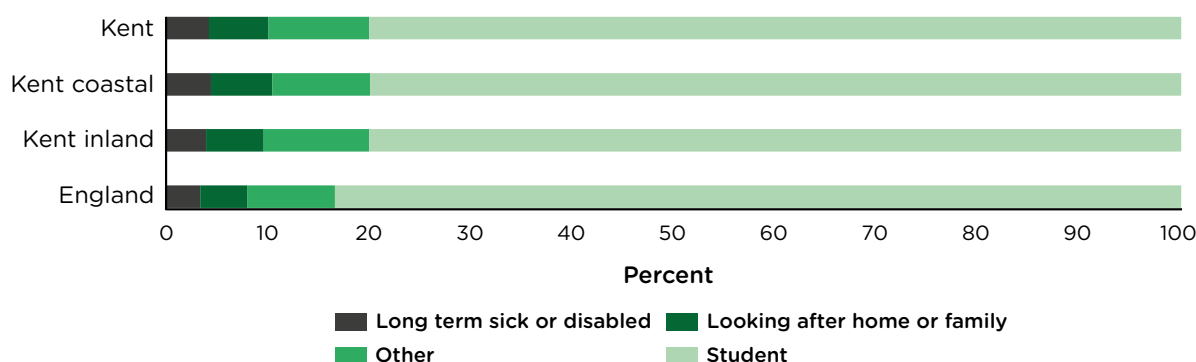
Figure 12 compares the reasons for economic inactivity, among young economically inactive residents in Kent coastal and inland areas and England.

The proportion of people from 16- to 24-years-old who are economically inactive due to being a student is lower in Kent (80 percent) than in England (83.5 percent). The proportion of residents from 16 to 24 who are economically inactive and looking after home or

family member(s) is higher in Kent coastal districts (6.1 percent) than in Kent inland (3.9 percent) and England average (3.3 percent).

The young residents who are economically inactive because of a long-term sickness or are disabled account for 4.3 percent economically inactive residents in Kent Coastal districts, also higher than in Kent inland (3.9 percent) and in England (3.3 percent).

Figure 12. Reason for economic inactivity, 16- to 24-years-old, Kent coastal and inland, Kent, England 2021



Source: ONS, CENSUS 2021

CHAPTER 4

QUALITY OF WORK

4A. INTRODUCTION

The connections between work and health are strong and complex. Work, or the lack of it, can influence health through a number of pathways, and conversely someone's health can affect what jobs they are available to them. There is a robust evidence base about the damaging effects of unemployment on health, and the protective effect of good quality work (Roelfs *et al.*, 2011; Marmot *et al.*, 2010; Lundin *et al.*, 2014; Paul and Moser, 2009; van der Noordt *et al.*, 2014; Balogh *et al.*, 2025).

In terms of psychological wellbeing, there is some evidence that employment status is as, or more, important than other key determinants like class, income and education (Richards and Paskov, 2016). Losing your job may increase your risk of death, although this effect appears to be weaker in the context of higher levels of unemployment across society (Martikainen, Mäki and Jäntti, 2007; Roelfs *et al.*, 2011). There is clear evidence that long-term unemployment is particularly damaging to health (Herbig, Dragano and Angerer, 2013) and evidence of improved health from unemployed people getting back into work (Carlier *et al.*, 2013; Rueda *et al.*, 2012).

However, not all jobs are good for health, and poor quality work, characterised by adverse physical or psychosocial conditions, by poor pay and insufficient hours, by precarity, job insecurity and the risk of redundancy, can be actively harmful to physical and mental health (Marmot *et al.*, 2020; Durcan, 2015; Bell, 2017; Tinson, 2020a; Grzywacz and Dooley, 2003; Law *et al.*, 2020; Balogh *et al.*, 2025). Research consistently finds that poor quality jobs can be as bad or worse for both physical and mental health than no job at all, (Broom *et al.*, 2006; Butterworth *et al.*, 2013; Pulford *et al.*, 2022; Butterworth *et al.*, 2011).

Good quality work, in contrast, includes safe working conditions for both physical and mental health, and also decent pay; learning, skills development and fair progression; job security; varied and interesting work; a balance of effort and reward; some autonomy, control and task discretion; support for employee voice and representation; and compatibility with a good work-life balance including flexible working where possible (Marmot *et al.*, 2020; Marmot *et al.*, 2022a).

Policies and interventions aimed at increasing employment do, therefore, have the potential to improve both physical and mental health, as well as reducing health inequalities by targeting a disadvantaged population: those currently unemployed or at risk of unemployment. By improving health, further knock-on effects include reducing health and care costs by decreasing the burden of ill health and long-term conditions. However, the evidence suggests that a single-minded focus on increasing employment without care and attention paid to the quality of jobs created or filled could have the opposite effect, damaging health.

There are large differences in mortality risks among different occupations, greatest in lower-skilled jobs (Katikireddi *et al.*, 2017) and lowest in professional and managerial occupations. This is likely related to the nature of the jobs themselves, including safety at work, but also to the way in which jobs shape other determinants of health, including income and social and economic status. Investment in skills, education and training, both for children and young people and throughout life can help people access higher-skilled and higher-paid jobs that better support good health. However, it is also necessary to improve pay and work conditions to protect those in lower-skilled jobs, who must also have the chance of a long and healthy life in which work has supported rather than damaged their health.

4B. STRESSFUL WORK

Having to undertake stressful work can be more detrimental to health than being unemployed (Chandola and Zhang, 2017). Evidence has linked chronic stress at work to poor mental health, coronary heart disease and metabolic syndrome (Chandola, Brunner and Marmot, 2006; Bosma *et al.*, 1997; Dragano *et al.*, 2017).

Stressful jobs are those that make high demands of employees but offer little control, or as those that ask for a great deal of effort but provide little reward in the form of pay, recognition or status (Marmot, 2004; Kivimäki *et al.*, 2007; Dragano *et al.*, 2017). These jobs are associated with worse physical and mental health, including higher risks of obesity, heart disease and diabetes, aspects of the 'metabolic syndrome' (Bell, 2017; Bosma *et al.*, 1997; Chandola and Zhang, 2017; Chandola, Brunner and Marmot, 2006; Marmot, 2004; Stansfeld and Candy, 2006).

To support health, jobs need to be stable and provide a good degree of autonomy and control, combined with support from fellow employees and managers. This kind of work can improve wellbeing by meeting the psychological needs of self-efficacy, self-esteem, a sense of belonging and meaningfulness (Durcan, 2015).

The importance of hierarchy in the workplace in shaping health inequalities was first established by the Whitehall studies of UK civil servants. The hierarchical and disempowering nature of the work that placed high demands on the worker while providing little control over work tasks was shown to play a key part in generating inequalities in health (Marmot, 2004; Marmot *et al.*, 1991).

In 2023/24 the Health and Safety Executive reported that there were 776,000 workers in the UK who reported themselves to be suffering from work-related stress, depression or anxiety (2,290 per 100,000 workers) and a total loss of 16.4 million working days as a result (an average of 21.1 days lost per case), with the main contributory factors being workload pressures and lack of managerial support. The proportion of workers reporting work-related stress had been trending upward prior to the pandemic, and post-pandemic levels are higher than pre-pandemic (Health and Safety Executive (HSE), 2024).



4C. WORKING HOURS AND FLEXIBLE WORKING

Working ‘long hours’, defined as 48 hours or more per week, increases the risk of experiencing fatigue and of accidents and evidence that long hours lead to stress, depression or mental ill health. In the UK approximately one in nine workers works more than 48 hours per week, and more than one in eight in Kent, as of the 2021 census, although the pandemic is likely to render that an underestimate (ONS, 2025). Workload pressures are the biggest contributor to workplace stress and work-related mental ill-health in Great Britain (HSE, 2024).

Shift working is associated with a number of negative health outcomes, including disrupted sleep patterns, symptoms of anxiety and depression, and increased risk of cardiovascular disease (Harrington, 2001). While shift working cannot be eliminated entirely, particularly in the healthcare and transportation industries, efforts should be made to limit this kind of work where possible and to protect the mental and physical health of shift workers by avoiding excessive hours and providing support where necessary.

Flexible working and reduced hours also have potential to support health. A recent systematic review provides some evidence that reduced working hours may increase employee well-being (Voglino *et al.*, 2022). This is always balanced against maintaining levels of productivity. It has long been established that the relationship between hours and productivity is not linear, and that, at least at some point, hours can be reduced with minimal or no cost to productivity (Pencavel, 2015). Recent research into a four-day week has shown some promise. In Iceland, large trials that together involved over one percent of the country’s entire working population, demonstrated improved measures of subjective health and wellbeing while maintaining overall productivity, and the majority of Iceland’s population have now either moved to reduced hours, or are on contracts that offer the right to do so in the future (Haraldsson and Kellam, 2021). A large trial in the UK reported similar benefits for wellbeing and mental health outcomes, as did a recent trial in Portugal, which included comparisons with ‘control’ companies (Lewis *et al.*, 2023; Gomes and Fontinha, 2024). In both cases, the majority of companies enrolled in the trial opted to maintain a four-day working week. From an equity perspective, it is worth noting that the Portuguese trial found the greatest benefits were felt by women and by lower-paid workers.

A 2021 survey of UK employers that have adopted a four-day working week for some or all their staff found that three quarters felt their staff were happier and 78 percent felt they were less stressed. The majority of employers believed they had reduced costs while maintaining productivity (Walker and Fontinha, 2022).

