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Long-term sickness and the London labour market

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Contents

1 Introduction

The link between long-term sickness and labour market participation has become a prominent issue among UK policymakers since economic inactivity due to ill-health rose following the pandemic.[1, 2] The latest Office for National Statistics (ONS) data showed that, in the 12 months to September 2024, 2.5m people were inactive because of long-term sickness in the UK.

Tackling health-related economic inactivity is central to the government's approach to its Get Britain Working White Paper, with the aim of **increasing the national employment rate from 75.8% to 80% in the long run**[3]. This employment strategy will rely, in part, on **greater devolution to local areas**, to integrate health, skills, and employment support.

However, London's population and labour market characteristics differ from the rest of the country. This means that national-level trends in long-term sickness and inactivity, may also be different in London. This note and an accompanying data file provide an evidence base for analysing long-term sickness in the capital.[4]

Definitions

- **Economically inactive** people are those not in employment who have not been seeking work within the last four weeks and/or are unable to start work within the next two weeks (ONS).[5]
- A **long-term health condition (LHC)** is defined in the ONS Annual Population Survey as a health condition that has lasted 12 months or more.
- A **work-limiting health condition (WLHC)** is a long-term health condition that limits the amount and/or the type of work someone can do. Not all long-term health conditions are work-limiting. Someone may report a work-limiting health condition and yet be in employment.

Key findings

- In the latest data for 2023, 15% of working-age Londoners, or **around 920,000 people**, had a work-limiting health condition, up from 13% and 720,000 people in 2014.

- In the 12 months to September 2024, **260,000 Londoners were economically inactive** due to long-term sickness, up from 215,000 in early 2014. That represents around 1 in 5 (20%) of London's economically inactive working-age population, up from 16% in early 2014.

- The growth in both WLHCs and economic inactivity due to ill-health has been **far slower in London than in the rest of the UK**.

- **2.4m hours of work** were lost due to sickness-related absences from work in 2023 in London, a sickness absence rate of 1.6%. This is up from 1.9m in 2014 (1.4%).

[1] Economic update: Inactivity due to illness reaches record. House of Commons Library.
[2] See for instance: "Britain has a bigger, but sicker, workforce than previously thought" (Resolution Foundation); "Three challenges for getting people on incapacity benefits into work" (Institute for Fiscal Studies); "What we know about the UK's working-age health challenge" (The Health Foundation).
[3] Get Britain Working White Paper (DWP, HMT, DfE)
[4] The data for all the charts in this note are in this file, alongside data referenced in the text and more.
[5] https://www.ons.gov.uk/employmentandlabourmarket/peoplenotinwork/economicinactivity#:~:text=People%20not%20in%20employment%20who,within%20the%20next%202%20weeks.

- The employment rate of people with a WLHC has risen by nine percentage points since 2014 to 51% in London. That is **lower** than that of people without such conditions (79%). **One in ten** employed Londoners reported a WLHC in 2023.

- When in work, Londoners with WLHCs were also more likely to be in **precarious forms of employment**, such as solo-self-employment or involuntary part-time work, than those without such conditions.

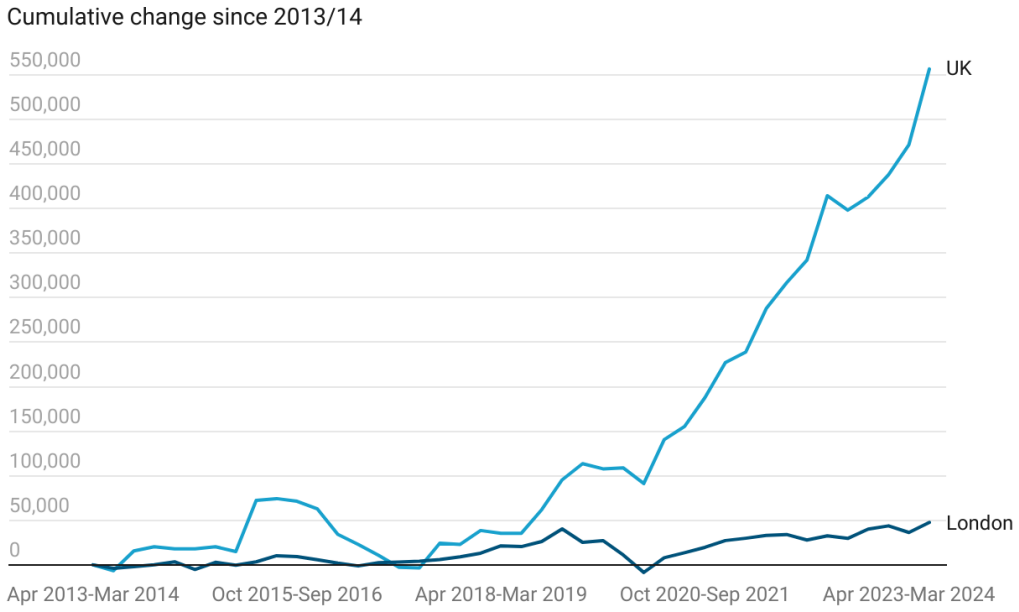
- **Some groups of Londoners have higher rates of WLHCs** than others. As well as older workers, people with lower levels of qualifications and people from most ethnic minority backgrounds have higher rates. Women have slightly higher rates of WLHCs than men.

- **Mental health conditions** have become more widespread in London's working-age population over the last few years and now make up the most common broad type of health condition among **young adults**. Mental health conditions are more strongly linked with economic inactivity than other illnesses.

2 Long-term sickness in London: Overall landscape

There has been a **rising trend of health-related inactivity in the UK** since around 2015, which accelerated following the pandemic (Figure 2.1). In London, there was a rise after the pandemic, but this was much slower than the UK.

Figure 2.1: Number inactive due to long-term sickness



Difference in number of people economically inactive due to long-term sickness over the decade.

Chart: GLA Economics • Source: ONS Inactivity by reasons • Created with Datawrapper

In the latest data, covering the 12 months to September 2024, long-term sickness was the third biggest reason for inactivity in London, representing more than **one in five inactive** people, behind students (34%) and people looking after the household (22%).[6]

Over the last decade, the share of economically inactive people (due to long-term sickness) who **say they want to find a job fell from 30% to 18%** in the capital, with a similar trend in the UK.[7]

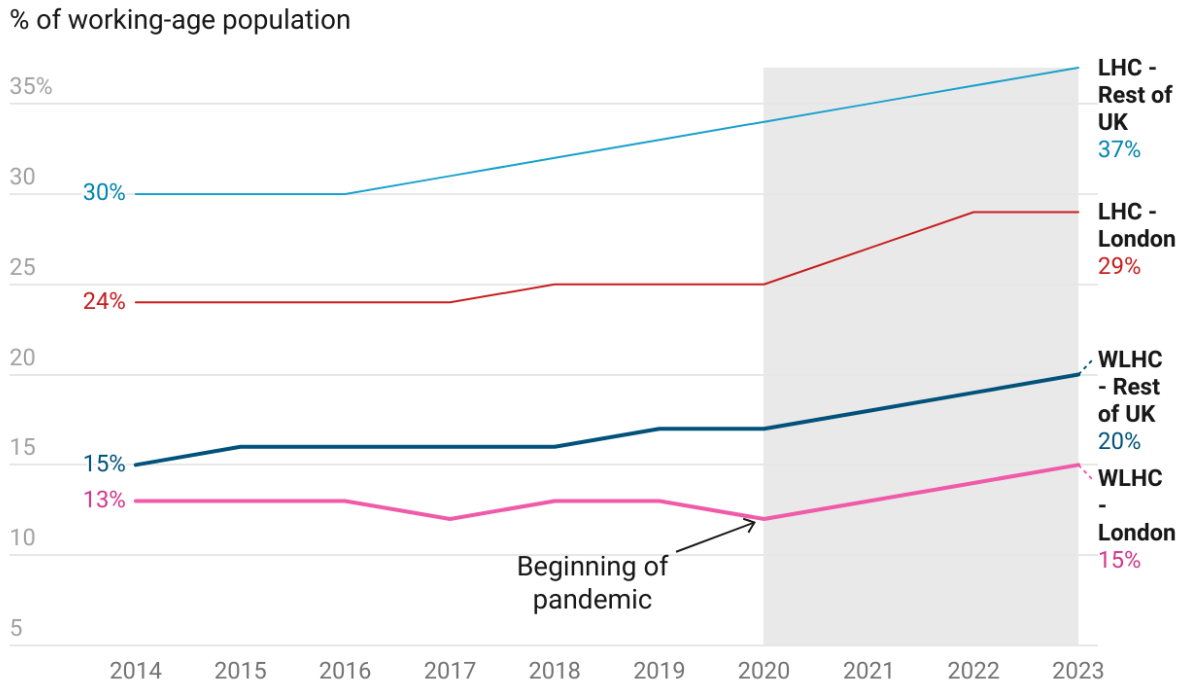
Beyond inactivity, 29%, or **1.8m**, of London's working-age population reported a long-term health condition in 2023, a five percentage-point (pp) rise on the decade (Figure 2.2). For **15%** of London's working-age population, or **920,000 people**, this long-term health condition **limited the kind and/or the amount of work** they could do.

