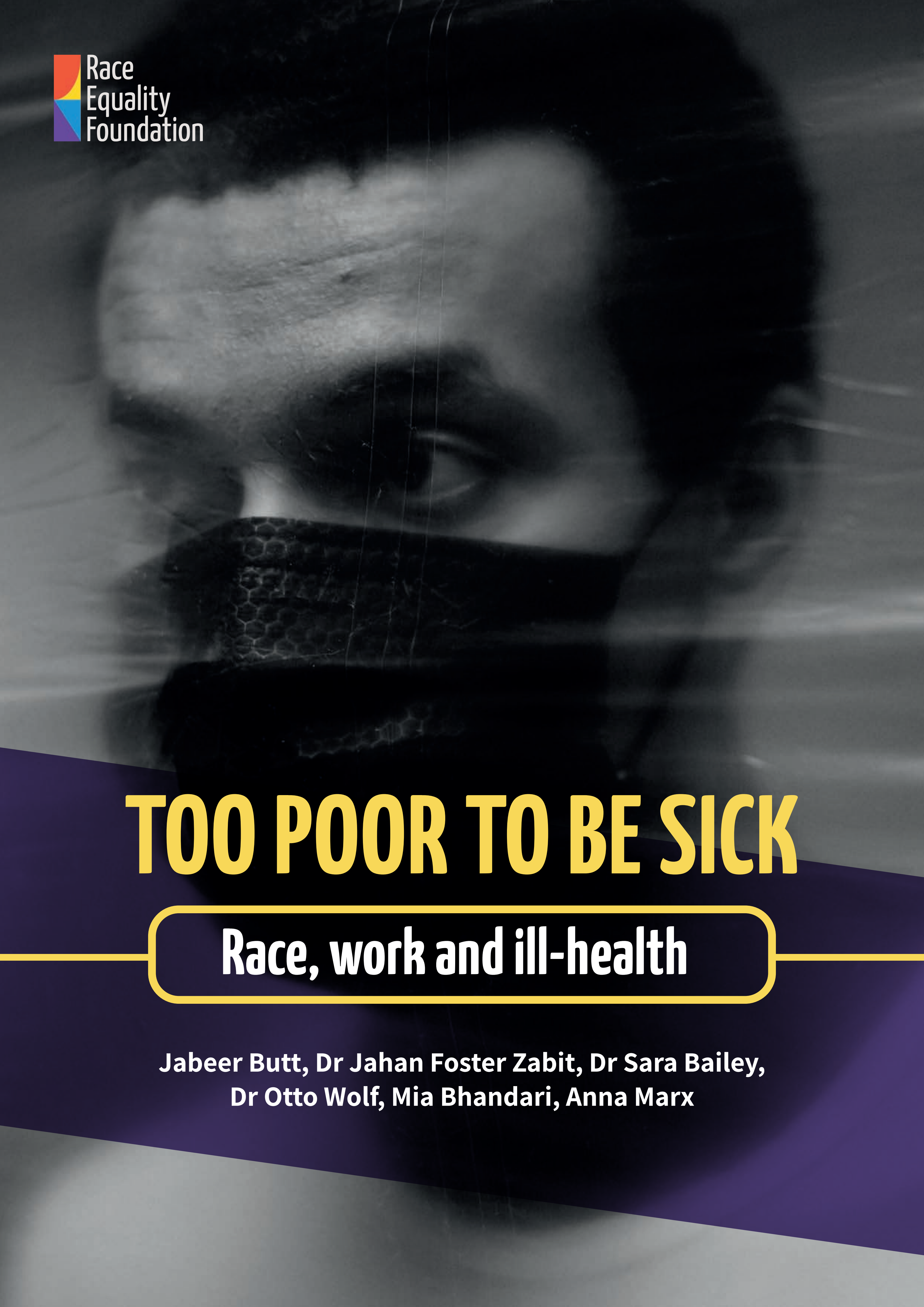

Race
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TOO POOR TO BE SICK

Race, work and ill-health

Jabeer Butt, Dr Jahan Foster Zabit, Dr Sara Bailey,
Dr Otto Wolf, Mia Bhandari, Anna Marx

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CONTENTS

EXECUTIVE SUMMARY

The intersection of work, ill health, and racial inequality constitutes a defining challenge for the UK labour market, yet it remains insufficiently addressed in national policy. As the workforce becomes increasingly diverse, with minoritised ethnic groups driving much of the net growth in the labour force over the last two decades, understanding the structural inequalities that contribute to minoritised ethnic individuals' ill-health in the workplace has become of growing importance.