This aligns with the research that has consistently shown that the most productive and wealthy countries are ones that work fewer hours (Ashford and Kallis, 2013). It may be that as nations become more productive, they free up more time for workers; or that, at least past a certain point, excessive work hours lead to a drop in productivity.

There has been a large increase in working from home since the Covid-19 pandemic. In the immediate aftermath of the pandemic, surveys suggested that most of those who had begun working from home, across the socioeconomic gradient, wanted to continue working from home at least some of the time, and a smaller number want to remain at home all of the time (Ussher, Rotik and Jeyabraba, 2021).

Flexible working should be encouraged as it can promote a good work-life balance, giving a degree of control over one’s life while also enabling social interaction at work, which is supportive of good mental health. Flexible working can be particularly beneficial for working families with children, or those with caring responsibilities or with some health conditions who might not be able to continue in the workplace if their on-site presence were required full-time. There is also some research evidence supporting the idea that flexible working conditions can lead to improved health outcomes (Joyce *et al.*, 2010).

The Interim report of the Inclusive Remote and Hybrid Working Study has highlighted the potential of hybrid and remote working to close the disability employment gap by making more jobs available and accessible to people with long-term health conditions and disabilities, but at the same time noted that demand for such jobs currently outstrips supply. The report recommends action to embed and expand such remote and hybrid jobs and to ensure that they are inclusive of the needs of disabled workers (Florisson *et al.*, 2025).

At present, options for flexible, remote or hybrid working are often concentrated in comparatively well-paid, desk-based office jobs and are less common for frontline and site-based jobs. These kinds of jobs carry

other increased health risks, both in terms of often being more physically demanding, and in offering less autonomy and control, as well as the effects of lower pay, as discussed above. However, work has been done with employers like Guy's and St Thomas' NHS Foundation Trust, Sir Robert McAlpine and Wickes, to develop and trial approaches to flexible working for frontline workers (Allen *et al.*, 2024). Improving health equity would be best served by ensuring that the benefits of remote, flexible and hybrid working are extended to all workers, by working with a range of employers.

The proposed Employment Rights Act will strengthen the right to flexible working by making it the 'default' assumption that employers must justify refusing. Employers, especially larger employers, are likely to already be planning necessary adaptation to this change in the law. As with other proposed changes to employment law, how this will play out fully is yet to be seen.

There are potential benefits for Kent in encouraging flexible working. The same research into a four-day work

week found that workers proposed using their additional time in a range of ways, many of which would support both the economy and health locally. This included volunteering; studying and improving skills; taking on additional work and entrepreneurship; spending money locally at shops and restaurants; and a range of activities that support health and wellbeing, including spending time with friends or exercising (Walker and Fontinha, 2022). Two thirds also said they would use their car less, offering both environmental and health benefits.

Similarly, increased working from home would reduce car usage, and support local economies. For Kent's more deprived coastal regions, more flexible working could help circumvent the issues with connectivity and transport links that currently limit job opportunities, as well as encouraging those in work to spend money locally, while allowing for the health benefits of coastal living. This is one reason why type and quality of jobs are a crucial component of supporting good work locally. Kent County Council and partners should support and encourage employers to offer flexible working, and lead by example wherever possible.



4D. INSECURE WORK

In the last 10 years there has been an increase in precarious employment: jobs that are low-paid, unskilled and offer insecure contracts (Marmot et al., 2020; Taylor *et al.*, 2017). Insecure employment can include self-employment or employment on temporary or zero-hour contracts (Citizens Advice, 2015). People in lower-skilled and lower-paid occupations and people from minority ethnic groups are more likely to be on zero-hour contracts than those in higher-skilled occupations and people from White backgrounds (Marmot *et al.*, 2020).

Job insecurity has been found to be associated with poor self-reported health (Tinson, 2020b). This may reflect reduced employment opportunities for people with health conditions, a detrimental effect on health of insecure employment, or a combination of the two. Whatever the cause, it should make insecure work an area of focus in seeking to improve health and reduce inequalities.

There is a significant body of evidence linking job insecurity and temporary employment to worse physical and mental health (Green, 2020; László *et al.*, 2010; Sverke, Hellgren and Näswall, 2002; Pirani and Salvini, 2015; Green, 2011; Otterbach and Sousa-Poza, 2016; Cottini and Ghinetti, 2018; Stansfeld and Candy, 2006). These outcomes are related to both perceived job insecurity, which is determined by a number of factors, including type of work, type of contract, broader economic trends, and personal characteristics; and employability, or how likely people are to be able to get another job. There is also some evidence of job insecurity contributing to increased healthcare usage and costs (Hamad, Modrek and Cullen, 2016).

Green (2020) notes that some of the health effects of insecure work can be moderated by improving re-employability. In other words, the negative effects of losing a job, or fearing losing a job, are reduced with increased confidence of getting a new one. The Work Foundation has expressed concern that the national effort to get people back to work, if not accompanied by due attention to issues of job quality, will result in forcing people into insecure work (Florisson, 2024). This should also be a concern locally for efforts in Kent. Good quality work requires that workers are not falsely classified as self-employed and are on secure contracts and fair terms of employment. This could make use of the Living Hours standard produced by the Living Wage Foundation, which covers accurate contracts that reflect the reality of the work, decent notice periods for shifts and a guaranteed minimum of 16 hours of work a week (Living Wage Foundation, 2023).

Reforms to zero-hours contracts and other elements of insecure work form part of the Government's proposed Employment Rights Bill. This would include the right to move to a guaranteed hours contract, and reasonable notice periods for shift cancellation.

4E. SICK PAY

Pay for sickness absence is essential in enabling workers to take time off to access healthcare and recover from illness or injury. The Covid-19 pandemic also highlighted the importance of pay for sickness absence in slowing the spread of disease, by enabling people with infections to stay away from workplaces and avoid contact with colleagues and clients.

Currently most workers in the UK receive some or all of their salary for a limited period of sickness absence, but it is estimated that about a quarter of workers are only eligible for statutory sick pay (SSP) at £118.75 a week for 28 weeks (after a three day waiting period), and up to 1.3 million over the lowest paid workers are not even eligible for SSP (DWP, 2025b). The UK's level of SSP is low in comparison to similar European economies, which typically provide sick pay as a proportion of earnings, and certainly falls below the minimum income required for healthy living (Liser *et al.*, 2016; Litsardopoulos *et al.*, 2025). From April 2026, the Employment Rights Act will change sick pay, including broadening of eligibility and removing the three day waiting period. However, workers on low incomes are particularly likely to receive no further employment benefits beyond SSP, so that those already facing disadvantage, and more likely to be in poor health, face the greatest income insecurity when they become unwell.

Those in insecure employment may also be more reticent to take sickness absence for fear of losing the job on which they are dependent. The Workforce Disclosure Initiative have consistently found that most companies that provide disclosure data report that permanent employees are covered by measures to ensure they take sick leave appropriately, but only a small fraction extend the same benefits to contractors and agency workers, and even fewer to subcontracted and third-party workers (Lush and Williams, 2023). In short, access to appropriate support through sick pay is least likely to be available and accessible for those who are more likely to be in need, in both financial and health terms. This damages health and prosperity and

widens inequalities. A critical aspect of reducing health inequalities by improving job quality in Kent, in addition to fair pay, hours and conditions, will be ensuring that sickness pay is adequate and available to all.

Sick pay, with its direct relation to health, is perhaps the most obvious employee benefit for consideration when focussing on health equity. However, other employee benefits also contribute to the social determinants of health and health inequalities. Workplace pensions significantly mitigate risks of low income in old age; and support for parental leave and childcare allow parents on lower incomes to remain in work, both maintaining income and avoiding de-skilling and damaging career progression. These relate closely to other Marmot priorities, including giving every child the best possible start in life.

The range of other employee benefits, from financial advice to health advice, to facilities to support active travel, are also all important to health. It is important that employers understand the full range of their impacts on health. Pay that is sufficient to support a healthy lifestyle, and health-supporting conditions of work, are likely to be more effective than well-meaning employers seeking to improve employee health by more direct health interventions, such as free access to a mental wellbeing app, or exercise classes. When those fundamentals are in place, however, there is scope for active health promotion at work (Organisation for Economic Co-operation and Development (OECD), 2022) as well as support for peoples living conditions – offering support for housing and financial issues, for instance.