Both the proportions of working-age Londoners with a long-term health condition in general, and a work-limiting one in particular, were broadly stable up to the pandemic. However, **there is a clear rise in these shares in London since the pandemic**.

[6] Source: ONS Inactivity by reasons – available on NOMIS

[7] See sheet 1 "LT sickness and inactivity" in accompanying workbook.

Figure 2.2: Prevalence of long-term health issues



Trends in share of 16-64 population with a long-term health issue and a work-limiting long-term health issue.

Chart: GLA Economics • Source: ONS Annual Population Survey • Created with Datawrapper

For the rest of the UK, the rise of LHCs predates the pandemic. The prevalence of WLHCs was also rising before the pandemic, although it also appears to have accelerated in the years since.

The prevalence of LHCs and WLHCs is lower in London than in the Rest of the UK. In 2023London had the lowest prevalence of WLHCs as a share of the population of any region/country of the UK.[8]

However, because of the size of London's working-age population, lower rates of sickness in London compared to the rest of the UK still translate into substantial absolute numbers (Figure 2.3).

Therefore, a lower prevalence of WLHCs in London compared to the rest of the UK, when expressed as a share of total population, does not mean it is a small-scale issue for the capital.

[8] See sheet 2b "WLHC by region" in accompanying workbook.

Figure 2.3: WLHC levels by region/country

Number of people with WLHC in 16-64 population, by region/country of the UK.

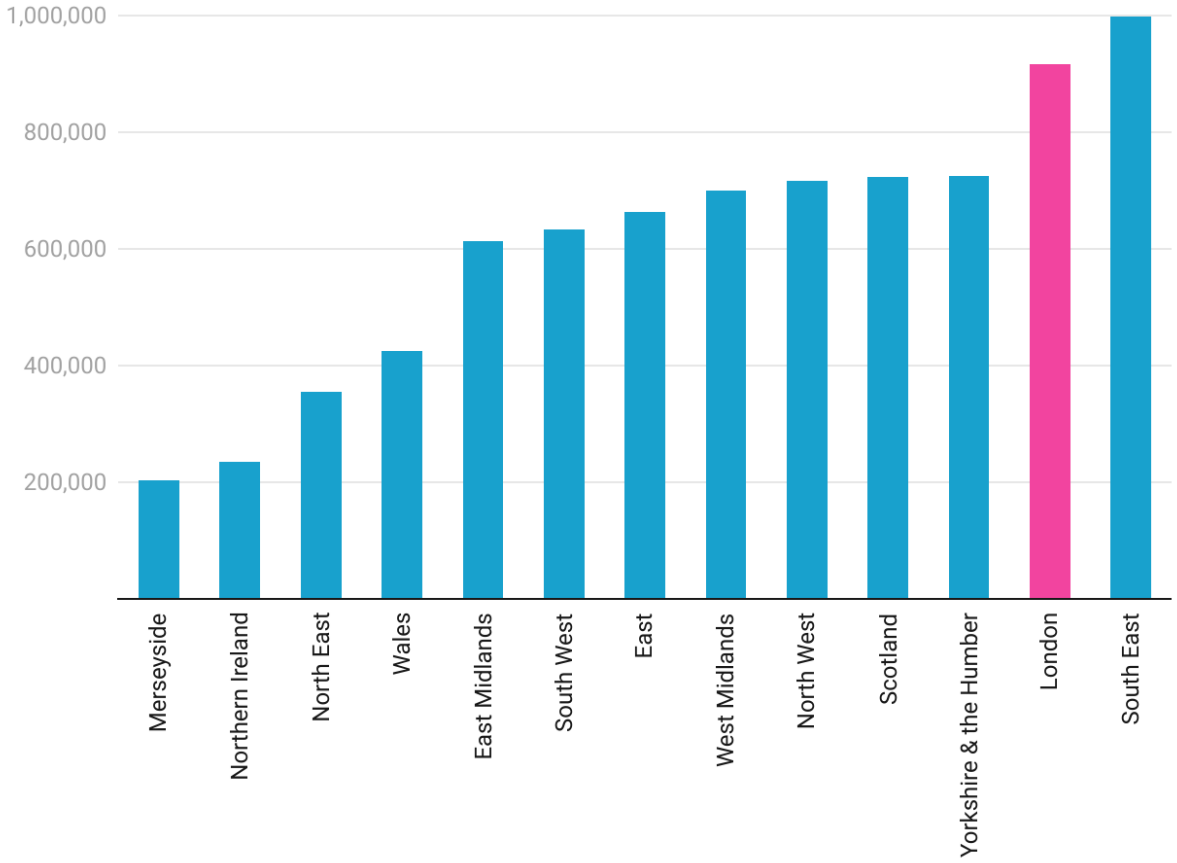
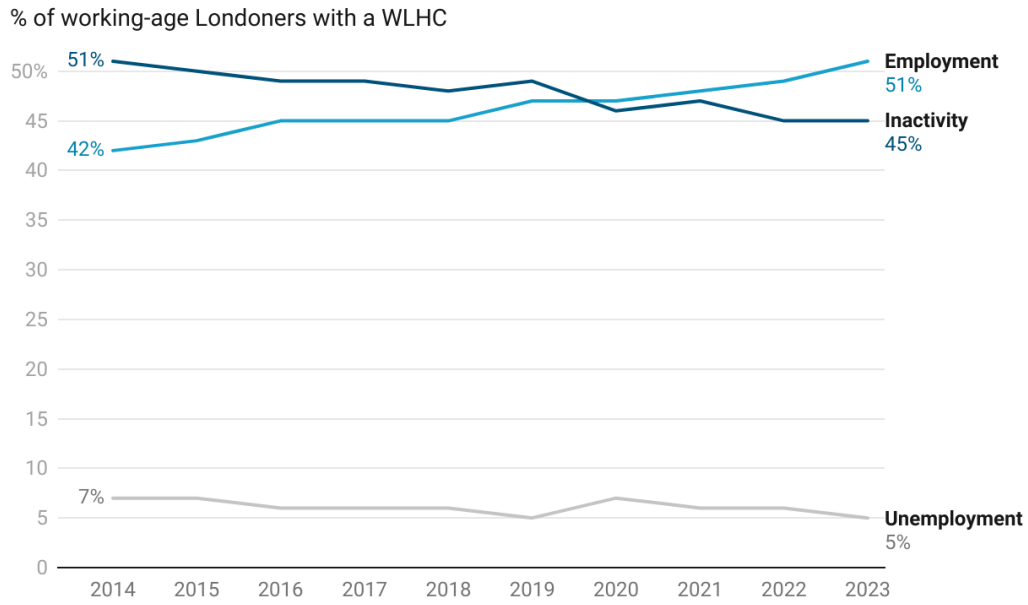


Chart: GLA Economics • Source: ONS Annual Population Survey • Created with Datawrapper

3 Work-limiting health conditions and labour market participation

People with a WLHC in London in 2023 had an employment rate of 51%, meaning they were slightly more likely to be in work than out of work (unemployed or inactive) (Figure 3.1). This corresponds to about **460,000 employed Londoners with a WLHC**, or about **one in ten workers** residing in London. This is also a **sharp increase** in a short time: in 2014, the employment rate of people with a WLHC in London stood at 42%.

