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Editorial

Economic inactivity and mental–physical multimorbidity

More than 20% (~8.7 million) of people aged 16–64 in the UK are neither working nor actively seeking work—economically inactive [1]. Over 2.5 million report their economic inactivity is due to ‘long term ill health’. Even when another reason such as ‘early retirement’ is provided, ill health may be a contributing factor [2], although this is rarely acknowledged and remains under-researched. Economic inactivity restricts labour market supply, impedes economic growth and reduces tax receipts making it the biggest labour market challenge we currently face. The increase in health-related economic inactivity since the pandemic (alongside rising ill health among workers) has already cost £15.7 billion (0.6% of GDP) in additional social security payments and forgone tax revenues [3]. Whilst for some individuals (though who and how many remains under-researched) economic inactivity may be a positive choice, for many it removes life chances, blunts opportunity, and reduces social and societal engagement.

Multimorbidity, the co-occurrence of two or more (normally long term) conditions in one individual, is ‘one of the greatest challenges facing health services, both presently and in the coming decades’ [4]. It is a priority for National Institutes for Health & Care Research (NIHR), the Academy of Medical Sciences and the wider healthcare system. Unmentioned in the 2008 Black report [5], there has been a steady increase in the prevalence of multimorbidity in working age adults in the last two decades [6]. The challenges of multimorbidity are exacerbated by widely recognized limitations of a secondary healthcare system that patients struggle to navigate and remains primarily set up to manage patients with a single condition.

Mental–physical multimorbidity (MPM) is an important subset of multimorbidity, under-recognized in health care and the workplace. Physical and mental disorders commonly co-occur, often making the management of each more difficult. Untreated this can lead to worse outcomes, though treating the mental disorder can improve physical outcomes. Many multimorbidity studies simply ignore mental disorders, and few give equal importance to mental disorders [7]. Almost all research on the co-occurrence of mental and physical disorders comes from cross-sectional studies—relatively little is known about pathways into MPM. Questions such as which disorder comes first, how long between additional diagnoses and at what point do people leave the labour market remain unanswered as

multimorbidity are constructed as a binary state rather than a dynamic process.

Social and economic factors contribute to the onset of multimorbidity [8]. Population mental health has been negatively impacted by the pandemic [9] and both unemployment and poor-quality work [10] are bad for both physical and mental health outcomes. At the same time, common mental disorders (CMDs) are the biggest reason for long-term sick leave in the UK [11]. Economic inactivity and MPM share important risk factors—social deprivation and lower educational attainment, for example, and in the UK share a similar geographical distribution [6]. It might be expected therefore that the academic and policy efforts being made to address the challenges of economic inactivity and multimorbidity would reflect these relationships and use the areas of overlap to leverage benefits for both issues.

In reality, addressing economic inactivity and MPM is being done without reference to each other and the importance of their relationship is being missed. For example, Rugulies *et al.* [12], in their paper on mental health at work, part of a major Lancet series, do not mention of the relationship between physical and mental health, whilst a recent NIHR report [13] on the intersection between multiple long-term conditions and health inequalities makes only passing reference to work and employment. Even when data exist their importance can be overlooked. The ONS report ‘Rising ill-health and economic inactivity because of long-term sickness, UK: 2019 to 2023’ [14] used Labour Force Survey data to analyse the health conditions reported by those who are inactive because of long-term sickness. There is an acknowledgement that the number of people reporting several long-term conditions (i.e. multimorbidity) had gone up, that 5 million (12%) of the working age population reported ‘depression, bad nerves or anxiety’, and that over half of the economically inactive population reported severe depression as a health condition. Yet crucial data are hidden in the tables without comment in the text. For example, in addition to a 27% increase in the number of economically inactive people reporting musculoskeletal disorders, the proportion of these reporting an additional mental disorder increased by over a quarter, and on top of a rise of more than a third in the number of economically inactive people reporting cardiovascular disease, the proportion reporting an additional mental disorder increased by 26%. Long-term (physical) health conditions are increasingly associated

with economic inactivity, and an increasing proportion of these individuals also have a mental disorder.

The trends in the current data point to two inescapable conclusions. First, the challenge of economic inactivity in the UK cannot be addressed if the underlying relationship with multimorbidity in general, and MPM in particular, are not better understood. Second, the rise in the prevalence of working age MPM and its associated impacts cannot be mitigated if occupational aspects such as precarious work, sickness absence, unemployment and early exits from the labour market remain under-recognized. Separately, but importantly, both economic inactivity and MPM exist on steep social gradients so would seem essential areas on which to focus efforts to reduce health inequalities, a UK-wide government priority.

There are key areas where improvements are necessary to address these issues. First, clinicians, researchers and policy-makers need access to better-quality data. Physical health data often sit separately to mental health data. Cartesian mind–body dualism remains alive in the electronic health records of UK patients. Limited work and employment data exists within routine health records—documenting occupation is not mandatory. Primary care data may contain specific patient-reported aspects of their job or their working environment, but detail and objectivity are often absent. Fit note data can be illuminating for some situations but remain limited. Secondary care data frequently contain minimal social and occupational histories. Similarly useful health data are missing from either social security or employment data for understandable reasons of confidentiality, and researchers often struggle to link even anonymised datasets. Had high-quality detailed data about occupation been available during the COVID-19 pandemic the ability to recognize vulnerable groups of workers would have been greater and potentially saved lives. Occupational health professionals should be at the forefront of improving the collection and use of better-quality data. Identifying modifiable risk factors across different groups in the labour market, especially with longitudinal data, will help reduce the risk of widening health inequalities, and increase awareness that for many patients the ability to return safely and sustainably to work is an important aspect of health care. Occupational health professionals can help ensure that more meaningful occupational data are collected in studies, which in turn will ensure that interventions are properly evaluated and that the findings are of maximum utility. Occupational health expertise will be essential in addressing the combined challenge of MPM and economic inactivity.

Second, whilst better data are necessary, they are not sufficient. There remains insufficient dialogue between clinicians, researchers and policy-makers about the way economic inactivity and MPM relate to each other. Siloed thinking rarely provides the best solution. Policy-making will always be about more than scientific evidence but at some level must be based on a model into which scientific evidence can feed. This requires more clarity about the underlying model, and willing scientists must be able to engage. Appropriate structures, better data, and continued leadership from occupational health will result in much swifter progress.

Better data and better communications need to translate into delivery of better services to working age people with multimorbidity. This is not, however, a simple call for ‘more

healthcare’ or more funding. The challenges of economic activity are not caused by a lack of healthcare and will not be solved by a ‘more of the same’ approach. A better understanding of both the upstream causes of both economic inactivity and MPM, and the challenges experienced by individuals with either or both should lead to health services better aligned with their needs. The ‘single system’ structure disadvantages those with multiple conditions [15]. Services need to appreciate that many working age patients have multiple physical conditions, and CMDs which cannot always be managed in primary care or within low intensity talking treatment services such as Improving Access to Psychological Therapies, and that struggling whilst at work, or wishing to recover sufficiently to return to work, is normal amongst working age patients and needs to be reflected in the care provided as well as the frameworks within which this care is provided.

Health-related economic inactivity is rising, and unchecked will increasingly impact the wider economy. Multimorbidity, especially MPM, is increasing amongst those of working age. Together, they cement disadvantage and worsen health inequalities. It is time to bring together clinicians, academics, researchers, policy-makers and people with lived experience to address an issue which will not be solved by any one group working alone.

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COMPETING INTERESTS

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