



The potential health implications of a changing labour market

A briefing for the Commission for Healthier Working Lives

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About the Commission for Healthier Working Lives

The Learning and Work Institute (L&W), Institute for Employment Studies (IES) and Royal Society for Public Health (RSPH) formed a new collaboration as research partners for the *Commission for Healthier Working Lives*, which was supported by the Health Foundation.

The *Commission for Healthier Working Lives* aimed to build consensus on the actions needed to address the UK's work and health challenges. It sought to improve understanding of health trends and inequalities and their impacts on individuals, employers and the economy. The final report [Action for Healthier Working Lives](#) sets out the Commission's recommendations to improve working-age health and help people with health conditions to access, remain in or thrive in the workforce.

This report is one of a series of commissioned reports, available at: www.health.org.uk/commission-for-healthier-working-lives

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IES project code: 6363



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Executive Summary

The UK faces a major challenge with respect to work and health. Recognising record levels of economic inactivity driven by poor health, the UK Government has a policy programme of welfare reform and increased employment support, while commissioning an independent review of the role of employers with the Keep Britain Working Review. Echoing the conclusions of the Commission for Healthier Working Lives, the discovery phase of the review has identified the importance of prevention, retention, early intervention and rapid rehabilitation in the workplace.

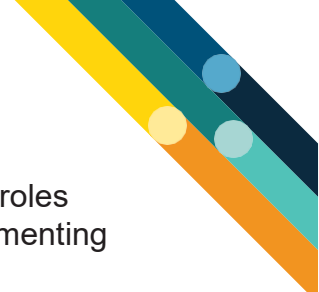
This briefing paper identifies occupations, industries and populations with the greatest health risks in the next decade using labour market projections, highlighting where action needs to be targeted. Based on the analysis, it is anticipated that in 2035 there could be a 5% increase in cases of work-related ill-health across occupations (compared with a 4% increase in the total number of jobs) costing the economy an additional £1bn compared with 2025. This cost comes from a greater number of working-days lost.

By 2035, it is estimated that there will be an additional 1.3 million days lost per year due to work-related ill-health. While this increase is largely driven by a higher overall number of jobs, 16% of the projected rise is because of a compositional shift towards more health-harming jobs in the economy.

The labour market projections anticipate that the growth in jobs between 2025 and 2035 will be concentrated in high skilled, white collar, non-manual work. The largest growth is anticipated in 'business, media and other public service professionals'. Across regions, London is expected to have the highest percentage increase in cases of work-related ill-health between 2025 and 2035 as a result of high overall job growth, predominantly in these 'white-collar' sectors.

The additional burden of work-related ill-health is anticipated to fall disproportionately on women because of growth in occupations such as health and personal service roles, where women are expected to form the majority of the workforce. These occupations have high prevalence rates of work-related ill-health, in particular work-related stress, depression and anxiety, driven by an imbalance between work demands and the available resources to meet them.

Over recent years, work-related stress and mental health issues have become more prevalent, whereas prevalence of musculoskeletal disorders (MSDs) has remained broadly flat. Although labour market projections suggest this trend is likely to continue, there are also several occupations (e.g. personal caring occupations, elementary administration and service occupations) with higher-than-average rates of work-related MSDs, where there is expected to be significant churn in the workforce, and thus more worker exposed to occupational risks.



To avoid increased risks to health in the future, redesigning and adapting job roles will be critical. New technology can assist in reducing physical demands, augmenting skills and capabilities if appropriately deployed, and the affected workforce is engaged in the design and implementation of that technology.

Providing psychologically safe working environments, where workers can express their needs and preferences for adjustments, is also associated with fewer health-related work limitations. For those with health problems, workplace flexibility and access to specialist workplace support (for example vocational rehabilitation) can support ongoing participation and recovery.

The analysis presented in this paper is illustrative, pointing to the health consequences of the UK government's central scenario of the changing composition of the labour market in the next decade. The purpose is to stimulate debate and hopefully encourage further, targeted action on improving health and wellbeing at work.



Introduction

The UK Government has set an ambitious target of an 80% employment rate. The Get Britain Working white paper has set out plans for reform including addressing the rise in people excluded from work because of ill-health, as well as improving the quality of work to prevent further detriment to the health of the working age population. The White Paper recommended the launch of an independent review into the role of employers in promoting healthy and inclusive workplaces, the Keep Britain Working Review. The purpose of the Keep Britain Working Review is to identify what can be done to:

- drive inclusive recruitment and retention of disabled people and those with a health condition;
- prevent people becoming unwell at work and promote healthy workplaces; and
- undertake early intervention for sickness absence and increase return to work.

Earlier this year, the Keep Britain Working Review published the findings from its 'discovery phase', reinforcing the importance of good work that prevents ill-health from occurring in the first place, alongside early intervention and structured return-to-work support where ill-health does occur.¹ Echoing the findings of the Health Foundation's Commission for Healthier Working Lives, it concluded that 'prevention, retention, early intervention and rapid rehabilitation in the workplace are likely to be more effective remedies over time. Good work can be protective of health and prevent issues from occurring. When ill-health does occur, we need to act more quickly and effectively'. The review has also concluded that 'in countries that perform better, the balance of investment and incentives within their systems is weighted towards prevention, retention and rapid rehabilitation. In the UK it is not'.

This briefing builds on the findings of the Commission for Healthier Working Lives and the direction set by the Keep Britain Working Review, identifying the occupations and industries with the greatest health risks and using labour market projections to anticipate where these risks may grow or decline in the future. The aim is to highlight sectors and job roles where preventative action should be targeted.

Limitations

This analysis projects how health challenges may be distributed across the labour market in 2035, based on current patterns of employment, work-related ill-health and labour market projections. It does not account for potential changes in the prevalence or composition of health conditions among working-age people, shifts in the types of roles people with health conditions undertake (which may evolve as workplaces become more or less accommodating), or changes in the risk different jobs pose to health. Nor does it factor in the possibility that future employment patterns may differ from current projections. As such, the findings are illustrative and intended to prompt debate about where health-related labour market challenges may be most significant in the future.

¹ <https://www.gov.uk/government/publications/keep-britain-working-review-discovery/keep-britain-working-review-discovery>



The current picture of work and health risks

In this section, we look at three measures that provide insight into the current interaction between the types of work people do and their health. These are:

- Jobs where there are high percentages of people with a health condition that say their health limits the amount of or type of work that they can do (a “work-limiting health condition”). This measure does not provide any indication of causality; it describes the parts of the labour market where there is a greater concentration of people working with health challenges. For example, an occupation where a high proportion of workers report a work-limiting health condition could indicate that it is a role that people with health conditions can more readily access (e.g. due to accessible skill requirements, geographic proximity, or opportunities for flexible working), that the work itself is more likely to cause or exacerbate health issues, or alternatively that there are features of the role that are difficult for people with health challenges to perform (e.g. physically demanding tasks or a lack of flexibility), hence making the worker more likely to view their background health condition as ‘work-limiting’.
- Jobs with high levels of work-related ill-health. In other words, where people occupying those jobs have indicated that they have a health condition that was caused by or made worse by the work they do.
- Jobs with low levels of job quality, or where aspects or dimensions of job quality linked to poor health are perceived as poor by people employed in these roles. Not all of the people working in these roles may have a health condition, but the nature of the work as perceived by them presents greater risks for developing ill-health from adverse working conditions in the future.

Where do people with work-limiting health conditions tend to work?

In 2024, of the 8.7 million people of working age in the UK who report a work-limiting condition, just under half (4.1 million) are currently working.²

Figure 1 shows the percentage of people within occupations that report a work-limiting condition. Workers are more likely to report a work-limiting health condition if they are employed in:

- Elementary administration and service occupations (which includes a diverse set of occupations including cleaners, kitchen and catering assistants, office administration, warehouse operatives, porters etc) (17% of people employed in this occupational group report a work-limiting health condition).
- Caring and personal service roles (which includes teaching and childcare support assistants, care workers, nursing auxiliaries, dental nurses, ambulance staff (excluding paramedics)) (16% of people employed in this occupational group report a work-limiting health condition).
- Health and social care associate professional roles (e.g. roles that provide

² Labour Force Survey (LFS), October-December 2024



skilled and technical support to health and social care professionals, such as pharmaceutical and dental technicians) (16% of people employed in this group report a work-limiting health condition).

- Customer service occupations (e.g. call and contact centre workers) (17% of people employed in this group of occupations report a work-limiting health condition).