Figure 3.1: Labour market participation and WLHC



Employment, unemployment and inactivity rates for people with a work-limiting health conditions in London.

Chart: GLA Economics • Source: ONS Annual Population Survey • Created with Datawrapper

This corresponds to about 160,000 more workers with a WLHC in London in 10 years. **This shows that it is possible to increase the employment participation of people even when they have a work-limiting health issue.** Nonetheless, the employment gap with people without WLHCs remains very large (Figure 3.2). The employment rate of people without WLHCs stood at 79% in 2023, a **28pp difference compared to people with WLHCs**.

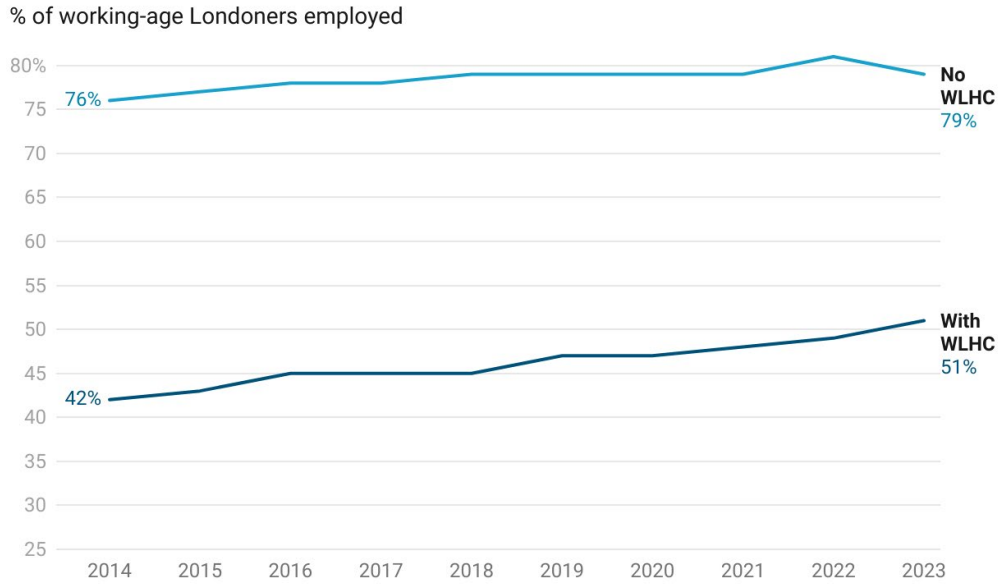
The employment rate of people with WLHCs was slightly higher in London than in the rest of the UK in 2023 (48%). The employment gap between people without and with WLHCs was higher in the rest of the UK than in London.[9]

Workers with WLHCs were not evenly found across occupations and sectors in London in 2023. The share of workers with a WLHC is much smaller in occupations such as Managers & Senior officials (7%), or Professional Occupations (8%), than in Elementary Occupations (18%) or in Administrative & Secretarial occupations (13%). Similar patterns emerge in industry sector data. For instance, 7% of Londoners employed in Banking & Finance have a WLHC, compared to 13% in Public Administration, Education and Health.[10]

[9]See sheet 3a "LM participation London-UK" in accompanying workbook.

[10] See sheet 4a "WLHC Occup and industry" in accompanying workbook.

Figure 3.2: Employment rate by health status



Employment rate for people without and with WLHC.

Chart: ONS Annual Population Survey • Source: ONS Annual Population Survey • Created with Datawrapper

Similar differences exist in the rest of the UK. However, for a given occupation or sector, a worker in London was less likely to have a WLHC than one in the rest of the UK. Further, the occupations and sectors with a lower prevalence of WLHCs are much more common in London than the rest of the UK.[11]

In addition, across a range of job quality indicators, **workers with a WLHC in London tended to be in worse quality employment** than those without a WLHC in 2023.[12]

Here, the dimensions of quality we look at are whether someone is satisfied with their current job arrangement (captured by whether they want to work more hours, and, if in part-time work, whether this part-time arrangement is chosen or involuntary), whether they are solo-self-employed (as solo-self-employment is typically associated with lower earnings)[13], and whether if they are an employee, their contract is temporary (an important dimension of job security)[14]. This is not an exhaustive set of indicators on job quality, but small sample sizes limited the types of possible analyses (for instance, on zero-hour contracts).

In 2023, workers with a WLHC were more likely to be in **involuntary part-time work**, i.e., to report working part-time because they could not find a full-time job — 5% of Londoners employed and with a WLHC were in that situation, compared to 2% of those employed and without a WLHC. They were also more likely to be **under-employed**, i.e., to want to work more hours than currently (11% vs 6%). They had a higher prevalence of **solo self-employment** (17% vs 13%). Employees with WLHCs were more likely to be on a temporary contract (7%) than those without WLHCs (4%).

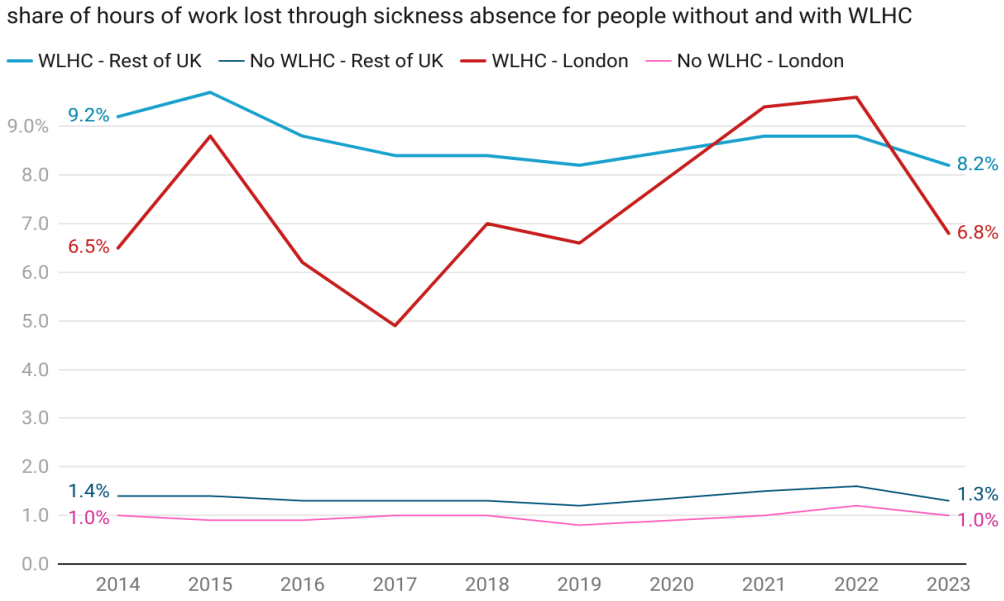
In the rest of the UK, we also find differences on these indicators between people without and with WLHCs, but they tend to be smaller.

[11] See sheet 4b "Regional indu occup" in accompanying workbook.
[12] See sheet 5 "Job quality gap" in accompanying workbook.
[13] See for instance: "What does the rise of self-employment tell us about the UK labour market?" (Institute for Fiscal Studies).
[14] See for instance: "Measuring labour market insecurity in the UK", (Work Foundation).

Another way to look at the employment of people with a WLHC is to turn to outcomes. We estimate the sickness absence rate in London, the percentage of total hours of work lost through sickness absences, to be 1.6% in 2023.[15]

This rate is the lowest of the regions and countries of the UK. But it also represents, because of the large size of the London labour market, the second highest total in absolute numbers: **2.4m hours of work were lost to sickness absences in London in 2023.** Figure 3.3 shows that sickness absence rates tend to be **much higher for people with a WLHC than people without**. In other words, among people with a WLHC, the rate of hours of work lost through sickness absences is much higher than among people without a WLHC.[16]

Figure 3.3: Sickness absence rates



Sickness absence rates show the ratio of hours of work lost through sickness absence to the total of hours worked. Here, they are shown by group: for instance, the thick red line represents the share of hours lost through sickness absence for people with a WLHC.