This report integrates a comprehensive scoping review of international and UK evidence with the lived experiences of minoritised ethnic individuals, to demonstrate how racialised employment patterns, alongside institutional racism within the workplace, directly contribute to poorer health outcomes and a constrained capacity to recover. A primary finding is the disproportionate concentration of Black, Asian and minoritised ethnic workers in low – paid, high-risk, and precarious sectors such as social care, retail, and hospitality – environments which are characterised by high physical demands, greater exposure to hazards, and a lack of access to workplace protections.

> “Health advantages observed in younger minoritised ethnic individuals are eroded by the realities of racism and disadvantage

In this regard, the evidence identifies a consistent pattern across the life course where the health advantages observed in younger minoritised ethnic individuals are eroded by the realities of racism and disadvantage – including within the labour market. These findings are conceptually underpinned by the 'weathering' hypothesis, which suggests that the cumulative physiological strain of navigating persistent racism and socio-economic disadvantage leads to an earlier onset of chronic illness.

The existing evidence indicates that for many minoritised ethnic groups, this decline becomes marked in their forties and fifties, as they face higher rates of multi-morbidity compared to their White counterparts. The interviews and focus groups we conducted, capturing the lived experience of people from Black, Asian and minoritised ethnic backgrounds who face health difficulties related to their employment, reinforce the human impact of these findings. Workers described the exhausting reality of managing long-term conditions, such as musculoskeletal issues or chronic stress, while navigating workplace environments that offer limited flexibility or support.

A central dimension of racial inequality in the workplace is the stratified access to workplace protections during periods of illness. Statutory Sick Pay (SSP) is identified as being inaccessible for many and insufficient to cover basic living costs. While the Employment Rights Act 2025 has eliminated some barriers to accessing SSP, such as the lower earnings limit and waiting periods, the flat rate of SSP remains too low to prevent financial hardship. This creates a ‘sick pay penalty’ that forces workers into presenteeism – attending work while unwell because they cannot afford to take time off. In contrast, while Occupational Sick Pay (OSP) provides a more liveable level of support, it is not a benefit to which many minoritised ethnic workers have equal access. Thus, those with the highest risk of work-related ill-health often have the weakest financial safety net.

> **“Workers described a profound anxiety that requesting adjustments or reporting health issues would lead to negative repercussions**

Furthermore, access to occupational health (OH) services and workplace accommodations is deeply unequal. The scoping review finds that OH services are largely absent in the precarious industries where minoritised workers are overrepresented. Where services do exist, the qualitative evidence reveals a pervasive lack of trust and a fear of disclosure among workers. Workers described a profound anxiety that requesting adjustments or reporting health issues would lead to negative repercussions. This fear is likely rooted in documented patterns of workplace bullying and institutional racism. Even when OH recommendations are made, the focus groups and interviews suggest they are often ignored by managers.

Despite the strength of these findings, significant evidence gaps continue to hinder effective policy intervention. While the lived experience of workers provides a vivid picture of these pressures, national datasets are rarely disaggregated by ethnicity. This impedes systematic, quantitative analysis of ethnic differences in sickness absence, fit-note use, and return-to-work outcomes. Further, much of the existing research treats racialised patterns as a demographic control rather than a structural driver of inequality. Crucially, no single study connects the full causal chain from racism and poor job quality to unequal workplace protections and, ultimately, delayed recovery or economic exit. Without this joined-up perspective, the specific mechanisms through which racialised labour market experiences translate into ill-health, a constrained capacity to recover and labour market exit remain under-researched.

Drawing together findings from both the scoping review and lived experience engagement, this report sets out key implications and priorities for future research and policy development across four areas. Based on the data collected, this report shows that structural racism operates through occupational segregation. Minoritised ethnic and migrant workers are disproportionately concentrated in jobs that increase their exposure to health risks, due to a range of factors including insufficient sick pay coverage and limited access to occupational health. The Employment Rights Act 2025 begins to grapple with issues related to health and employment, however, it does so without engaging with issues arising from racialised employment patterns. To address this, future work must integrate a racial-equity perspective into data collection and policy formulation. This integration can begin with these priorities for future work:

Measurement

Improve the integration of ethnicity and migration variables into national data related to employment and ill-health including quantifying racial disparities related to sick-pay access, fit-note use and return-to-work rates.