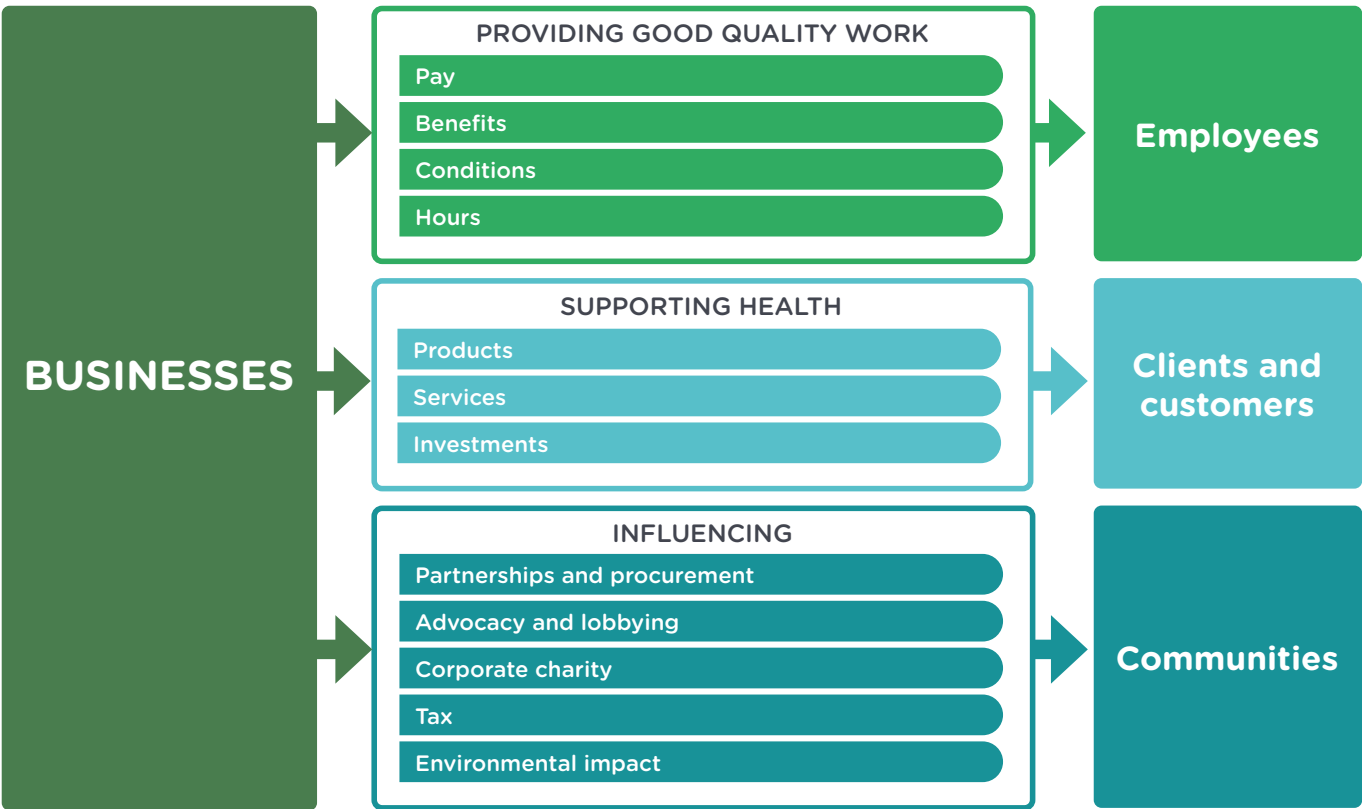
4F. THE ROLE OF BUSINESSES IN SHAPING HEALTH

Health equity should be a core consideration across all industries and businesses, just as environmental sustainability is becoming. As such, at the IHE, we call for ‘H’ for health to be added to Environmental, Social and Governance (ESG) initiatives (Marmot *et al*, 2022).

Figure 13 summarises three key facets through which businesses shape health. This framework illustrates three key facets through which businesses shape health: providing good quality work to their employees, supporting the health of their clients/customers, and influencing communities through their influencing

power. If not sufficiently prioritised, businesses harm the potential to actively harm health if their influence is not used correctly. Not only is this the ‘right’ thing to do, but there are benefits for businesses too, such as through improved employee health and wellbeing.

Figure 13. The IHE framework of how businesses shape health



The bulk of this report clearly sets out the close association between health and wealth on this first theme: the importance of providing good quality work to their employees. Examples of those include issues addressed elsewhere in this chapter, such as provision of adequate pay, fair working hours, and decent working conditions.

However, as Figure 13 shows, businesses also have the power to drive better health at a macro-scale too. Beyond directly shaping the pay and conditions of employment for their employees, businesses and employers influence the health of their customers and the communities in which they operate.

On the second theme, the goods, services and investments of a business impact the health of their clients and customers. Taking the example of food businesses that market products directly to consumers: a heightened focus on health equity could look like increasing the provision, accessibility and affordability of healthy food, a well-known driver of health inequality. However, sometimes a firm may consider it anti-competitive to take voluntary action on health, which may result in reduced profits for the organisation.

This moves us onto the third way in which businesses can shape health: using their influencing power to set lobby Government on the setting of industry standards. Continuing with the example of accessibility to healthy food, it may be that implementation of government regulation – such as has been done through the recent Healthy Food Standard – may be more impactful. Several large food manufacturers and supermarkets used their influencing power to push this agenda, which is now in the process of becoming legislation. This is a good example of how businesses can use their influencing power to improve the health of wider communities.

Another example of how businesses can improve the health of the wider community is through their role as ‘anchor institutions’. While generally in reference to public sector organisations, these are organisations physically rooted in a place that can either directly or indirectly shape the health of the local population. They can leverage their position as an employer, a provider of services, an owner of local buildings and land, etc, all to shape health.



4G. OPPORTUNITIES AND BARRIERS TO PROGRESSION

To tackle inequalities in health, it is also important to consider recruitment, retention and promotion at work. When good jobs are only available to those with fewer socioeconomic and other disadvantages, they run the risk of perpetuating or deepening inequalities. The IHE's report into structural racism highlighted evidence of discrimination in hiring practices, job opportunities, pay and progression (Marmot *et al.*, 2025).

Gender inequality remains a significant issue in the world of work, and much of the research into work and health does not fully take into account the effects of sex and gender (Quinn and Smith, 2018). Women still carry the greater part of the burden of unpaid domestic work, including childcare, which contributes to persistent inequalities in pay and progression, especially for women taking on a dual role of domestic and paid work. This 'double burden' may itself have deleterious effects on health (Seedat and Rondon, 2021).

Employers should be encouraged to be proactive in supporting individuals with recognised protected characteristics who may face barriers to employment, and barriers to career progression once in employment. For employers, this has the added benefit of widening the pool of available talent. Increasing employability among disadvantaged groups, including identified groups within Kent including care leavers, veterans and young people excluded from education (part of NEET), is the critical link between the skills agenda and good quality jobs.



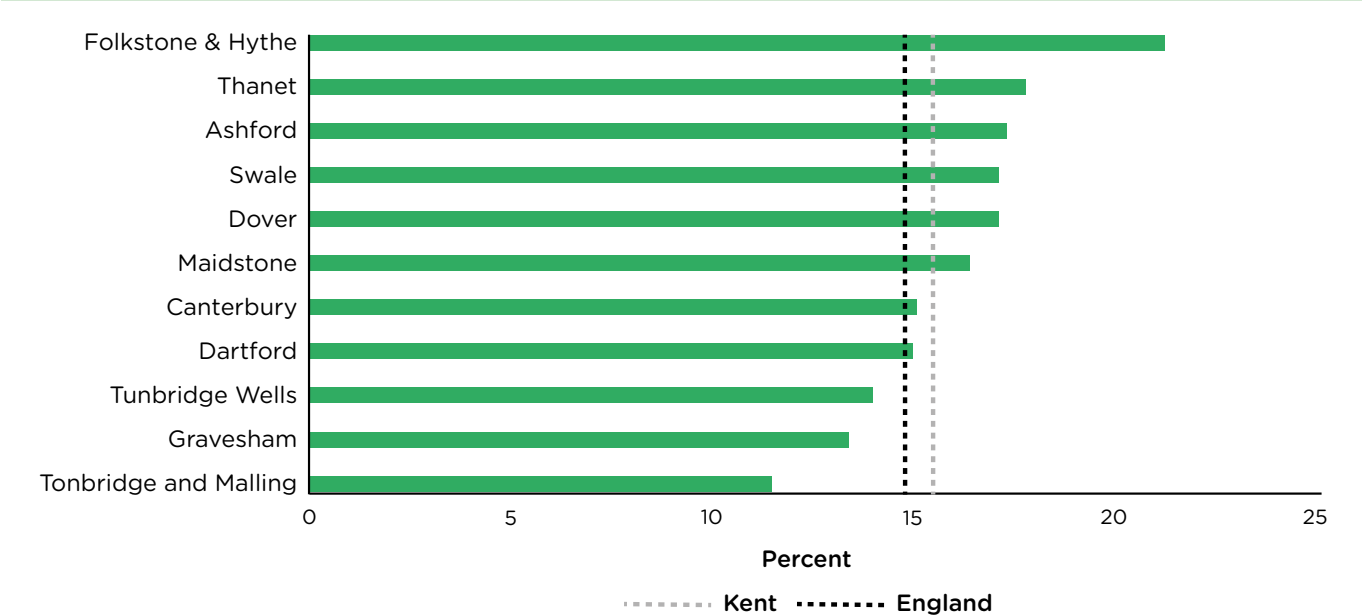
4H. QUALITY OF WORK IN KENT

A focus on quality work will influence the development of education and skills programmes, to ensure the skills that give access to good-quality, health-supporting work. In addition, work with employers, public, private and third sector, gives opportunities to make the case for the importance of good quality work, expand on its characteristics, and encourage adoption of best practices. Public sector partners, including Kent County Council, District Councils and NHS bodies can lead by example, both through their own employment practices, and through their contracting, ensuring that contracted and outsourced work must also meet standards of good quality.

As shown in Figure 14 the percent of employees earning below the living wage is higher in Kent (15.4 percent) than in England (14.7 percent). There are wide differences between coastal and inland areas. Specifically, the number of employees earning below the living wage is higher in five of the six the coastal districts such as

Folkestone and Hythe (21.1 percent) and Thanet (17.7 percent), both relatively more deprived than Kent and England’s averages. Meanwhile, the inland districts show nearly half the level of employees earning below the living wage in Tonbridge and Malling (11.4 percent).

