

Commentary

Health-related economic inactivity, or sickness as surplus? Governing worklessness in post-pandemic capitalism

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Responding to growing political concerns that posit health-related economic inactivity (HREI) as simultaneously a threat to economic growth and a matter of individual behaviour and labour market participation, this commentary critically interrogates the structural foundations of worklessness within capitalist polities. We argue that HREI cannot be understood as either a residual labour market issue or an individual problem of poor health. Rather, inactivity is symptomatic of deeper systemic logics that determine who is deemed economically valuable and who is rendered surplus. We examine contemporary UK 'workfare' policy, in which welfare payments are made conditional on work related activity, and thus extend labour market logics into health and welfare systems. These systems are increasingly tasked with prioritising productivity over care. Policy imperatives discipline the inactive through mechanisms such as activation, conditionality and welfare reform, while obscuring the structural determinants of ill health and labour market exclusion, reinforcing a moral economy in which health is instrumentalised for economic ends. This commentary champions a politics of care over activation whilst calling for a reimagining of the relationship between public health, work and employment; one that prioritises a politics of care, centring equity, solidarity and unconditional support whilst resisting reductionist, orthodox economic models that use labour market participation as a core measure of human value.

Introduction

Health under capitalism is an impossibility. Under capitalism, to attain health you must work, you must be productive and normative, and only then are you entitled to the health you can buy. This fantasy of individual health under the political-economic conditions of capitalism only ever exists as a state one cannot be, to which one must always strive. (Adler-Bolton & Vierkant 2022, p. 8)

Adler-Bolton and Vierkant's (2022) deliberately provocative formulation exposes a central tension within contemporary political economies of health. It highlights how access to, and understandings of, health

are increasingly structured by economic logics that tie wellbeing to productivity. While not denying that many population health indicators have improved historically, this framing draws attention to the persistence of inequalities and the conditionality of health within capitalist systems. Their perspective aligns with critical scholarship that understands health as socially produced and unequally distributed through the organisation of housing, work, welfare and care rather than as simply the outcome of individual pathology or clinical intervention (Bambra et al. 2005, Schrecker & Bambra 2025, Simpson et al. 2025). Within this perspective, health-related economic inactivity (HREI) is both a manifestation and a driver of health inequality, reflecting and reinforcing complex social epidemiologies of illness with significant consequences for work, welfare and public health.

Across high-income settings, welfare and labour market policies increasingly tie access to support to labour market participation. Canadian income support reforms, for example, have been criticised for linking welfare eligibility and paid work (Taher et al. 2025). Such policies are frequently underpinned by the assumption that employment is beneficial for both health and wellbeing. While a substantial body of evidence suggests that paid employment, particularly ‘good work’, does support health and wellbeing (Waddell & Burton 2006, Marmot et al. 2010), these relationships are uneven and highly contingent. For many experiencing insecure, low-paid or poor-quality employment, the benefits of work are limited and may in some cases be detrimental to health (Schrecker & Bambra 2025).

Against this backdrop, our Commentary takes the UK as a case, critically interrogating what the framing of HREI within contemporary policy discourse reveals about the relationship between health, work and economic value. A key reference point is *Keep Britain Working* (Mayfield 2025), an independent review commissioned by the UK Department for Work and Pensions (DWP) to inform government policy on rising levels of health-related labour market inactivity. The review largely framed long-term illness as a challenge to labour market participation and productivity, while giving comparatively less attention to the wider structural inequalities that shape patterns of illness and labour market exclusion. It asserted that workers have responsibilities and that ‘disengaging from work and potential support leads to detachment and dependency’ (Mayfield 2025, p. 2). Such framing extends activation logics into the domain of care, recasting health as a resource to be optimised for economic ends. In doing so, it shifts responsibility for systemic failures onto individuals and workplaces while eliding the political determinants of illness, poverty and insecure work (Schrecker & Bambra 2025).

We argue for a critical reframing of HREI, not as a residual labour market issue or as the outcome of individual deficits of human capital, but as a public health problem, rooted in political economies of health that equate human value with labour market participation. In doing so, our commentary draws on and extends Adler-Bolton and Vierkant’s (2022) critique of health under contemporary capitalism, applying its central insights to current debates on HREI and labour market participation. This reframing is not only conceptually necessary but is a timely counter to current policy discourse that subordinates health to economic productivity, eroding principles of care, equity and public wellbeing (Adler-Bolton & Vierkant 2022, p. 8).

A Public Health Problem?