Chart: GLA Economics • Source: ONS Annual Population Survey • Created with Datawrapper

About **970,000 hours of work** were lost to sickness absences of workers with a WLHC in London in 2023. This means that workers with a WLHC make up a disproportionate share of these lost hours. About **10% of employed Londoners have a WLHC** (see above), but they represented **43% of all hours lost to sickness absence** in London in 2023.

The high sickness absence rates suggest that economic output could be higher if these workers did not have a WLHC. Sickness absences have generally been found to contribute to the UK's current growth and productivity issues, while there is evidence showing that the hourly pay of workers with a WLHC is lower than for those without.[17,18]

[15] See sheet 6a "Sickness absence by region" in accompanying workbook.
[16] Note that the 1.6% overall figure mentioned earlier cannot be obtained by averaging the rates shown below for people with and without WLHC. These rates are computed within these groups, but these groups are of very different sizes. To obtain the 1.6% figure, the average needs to be weighted buy each group's population size.
[17] "Economic growth requires breaking the cycle of poor work and ill health", LSE Business Review.
[18] "How can the next government improve the health of the workforce and boost growth?", The Health Foundation.

4 Health conditions and demographic characteristics

London's population differs in many respects from the rest of the UK. These differences may help better understand the relationship between long-term sickness and the labour market in London.

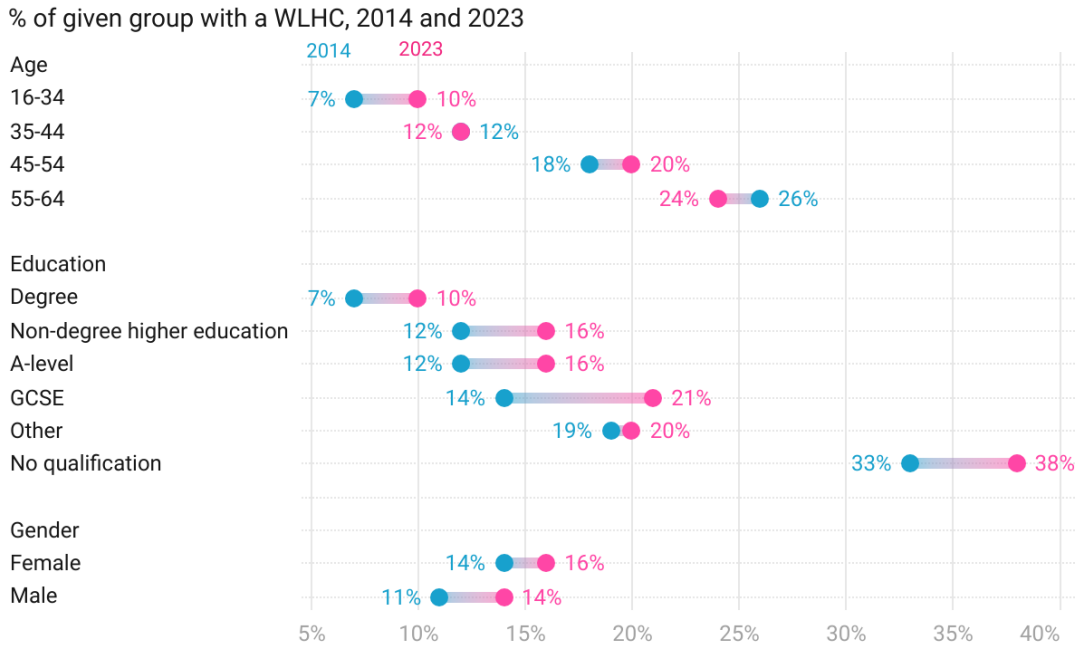
London's population is, on average, younger than the rest of the UK's.[19] People aged 16-34 made up 41% of London's working-age population in 2023, compared to 37% elsewhere. Conversely, 15% of working-age Londoners were aged 55-64, compared to 21% in the rest of the UK.

London's population is also **more highly educated**. Some 54% of working-age Londoners held a degree or equivalent in 2023, compared to 35% in the rest of the UK. Also, just 5% in London had no qualifications at all, compared to 7% elsewhere.

Finally, London's population is **much more ethnically diverse**: 42% of working-age Londoners were from a minority ethnic background (defined as all non-White backgrounds) in 2023, compared to 13% elsewhere in the UK.

We explore how the prevalence of WLHCs vary across these characteristics, in addition to gender, and how they may relate to labour market participation for Londoners (Figure 4.1).

Figure 4.1: WLHC rate by characteristic



Proportion of socio-demographic group with a WLHC, 2014 (blue) and 2023 (pink).

Chart: GLA Economics • Source: ONS Annual Population Survey • Created with Datawrapper

The prevalence of WLHCs clearly increases with age. In 2023, 24% of Londoners aged 55-64 had one, compared to 20% of those aged 45-54, 12% of those aged 35-44, and 10% of those aged 16-34.

For this youngest age group, there was, however, a rising trend in the second half of the last decade, which accelerated in the post-pandemic years.[20] The prevalence of WLHCs is now higher for this group than 10

[19] See sheet 7 "Demographic profile LDN-UK" in accompanying workbook.

[20] See sheet 8 "WLHC by demographics" in accompanying workbook for results for each group and each year between 2014 and 2023.

years ago. On the other hand, for the oldest age group, the prevalence of WLHCs was declining in the years prior to the pandemic. Although it has rebounded slightly since, it remains lower than a decade ago.

There are also clear differences **by highest education level.** More than one in three Londoners without any qualifications reported a WLHC in 2023, compared to one in ten Londoners educated to degree level. Very few Londoners hold no qualifications at all, however. The WLHC prevalence for degree-educated Londoners remains lower than for Londoners with any other level of education.

There is, finally, **a gender gap in WLHCs** in London. Women have a higher prevalence of WLHCs than men (16% versus 14% in 2023). However, the gap is smaller than for other characteristics considered.

Similar patterns of inequality appear in the rest of the UK. However**, for most categories, the share of WLHCs in London is lower** than for the same group outside of London.[21] For instance, while younger people outside of London are less likely to have a WLHC than older people outside of London, they are more likely to have a WLHC than younger people in London.

Therefore, it is unclear whether the lower prevalence of WLHCs in London in general compared to the UK comes from a population with different characteristics (younger, more educated), or remains even when controlling for these factors, which would hint at structural reasons such as healthcare services (waiting lists or general practitioner to population ratios) for the difference.

The picture is more complex when it comes to ethnicity (Figure 4.2). Londoners from a **White ethnic background had a lower WLHC rate (14%) than Londoners from most minority ethnic groups in 2023**, except Londoners from Indian ethnic backgrounds (10%). The highest prevalence of WLHCs is found among Londoners from Pakistani or Bangladeshi ethnic backgrounds (19%).

However, this pattern seems to be quite **London-specific.** Outside of London, people from a White ethnic background had the joint highest rate of WLHCs of all ethnic groups (21%). While, the WLHC rate for people of a Black ethnic background falls from 17% in London to 12% in the rest of the UK.

These demographic characteristics may also be related to the probability of employment in cases of WLHCs.[22]

For instance, older Londoners are not just more likely to have a WLHC: when they have one, the **employment gap with people without WLHCs is bigger** than the same gap among younger people. The employment rate of Londoners without WLHCs in 2023 was 72% for the 16-34 age group, and 75% for the 55-64 age group. For Londoners with WLHC, it fell to 51 and 39%, respectively.

In terms of **education,** employment rates are extremely low for people with WLHCs without any qualifications: 15% in 2023 in London. However, they are a rather small group. Employment rates were also very low in 2023 for people with WLHCs whose highest qualification level is GCSE, or Other qualifications (36%). By contrast, the employment rate of degree-educated Londoners with WLHCs was 72% (compared to 88% for those without).