Figure 14. Employees earning below the Living Wage Foundation’s living wage, percent, Kent districts, Kent, and England, 2025



Source: ONS, 2026

CHAPTER 5

EDUCATION, SKILLS AND HEALTH

5A. EDUCATION AND HEALTH

Education is one of the most important social determinants of health and reflects and drives societal inequalities. Pupils from more advantaged backgrounds spend more years in education and have higher attainment, on average, than those from more deprived backgrounds. There are stark inequalities in attainment at every stage of school related to eligibility for free school meals (FSM).

Education can be a powerful way to break the cycle between disadvantage, worse prospects and poor health and ensure children from disadvantaged backgrounds have the knowledge, skills and capabilities they need to live healthier lives, increasing opportunities and reducing inequality across society. There is strong evidence both internationally and within England that education has benefits for health in the long term (Marmot *et al.*, 2010; PHE, 2021; Davies *et al.*, 2018; Balaj *et al.*, 2024; Hamad *et al.*, 2018; Liu, Ji and Zhu, 2024; Raghupathi and Raghupathi, 2020).

Education affects health through several pathways. By improving life chances and future earning potential, greater educational attainment leads to lower unemployment, better quality jobs and higher incomes, which then allow for better health. Education can also provide children and adults with the skills and capabilities they need to look after their own health, cope with stress and adverse events, and make best use of available healthcare services. Higher educational attainment is also linked to reduced levels of harmful lifestyle factors like smoking and obesity.

Conversely, health also affects education. Children and young people struggling with physical or mental health problems may find their ability to engage with education and get the most out of schooling is impaired. Good health and a good education are therefore mutually dependent on each other.

In 2023, persistently disadvantaged pupils, defined as those who have been eligible for FSM for at least 80 percent of their time at school, were the equivalent of nearly a year behind their peers at key stage 2 and nearly two years at key stage 3 (Andrews and Cruikshanks, 2024). This gap has widened since the pandemic.

Exclusions and suspensions are associated with worse outcomes, both in terms of educational attainment and longer-term health and employment outcomes, although it can be difficult to separate this effect from the effects of the pre-existing disadvantages that increase the risk of suspension and exclusion in the first place (Joseph and Crenna-Jennings, 2024).

Education is, of course, not just about schooling (Dyson *et al.*, 2009). The home environment affects children's ability to study and is impaired if they are trying to work in an overcrowded home, one affected by cold and damp, in temporary accommodation, if there is conflict at home, or any of other stresses brought on by poverty and disadvantage (Donkin and Marmot, 2024). The ability of their parents to provide support will be limited if their parents are working multiple low-paid and insecure jobs. Similarly, parental physical and mental health problems will affect a child's progression. This is why it is important that the other building blocks of health are addressed alongside education, to, in the words of the Marmot principles, enable all children, young people and adults to maximise their capabilities and have control over their lives.

There are also ethnic inequalities in educational attainment. At Attainment 8 level, the average score varies from 65.5 and 59.4 for pupils in the Chinese and Indian ethnic groups, to 26.8 and 20.3 for pupils in the Irish traveller and Gypsy Roma ethnic groups (Department for Education (DfE), 2024b). Economic and ethnic disadvantage can compound. By the end of secondary school, disadvantaged pupils of Chinese ethnicity are six months behind their non-disadvantaged peers, while disadvantaged White British pupils are 23 months behind theirs, and White Irish pupils 30 months behind (Tuckett *et al.*, 2024). Overall, by the end of secondary school, pupils of Chinese ethnicity were almost five years ahead of Gypsy Roma pupils.

Other groups also experience unequal outcomes from education, including children in social care groups (including children in need, children on a child protection plan, and looked-after children) and children with special educational needs (SEN). Pupils in these social care groups are twice as likely to have a special educational need as the general pupil population, and all of these groups have lower educational attainment (Department for Education (DfE), 2024c).

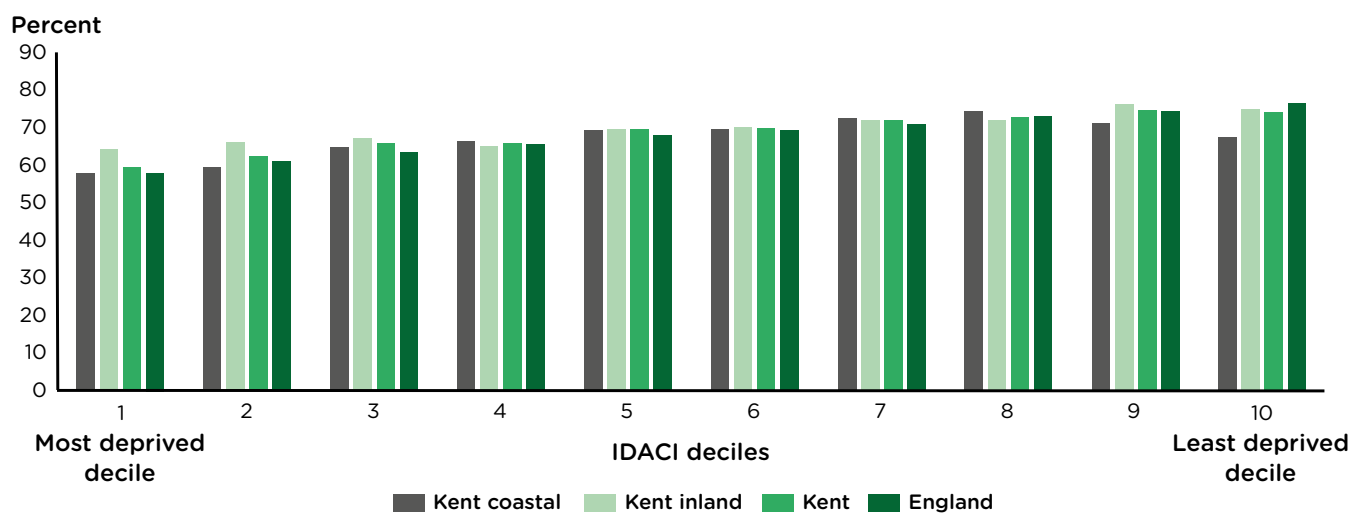
5B. EDUCATION IN KENT

Levels of development at the end of reception can also be related to income as well as area deprivation shown in Figure 15 shows levels of development at the end of reception for Kent coastal and inland areas, and for Kent and England across the Income Deprivation Affecting Children Index (IDACI) deciles.

On average, Kent pupils have a slightly higher level of development at this stage than in England. However, among children living in more deprived deciles levels of development are lower and particularly so in Kent coastal districts than in inland districts. This suggests that at a similar level of income, children living in coastal areas have a lower level of development than children living in inland Kent. In the fourth, fifth and seventh deciles, the differences between coastal and inland populations are smaller. Meanwhile, the eighth decile is the only one in which reception children living in coastal areas have a higher level of development than those who are living in Kent inland districts



Figure 15. Pupils achieving a good level of development at the end of reception, by Income Deprivation Affecting Children Index (IDACI) decile, Kent coastal and inland districts, Kent and England, 2022/23



Source: DfE, ONS, 2026

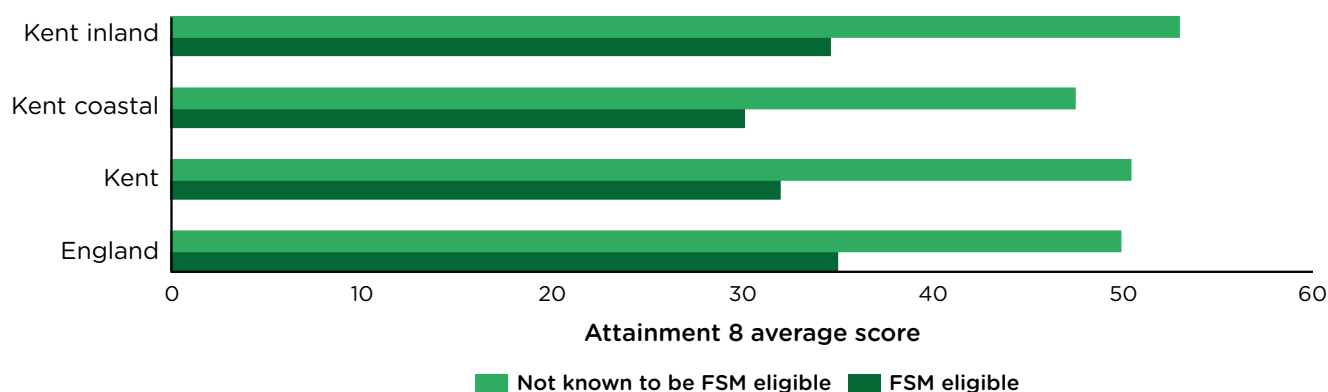


The Attainment 8 average score describes the achievement in 8 disciplines at the end of key stage 4, indicating the school performance of pupils who are preparing for their GCSEs. In Kent, as across England, pupils who are not eligible for FSM tend to perform better on the Attainment 8 average than their counterparts across England. However, in Kent pupils eligible for FSM have a lower average score than pupils eligible for FSM in England. Pupils not eligible for FSM and living in Kent inland districts perform better than

in England on average (53 vs 49.9), and the gap in attainment score is wider than England between pupils eligible and not eligible for FSM.