Governments across high-income countries have become increasingly preoccupied with rising rates of economic inactivity, defined as the status of being of working age but neither in employment nor actively seeking or available for work (ILO 2024, OECD 2024). While this category encompasses students, carers and others outside the labour market, policy attention has increasingly focused on HREI, where exclusion from work is associated with long-term illness, disability and disadvantage. Importantly, this is not simply a story of individual illness or impairment. Disability and labour market exclusion are also produced through social, economic and environmental barriers that restrict opportunities for participation. In the UK, unemployment accounts for only a small proportion of worklessness compared with the much larger economically inactive population. In 2025, 1.4 million people were unemployed compared with nine

million who were economically inactive (ONS 2025). Similar trends are evident across high-income countries, where inactivity is increasingly framed as a challenge to productivity and economic growth (OECD 2024, ILO 2024). Yet the growth of HREI must also be understood in the context of prolonged austerity, underinvestment in public services and widening regional inequalities, all of which have contributed to deteriorating population health and labour market exclusion (Simpson et al. 2025). Following the pandemic, HREI has become the leading cause of labour market non-participation in the UK and a major focus of policy intervention (ILO 2024, UK Labour 2025).

More than a labour market trend or epidemiological observation, HREI provides a lens through which to examine the relationship between health, work and economic value in contemporary capitalist societies. Here, we approach HREI not merely as an epidemiological artefact that challenges labour market governance, or as a technical problem of public policy. Rather, we understand inactivity as symptomatic of deeper structural contradictions in the social organisation of work, health and care; contradictions that imagine illness as a problem for labour markets, rather than interrogating how dominant conceptions of work, productivity and value produce the very conditions that posit the sick as surplus: individuals rendered economically redundant by systems that equate human value with productivity. These models obscure the role of structural inequality, underinvestment in health systems and the design of labour markets that fail to accommodate illness, disability and fluctuations in capacity to work over time. Furthermore, such dynamics actively produce and sustain regional inequalities, one of the most enduring and consequential challenges facing the UK's health and economic systems (Simpson et al. 2025).

Our critical political economy of health perspective illuminates that, despite dominant neo-liberal doxa, health is not merely a personal asset to be optimised for labour, but a terrain of struggle; one in which the sick, disabled and economically unproductive are cast as surplus to the needs of capital. Following Adler-Bolton and Vierkant (2022), we contend that recent populist political framings of HREI as a barrier to economic growth elide the foundational assumptions of capitalist health systems: that health is valuable only insofar as it enables productivity and consumption; that those unable to work are construed as a fiscal and social burden to be managed rather than supported; and that full citizenship is increasingly tied to becoming both a productive worker and active consumer, each imagined as essential to individual and collective wellbeing.

What follows critically considers the implications of current political discourse that frames reducing economic inactivity generally, and HREI specifically, as a panacea for economic growth (UK Labour 2025). Within these policy and political framings, new alliances between employers, health and welfare services have been created to govern the workless, predicated on holistic interventions that address both market demand and perceived human capital deficits, instigating sweeping programmes of welfare reform and enhanced employment support (DWP 2025 p. 15-16). Here, getting people back to work becomes a strategy for enriching individual and community wellbeing whilst delivering growth. Though aspirant to create inclusion, equity and opportunity, these approaches are constrained by structural factors that reproduce the causes of inactivity: poverty, discrimination, environmental degradation and health and healthcare inequalities. Further, where strategies seek holistic solutions by aligning employment support with welfare reform, particularly where conditionality¹ is invoked, the consequences are significant, reinforcing stigma, exacerbating stress and deterring engagement (Green et al. 2017). The repercussions for the sick and disabled are often profound, resulting in prolonged exclusion from the labour market, deepening poverty and worsening health outcomes (Porter et al. 2022).

¹ Conditionality is the practice of making access to welfare support contingent upon compliance with behavioural requirements related to employability, job-seeking or labour market participation (Ingold 2024).

Reframing Economic Inactivity

A political economy perspective highlights how HREI is shaped by systems of work, welfare and social value rather than individual deficits. Central to this perspective is the recognition that, in capitalist societies, work is not only a source of income but a key determinant of status, rights and full citizenship. As a consequence, those who are unable to participate in paid employment are often constructed as dependent or deficient, reinforcing a moral economy in which the economically inactive become subject to surveillance, judgement and intervention (Tyler 2020).