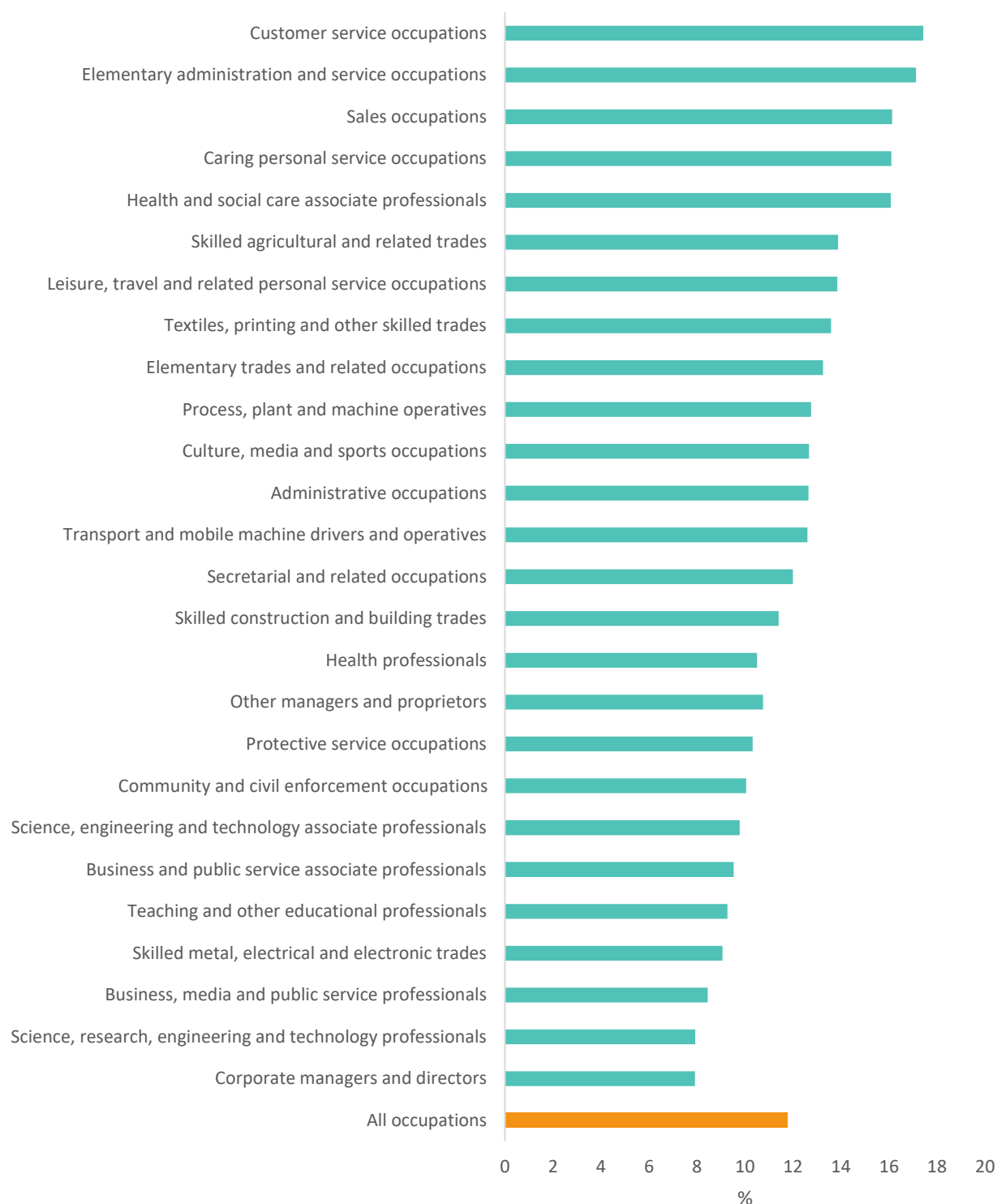
Women, older workers over the age of 45, those with lower educational attainment, and some minority ethnic groups are more likely to report a work-limiting condition.³ While work-limiting health conditions are more prevalent among older workers, recent years have seen a rise in the number of younger people with work-limiting conditions driven by an increase in mental ill-health among younger people.⁴

³ Atwell S, Vriend M, Rocks C, Finch D (2023) What we know about the UK's working-age health challenge. The Health Foundation.

⁴ Atwell S, Vriend M, Rocks C, Finch D (2023) What we know about the UK's working-age health challenge. The Health Foundation.

Figure 1: Work-limiting conditions are more prevalent among people working in elementary and service occupations

Percentage of employed population 16-64 years of age within each sub-major occupational group who report a health condition that limits the amount and/or type of work they can do. United Kingdom, 3-year average, 2021-2023



Source: IES analysis of Annual Population survey 2021-2023

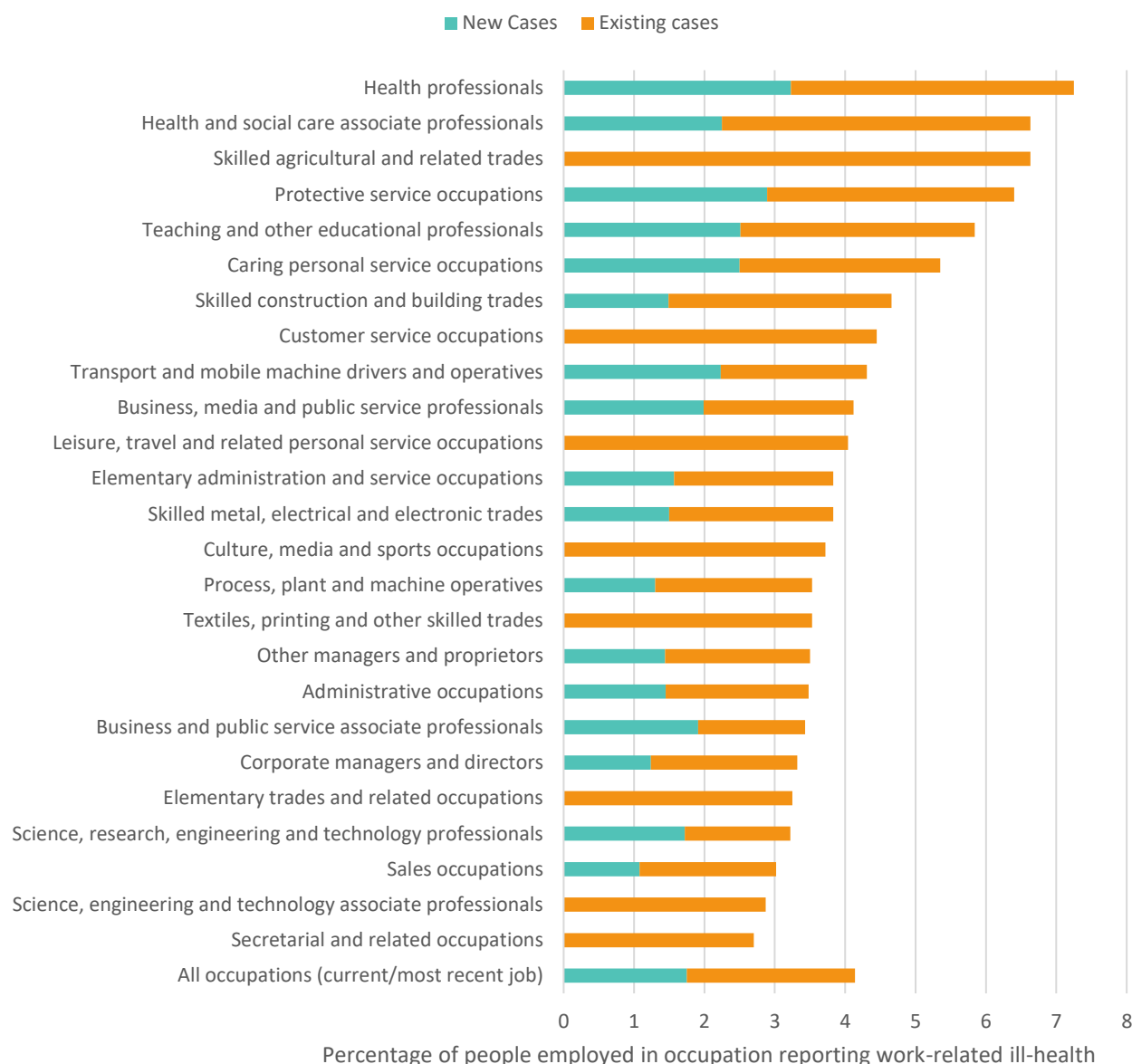
Which occupations have the highest rates of work-related ill-health?

Figure 2 shows the types of occupation with the highest levels of ill-health caused or made worse by work. Occupations with relatively high levels of work-related ill-health are listed below (the percentage of people within the occupational group reporting ill-health caused or made worse by work is shown in brackets):

- Health professionals (e.g. generalist and specialist medical practitioners, physical and psychological therapists, nursing professionals) (7%).
- Health and social care associate professionals (e.g. roles that provide skilled and technical support to health and social care professionals) (7%).
- Protective service occupations (e.g. frontline roles in the armed forces, police, fire service, prison service) (6%).
- Teaching and other educational professionals (e.g. teachers in higher education (HE), further education (FE), secondary and primary school) (6%).
- Caring personal service occupations (e.g. teaching and childcare support assistants, care workers, nursing auxiliaries etc) (5%).
- Skilled construction and building trades (e.g. roofers, plumbers, carpenters, bricklayers) (5%).
- Transport and mobile machine drivers and operatives (e.g. heavy and large goods vehicle drivers, bus and coach drivers, taxi drivers) (4%).
- Customer service occupations (4%).
- Skilled agricultural trades (e.g. gardeners, farmers etc) (7%).

Figure 2: Work-related ill-health is most prevalent in health professional roles

Percentage of people within each sub-major occupation reporting ill health caused or made worse by work, for people working in the last 12 months Great Britain, (per 100,000 workers), 3-year average, 2021/22-2023/24



Note: New cases are missing where data is not available.

Source: Institute for Employment Studies analysis of the Labour Force Survey

The nature and drivers of work-related ill-health vary across occupations.

Work-related stress, depression and anxiety

Cases of work-related stress, depression and anxiety are more prevalent in:

- Health professional and associate professional roles in health and social care (4% of those employed in health professional roles, and 5% in associate



professional roles in health and social care report work-related stress, depression or anxiety).

- Teaching and other educational professionals (3% of people employed in these roles report stress, anxiety or depression caused or made worse by work).
- Protective service occupations (i.e. police, fire services etc.) (4% of people employed in these roles report work-related stress, depression or anxiety).
- Caring and personal service occupations (3% of people employed in these roles report work-related stress, depression or anxiety).

The main drivers of work-related stress, depression and anxiety in general are workload pressures (including tight deadlines and too much responsibility) and a lack of managerial support.⁵ The precise combination of drivers of work-related stress will vary across these occupations. Aspects of job quality that are contributing to poor health in the sectors in which these occupations are located provide some more detailed understanding of the drivers at play (see Table 2).

Compared to musculoskeletal disorders (MSDs) cases of work-related stress, depression and anxiety are associated with, on average, longer periods of time away from work (21.1 working days lost per case compared with 14.3 days MSDs), as well as a higher risk of exiting the labour force completely.⁶

Women are more likely to report cases of work-related stress than men, with women between the ages of 25 and 34 reporting the highest rate (approximately 3% of women in this age group report work-related stress, depression or anxiety). This in part reflects the types of occupations in which women are more likely to work, compared with men (e.g. health and social care, teaching and education).⁷

Recent years have seen increasing rates of work-related stress, depression and anxiety.⁸ The increase in the rates of stress, depression and anxiety likely reflects a range of factors including the continued shift towards different types of employment and occupational mix, changes in job quality (e.g. work intensification, job insecurity), and changing awareness of and attitudes to mental health.⁹ If these trends continue, and without mitigating interventions, the burden of work-related stress may grow.