Figure 16 shows that pupils living in coastal districts perform less well than those living in Kent inland and on average in England, whether they are eligible for FSM or not and levels among pupils eligible for FSM and living in coastal areas are particularly low.

Figure 16. Attainment 8 average score by FSM status, Kent inland, Kent coastal, Kent and England, 2024/25



Source: DfE, 2026

5C. SKILLS AND HEALTH

There is a considerable evidence base to show that spending more years in skills development and adult education is linked to better physical and mental health, wellbeing and social integration (Marmot *et al.*, 2010; Marmot *et al.*, 2020; Augar *et al.*, 2019).

Skills development and adult education provide a range of health benefits. Directly, there is evidence for adult learning improving wellbeing, especially for more disadvantaged groups, including those who live in deprived areas, have low levels of skills, poor health and disability, experience discrimination and exclusion, and are socially isolated; as well as parents and carers or those whose quality of life and confidence could be improved by participating in skills building programmes (What Works Wellbeing, 2017; Augar *et al.*, 2019). In addition, education may also improve health literacy and encourage healthy behaviours (Allen, 2014a).

Skills offer routes to better quality employment, higher pay, opportunities for advancement and greater social interaction, all of which can contribute to better health. Adult learning delivered locally in community settings provides opportunities to build social networks, develop hobbies, reduce loneliness and develop confidence and wider abilities (APLW, 2022).

There is also evidence of additional social, physical and psychological benefits accruing to retired people from lifelong learning (Jenkins, 2011; Narushima, 2008; Dench and Regan, 2000; Noferini, Allen and Marmot, 2023). The focus of the Marmot work in Kent is on work and skills for work, therefore lifelong learning for retired people will not be discussed at length, but this population should not be overlooked.

Recent analysis has provided evidence that building skills provides a strong return on investment, particularly in poorer-performing areas, and that the benefits of upskilling are highly likely to remain in place, rather than being lost through out-migration (Advani, Cornish and Crawford, 2022). However, the same analysis has found that around one-third of the differences in earnings between better and poorer performing areas cannot be attributed to individual characteristics like qualifications, underscoring the need for wider investment, including in widening career opportunities and improving the quality of work.

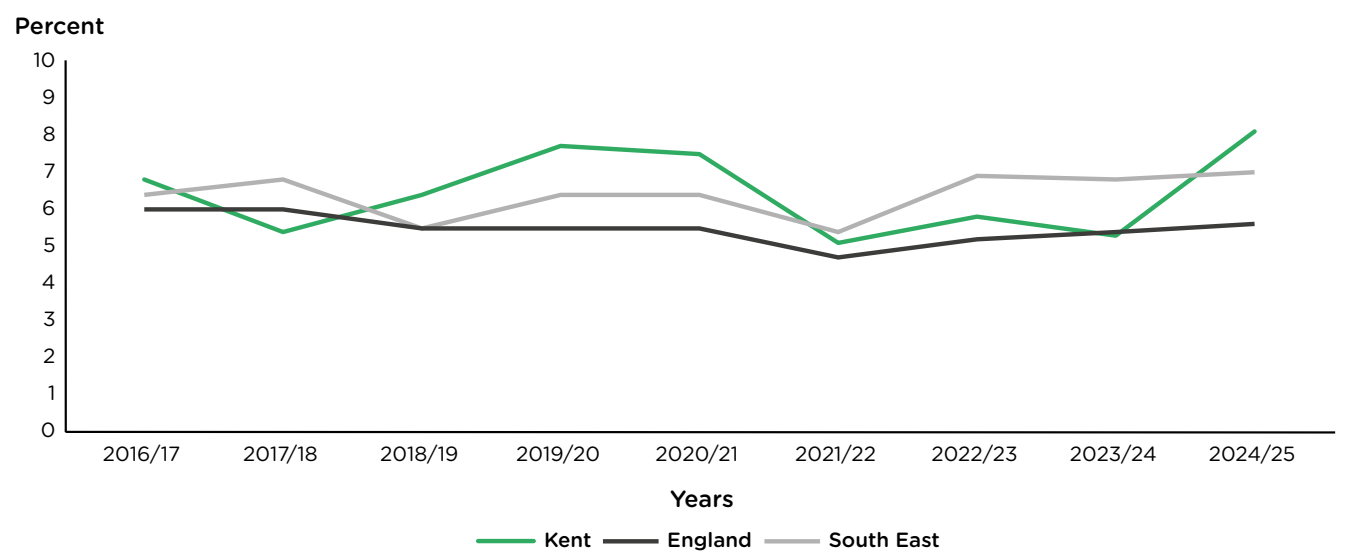
The skills landscape is complex. At a national level, a new body, Skills England, has been created to provide high-level oversight. Reform to funding for skills development is also underway, with a Lifelong Learning Entitlement set to replace current funding systems from 2026/27. In Kent, the skills landscape includes sixth form schools and colleges; further education colleges; universities; community learning and skills; adult learning; apprenticeships; in-work training; volunteering and more. These include so-called 'hard' and 'soft' skills, formal and informal qualifications.



5D. SKILLS IN KENT

Figure 17 shows that the percentage of 16- to 17-year-olds who are NEET in Kent has been higher than in England between 2016-2024, except in 2017/2018. An important increase is observed between 2023/2024 and 2024/2025. The proportion of young people who are NEET is also higher in the South East region and more research is needed to understand the drivers of these heightened levels.

Figure 17. 16- to 17-year-olds Not in Education, Employment or Training (NEET) or whose activity is not known, percent, Kent, South East, and England 2016 to 2025

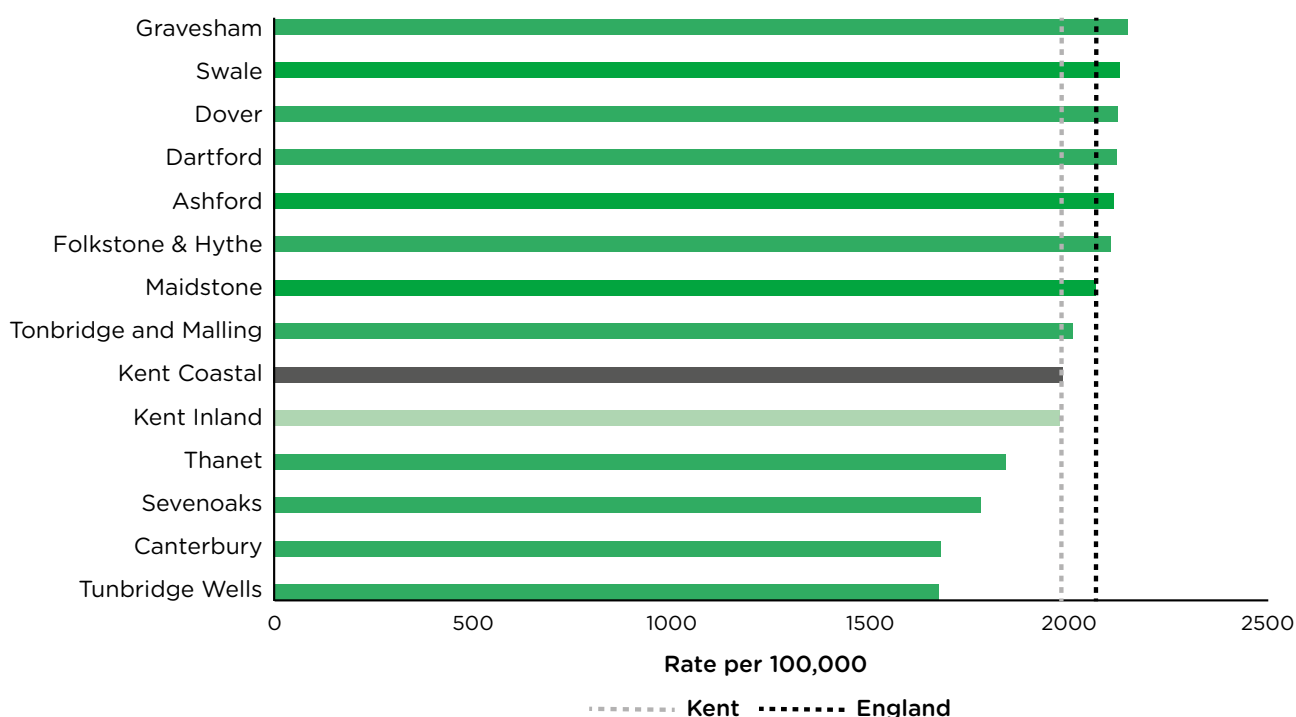


Source: OHID, DfE, 2026

The participation rate in apprenticeships is defined as “the number of all age (16+) learners participating on an apprenticeship in England” by the DfE and is published for each academic year (DfE, 2026). Figure 18 shows the availability of apprenticeships in Kent (1,979 per 100,000) is slightly lower than in England (2,065 per 100,000). The level in coastal and inland districts is similar. Within districts, Tunbridge Wells and Canterbury have the lower rates of participation (1,671 per 100,000 and 1,676 per 100,000 respectively), compared to Gravesham, Swale, Dover and Dartford having rates over Kent and England’s averages. Swale and Dover are both coastal districts and more deprived than the other areas. The greater prevalence of apprenticeships in more deprived areas, shows positive steps to reduce NEET in more deprived areas, with the exception of Thanet.