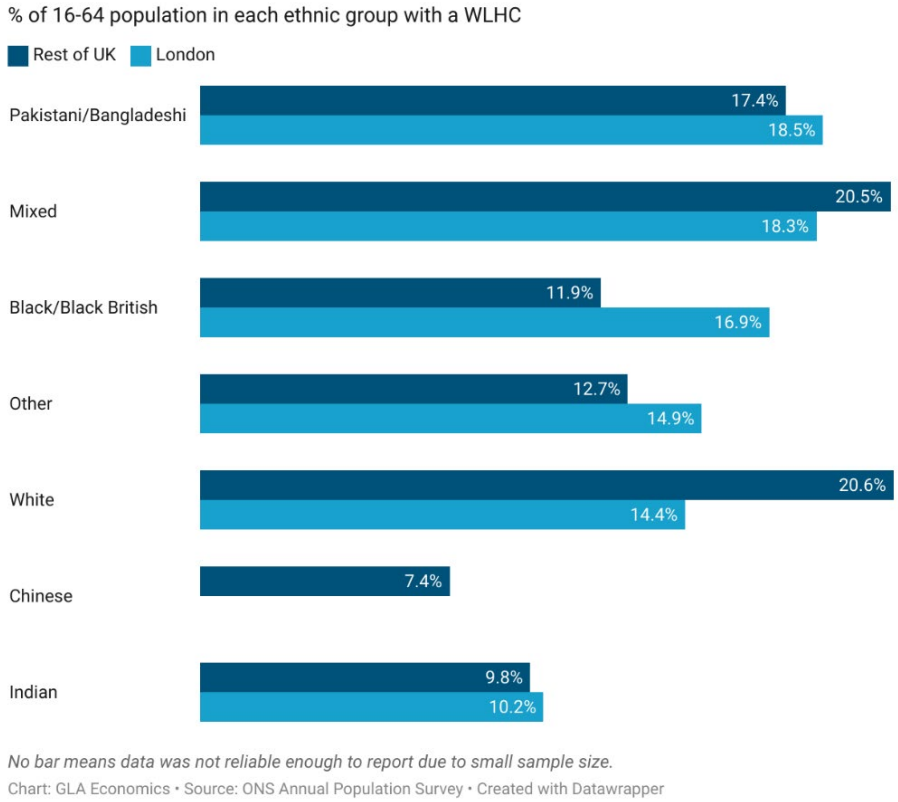
Finally, in 2023, the employment rate of women without WLHCs (74%) was lower than for men without WLHCs (84%). However, **women with a WLHC were more likely to be in employment than men with**

[21] See sheet 8 "WLHC by demographics" in accompanying workbook.
[22] See sheet 9 "LM participation WLHC demographics" in accompanying workbook.

a WLHC (54% and 47%, respectively). The WLHC employment gap was therefore bigger for men than women.

Employment results by ethnicity and WLHC status are not available, as sample sizes are too small to be reliable.

Figure 4.2: WLHC rate by ethnic group



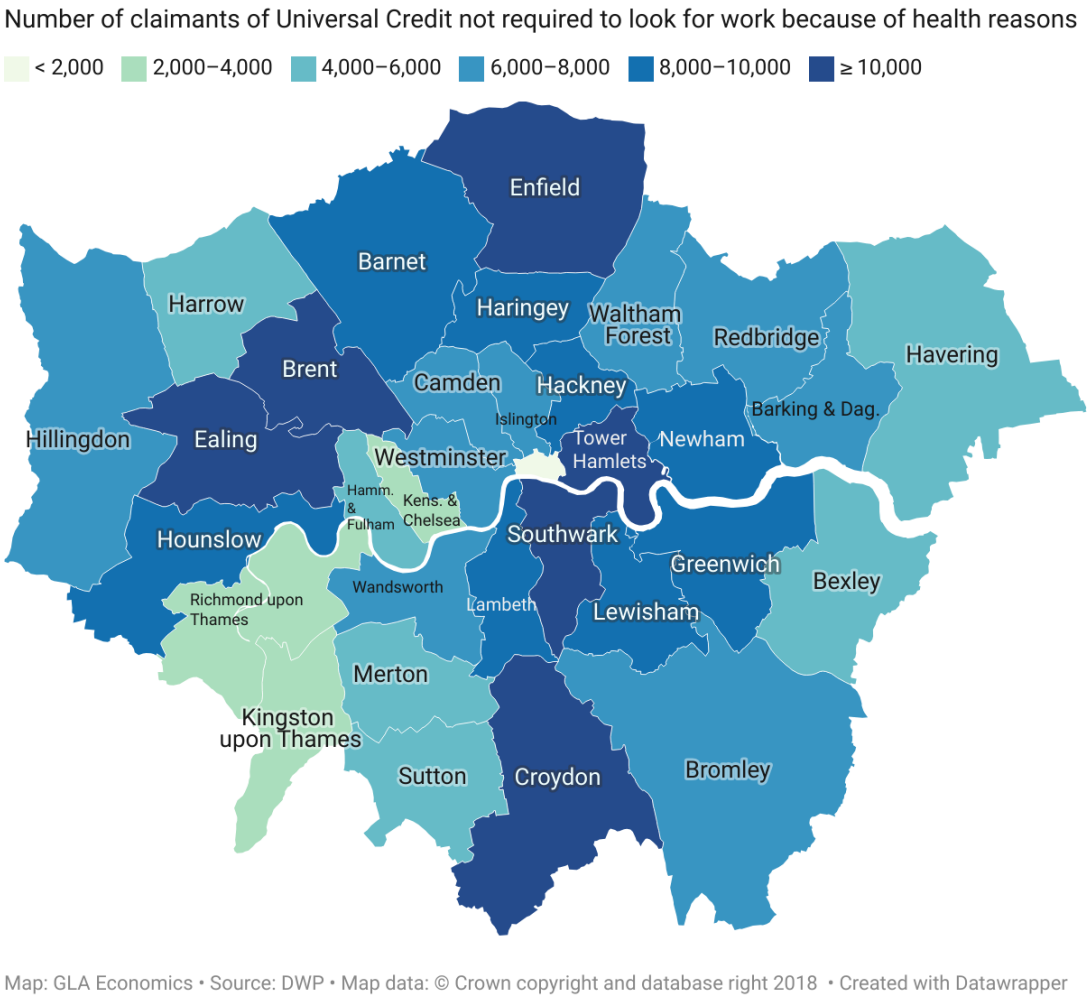
Overall, we see a degree of inequality in the prevalence of WLHCs. Older Londoners, Londoners with lower levels of qualifications, and most minority ethnic backgrounds in London, are more likely to have a WLHC than younger Londoners, Londoners with a degree, and Londoners from a White ethnic background.

These characteristics also are linked to the likelihood than someone with a WLHC would be in employment. Alongside the earlier finding that lower-skilled occupations tend to have a higher WLHC prevalence, these findings suggest that more disadvantaged groups are more likely to have a WLHC.

Note that these **different socio-demographic characteristics are correlated** — for instance, younger workers are more likely to have degrees than older workers (because of the expansion of university access in the 2000s) as well as being more likely to be in better health. The analysis here does not allow us to identify which of the studied demographic characteristics matter more.

Finally, a different way of looking at inequality in the likelihood of long-term health conditions is to see how it differs within London. **To study the borough level**, we need a different source of data and use the number of people claiming Universal Credit who are not required to look for work or prepare for work search due to health reasons, as a proxy for the prevalence of ill-health, in September 2024 (Figure 4.3).

Figure 4.3: Ill-health and benefit claims by boroughs, September 2024



There are important variations across London boroughs, with darker shades of blue representing higher levels of claimants. High numbers are found both in Inner London boroughs (Tower Hamlets, Southwark) and Outer London boroughs (Croydon, Enfield). The broader point is that, while at London level, ill-health-induced economic inactivity is lower than in the rest of the UK, there are areas within London for which it will be a bigger issue than others.