Musculoskeletal disorders

Cases of work-related MSDs are more prevalent in the occupations listed below (the approximate percentage of the workforce in the occupation affected is shown in brackets):

⁵ Health and Safety Executive (2024) Work-related stress, depression or anxiety statistics in Great Britain 2024. HSE.

⁶ <https://www.hse.gov.uk/statistics/dayslost.htm>

⁷ Health and Safety Executive (2024) Work-related stress, depression or anxiety statistics in Great Britain 2024. HSE.

⁸ Health and Safety Executive (2024) Historical picture statistics in Great Britain, 2024. Trends in work-related ill-health and workplace injury. Data up to March 2024. HSE.

⁹ Dragano, N., Gerö, K. and Wahrendorf, M.S., 2024. Mental health at work after the COVID-19 pandemic: What European figures reveal. European Agency for Safety and Health at Work, Luxembourg. Publications Office of the European Union, 2024.

- Skilled agricultural and related trades (5% of those employed).
- Skilled construction and building trades (3% of those employed).
- Transport and mobile machine drivers and operatives (3%).
- Skilled metal, electrical and electronic trades (2%).

There are also higher than average prevalence rates in caring and personal service occupations (1%), elementary administration and service occupations (2%), leisure and travel occupations (2%), and health professionals (1%).¹⁰

The main drivers of work-related MSDs are reported to be having to work in awkward or tiring positions, manual handling, keyboard or repetitive work.¹¹

Men are more likely to suffer from MSDs caused or made worse by work, than women, with the prevalence rate highest among men in the 55+ age group (0.5% of men in this age group are affected). Prevalence increases with age with the next highest prevalence rate is among women in the same age group (0.4% of women in this age group are affected).

After a downward trend in rates in MSDs in the 1990s, rates have been broadly flat since (affecting around 1.6% of those in work). In combination with the rising trend of work-related stress, this has led to an overall shift in the burden of work-related ill-health towards mental ill-health.¹²

Regional variation in work-related ill-health

At a regional level, London and the South East of England have the highest prevalence of work-related ill-health, driven by relatively high rates of work-related stress, depression and anxiety.

¹⁰ Health and Safety Executive (2024) Work-related musculoskeletal disorders statistics in Great Britain, 2024. Data up to March 2024. HSE

¹¹ Health and Safety Executive (2024) Work-related musculoskeletal disorders statistics in Great Britain, 2024. Data up to March 2024. HSE

¹² Health and Safety Executive (2024) Historical picture statistics in Great Britain, 2024. Trends in work-related ill-health and workplace injury. Data up to March 2024. HSE.

Table 1: London and the South East of England have the highest prevalence levels of work-related ill-health, driven by high rates of stress, depression and anxiety.

Estimated prevalence (total cases of work-related illness) and rate of self-reported illness caused or made worse by current or most recent job, by country/region, for people working in the last 12 months Great Britain, 3 -year average, 2021/22-2023/24.

Country/Region	All-work related illness		Musculoskeletal disorders		Stress, depression or anxiety	
	Averaged estimated prevalence (000s)	Averaged rate per 100,000 employed in the last 12 months	Averaged estimated prevalence (000s)	Rate per 100,000 employed in the last 12 months	Averaged estimated prevalence (000s)	Rate per 100,000 employed in the last 12 months
Great Britain	1,760	5,220	499	1,480	866	2,570
England	1,542	5,240	437	1,480	747	2,540
Scotland	128	4,660	37	1,340	70	2,560
Wales	90	5,870	25	1,630	49	3,190
North East	62	5,060	14	1,120	32	2,630
North West	187	5,150	42	1,160	96	2,660
Yorkshire and The Humber	162	5,840	47	1,710	73	2,640
East Midlands	122	4,830	41	1,630	52	2,040
West Midlands	152	5,080	40	1,350	72	2,400
East	152	4,590	46	1,380	75	2,260
London	241	4,790	50	990	135	2,680
South East	276	5,550	92	1,860	129	2,590
South West	189	6,330	64	2,160	84	2,810

Source: IES Analysis of Labour Force Survey (LFS)

In which industries do workers report poor job quality conditions that are harmful to health?

Industries where there are aspects of job quality that are potentially detrimental to health pose a risk to the health of the people employed in those sectors. A previous report by the Institute for Employment Studies, supporting the Commission for Healthier Working Lives, previously highlighted the industrial sectors where risks to health through poor job quality were greatest.¹³

Table 2 highlights the variation in dimensions of job quality linked to poor health across sectors. The red areas indicate relatively adverse job quality conditions.

¹³ Wilson T, Sharma M, Gifford J (2024) Exploring the interactions between job quality, industries and health. A report by the Institute for Employment Studies for the Health Foundation's Commission for Healthier Working Lives.



Workers operating in the health and social care sector are more likely than average to experience an imbalance between work demands and the available resources to deliver it. They are more likely than average to experience physical or emotional burnout, to work in tiring positions, and to experience discrimination in the workplace, all of which are potentially detrimental to health. Workers in the education sector are also more likely than average to experience physical or emotional burnout.

Table 2 also illustrates a different pattern of adverse job quality indicators that may be harmful to health in the construction and transport and storage sectors. Long working hours, poor work-life balance, lack of managerial support, low autonomy and few chances to use existing skills all score lower than average. In addition, workers in the construction sector report working in tiring positions and are more likely than average to experience discrimination.

There are also widespread risks to job quality and health in the commerce and hospitality sector, with workers reporting job insecurity, long working hours, physical and emotional burnout, working in tiring positions, discrimination, lack of control over work and few chances to use their skills.

Workers in the agricultural sector report long hours and having to work in tiring positions.

There are clear interactions between the nature of job quality experienced in different sectors, and the work-related ill-health profile in occupations that predominate in those sectors. For example, the high levels of work-related stress observed in health professionals is linked to the high levels of imbalance in work demands and resources, reported by workers in the health and care sector.¹⁴ Equally, the relatively high levels of work-related MSDs observed in the construction sector is linked to having to work in tiring positions and long working hours.

¹⁴ Wilson T, Sharma M, Gifford J (2024) Exploring the interactions between job quality, industries and health. A report by the Institute for Employment Studies for the Health Foundation's Commission for Healthier Working Lives.

Table 2: Job Quality dimensions by industry, UK, 2021

		Industry (proportion of total workforce)										
Job Quality Indicators		Financial Services (5%)	Other Services (25%)	Public Admin (8%)	Education (10%)	Health (14%)	Commerce and hospitality (15%)	Industry (10%)	Construction (6%)	Transport and storage (5%)	Agriculture (1%)	All industries (100%)
Job security	Job insecurity	24%	31%	19%	25%	27%	30%	24%	36%	39%	9%	28%
Working hours	Long hours (48 or more/week)	13%	20%	14%	21%	17%	17%	23%	32%	37%	61%	20%
	Poor work-life balance	12%	15%	13%	18%	18%	21%	18%	20%	32%	13%	18%
Demands and control	Work in tiring positions	11%	33%	17%	36%	51%	45%	41%	56%	34%	61%	38%
	Experience physical / emotional burnout	16%	29%	34%	45%	43%	40%	35%	35%	35%	37%	36%
	Little work autonomy	8%	11%	7%	18%	23%	25%	13%	21%	40%	0%	17%
	Few opportunities to use skills or knowledge	7%	10%	8%	10%	11%	13%	12%	13%	20%	1%	11%
	No employee representation	59%	64%	18%	26%	31%	66%	63%	65%	37%	75%	50%
Relationships	Little managerial support	4%	10%	5%	8%	8%	10%	13%	19%	12%	2%	9%
	Experienced discrimination in last 12 months	8%	12%	11%	10%	14%	16%	15%	14%	9%	3%	12%

Note: Green highlights above average figures and red below average. Source: IES analysis of European Working Conditions Telephone Survey 2021, UK data



Overview of labour market projections

Having described the industrial and occupational pattern of risks to health in the current workforce, we now consider how the employment mix is projected to change in the future, what is driving those changes, and the implications for future risks to the health of the working age population.

The Skills Imperative 2035 sets out projections for the industrial and occupational composition of employment in the UK.¹⁵ The projections seek to understand the impact of long-term trends affecting the supply and demand side of the labour market, such as the increased adoption of technology by employers, and demographic changes such as population ageing. The projections provide an indication of the change in the compositions of jobs – how many people will be working in different job roles and industrial sectors, compared with the current labour market – as well as the amount of movement in and out of jobs over the period.

Key assumptions

The projections cover a range of scenarios including a baseline projection which sets out what the labour market is likely to look like if current trends continue at a similar pace into the future. The baseline projection is considered the minimum level of structural change the labour market may experience and the most realistic assessment of what will happen based on what we know now.

The projections also include a consideration of what may happen under different scenarios, such as a faster pace of adoption of new technology or improved quality of health or education services. Under all scenarios the anticipated changes to the labour market remain similar in type (although differ in scale), are considered resilient to short-term shocks and represent long-term structural change in the UK economy.

In all scenarios, the projections cover both the net change in requirement for a particular occupation (whether an occupation will grow or decline in size) and estimates of replacement demand (i.e. even if the overall size of an occupation is projected to decline, new workers may be needed to replace those leaving an occupation due to retirement, ill-health or other reasons).

Overall trends

The 2035 projections describe a slow and steady shift towards a service-oriented economy, driven by a range of factors including an ageing population, increased adoption of technology, and globalisation. The main baseline scenario anticipates growth in both business and non-market services (e.g. health, education) alongside a decline in manufacturing. Changes in the occupational mix of employment are largely driven by changes in the industrial structure of employment. Overall, between 2025 and 2035 there are anticipated to be an additional 1.5 million new jobs, a 4% increase over the period.