Figure 18. Participation rate in apprenticeships per 100,000, Kent districts, Kent Coastal and Inland, Kent and England 2024-2025



Source: DfE, 2026

The Kent Local Skills Improvement Plan has identified priority sectors for skills development, including key industries for Kent, such as construction; manufacturing and engineering; fresh food and food production; health and social care; and education, as well as industries with emerging skills needs like logistics and creative industries. It identifies key themes like decarbonisation, digitalisation and small and medium-sized enterprise (SME) engagement, driven through greater collaboration (Kent Invicta Chamber of Commerce, 2023) which has already begun in earnest (Kent Invicta Chamber of Commerce, 2024).

Skills bootcamps, aimed at the recently unemployed, self-employed, or returning to work, will focus on key sectors in Kent, including construction, agri-food, and health and social care (Kent Adult Education (KAE), 2025). For individuals, these are free to access, funded by the Department of Education, while employers seeking to upskill their workforce can access the bootcamps for 30 percent of the cost, or 10 percent if an SME.

The purpose of Marmot Place engagement with this skills agenda, as with other aspects of work and skills, is not to duplicate the extensive work already taking place. Instead, it is to provide an additional health and inequalities lens through which to examine the work already going on, and to provide partners with the additional power of the health equity argument to support their work.

The IHE has previously developed a number of recommendations for skills building in London covering: target underserved populations; tackle barriers to participation in skills programmes; and strengthen the role of public health and partnerships with employers in skills programmes (Noferini, Allen and Marmot, 2023).

The aim of the Marmot work in Kent must be to ensure that the already-established skills and employment strategies and programmes, take health equity as an additional key consideration, with a role for public health. The Marmot work focuses on support and partnership and leveraging the right skills from all partners. The approach helps ensure that equity remains a consideration across all aspects of the skills landscape.

CHAPTER 6

WHAT WORKS IN SHAPING INTERVENTIONS FOR GOOD WORK?

Measures across three domains (quality of work; getting people into work; keeping people in work) are considered to have the maximum impact on improving health and reducing health inequalities. These measures are likely to be supportive of each other: for example, good quality jobs that provide a degree of flexibility and autonomy as a default to all workers are going to be better placed to make the appropriate adjustments needed to keep people with health needs in work. Similarly, getting people back into employment requires there to be good quality jobs available, both from the economic and health perspectives. From the economic perspective, it is hard to incentivise and motivate people into work if the job offered is low paid and low quality. More importantly, from the health perspective nothing will be gained from moving people from being economically inactive if that move is into a job that damages their health.

Given the importance of employment as a social determinant of health, disadvantaged groups must be explicitly prioritised when planning measures to help people into work. In particular, given the long-term effects of early unemployment on career prospects, and thereby on health, young people should be a focus, particularly NEET and groups at high risk of becoming NEET, including care leavers.

ADOPTING BEST PRACTICE

It is important that efforts to improve work and health are informed by the best available evidence of what works. However, we must be realistic about what type and level of evidence is likely to be available. This is particularly important when working with colleagues in healthcare and public health who may have very different expectations and norms around evidence-based practice than outside partners. There are numerous reasons why social policy interventions lack the same kind of evidence base that is available for medical interventions, and why that may not be a reasonable thing to expect, or to make a prerequisite for action.

A particular approach to getting people with disabilities back into work may be effective in Birmingham, but not in Thanet. In part, this is because these populations differ in important ways, including demographics, skills and industrial histories, but also because this intervention will inevitably sit as part of, or alongside, other interventions and systems. Similarly, the intervention as practised in Birmingham is not going to look exactly like the 'same' intervention in Thanet. There are far more ways such complex interventions are likely to vary - personnel, location, details of approach and so on - than, for example, a medication.

This is a relatively obvious point, but it has further implications. The Health Equity Evidence Centre has produced a 'what works' evidence brief for health and care interventions to support people from disadvantaged backgrounds in returning to work (Harasgama *et al.*, 2025). One thing to note is that, having reviewed 57 studies, none of their key recommendations were provided with 'high'

certainty, but low to moderate, indicative of the difficulty in establishing certainty in this area. Nevertheless, they conclude that '[g]enerally, effective interventions were multicomponent, multidisciplinary, involved the workplace, and for some conditions, were individualised' (Harasgama *et al.*, 2025).

This is an important conclusion and should inform work in Kent. It is, however, evidently not a simple blueprint for a maximally effective intervention that can be immediately put into action. The key recommendations are more principles that should be incorporated into the way interventions are planned and carried out than a menu of specific effective interventions that can be easily transplanted to a different context. In fact, these principles themselves emphasise adaptability and variety.

It is important to be realistic from the start about the timescales that will be required to effectively test out approaches; the level of evidence that is necessary and proportionate for given approaches; and the level of ambition and commitment that will be required to achieve health equity at scale.

EMBEDDING EMPLOYMENT SUPPORT INTO HEALTH AND COMMUNITY SETTINGS

There is evidence supporting the principle of co-locating employment advice with health services. A pilot project in 2006 established that GPs and patients welcomed the presence of employment advisers in primary care (Sainsbury *et al.*, 2008). A randomised trial has showed strong evidence for the benefits for vocational advice in a primary care setting for patients with musculoskeletal pain (Wynne-Jones *et al.*, 2018). In Kent, a similar scheme has been piloted in Maidstone.

A systematic review of employment interventions in health settings identified five key features of successful interventions: a multidisciplinary team that communicates regularly and collaborates; a comprehensive package of services; one-on-one and tailored components; a holistic view of health and social

needs; and prospective engagement with employers (Pinto, Hassen and Craig-Neil, 2018).

Evaluation of the Work Well project in South London suggested that tailored employment support was effective for unemployed or economically inactive clients with common mental health problems in moving them to employment, education, training and/or participation in volunteering, valued in particular for its person-centred and holistic approach within a destigmatised service in neither a clinical setting nor a JobCentre (Robotham and Couperthwaite, 2022). This aligns with feedback from Coventry's JobShop approach, taking employment advice out of Job Centres and into the high street.

An initiative to place employment advisers in Improving Access to Psychological Therapies' (IAPT) services (now known as NHS Talking Therapies for anxiety and depression) across England was well-received by therapists, employment advisers and clients alike, freeing up therapists to focus on delivering therapy and providing access to clients in need of employment support (Loveless, 2019). In terms of outcomes, there was some evidence of beneficial impacts on mental health, as well as helping those out of work back into employment (Purdon, Bryson and Downing, 2022). For clients currently in work, there was some evidence that seeing an employment adviser was associated with moving out of work, likely due to a selection effect, whereby those who accepted seeing an employment adviser were most likely to be those who considered their mental health issues related to conditions at work.

SUPPORTING PEOPLE WITH DISABILITIES AND LONG-TERM HEALTH CONDITIONS INTO WORK

In terms of employment support for people with disabilities and long-term health conditions, there is good evidence for the effectiveness of the Individual Placement Support (IPS) model in getting individuals with severe mental illness into work and sustaining that work, and growing evidence for its effectiveness for a wider cohort of physical and mental health issues (Learning and Work Institute (L&W), 2019). IPS as a model is characterised by eight principles: a focus on competitive employment outcomes rather than volunteering or sheltered work; zero exclusion, open to anyone who wants to work; rapid job searching within four weeks; attention to client preferences; integration of employment specialists in clinical teams; employment specialists forming relationships with employers based on client work preferences; inclusion of benefits counselling to ensure no one loses out by seeking work; and ongoing individualised support for client and employer. Other characteristics of effective interventions outside of the IPS model include personalisation, integration with other services, and early intervention to prevent labour market exit (L&W, 2019).

Two large Health-led Employment Trials tested the provision of 12 months of IPS for individuals experiencing mild to moderate physical and/or mental health conditions in primary and community care settings on a range of employment and health and wellbeing outcomes (DWP, 2022). One trial in Sheffield City Region recruited both an out-of-work and an in-work but struggling group, while another in the West Midlands recruited only out of work participants. The results of these trials were mixed: for example, in the West Midlands, there was good evidence of improved employment outcomes, while these effects were not seen in the out-of-work group in Sheffield. Conversely, the participants in Sheffield saw improvements in health and wellbeing outcomes that were not seen in the West Midlands. Overall, there were high levels of satisfaction with IPS support, and good progress on 'movement to work' measures. These trials suggest good potential for wider IPS support but also demonstrate the difficulties in assessing large and complex interventions with high levels of inherent variability in practice, contributing to the differences in observed impacts and effectiveness.

Similarly, the evaluation of the Work and Health Programme, run as a randomised control trial between 2018 and 2020, is limited by the variability of provider and delivery across different areas of the country (DWP, 2023). Qualitatively, providers felt that flexibility, the provision of a dedicated contact to participants, and the long-term assistance were effective elements of the programme, and that a holistic approach to understanding the needs and barriers of participants was critical to success. Participants similarly identified flexibility and duration as positive aspects, as well as a positive and friendly delivery environment and a broad approach to support beyond the focus on finding work.

Another programme was Work Choice, a voluntary employment programme for people with disabilities who faced barriers to employment or were at risk of losing their job. Again, this involved DWP contracting a range of external providers to provide support for both gaining employment and remaining and progressing in employment. Evaluation suggests that this programme was effective in improving employment outcomes, and cost-effective in terms of increased earnings for participants, returns to the Exchequer and total benefits to society (DWP, 2025g). The complexity and variability of the programme limits what can be directly applied locally, but it indicates the potential for effective employment support to be cost-effective for the system as whole. It may also be worth noting that Work Choice was a voluntary programme, while the Work and Health Programme found better outcomes for voluntary participants than those whose involvement was mandatory (DWP, 2023).