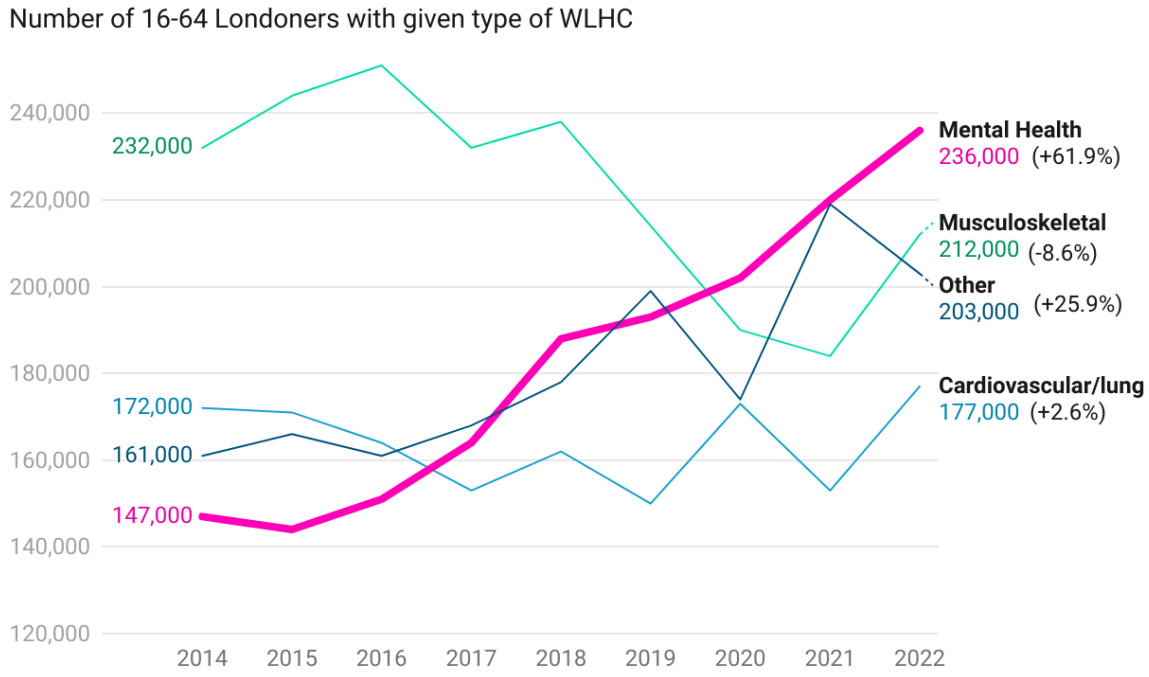
5 Types of health conditions

Health conditions are grouped under four broad types in the data, as summarised in Table 5.1. The most striking finding is the rise in the number of Londoners affected by **a work-limiting mental health condition**, as shown in Figure 5.1.

Table 5.1: Broad groups of conditions in the data

Broad group	Cardiovascular/ lung	Musculoskeletal	Mental health	Other conditions
Includes:	*Chest or breathing problems, heart, blood pressure, asthma, bronchitis).*	*Problems or disabilities with arms, hands, legs, feet, back or neck).*	*Depression bad nerves or anxiety, severe or specific learning difficulties, mental illness, phobias, panics, autism.*	*Difficulty in seeing, difficulty in hearing, speech impediment, stomach, liver, kidney or digestive problems, diabetes, severe disfigurement, skin condition, epilepsy, progressive illness e.g., cancer, Parkinson's, any other conditions.*

Figure 5.1: Types of health conditions



In brackets behind the 2022 figure is the % change between 2022 and 2014.

Chart: GLA Economics • Source: ONS Annual Population Survey • Created with Datawrapper

In 2014, about 147,000 working-age Londoners reported a work-limiting mental health condition, less than any other broad types of illnesses. In 2022 (the latest available year of data regarding illness type), around

236,000 of them did, more than any other broad type of illnesses, and an increase of nearly 62%, or 90,000 people, on the period.

It is worth noting that the **rising trend precedes the pandemic,** starting in the middle of the 2010s.

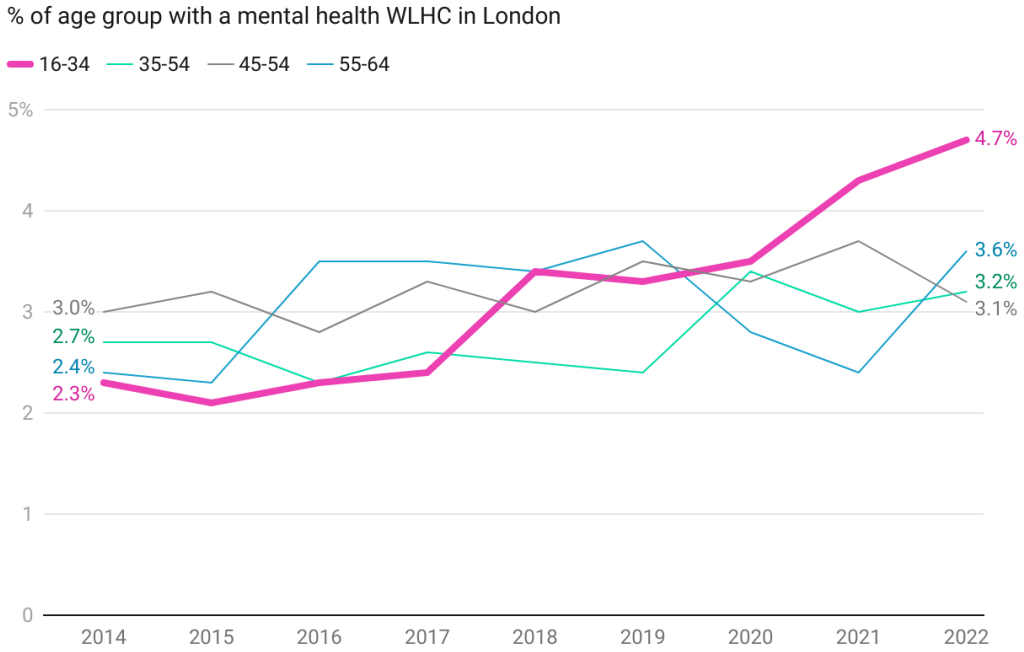
This has been by far the biggest increase. The period also saw a rise in "other" conditions. The number of Londoners affected by a musculoskeletal condition was, on the other hand, falling in the last 10 years, but **that trend has reversed since the pandemic**.

The analysis show that these trends also hold as a share of the population – for instance, **the share of 16-64 Londoners with a work-limiting mental health condition rose from 2.5% in 2014 to 3.8% in 2022**.[23]

Generally, London follows similar trends as the rest of the UK, where mental health WLHCs are now the most common type in the 16-64 population, with 5.8% reporting one in 2022.[24] But, in 2022, for a broad type of condition, the share of 16–64-year-olds with each condition **tended to be lower in London** than elsewhere in the UK.

The rise in the prevalence of WLHCs has been **driven by young adults in London** (Figure 5.2).

Figure 5.2: Prevalence of mental health WLHC by age group



Proportion of age group reporting a long-term mental health condition limiting the kind or/and amount of work they can do.