Under all scenarios, employment in the health industry is expected to grow the fastest, driven by an ageing population. Most new jobs created are anticipated to be taken by women, on the assumption that the occupational structure of employment remains broadly similar in gender terms to what it is today, and that we do not see men and

¹⁵ Wilson et al (2022) The Skills Imperative 2035: Occupational Outlook - Long run employment prospects for the UK. NFER

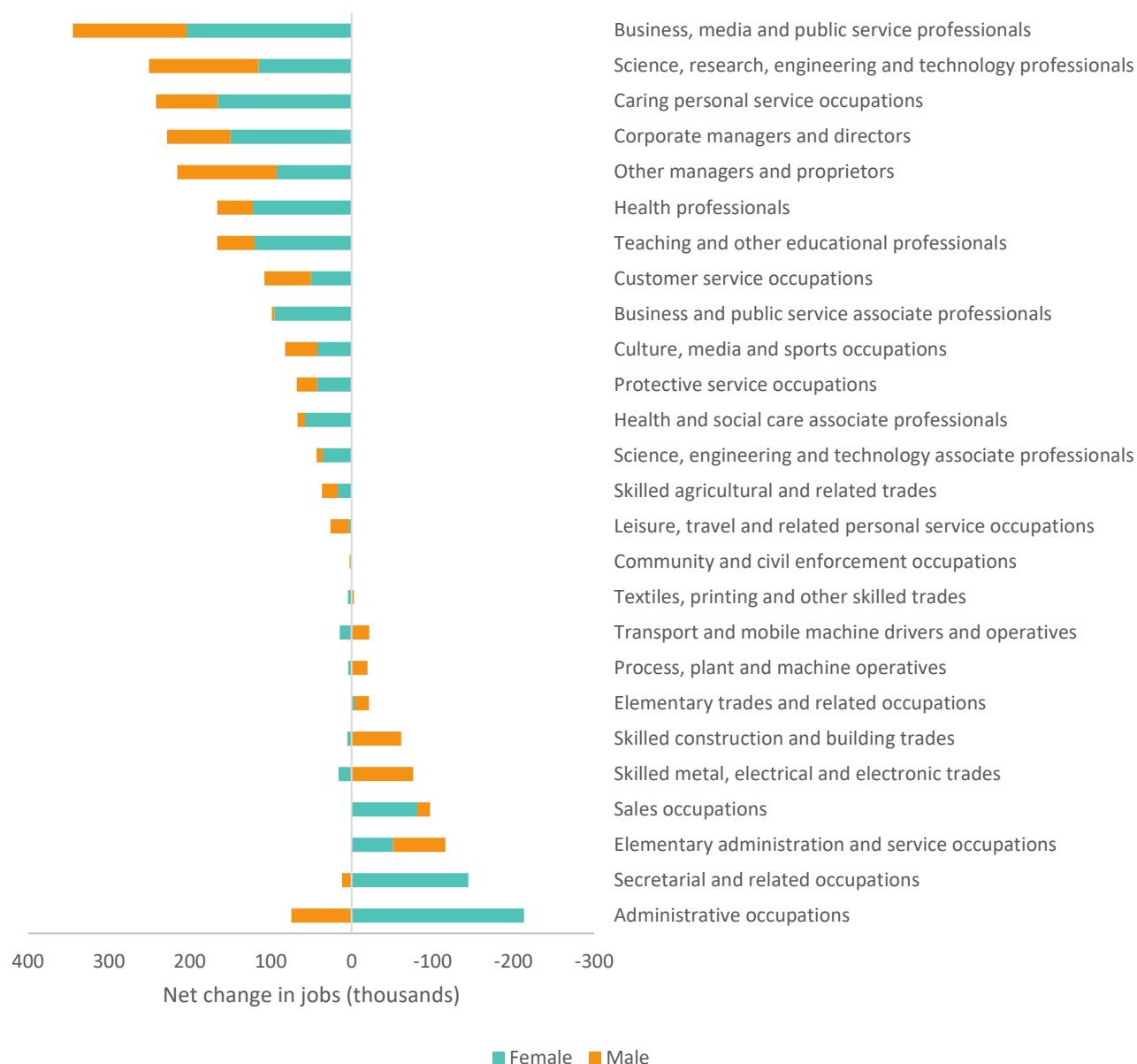


women doing a wider range of jobs than is the case today. In contrast, jobs considered to be most vulnerable to automation are held by men (e.g. in the manufacturing sector where productivity is anticipated to grow even though the number of workers in the sector is anticipated to decline).

In terms of the broad skill level of occupations, the baseline projections anticipate that the growth in jobs will be concentrated on high-skilled, white collar, non-manual work.

Figure 3: Business, media and public service professionals is the occupational group anticipated to grow the most between 2025-2035.

Net change (thousands) in the number of people employed in sub-major occupations between 2025-2035, broken down by gender.



Source: NFER projections based on Labour Force Survey (LFS)

Figure 3 illustrates that in the period 2025-2035, the largest growth in occupations is predicted in:

- Business, media and other public service professionals (an additional 345,000 jobs, or 15% of the current workforce).
- Science, research, engineering and technology professionals (250,000 additional jobs, or 10% of the current workforce).

- Caring and personal service occupations (242,000 additional jobs, or 11% of the current workforce¹⁶).
- Corporate managers and directors (228,000 extra jobs or 9% of the current workforce).
- Other managers and proprietors (216,000 additional jobs or 19% of the current workforce).
- Health professionals (166,000 additional jobs, or 10% of the current workforce).
- Teaching and other educational professionals (166,000 additional jobs or 10% of the current workforce).
- Customer service occupations (an additional 108,000 jobs or 23% of the current workforce).

The biggest declines are anticipated in:

- Administrative (139,000 fewer jobs or 6% of the current workforce).
- Secretarial and related occupations (133,000 fewer jobs or 27% of current workforce).
- Sales occupations (97,000 fewer jobs or 7% of current workforce).
- Skilled metal, electrical and electronic trades (60,000 fewer jobs or 6% of current workforce).
- Skilled construction and building trades (57,000 fewer jobs or 6% of the current workforce).

In addition, several occupations are anticipated to experience a high replacement demand between 2020 and 2035.¹⁷ In other words, there is anticipated to be a large number of people that will leave the occupation and who will need replacing over the period. For example, the replacement demand for caring and personal service occupations between 2020 and 2035 is anticipated to be around 1.4 million new people working in the occupation. Occupations with a relatively high projected replacement demand between 2020 and 2035 include:

- Elementary administration and service occupations (approximately 1.5 million new entrants required, or 59% of the current workforce).
- Caring personal service occupations (approximately 1.4 million new entrants required, or 64% of the current workforce).
- Business media and public service professionals (approximately 1.4 million new

¹⁶ Size of the current workforce is taken from the Annual Population Survey, data as at March 2025

¹⁷ The estimated number of employees required to replace those who leave the labour force on a permanent or semi-permanent basis during the given time period, because of retirement, family formation, mortality or other reasons (Wilson et al, 2024)

entrants required, or 61% of the current workforce).

- Administrative occupations (approximately 1.3 million new entrants required, or 53% of the current workforce).
- Corporate managers and directors (approximately 1.3 million new entrants required, or 53% of the current workforce).

In most of these occupations, replacement demand is anticipated to be fulfilled by women. This is especially the case in caring personal service occupations, administrative and elementary administrative occupations.

Table 3 provides information on anticipated replacement demand between 2020 and 2035 at sub-major occupational group level¹⁸.

Table 3: Replacement demand by occupation and gender, Great Britain, 2020-2035.

Occupational Group	Replacement demand 2020-2035		
	Total replacement demand (thousands)	Males (thousands)	Females (thousands)
Corporate managers and directors	1,272	733	539
Other managers and proprietors	807	433	374
Science, research, engineering and technology professionals	876	561	315
Health professionals	939	179	759
Teaching and other educational professionals	963	266	697
Business, media and public service professionals	1,393	669	724
Science, engineering and technology associate professionals	256	151	105
Health and social care associate professionals	395	69	327
Protective service occupations	162	91	71

¹⁸ Figures not reported for 2025-2035.



Culture, media and sports occupations	358	157	202
Business and public service associate professionals	1,004	423	581
Leisure, travel and related personal service occupations	369	108	261
Community and civil enforcement occupations	15	8	7
Sales occupations	901	273	628
Customer service occupations	352	112	240
Process, plant and machine operatives	343	240	103
Transport and mobile machine drivers and operatives	654	590	64
Elementary trades and related occupations	148	96	52
Elementary administration and service occupations	1,500	626	875
Administrative occupations	1,349	356	993
Secretarial and related occupations	340	19	321
Skilled agricultural and related trades	205	147	58
Skilled metal, electrical and electronic trades	396	361	35
Skilled construction and building trades	375	362	14
Textiles, printing and other skilled trades	270	121	149
Caring personal service occupations	1,426	207	1,219
All occupations	17,069	7,356	9,713

Source: NFER projections using LFS



The health implications of expected labour market change

The effect on jobs undertaken by people reporting work-limiting conditions

Figure 1 highlights the occupations where a higher proportion of workers report having work-limiting health conditions. Among these, caring, personal service, customer service, and health and social care associate occupations are projected to see the greatest growth by 2035, collectively representing approximately half (49%) of the new jobs to be created. This presents both an opportunity and a risk.

One reason these roles are disproportionately held by people with health conditions is that they tend to be more accessible, both in terms of location and skill requirements. As these occupations grow as a share of the overall labour market, they could provide greater number of opportunities for people with health conditions to participate in work.

However, as explored further in the following sections, many of the occupations where workers report high rates of work-limiting health conditions also carry elevated risks to health. For example, workers in the health and social care sector are more likely than those in other sectors to experience emotional or physical burnout, or to work in tiring or physically demanding positions (see Table 2). Similarly, workers in the commerce and hospitality sectors, which include many customer service roles, are more likely to report a range of poor job quality indicators, including low job security.