Design and evaluation

Assess future reforms to Statutory Sick Pay and occupational health for different ethnicity and employment types, developing co-production mechanisms for related policy and guidance.

Mechanisms and lived experience

Support mixed-methods research that investigates how racism and discrimination operate through employment practices, benefit eligibility and healthcare navigation.

Framing and accountability

Recognise racism as a determinant of health within work and welfare policy.

In conclusion, the intersection of racial inequality and workplace ill-health creates a cycle of disadvantage that cannot be addressed by race-neutral policies. The evidence demonstrates that for many minoritised ethnic workers, the current structure of the UK labour market accelerates physical decline while simultaneously impeding access to the financial and institutional support necessary for recovery. Until the significant evidence gaps in national data are addressed and the racialised nature of job quality is acknowledged, these structural barriers will continue to drive ill-health in the workplace and economic exit. A robust policy response must ensure that racism no longer functions as a determinant of minoritised ethnic groups’ long-term health and economic participation.

INTRODUCTION

Ill-health is now one of the most significant pressures on the UK labour market, yet national discussions rarely address how these challenges intersect with racial inequality. As the workforce becomes more ethnically diverse, understanding how work, health and wider systems of protection interact has become increasingly important. This report examines these relationships by bringing together a scoping review of existing evidence with new qualitative research involving workers of Black, Asian and minoritised ethnic backgrounds. Its purpose is to clarify what is currently known, illuminate lived experience that is not covered by national datasets, and identify the mechanisms through which work and ill-health may combine to produce unequal outcomes.

The report proceeds in eight parts.

Section 1 outlines long-term demographic changes and the increasingly diverse composition of the UK workforce.

Section 2 examines comparative health patterns across the life course, highlighting the earlier onset of long-term conditions among minoritised groups and their poorer experiences of care.

Section 3 introduces the concept of weathering to situate these patterns within the cumulative effects of inequality.

Section 4 explores how sick pay, occupational health and workplace practices shape people's ability to recover, drawing on both the evidence base and participants' accounts.

Section 5 synthesises findings from our scoping review and interviews, identifying cross-cutting mechanisms, particularly insecurity, discrimination, and structural gaps in protection.

Section 6 identifies several consistent patterns emerging from the research.

Section 7 sets out implications for policy, practice and future research, emphasising the need for a racial-equity lens in reforms to work, health, and social protection.