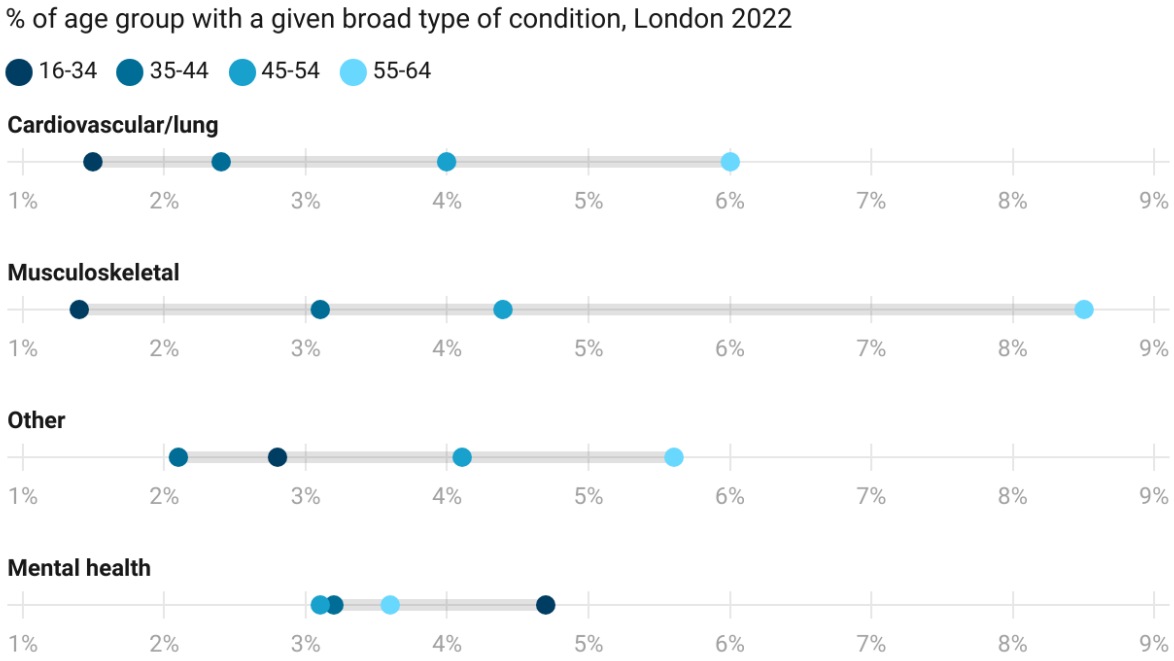
Chart: GLA Economics • Source: ONS Annual Population Survey • Created with Datawrapper

In the latest data, 1 in 20 Londoners aged 16-34 reported a mental health condition limiting the kind and/or type of paid work they could do. Again, this rise pre-dates the pandemic.

[23] See sheet 10 "WLHC by type of condition" in accompanying workbook.
[24] See sheet 10 "WLHC by type of condition" in accompanying workbook.

Mental health WLHCs are more prevalent among younger working-age Londoners than in older age groups. This is different from cardiovascular/lung and from musculoskeletal WLHCs, which become more prevalent as age increases. "Other" WLHCs are slightly more prevalent for 16-34 aged Londoners than for 34-44 aged Londoners, but the prevalence in both groups is lower than for the 45-54 age group and the 55-64 age group.

Figure 5.3: Prevalence of different types of conditions by age



Proportion of age group reporting a long-term condition limiting the kind or/and amount of work they can do.

Chart: GLA Economics • Source: ONS Annual Population Survey • Created with Datawrapper

The rise in mental health WLHCs among younger working-age Londoners, and the higher prevalence of other types of conditions amongst older age groups, may be related to patterns of health-related economic inactivity since the pandemic (Figures 5.4 and 5.5).

Economic inactivity is indeed related to age, with higher levels of inactivity amongst **younger working-age Londoners (16-24) and older ones (50-64)**. On the other hand, the number of economically inactive Londoners in the 25-49 age group has been falling over the period (Figure 5.4).

Long-term sickness is not the only reason for inactivity. Younger age groups will tend to include more students, while older age groups will have more retired people. Nonetheless, Figure 5.4 also shows a link with long-term sickness.

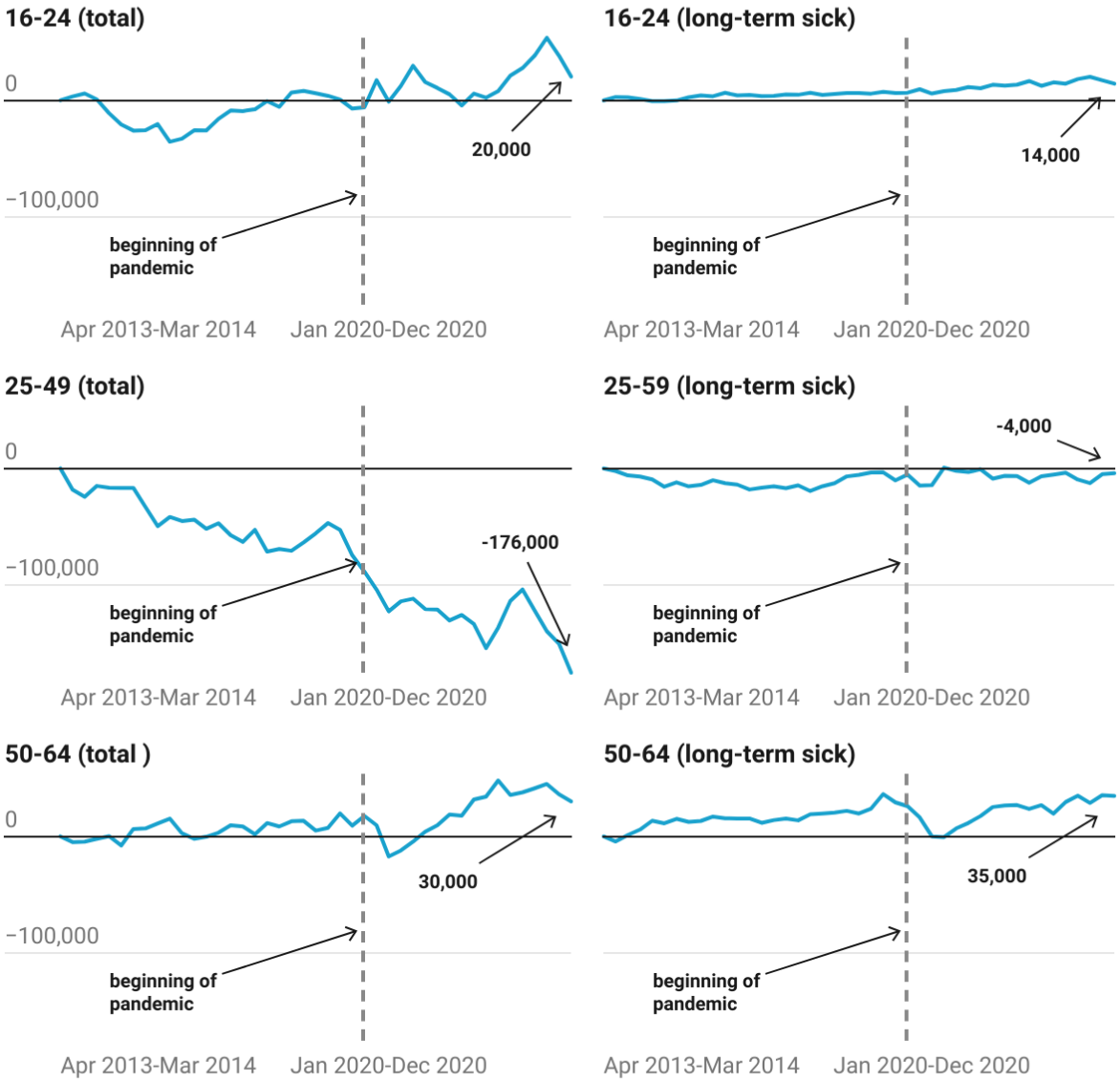
We do not see a rise in health-related inactivity among Londoners aged 25-49 over time: the number has been broadly stagnating. Instead, what we see is a **rebound since the pandemic for Londoners aged 50-64**, and **a steady rise over the last 10 years for Londoners aged 16-24**.

Over the last 10 years, the number of Londoners aged 16-24 who are economically inactive rose by 20,000, and the number of those economically inactive due to long-term illness rose by 14,000. The rise in long-term sickness alone hence amounts to **70% of the increase in total inactivity** in this age group.

For Londoners aged 50-64, total economic inactivity rose by 30,000 people over the last 10 years, and the number economically inactive because of long-term illness rose by 35,000. So, if it was only for long-term sickness, inactivity amongst older working-age Londoners would have **risen even more** – it is only decreases in inactivity due to other reasons that have limited the rise.

Figure 5.4: Economic inactivity and long-term sickness by age group

Cumulative change since 2014 in total number of economically inactive working-age Londoners (left panel) and in number of working-age Londoners inactive due to long-term sickness (right panel), by age group.