This overlap, between the roles that people with health conditions are more likely to do and those that are more likely to harm health, is likely to be partly causal. It also reflects structural factors. These roles tend to be more readily available in areas with lower average education levels and fewer professional occupations, where health conditions are also more prevalent. As a result, health and social care, personal service, and customer-facing jobs often make up a larger share of local employment opportunities.

This highlights the need to focus on improving the quality of these roles in the future. To maximise their potential to support people with work-limiting health conditions, elements of the work will need to be redesigned to make them more accessible. This could include, for example, expanding working time flexibility in health and social care roles, or using new technologies to reduce physical demands. Focusing on job quality in these growth occupations would help ensure these roles provide meaningful opportunities, while reducing the risk of causing or worsening health problems.

The effect on jobs with high rates of work-related ill-health

Figure 4 plots the anticipated growth or decline of selected occupations against the current work-related ill-health prevalence rate. The chart highlights where the change in future job roles has the greatest potential impact on health given current prevalence rates.

For example, the occupational group 'health professionals' has the highest current prevalence rate of work-related ill-health and is anticipated to grow in size by 166,000 jobs in the ten-year period. Conversely, over the same period, there is an anticipated net decline in administrative occupations. This occupation has a relatively high ill-



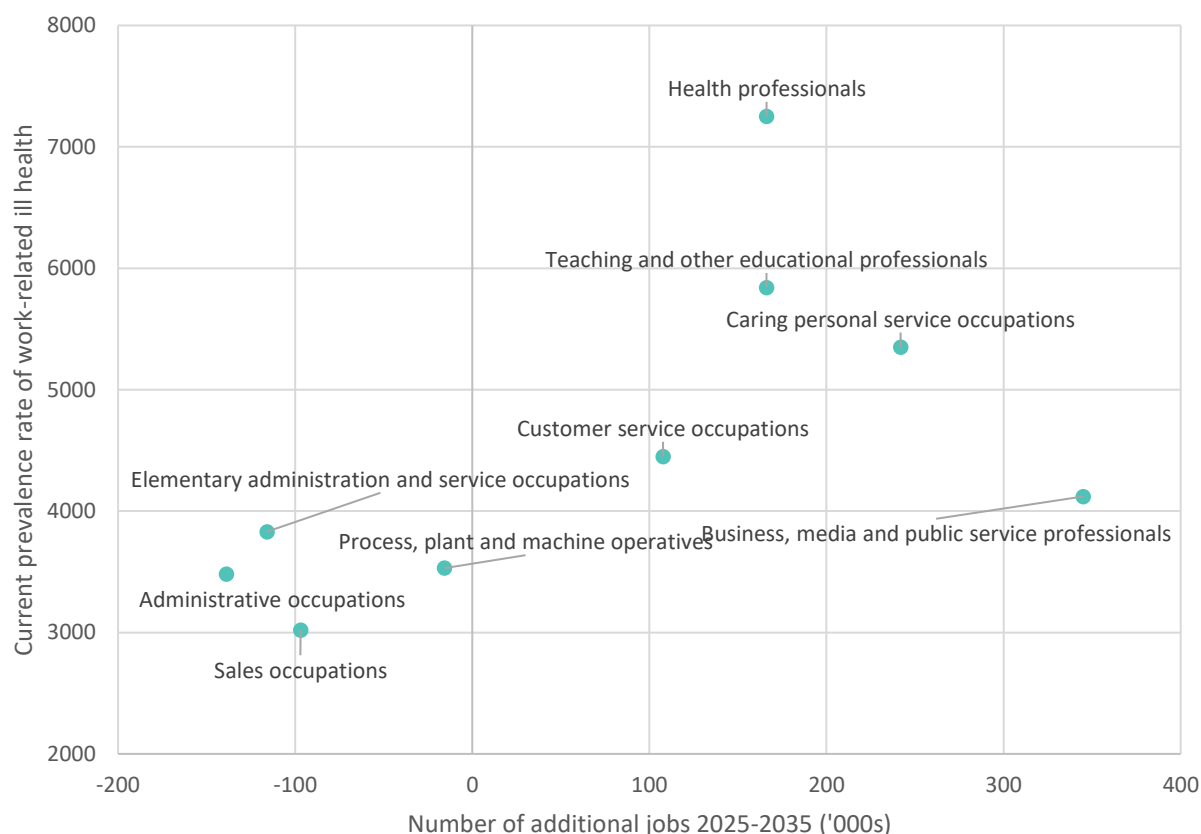
health prevalence rate, although not as high as some of the other occupations anticipated to decline (e.g. elementary administration and service occupations). The chart also shows that the occupations that are anticipated to grow the most have higher current prevalence rates than those occupations anticipated to decline the most.

There are several occupations that are both projected to grow in size in the years between 2025 and 2035 and which currently have a high prevalence of work-related ill-health:

- Health professionals.
- Caring and personal service occupations.
- Teaching and other educational professionals.
- Customer service occupations.
- Business, media and public service professionals.

Figure 4: Health, caring and personal service occupations have relatively high present levels of work-related ill-health and are anticipated to grow in size in future years.

Current work-related ill-health prevalence rates in **selected occupations** (rate per 100,000 employed in last 12 months) against projected employment growth (net change in jobs (thousands)) between 2025 and 2035.



Note: For ease of reading, only selected occupations are represented. Occupations anticipated to increase or decline by 100,000 jobs are presented.

Source: IES analysis of Labour Force Survey data and NFER national labour market projections.

Extending the analysis further, we can provide an indication of the scale of risk to health from shifts in occupations by assuming that current prevalence rates of work-related ill-health hold in the future, and applying them to projected employment growth between 2025 and 2035. Based on current figures, comparing 2035 with 2025, there could be an additional 75,000 cases of work-related ill-health across occupations, representing a 5% increase on the current number of reported cases of work-related ill-health. This overall change reflects the balance between occupations that are anticipated to experience an increase in cases and those expected to experience a decrease in cases. Both administrative and elementary administrative and service occupations are anticipated to see a decline of around 4,000 cases each. In comparison, the growth in number of cases of work-related ill-health between 2025 and 2035 is anticipated to be highest in:

- Business, media and public service professionals (roughly 14,000 additional

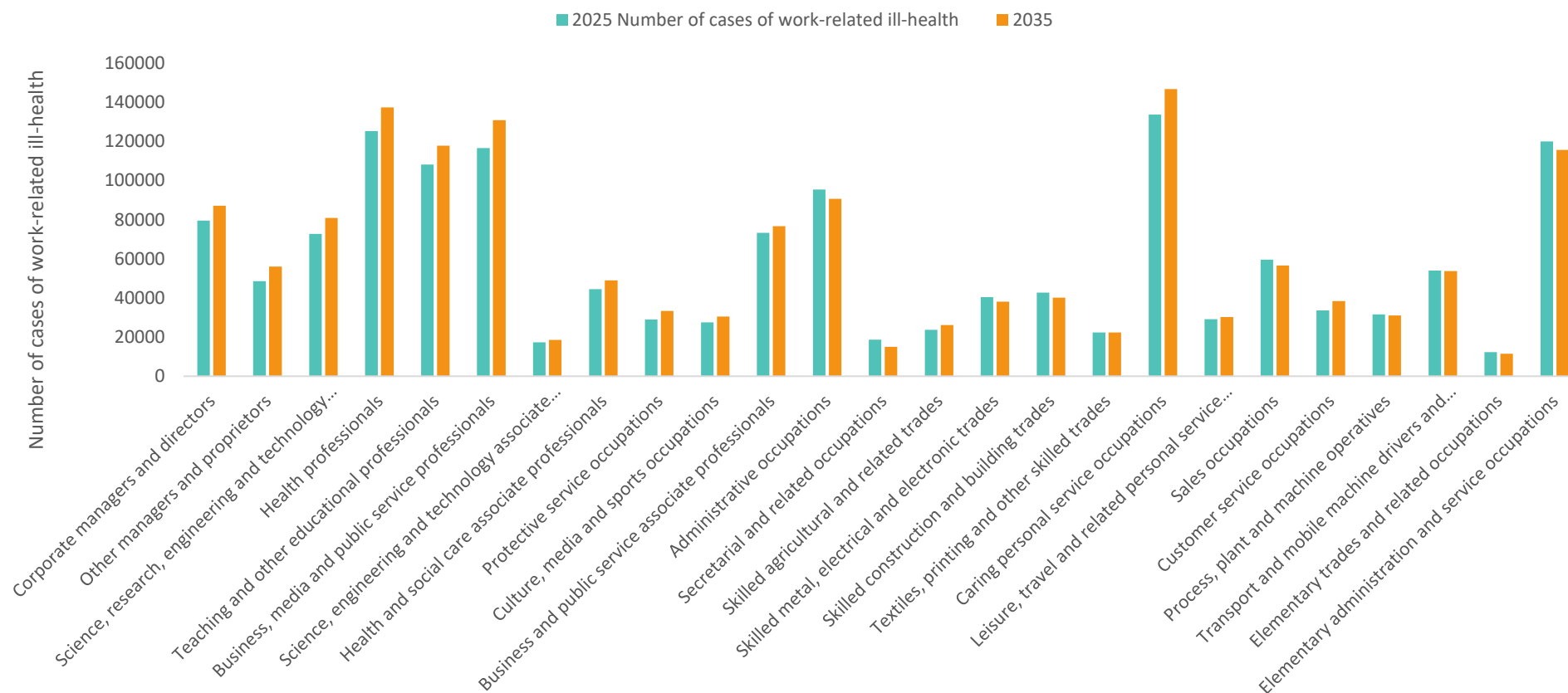


cases).

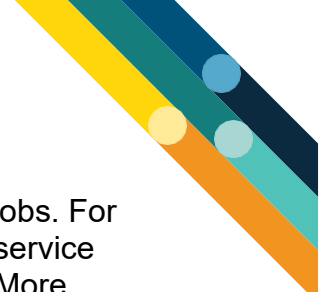
- Caring and personal service occupations (roughly 13,000 additional cases).
- Health professionals (approximately 12, 000 additional cases).
- Teaching and other educational professionals (approximately 10,000 additional cases).