Finally, the conclusion is presented in **Section 8.**

1. Demographic change and the transformation of the workforce

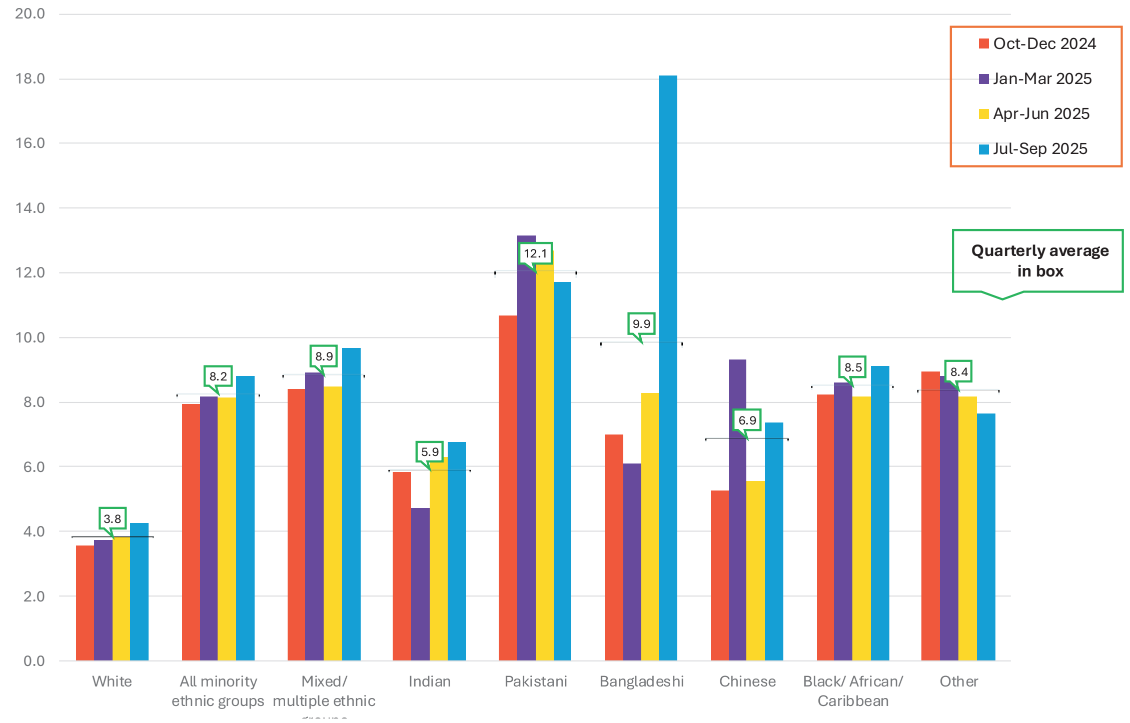
The story of work and health in contemporary Britain begins with demographic change. The population of England and Wales has become markedly more diverse over the past two decades. According to Census 2021 data, the total population stood at around 59.6 million, of which 81.7% (48.7 million) identified with a White ethnic group and 18.3% (10.9 million) identified with Black, Asian, Mixed or Other ethnic backgrounds (ONS, 2021). This represents a substantial increase from 14% in 2011, reflecting a long-term trend towards greater ethnic diversity.

Importantly, the age profile of these groups differs sharply. People from Black, Asian and minoritised ethnic communities are, on average, significantly younger than their White counterparts, with median ages of 27 for Bangladeshi, 29 for Pakistani, and 30 for Black African communities, compared with 43 years for White British people (ONS, 2023). While there has been some ageing within these groups, they remain a younger cohort overall, concentrated in the working-age population.

This demographic shift is reshaping the ethnic makeup of the UK workforce. Ayrton and Holden (2021) highlight that most of the net growth in the labour force between 2002 and 2018 came from Black, Asian and minoritised ethnic groups, mirroring the population change. Yet, this diversification of the workforce has not translated into equal access to opportunity (Ayrton and Holden, 2021).

Workers from these backgrounds remain disproportionately represented in low-paid, insecure, and high-risk sectors, such as social care, retail, hospitality, transport, and healthcare support and are more likely to experience unemployment or underemployment (Walcott and Nightingale, 2025). Whilst the quarterly unemployment rate varies across different ethnic groups over the twelve months to September 2025, the consistent picture is that unemployment rates are higher for all groups than is the case for the White ethnic group (see figure 1).

Figure 1: Quarterly percentage unemployment rate by ethnic group from Oct 2024 to Sept 2025



Source: Labour Force Survey (2025) – Employment by Ethnicity (accessed 16/12/2025)

2. Comparative health status and patterns across the life course

Comparative studies of health status by ethnicity reveal a complex picture that changes over time. At younger ages, people from Black, Asian and minoritised ethnic backgrounds generally report similar or better overall health than their White counterparts. However, this advantage does not persist across the life course. From mid-life onwards, particularly after age 50, these groups experience a more rapid decline in health and higher prevalence of long-term conditions, with differences becoming especially pronounced in later life.

Hayanga et al.'s (2023) systematic review suggests that while minoritised ethnic groups experience lower multiple long-term conditions (MLTCs) prevalence in early adulthood, they face earlier onset of MLTCs than White people, which commonly emerge in their forties and fifties. They are also more likely to live for longer with these conditions once they occur. This pattern points to an acceleration of morbidity with age rather than higher baseline illness in youth. Furthermore, Hayanga et al.'s (2024) analysis of primary-care data shows that people from Bangladeshi, Pakistani, Indian, Black African and Black Caribbean backgrounds report poorer experiences of care for MLTCs, suggesting that inequalities in health outcomes are compounded by differential access and quality of treatment.