INTERVENING EARLY TO REDUCE LONG-TERM UNEMPLOYMENT

The Commission for Healthier Working Lives, led by the Health Foundation, places emphasis on the importance of early intervention, noting that this is standard practice in countries such as Denmark and the Netherlands, where return-to-work support is available before individuals move to long-term out-of-work benefits (Rocks *et al.*, 2025). The recognition of the importance of early intervention, often therefore involving employers early in the process when implementing interventions designed to keep people in work or prevent them falling out of work, is a common theme across research and policy documents. Employers, both public and private, not forgetting voluntary, care, faith and social enterprise (VCFSE) employers, will be indispensable partners in the Marmot work. This includes in the design and planning of interventions, as well as their delivery.

Evidence of what works to reduce the proportion of young people who are NEET aligns with many of the findings about getting people into and keeping them in work more generally. A successful strategy requires early intervention, tackling the barriers that young people face when attempting to move into education or employment, working across organisational and geographical boundaries, the involvement of local employers, and active monitoring and evaluation, including tracking individual trajectories (Allen, 2014c). Best practice from other successful programmes should be borne in mind when commissioning new services, examples of which can be found in previous work from the IHE (Allen, 2014b). For example, it is important that courses are accredited, differ from a school environment, and are developed in partnership with young people.

RETHINKING THE ROLE OF EMPLOYERS

There is evidence that workplace-based interventions can help get people on sick leave back to work more quickly and reduce cumulative duration of absence, as well as improving pain and reducing disability for worker with musculoskeletal disorders (van Vilsteren *et al.*, 2015). This underscores the importance of involving employers, and of intervening relatively early, rather than waiting for inactivity and disability to compound. The evidence for similar levels of benefit for common mental health problems is less well established (van Vilsteren *et al.*, 2015; Axén *et al.*, 2020).



Some have argued for a more fundamental rethinking of the role of employers. Litsardopoulos *et al.* (2025), drawing on international comparisons, argue for the further development of occupational health, with the aim of destigmatisation of physical and mental health in the workplace, increasing reporting and allowing for earlier intervention. This suits well with a social determinants and prevention-focussed approach, broadening the remit of occupational health to include the promotion and maintenance of good health. Reforming occupational health at a local level is likely to require at least a two-tier approach, encouraging larger employers to modify their approaches, and supporting small and medium enterprises who may not have the resources to provide much occupational health support independently. As a first step, working with large NHS employers to model good practice has potential, given the presence of relevant expertise as well as a direct incentive to reduce healthcare need downstream.

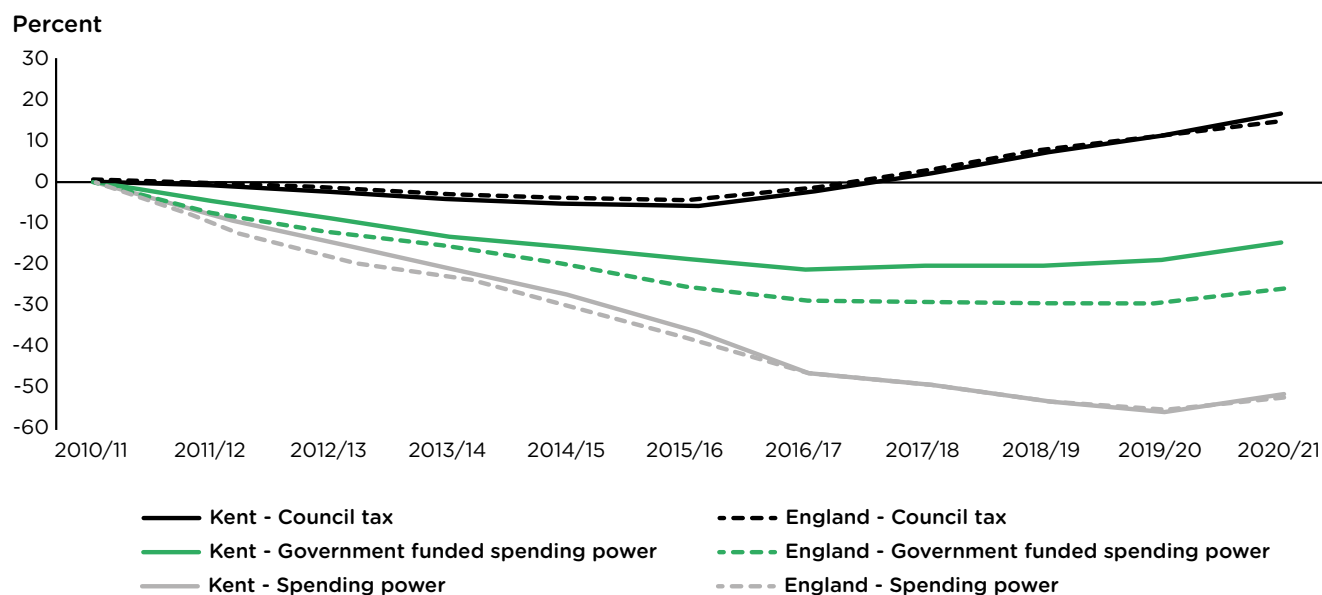
Qualitative research has also supported the importance of better integration between health and employment support systems for people with health challenges, including closer links between employers and healthcare providers, and a more holistic approach to health on the part of employers (Imafidon *et al.*, 2025).

FINANCIAL AND POLITICAL CONTEXT

One important reality is that all this work is taking place within a resource-constrained environment. Local government has seen its funding fall in real terms for well over a decade, and cuts have fallen hardest on areas already experiencing higher levels of deprivation and worse health.

Figure 19 below shows how spending power for councils in England, and for Kent specifically, has fallen precipitously.

Figure 19. Spending power and its components indexed to 2010/11, Kent and England, 2010/11 to 2020/21

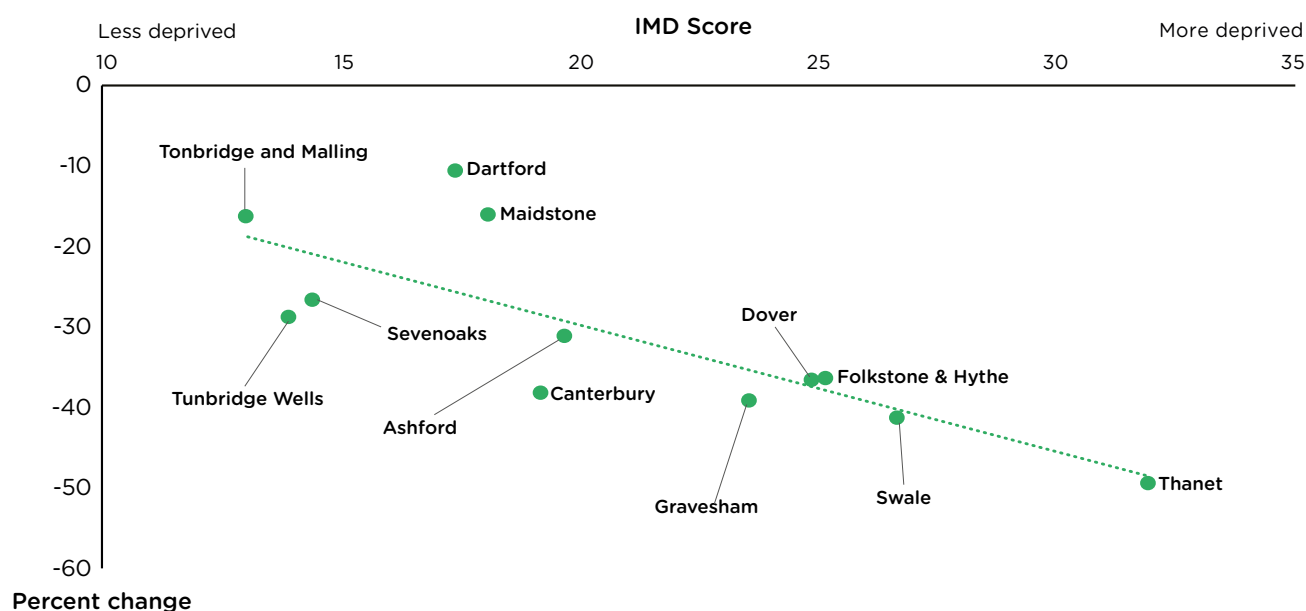


Source: National Audit Office, 2026

The change in spending power per-capita, compared with districts' Index of Multiple Deprivation scores, shows that populations living in more deprived districts have generally experienced a greater decrease in

local authority spending power (Thanet and Swale). Conversely, in less deprived districts, the reduction in spending power has been smaller (Tonbridge and Malling and Dartford), as illustrated by Figure 20.

Figure 20. Change in spending power per capita and IMD 2025, Kent districts, between 2010/11 and 2020/21



Source: National Audit Office, ONS, 2026

In terms of health, despite successive Governments recognising the need to improve illness prevention and health promotion, NHS spend remains heavily weighted toward the acute and away from prevention and primary care. In 2022/23, £62.6 billion went to acute care, compared to £9.7 billion for primary care, £7.8 billion for community healthcare, and a relatively small £2.7 billion to the public health grant (Gainsbury and Julian, 2024).