Figure 5: Number of cases of work-related ill-health is anticipated to increase the most in business, media and public service professional occupations between 2025 and 2035.

Number of cases of work-related ill-health by occupation between 2025 and 2035 based on current work-related ill-health prevalence rates and occupational projections.



Source: IES analysis of UK labour market projections and HSE figures on work-related ill-health prevalence rates

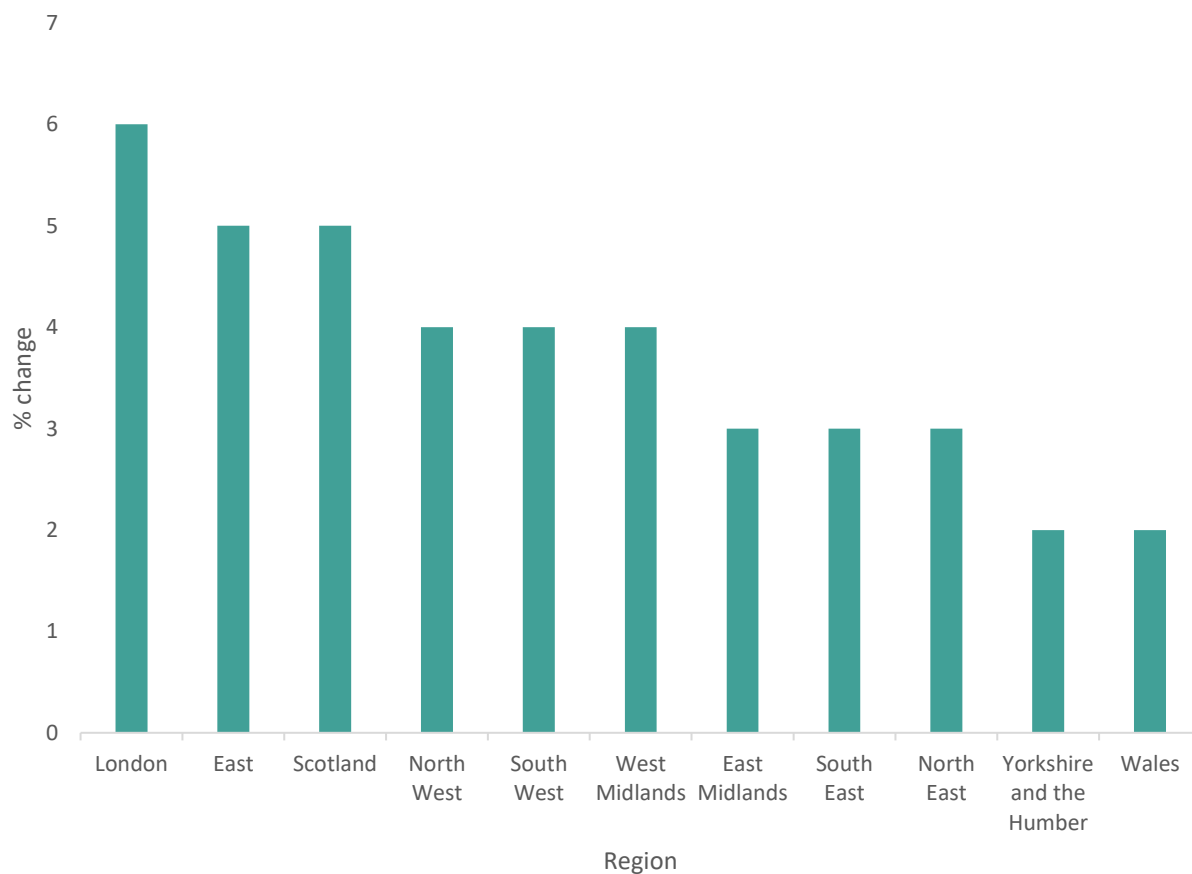


Across all of these occupations, women represent the greatest share of new jobs. For example, out of the projected 345,000 additional business, media and public service professional jobs, 204,000 or 60% are anticipated to be taken up by women. More pronounced differences are apparent for health professionals (73%), caring personal service occupations (69%), and teaching and other educational professionals (72%).

Figure 6a presents regional analysis of how the burden of additional cases of work-related ill-health may fall geographically between 2025 and 2035 based on regional occupational projections and current prevalence rates of work-related ill-health for occupations. The Figure shows that the greatest percentage increase in cases is anticipated to be in London, followed by the East of England, Scotland and the North West of England. In terms of numbers, **additional cases of work-related ill-health** are anticipated to be highest in London, the South East of England, the South West and North West of England (Figure 6b). In almost all regions, women make up most of the additional cases, except for London where the additional cases are split more evenly between men and women. This is largely a result of the greater concentration of managerial and professional roles in London and a more balanced representation of men and women in the additional jobs created in these occupations. In all regions, the overall total of additional cases of work-related ill-health are, in part, a consequence of an increase in cases from growing occupations and a decline in cases linked to occupations that will decline in size. In London, for example, there are projected to be an additional 15,500 cases from growing occupations, in particular professional and managerial jobs (Figure 6c), and a decline of approximately 2,000 cases from occupations expected to decline in number.

Figure 6a: London has the highest projected increase (%) in cases of work-related ill-health between 2025 and 2035

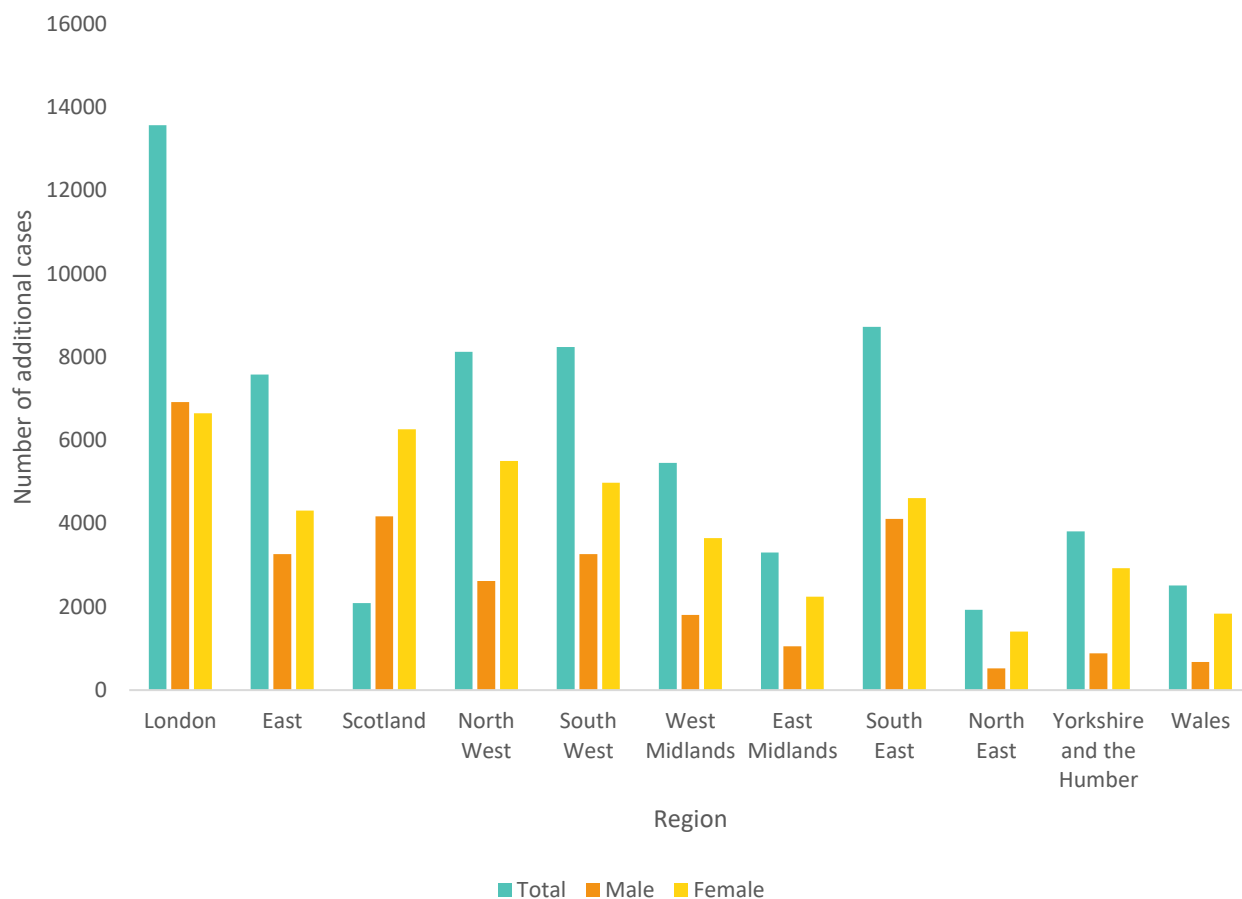
Percentage change in cases of work-related ill-health between 2025 and 2035 by region, based on occupational projections and current occupational prevalence rates of work-related ill-health.