These assumptions continue to shape contemporary understandings of economic inactivity and the policy responses designed to address it. Economic inactivity generally, and HREI specifically, have become increasingly framed as threats to productivity, fiscal sustainability and economic growth (UK Labour 2025). Media and political discourse frequently reproduce narratives contrasting the ‘hardworking taxpayer’ with the ‘undeserving claimant’, reinforcing reductive binaries between work and dependency (Patrick 2017). Within this framing, the sick and disabled are expected to justify non-participation while demonstrating a commitment to returning to work, regardless of structural barriers. The result is the legitimisation of surveillance, conditionality and intervention in the lives of those judged economically unproductive. Such discourses position the economically inactive as a latent labour force whose ‘activation’, through welfare reform, employment support and behavioural interventions (Martin 2015), is justified not only as an economic imperative but also as a moral necessity. In doing so, attention is diverted from the structural determinants of labour market exclusion towards individual responsibility, reinforcing a policy environment in which the sick and disabled face increasing pressure to engage with employment support or return to work.

The recently launched *WorkWell* pilot in the UK (NHS 2025) exemplifies the reconfiguration of health as a tool of economic governance and the increasing instrumentalisation of health systems in support of labour market activation. Operating across 15 regions, the programme aims to support up to 56,000 disabled people and people with health conditions into employment by Spring 2026. By embedding job coaches and occupational therapists within General Practice, *WorkWell* brings healthcare more directly into the governance of labour market participation. Crucially, the ‘fit note’², once a mechanism of clinical support and protection, is increasingly reframed as a gateway to employability, with its use tied to assessments of work readiness rather than medical need. The effect is to reposition illness less as a condition warranting care and support than as a barrier to economic participation requiring intervention and correction.

Conditionality, Surveillance and the Medicalisation of Worklessness

Policy imperatives towards the medicalisation and moralisation of worklessness blur boundaries between health and employability (Ryan 2019). Personal responsibility and conditionality are central, with access to financial support increasingly contingent upon compliance with work-related activities, including health interventions, employability training and reassessment of fitness for work. These approaches are underpinned by a behavioural logic that individualises responsibility for inactivity, diverting attention from the economic, institutional and labour market conditions that shape participation.

An example is the longstanding Work Capability Assessment (WCA), a functional assessment used by DWP to determine eligibility for work-related benefits. This assessment has been widely criticised for inconsistency and poor medical accuracy, particularly in relation to complex, fluctuating and mental

² In UK primary care, a ‘fit note’ (Statement of Fitness for Work) is issued by a GP to indicate whether a patient is unfit for work or to return with adjustments. Originally a clinical assessment tool, it has been reframed within welfare policy as a gateway to work readiness (DWP 2023).

health conditions, and often experienced as stressful and dehumanising (UK Parliament 2017). It is also widely criticised for its reductive and punitive approach to assessing disability and illness, often failing to reflect the complexity of long-term health conditions. At the same time, employers and healthcare workers are enlisted as agents of activation, tasked with identifying and managing the risk of ‘worklessness’ through early intervention and return-to-work planning (Friedli & Stearn 2015).

While active labour market policy is often understood more broadly to include both supply- and demand-side measures, UK policy has tended to prioritise supply-side interventions targeting individual behaviour and labour market participation. Typically focused on labour supply and targeting an imagined latent workforce, these policy instruments give limited attention to demand-side factors, such as the availability of suitable employment, which are shaped by regional economic conditions (Beatty & Fothergill 2016). This reinforces narratives of personal responsibility, positioning the economically inactive individual as the problem to be solved through addressing perceived human capital deficits (Ingold et al. 2025). However, employment data consistently shows lower inactivity in stronger economies, challenging this assumption (Porter et al. 2022). Despite this, policy continues to prioritise supply-side activation (Mayfield 2025).

For the most vulnerable, welfare conditionality operates not only as a set of technical regulatory tools but as a form of social control, inflicting symbolic and material harm through surveillance, coercion and the threat of destitution (Wright et al. 2019). Reflecting a broader shift from welfare as a right to disciplinary workfare, such regimes do not simply fail to support those with health-related barriers to work but actively undermine wellbeing, reinforcing a moral economy in which poverty and illness are treated as evidence of personal failure (Patrick 2017). In this context, economic inactivity is not a neutral category of labour market analysis, but a politically constructed status governed through punitive systems that obscure structural determinants and reproduce exclusion. The contradictions of positioning individuals as both problem and solution for economic growth remain clear (Barford & Gray 2022).

Health Systems as Economic Systems: Interventions that work?

The implications for public health are profound. The launch of *WorkWell* offers a striking example of strategies to govern HREI through behavioural and labour market logics rather than public health principles. Embedding job coaches and occupational therapists into primary care settings, the programme reframes General Practice as a site of employment triage (DWP & DHSC 2025). Here the fit note becomes a tool for enforcing employability, blurring the line between clinical judgement and labour market conditionality, to be combined with employment focused interventions such as job coaching, gym membership and debt advice within GP practices.