These findings align with the broader literature reviewed by Stopforth et al. (2023), which describes how ethnic inequalities in health evolve across the life course. During early adulthood, some protective factors, such as healthier lifestyle behaviours or selective migration ('healthy migrant' effects) are evident. Yet over time, exposure to material disadvantage, discrimination and poor-quality work environments erodes these advantages, leading to earlier onset of chronic illness and multimorbidity.

> “Exposure to material disadvantage, discrimination and poor-quality work environments erodes these advantages, leading to earlier onset of chronic illness and multimorbidity

Walcott and Nightingale's (2025) report reaches a similar conclusion. After age-standardisation, it finds that diagnosed ill-health is higher among people of Pakistani, Bangladeshi and Black Caribbean backgrounds than among White groups, and that differences cannot be explained by socioeconomic status alone. Analyses of self-reported health show widening inequalities from mid-life onwards: rates of poor health among Pakistani women in their fifties are comparable to those of White British women in their eighties, and among Bangladeshi women in their forties to those of White women in their seventies.

Mental health trajectories reveal related disparities. Studies consistently show higher prevalence of severe mental illness, including psychosis, among Black Caribbean and mixed-ethnicity groups (Hayanga et al., 2023; Stopforth et al., 2023), while common mental disorders such as anxiety and depression are more frequently reported by women from minoritised ethnic backgrounds but remain under-diagnosed and under-treated (Bignall et al., 2020).

Taken together, the evidence suggests that the comparatively better health seen among minoritised ethnic groups at younger ages masks a steeper decline across adulthood. By mid-life, the combined effects of work intensity, economic insecurity, and chronic stress lead to earlier onset of long-term conditions and poorer recovery from ill-health.

> “Health Foundation (2023) analysis shows marked variation in the prevalence of work-limiting health conditions by ethnicity...

Finally, while recent policy analyses have drawn attention to the growing number of people leaving work or becoming economically inactive because of ill-health (Commission on Health and Prosperity, 2024; Commission for Healthier Working Lives, 2025; Keep Britain Working Review, 2025), ethnicity has remained largely marginal to this debate. Some recent analyses have begun to disaggregate trends by ethnic group. For example, Health Foundation (2023) analysis shows marked variation in the prevalence of work-limiting health conditions by ethnicity, with people of Bangladeshi and Pakistani ethnicity among those most likely to report conditions that limit the type or amount of work they can do, alongside persistently lower employment rates among several minoritised groups. IPPR (Thomas, et al, 2023) analysis using Understanding Society data similarly indicates that long-term illness and mental distress are patterned by ethnicity, intersecting with deprivation, insecure work and poor job quality.