This is important context and may motivate local government and public health funders to be more discriminating and risk averse. In short, to seek out the single most cost-effective measures for improving health. The danger is that this can contribute to ‘analysis paralysis’, and it is important to consider opportunity costs in the context of the social determinants of health. This involves consideration of vicious and virtuous cycles.

TURNING VICIOUS CYCLES INTO VIRTUOUS CYCLES

Virtuous cycles and synergies between work and health are needed. For example, programmes focussing on developing green skills in construction, particularly for underrepresented populations, can benefit health equity through providing skills for good jobs and alleviating poverty, as well as supporting retrofitting programmes that reduce fuel poverty and the ameliorate the health effects of cold and damp homes, as well as contributing

to reducing the health harms of climate change. Similarly, developing skills and employment opportunities in health and social care can also help tackle the workforce crisis in social care, and prevent escalation of care needs for individuals, also reducing costs for local government. Identification of these opportunities allows cost-effectiveness to be maximised, and by identifying a range of benefits and cost-savings across different parts of the system, may facilitate more strategic use of shared budgets.

As referred to in Chapter 1, IHE recommends the principle of proportionate universalism. With regards to work and health, those in greatest need of support are likely to be those furthest from the labour market, who may never have been employed, or been unemployed for a long time, and who will need the greatest amount of support to get into good quality, health-supporting work. Equity demands that we prioritise this group. However, in so doing, we run the risk of ignoring the evidence that early intervention, and early involvement of employers, for those who have just become unemployed, or are in danger of becoming unemployed, can be more cost-effective, the equivalent of moving to prevention rather than treatment. We cannot afford to focus all support on those most at need, rather than prevent others falling out of the workforce. This requires a proportionate universalist approach to work and health.



CHAPTER 7

PRINCIPLES TO ADHERE TO FOR IMPROVING WORK AND SKILLS FOR WORK IN KENT

Drawing from a review of the literature, previous experience of Marmot Places, and expert opinion, we propose four evidence-based characteristics of effective interventions and systems that should guide the work in Kent.

The purpose of the Marmot work is to provide a health equity lens through which to view questions of work and health, encourage connections and partnerships, and influence design and delivery across the system, rather than providing ‘plug and play’ solutions that can be picked up from one place and put down in another context.

It is probably less important to identify very particular interventions that have been piloted elsewhere and try to reproduce them in Kent as it is to take the principles that successful interventions have been based on and then adapted to a local context.

1. Be person-centred

Being person-centred is about centring the needs of our populations, rather than the structures and procedures of services and the system itself. In other words, taking each person as an individual, with their own needs and priorities to be addressed, rather than forcing them into existing pathways.

This is of course, easier said than done. It requires a place-based system that is well-integrated, so that services form a cohesive whole rather than a scattering of unconnected resources that are difficult to navigate, especially for the most disadvantaged. This necessitates at a minimum effective signposting, but should go beyond to encompass opportunities for co-location and co-delivery; quick and effective referrals; robust data sharing; targeted outreach; and upskilling, incentivising and empowering those in service delivery to take a holistic view of clients, customers, patients and the population as a whole, rather than a tunnel-vision focus on their own area.

A related concept is ‘no wrong door’. Due to the vicious cycles mentioned above, the wide-ranging of deprivation and disadvantage, and the interconnected nature of the social determinants of health, health and social problems often cluster. The social determinants of health are also often the social determinants of crime, and fire services have pointed out that these are also the social determinants of fires. This means that individuals and families most at need often come to the attention of some branch of public services, or VCFSE providers. It is important that they are not lost, and every contact is a potential route to every source of support. This requires coordination and cooperation, and an end to siloed thinking.

Being person-centred also means approaching each individual in a holistic way, and not assuming that we know what the most important problem is. If we want to help people with health problems into work, it is important that our services are flexible enough

to recognise that if a client perceives their housing situation as their most pressing need, they probably know best. If we can effectively refer to the appropriate support, that may remove the barrier to returning to work for that individual. This is true for services, from health and social care, to the DWP, but also applies to employers, who can also have an important role as a route to appropriate support for their employees.

In Kent there is already work to facilitate connections across the system. ReferKent operates as a directory of available services and a referral hub, and the Joy Marketplace app does a similar job facilitating social prescribing referrals, both for professionals and self-referral. Facilitating these connections, increasing awareness of and maintaining tools like these will be critical. It is important that the right hand knows what the left is doing, so that work is neither duplicated nor contradictory.

2. Work collaboratively

To be effective, the Marmot work will need to be in partnership with local communities and with a broad range of organisational partners and stakeholders. This is critical to ensure that solutions are locally acceptable and meet local needs. It is also necessary to ensure that the work feels like it is locally owned and achieves the necessary buy-in across the system, especially if the structures and the focus on health equity are to persist long-term, beyond the initial two years of close engagement with the Institute of Health Equity.

In particular, it is critical that employers are involved from the start. Improving health through the world of work in Kent will involve working with employers, public and private, to encourage principles of good working, including decent pay and conditions, allowing all employees to have some control over their working hours and environment where possible, variation in tasks, and systems for recognition and reward for work, that are purposeful and health-promoting. This extends to contracting and tendering, especially for public sector employers who can be encouraged to recognise the contribution they can make to their core public service purpose through their employment practices.

One third of all people in employment living in Kent are employed in public administration, education or health (Kent Analytics, 2024). This gives huge scope for public sector employers to lead the way in modelling good quality employment.

We can also identify good private sector employers and recognise and reward their approaches. Several local authorities have established good work criteria and

programmes to support efforts to offer good quality work, some of which are covered in case studies above. Adherence to these principles can be a requirement for organisations to have contracts with local authorities and public service organisations. These principles can also be adhered to by private businesses, who ensure that organisations they contract with are offering good quality work.

As well as employers, public bodies and services, it is important that the people of Kent and its communities are involved as much as possible in setting priorities and design and delivery of interventions. The ideal is co-production, which goes beyond consultation, and necessitates wide engagement and involvement from the very start of the programme. It is not always possible to truly co-produce all interventions, for example when funding and direction comes from central government, but in all cases community engagement must be a consideration. The minimum should be to keep communities informed and engaged, to be honest about what it is in their power to change and what is not, to listen and respond to feedback, be adaptable wherever possible, and be open about decision-making. In this way, we can stop doing things to the people of Kent and start doing things with them.

3. Plan strategically for the long term

Long-term planning means providing confidence that the things we put in place today will be there tomorrow. Just as integrating services makes them easier to navigate, consistency is just as important for partners across the system including clients and patients, employers and employees. At present, much of the policy landscape is characterised by short-termism and this has been identified as one of the key barriers preventing an effective focus on prevention in local government (Edgington, Thomson and Paine, 2025). The Commission for Healthier Working Lives also identified a lack of consistency and continuity in the UK's policies as a barrier, noting that other countries see greater success with more stable, evolving approaches, rather than unstable isolated interventions that come and go (Rocks *et al.*, 2025).

Long-term strategic approaches are as noted above, also necessary for good evaluation. Having an impact downstream from interventions upstream of necessity takes time. This was discussed at a Kent and Medway Integrated Care System (ICS) event in Gravesend in 2024, where partners from healthcare and beyond attendees were repeatedly exhorted by senior ICS figures to hold their nerve. Where we have a good evidence base, we must be bold in implementation and realistic about the timescales it will require.

Longer-term thinking commits to maintaining and refining interventions and programmes based on these principles, rather than generating a hodgepodge of short-lived interventions, pilots and short-term funding

pots. Partners, including in the VCFSE sector, may be reticent to promote a service or intervention if there is no certainty that it will still be there in a year's time. This does not mean obstinately sticking with what is not working, but being adaptable, flexible and iterative, taking a 'test and learn' approach.

Taking a strategic view across the whole system can be seen as the necessary corollary of being person-centred, because it decentres organisations and their internal processes. Thinking about work and health necessarily involves employers, healthcare, education and skills, social care and childcare, and beyond, involving a range of services. Without coordination at a strategic level the result can be unnecessary duplication of work, missed learning and insight, contradictory incentives, and a system that is impossible to navigate for the populations that we serve.

4. Take an asset-based approach

Being asset-based hinges on the recognition that we are not starting from scratch: in terms of the evidence and data that is available; in terms of programmes and initiatives already underway; in terms of engaged partners, from education and skills providers, to healthcare, the voluntary sector and public and private employers; in terms of the people of Kent and their skills; in terms of the geography and economy of Kent, and more.

In Kent, there is already a great deal of work around employment, skills and health. The Marmot work should seek to support and connect these strands, not to duplicate work or try to reinvent the wheel.

Being asset-based also means recognising what resources, including potential partners, are currently underutilised, and considering the levers that are already available to partners in this work. As noted above, in a resource-constrained environment it is ever more important that we use every resource available. This can be simply a question of making the right connections and improving communication.

VCFSE organisations often report that they are underutilised by risk-averse local government partners. When they are, excessive administrative burdens are often in place, accompanying short-term small funding settlements that make it impossible for them to plan services. Service provision is not temporally symmetrical – when a service loses funding, or faces uncertainty and is forced to close, expertise and experience is lost that cannot simply be purchased back. This is another key reason why there is necessity for longer-term strategic planning.

Being asset-based, recognising work already happening, also helps strengthen partnerships. This ensures that health equity becomes something that the system across Kent can take ownership of, rather than being perceived as something imposed from outside.

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