For each age group, the left-hand side graph represents the difference in the total number of economically inactive people at a given date and the number in 2014. The right-hand-side graph does the same for people economically inactive due to long-term sickness. The arrow points to the value of the cumulative change in the latest data point (2023/24). Note that the right-hand side can be bigger than the left-hand side, for a given age group: this would be because reasons for inactivity other than long-term sickness would have decreased and brought the overall number of economically inactive people down.

Chart: GLA Economics • Source: ONS Inactivity by reasons • Created with Datawrapper

For the UK as a whole, the links between rising inactivity and long-term sickness are even clearer. For the 16-24 age group, overall inactivity rose by around 35,000 people but the number inactive due to long-term sickness rose by about 140,000 over the last 10 years. For the 50-64 age group, the respective figures are 120,000 and 280,000. Even for the 25-49 age group, for which the number economically inactive fell by around 410,000, the number economically inactive due to long-term sickness rose by about 150,000.

These figures show that if it was only for long-term sickness, overall inactivity in the UK would have risen much more – but changes in the number of people inactive for other reasons have limited that rise. A key change has been the decrease in women inactive because of looking after the family/home, which has also been the case in London.[25]

These results need to be put in perspective with results regarding the type of conditions affecting Londoners, which showed that most types of WLHCs were more prevalent for the oldest working-age Londoners, except for mental health, with a strong rise in mental health WLHCs among younger working-age Londoners. It suggests that policy responses seeking to re-engage economically inactive people with long-term health issues may need to be **differentiated by age group and illness type**.

Another way to study this is to look at the link between labour market participation and broad illness type (Figure 5.5).

Inactivity rates tend to be higher for people with a mental health WLHC (52% in 2022). This is down from 65% in 2014: as the prevalence of mental health WLHC rose in London, the inactivity rate of people with WLHCs fell. But it remains the highest, compared to other types of conditions.

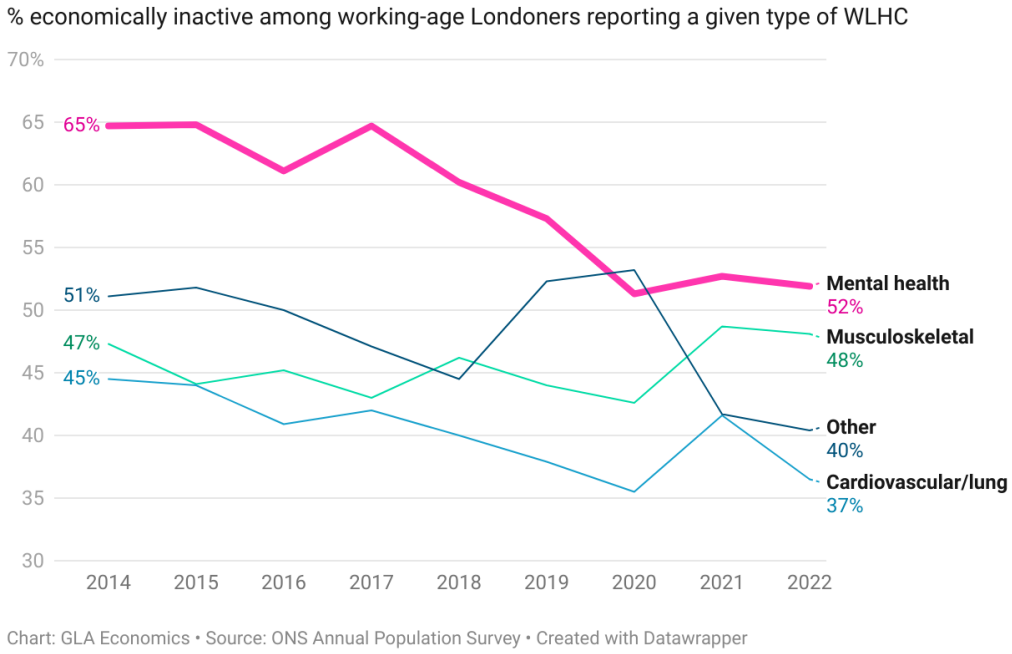
By contrast, inactivity rates for people with a Cardiovascular/lung WLHC was only 37%, and 40% for people with Other WLHCs. They also fell over time. Inactivity for people with Other conditions rebounded and peaked around the pandemic but fell since.

On the other hand**, economic inactivity associated with musculoskeletal WLHCs rose after the pandemic**, with an inactivity rate of 48% in 2022.

Again, these patterns are consistent with mental health issues being most prevalent and rising amongst young working-age Londoners, and musculoskeletal issues disproportionately affecting older working-age Londoners, and these two groups being at the heart of long-term sickness and inactivity in London.

[25] See ONS Economic inactivity by reason

Figure 5.5: Inactivity rates by type of condition



Musculoskeletal conditions are also unique in being associated with a higher rate of economic inactivity in London than elsewhere in the UK. The reverse is true for the other three big groups of WLHC.[26]

In terms of other characteristics, for the four broad groups of health issues, **the prevalence increases as the highest level of qualification decreases.** By gender, there are no obvious differences regarding the prevalence of cardiovascular/lung issues and mental health issues. But **women are more likely to have musculoskeletal issues, and "Other" conditions**. Sample sizes are too low to produce conclusive results regarding ethnicity.[27]

[26] See sheet 12 "Condition type and inactivity" in accompanying workbook.
[27] See sheet 11 "Condition type and demographics" in accompanying workbook.

6 Summary

London has a lower prevalence of WLHCs in its working-age population than the rest of the UK, and a less marked rise in inactivity due to ill-health since the pandemic than the rest of the UK. Nonetheless, the WLHC prevalence has been rising in the last 10 years in London, and inactivity due to long-term sickness represents one in five inactive Londoners.

Further, lower rates still translate into substantial absolute numbers given the size of London. There is, therefore, a long-term sickness issue in London's working-age population, with London-specific challenges.

This challenge is particularly acute for younger working-age Londoners, especially in terms of mental health, and older working-age Londoners, for physical health conditions.

Londoners from most ethnic minority groups and Londoners with lower levels of education are also more affected. While the employment rate of Londoners with WLHCs has been rising over time, it is still much below the employment rate of Londoners without WLHCs. The employment of Londoners with WLHCs tends to be more precarious, concentrated in certain occupations, and is associated with more absences due to sickness.

7 Appendix: methodology and data sources

Most results are based on GLA Economics analysis of microdata from the ONS Annual Population Survey[28] (APS). They focus on the 2014-2023 period, 2023 being the latest year available. For each year, the January-December APS is used. Before 2014, changes in how the variables were defined mean that the data are not directly comparable. These analyses use weights, i.e., they are representative of the overall London population.

There is also data coming from the ONS Economic Inactivity by Reason tables. The focus is on the 16-64 population residing in London, unless otherwise specified. The borough-level map uses DWP data on Universal Credit claimants available from Stat-Xplore.

Following ONS guidance, APS estimates based on a sample size below 25 are deemed too unreliable to be shown. This threshold still means that some estimates will be based on rather small sample sizes. Sample sizes have been falling since the pandemic in the UK, and there have been issues with the reliability of official labour market statistics in that time[29].

The reader is invited to refer to the accompanying Excel document, which shows the underlying sample size of each result published here, and the associated standard error, a measure of the reliability of the result. Higher standard errors indicate that results may be less reliable.

More generally, results shown here should be treated cautiously, especially those relating to breakdowns by socio-demographic characteristics, and any large fluctuations since 2020. This means looking at the result for any particular year in the context of the general trend over time and focusing on general evolutions rather than on specific year-on-year changes.

Note that the health data used here are reported by respondents to the Annual Population Survey. They are not medical data from GP practices or the NHS. This induces limitations, potentially linked to reporting errors.

[28] Office for National Statistics. (2024). Annual Population Survey. [data series]. 8th Release. UK Data Service. SN: 200002, DOI: http://doi.org/10.5255/UKDA-Series-200002

[29] https://www.ons.gov.uk/news/statementsandletters/statementonthelabourforcesurvey

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