Source: IES analysis of Labour Force Survey and NFER labour market projections

Figure 6b: London has the largest number of additional cases of work-related ill-health

Net change in number of cases of work-related ill-health based on occupational projections 2025-2035 by region and current occupational prevalence rates



Source: IES analysis of Labour Force Survey and NFER labour market projections

Figure 6c: Growth of cases of work-related ill-health in London driven partly by increase in number of professional jobs

Net change in number of cases of work-related ill-health by region and occupation within region 2025-2035

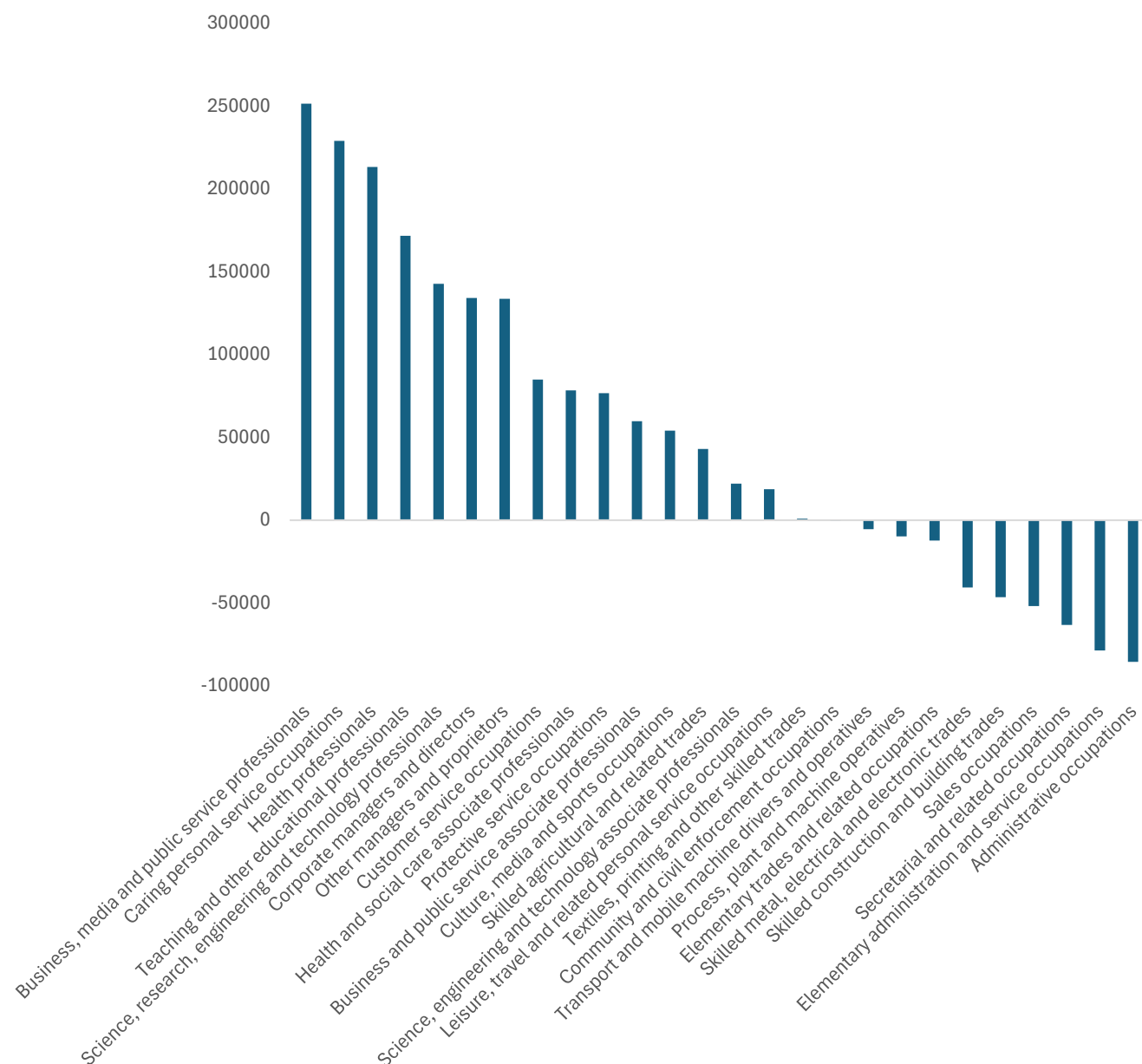


Source: IES analysis of Labour Force Survey and NFER labour market projections

The number of additional working days lost due to work-related ill-health can be computed in a similar way, using the average number of working days lost per case. Figure 7 illustrates projections for the additional number of working days lost due to work-related ill-health for different occupations. The projections are based on current prevalence rates, the average time taken off work for a case of work-related ill-health, and projected number of additional jobs in each occupation. The Figure shows that an additional 200,000 – 250,000 working days lost are projected among business, media and public service professionals, health professionals and caring personal service occupations. In total, there are an anticipated additional 1.3 million working days lost comparing 2035 with 2025, comprised of 1.7 million more days lost in occupations anticipated to grow and roughly 400,000 fewer working days lost in declining occupations. Approximately 16% of the change in the burden of ill-health is a consequence of a projected change in the composition of the labour market between 2025 and 2035 in terms of the relative share of different occupations. The remainder is a consequence of an increased number of jobs in 2035.

Figure 7: The projected growth of business, media and public service professionals will cause in excess of an additional 200,000 working days lost.

Number of additional working days lost due to work-related ill-health by occupation between 2025 and 2035.



Source: IES analysis of Labour Force Survey and UK Labour Market Projections

Based on analysis by the Health and Safety Executive, the human and financial cost of a case of absence from work due to ill-health lasting 7 days or longer is £44,800.¹⁹ For cases of absence shorter than 7 days, the human and financial cost is estimated to be £1,230. The HSE also estimates that cases of 7 days or longer represent approximately 25% of cases. Based on these figures, the human and financial costs of

¹⁹ Health and Safety Executive (2024) Costs to Britain of workplace fatalities and self-reported injuries and ill-health, 2022/23. HSE.

the **additional** cases of ill-health across occupations would equate to roughly £1bn (£909 million) comparing 2035 with 2025. In the business, media and public services occupation the additional working days lost would equate to roughly £170 million per year.

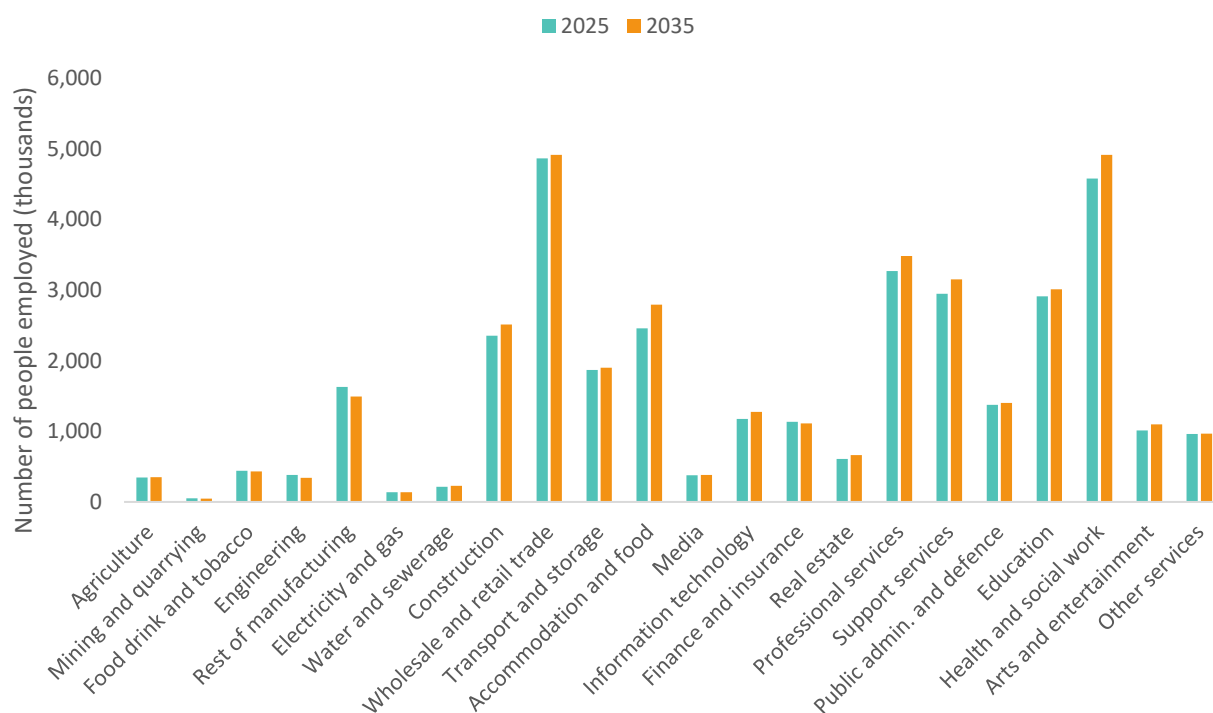
The effect on industries where job quality presents a risk to health.

Figure 8a below shows the projected employment breakdown by industrial sector in 2025 and 2035. The Chart illustrates that the sectors that are anticipated to grow the most over the period are:

- Health and social work (a 7% increase or 338,000 new jobs).
- Accommodation and food (a 14% increase or 335,000 new jobs).
- Professional services (a 7% increase or 216,000 new jobs).
- Support services (a 7% increase or 204,000 new jobs).
- Construction (a 7% increase or 156,000 new jobs).
- Information technology (a 8% increase or 95,000 new jobs).