Broadly described as a social prescribing model (Gibson et al. 2021), *WorkWell* explicitly acknowledges the complex social factors and settings that shape participation in work. While interventions such as social prescribing, occupational therapy and voluntary job coaching may improve wellbeing, social connectedness and participation for some individuals, particularly where they are sustained and properly resourced (Marmot et al. 2010, p. 134), their effectiveness remains contingent on wider social and economic conditions. Gibson et al. (2021, pps. 6-8) argue that interventions focused on personalised support cannot, in themselves, address the structural inequalities that shape health and participation and may risk reproducing existing inequalities where access to resources and other forms of capital remains uneven. In contexts characterised by insecure work, fragmented provision and structural inequality, such approaches risk functioning as palliative responses that address the symptoms, rather than the causes, of exclusion from the labour market.

In this context, framing fit notes as a ‘dead end’ (DWP 2025) and promoting behavioural interventions such as gardening or gym use presumes that inactivity stems from poor lifestyle choices or low motivation, obfuscating the political determinants of long-term illness and employment precarity (Dorrington et al. 2018). Within this model, illness is increasingly understood through the lens of

employability, with recovery defined in terms of work readiness and patients recast as workers-in-waiting. However, the resulting shift in GP and primary care roles, from clinical certification to work and health support services, risks reifying biomedical models of illness as a problem of individuals and human capital deficits, rather than systemic inequalities, collapsing the boundary between spaces of care and welfare surveillance and transforming GP surgeries into potential vectors of labour market discipline.

The reconfiguration of fit notes into behavioural gateways rather than clinical assessment exemplifies the shift from care to productivity enforcement apparent in current workfare policy. In initiatives like *WorkWell*, the sick role is no longer protected or depoliticised; it is governed, evaluated and rehabilitated in line with labour market logics. Following Adler-Bolton and Vierkant (2022), we can understand this as part of a wider reconfiguration of health systems around capitalist imperatives, where health is treated simultaneously as an individual responsibility and a necessary prerequisite for productivity.

Discussion

Approaches to reducing HREI increasingly reflect a policy shift from passive welfare provision towards active labour market engagement, with significant implications for public health. Within this framing, HREI is understood primarily as a barrier to economic growth rather than as a manifestation of wider failures in health, welfare and labour market systems. This convergence of health and economic imperatives risks recasting the sick and disabled into workers in waiting, transforming care into a form of conditional support tied to labour market participation. Health systems are increasingly drawn into the governance of economic inactivity and reconfigured as mechanisms of social control tasked with managing, monitoring and rehabilitating those rendered surplus within economic systems reluctant to accommodate sickness, disability and vulnerability.

A critical public health perspective offers a different interpretation. Rather than viewing economic inactivity as a technical challenge of activation, HREI should be understood as a complex social and political phenomenon shaped by interlocking determinants including poverty, insecure work, discrimination, disability, regional inequality and unequal access to care. Responses to HREI must therefore move beyond behavioural explanations and simplistic assumptions about individual responsibility. The economically inactive are not a residual population to be managed or disciplined but individuals whose opportunities and life chances are structured by broader social, economic and political conditions.

The architecture of emerging employment support for ill people and those with disabilities in the UK and elsewhere has profound implications for public health. When access to income, support and services becomes increasingly conditional on behavioural compliance, surveillance and the threat of destitution, health risks becoming subordinated to economic imperatives. This challenges a foundational public health principle; that health is a social right rather than a reward for productivity. In many of the UK's poorest regions, exclusion from employment is closely bound to entrenched poverty, insecure work, poor health and spatial inequalities (Simpson et al. 2025). Policies that focus primarily on labour supply or individual employability risk obscuring these structural realities and reproducing the very inequalities they seek to address.

Equally, claims that work is inherently health promoting become difficult to sustain where employment is insecure, low paid, inaccessible or secured through punitive forms of conditionality. A genuine public health approach must therefore move beyond narratives of activation, employability and human capital deficits, recognising that improvements in population health require action on the social and economic conditions that shape participation in work. This includes investment in secure and dignified employment, reductions in poverty and inequality, and unconditional access to care and support. In Adler-Bolton and Vierkant's (2022) terms, we must detach health from value. The role for a critical

public health is to support this, resisting the reduction of wellbeing to employability whilst rejecting the management of surplus in favour of solidarity, redistribution, and the unconditional right to care.

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Conflicts of interest

The authors declare they have no competing interests.

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