Figure 8a: Health and social work is the industrial sector anticipated to add the most new jobs between 2025 and 2035, Great Britain

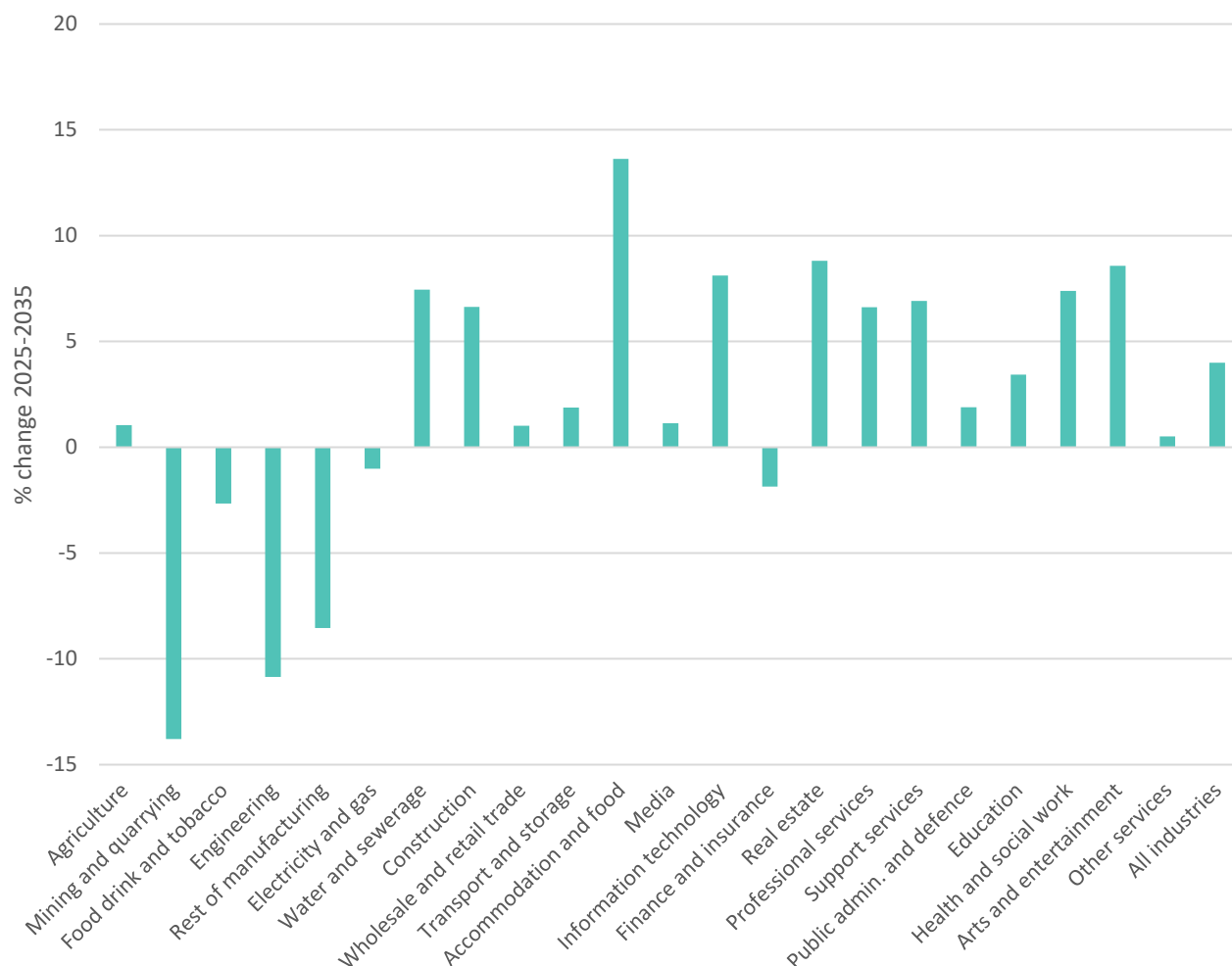
Projections of numbers of people employed by occupation in 2025 and 2035, Great Britain



Source: IES analysis of NFER UK labour market projections

Figure 8b: Accommodation and Food is the industrial sector anticipated to show the greatest percentage increase in jobs between 2025 and 2035

Percentage change in number of people employed in industrial sectors between 2025 and 2035



Source: IES analysis of NFER UK labour market projections

Several of these industries are associated with adverse job quality factors that may harm health. For example, as previously discussed, the health and social care sector is characterised by relatively high levels of imbalance between work demands and resources. Equally, the accommodation and food services industry is characterised by adverse job quality indicators across job (in)security, poor work-life balance, low autonomy and support, and the experience of discrimination. Construction is also expected to grow (largely due to the demand for housing) with that industry characterised by a range of risks to health from lack of job security, long hours, working in tiring positions, and the experience of discrimination.

Implications

The analysis presented here offers insight into the potential future distribution of ill-health and work-related health risks across the labour market, based on current patterns and expected labour market trends. While the findings represent a plausible scenario, as with all projections, there remains inherent uncertainty due to unforeseen changes in health risks and the occupational make-up.

At a high level, the analysis suggests that occupational change is likely to affect some groups and regions more than others. Women are expected to take up the majority of new roles in the economy, including most of the additional roles associated with high or elevated health risks. London, because of its large overall economy, is projected to see the greatest increase in jobs that pose health risks followed by the South East and South West of England. However, as employment in London is less concentrated in service-based roles, it is the only region in England where these additional risks are not expected to fall disproportionately on women. The rest of this section considers implications for the occupations where the increased health risk is greatest.

The numbers of people, especially **women, working in occupations involving caring and supporting others such as care workers, childcare support assistants, and nursing auxiliaries** is anticipated to grow in the next 10 years. Additionally, there are likely to be a significant number of new entrants needed to these occupations to replace those leaving them. These occupations currently have high levels of work-related mental and physical ill-health and poor job quality. Working in tiring positions, physical and emotional burnout, lack of control and discrimination are all above average in the sector in which these roles are located. Improving job quality and reducing physical and emotional demands in these occupations will require adjusting work to fit capability, especially for the relatively high proportions of people in these occupations who report work-limiting conditions, as well as the judicious use of new technology to reduce work demands and redesign work to support better wellbeing.

Remaining within the health sector, there is anticipated to be growth in **health professional occupations such as medical practitioners, physical and psychological therapists, and nursing professionals**. This occupational group has the highest current prevalence rate of work-related ill-health, driven largely by work-related stress, depression and anxiety. Women are anticipated to fill most of the additional jobs created in the next decade.

Addressing the work conditions that drive burnout in these occupations is both essential today and will become increasingly more so in future years if the projections are correct. Prior research on addressing work intensification in the health and social care sector has looked at various practices such as the introduction of workload algorithms²⁰ and high-performance work practices but have proved inconclusive in their effects²¹.

Further research is needed to identify what interventions can successfully change

²⁰ Willis, E., Toffoli, L., Henderson, J. and Walter, B., 2008. Enterprise bargaining: a case study in the de-intensification of nursing work in Australia. *Nursing Inquiry*, 15(2), pp.148-157.

²¹ Rees, G.H. and Gauld, R., 2017. Can lean contribute to work intensification in healthcare? *Journal of health organization and management*, 31(3), pp.369-384.



organisational culture and working conditions to support better wellbeing at a systems level.

Technology has the potential to help adjust the balance between work demands and the available resources to meet them, impacting wellbeing. On the potential positive side, the use of new technologies such as robotics and exoskeletons could reduce physical demands, and the wider use of Artificial Intelligence (AI) could potentially reduce administrative workloads and enable workers to focus on more meaningful and fulfilling parts of their role.

On the negative side, technology may lead to increased pace and intensity of work, and reduced autonomy. Research on the impact of automation on worker wellbeing suggests that outcomes depend a great deal on the context. In particular, the extent to which employees are involved in the decision-making and design process and are supported with the requisite skills and training to benefit from the technology.²² More research needs to be done to identify and spread good practice with respect to how new technology can be introduced at work to improve work design in a way that improves both wellbeing and productivity, rather than enhancing productivity at the expense of wellbeing.

There is also high occupational growth projected in business, media and public service professions, where the primary risk to health is stress, depression and anxiety driven by unsustainable work demands. Much the same picture applies to **teaching and other educational professionals**, an occupational group expected to grow in the next decade, and characterised by high levels of work-related stress, physical and emotional burnout. Women, again, dominate the anticipated growth of new jobs in the occupation. Prior work by the TUC highlights this group as enduring high levels of work intensity and has outlined some suggested ways in which work in the sector could be reshaped to address it.²³

The number **of people working in customer service occupations such as contact and call centre workers** is anticipated to grow. These occupations are associated with higher-than-average levels of work-related ill-health driven by work-related stress and are in sectors with higher-than-average levels of job insecurity, discrimination, and burnout. Young people may be particularly affected given their presence in these types of occupations. There are relatively high numbers of people working in these occupations currently who report health conditions that limit the amount or type of work that they can do, a situation that may worsen if action to address working conditions is not taken.

Prior research has demonstrated that the availability of flexible working arrangements and a psychologically safe working environment where workers can express their needs and preferences are associated with fewer health-related work limitations.²⁴

²² Rohenkohl, B. and Clarke, J., 2023. What do we know about automation at work and workers' wellbeing. *Literature Review*.

²³ TUC (2023) Work intensification: The impact on workers and trade union strategies to tackle work intensification. TUC

²⁴ Vanajan, A., Bültmann, U. and Henkens, K., 2020. Health-related work limitations among older workers—the role of flexible work arrangements and organizational climate. *The Gerontologist*, 60(3), pp.450-459.



Increasing the incentives for employers to adapt working conditions, as well as expanding the availability and quality of affordable vocational rehabilitation support would enable the adaptation of working conditions to suit individual needs. AI applications may also help by smoothing the process of matching job adaptations with employee needs and preferences. More broadly, improving job quality through higher autonomy, support and lower psychological job demands can reduce the risk of workers with ill-health exiting work.

Elementary administration and service occupations are anticipated to need a high number of new workers to enter the roles as existing workers leave due to retirement, ill-health or other reasons. These occupations are associated with higher-than-average levels of work-related musculoskeletal disorders and are in sectors associated with higher-than-average levels of job insecurity, physical and emotional burnout and discrimination. Improving working conditions in these sectors and occupations will help support existing workers to remain in work but also ensure that future entrants do not experience poor health as a consequence of poor working conditions.

Both ***construction and transport and storage are sectors with higher-than-average levels of job insecurity, long working hours, and poor work-life balance.*** They have high levels of work-related ill-health, especially musculoskeletal disorders among older men. Employment in the construction industry is anticipated to grow due to increased housing demand. While the specific occupations in that sector with the highest current rates of work-related ill-health (e.g. skilled construction and building trades) are anticipated to decline in the next decade, improving working conditions in these sectors is likely to be important as the sector grows in size.

The purpose of this paper has been to highlight, based on current labour market projections and if the quality of work stays broadly similar, the occupations, population groups, and regions that will face elevated risks to health related to work in the next decade. This will hopefully act as a spur to further, targeted action on improving health and wellbeing at work.

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