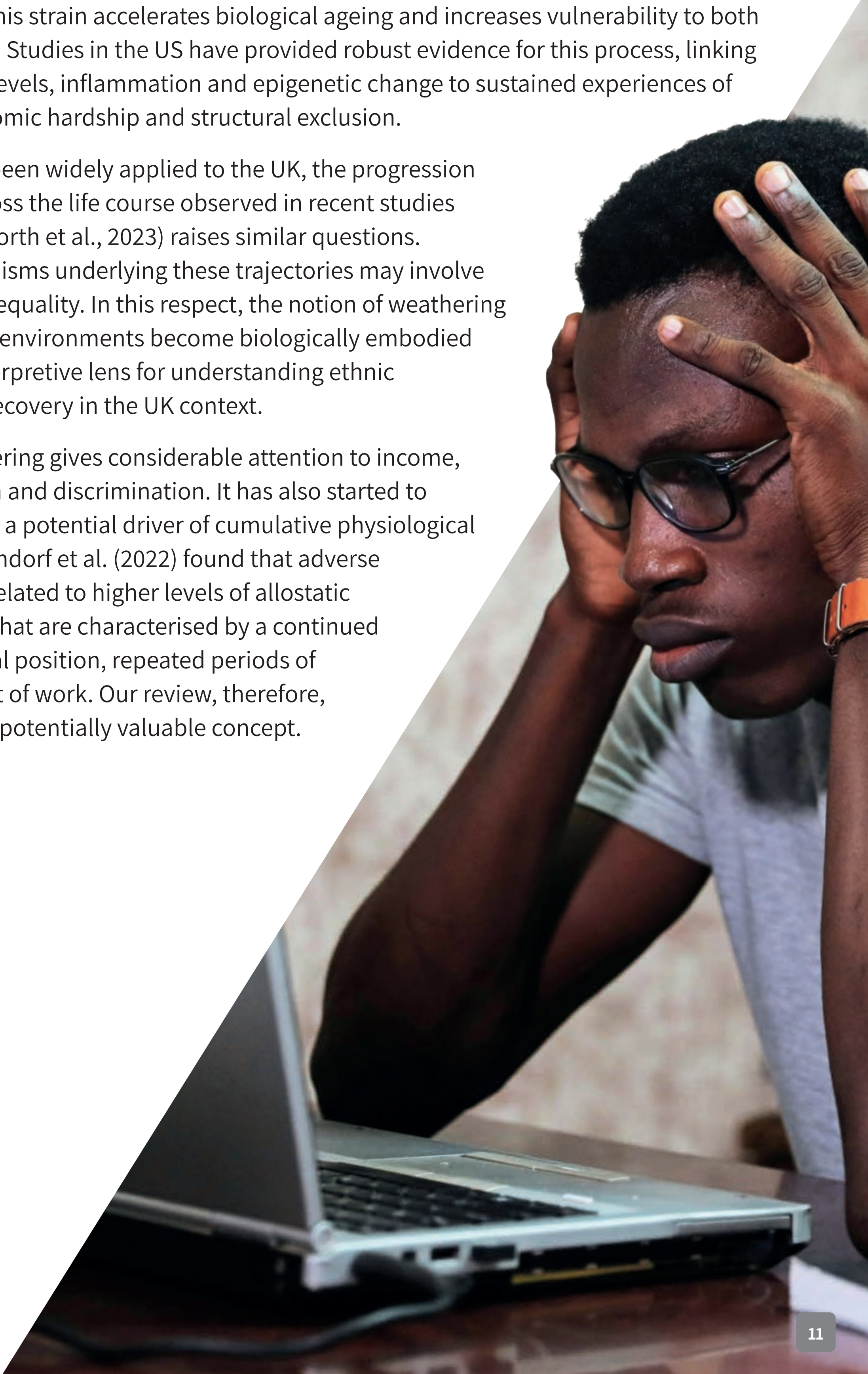
However, these analyses remain limited in important respects: they focus primarily on prevalence and labour market status rather than on pathways out of work; they rarely examine changes over time by ethnicity in health-related exits from employment; and they do not explicitly interrogate the role of racism and racial discrimination in shaping exposure to ill- health, access to support at work, or the likelihood of remaining in or returning to employment. As a result, despite growing recognition of a working-age health crisis, there remains a significant evidence gap in understanding how ill-health contributes to labour market exit among Black, Asian and minoritised ethnic groups, and the extent to which these patterns reflect structural and institutional racism rather than individual health alone.

3. Weathering and the cumulative effects of inequality

The pattern of health inequalities observed in the United Kingdom invites comparison with research from the United States on the concept of 'weathering'. First developed by Geronimus (1992) and extended in subsequent studies such as Simons et al. (2021), the weathering hypothesis proposes that chronic exposure to social and economic adversity leads to cumulative physiological strain, or *allostatic* load. Over time, this strain accelerates biological ageing and increases vulnerability to both physical and mental illness. Studies in the US have provided robust evidence for this process, linking indicators such as cortisol levels, inflammation and epigenetic change to sustained experiences of racial discrimination, economic hardship and structural exclusion.

While the concept has not been widely applied to the UK, the progression of health disadvantage across the life course observed in recent studies (Hayanga et al., 2023; Stopforth et al., 2023) raises similar questions. It suggests that the mechanisms underlying these trajectories may involve the cumulative effects of inequality. In this respect, the notion of weathering and its focus on how social environments become biologically embodied may provide a valuable interpretive lens for understanding ethnic inequalities in health and recovery in the UK context.

The US literature on weathering gives considerable attention to income, neighbourhood deprivation and discrimination. It has also started to examine the role of work as a potential driver of cumulative physiological stress. For example, Wachendorf et al. (2022) found that adverse employment histories are related to higher levels of allostatic load, particularly histories that are characterised by a continued disadvantaged occupational position, repeated periods of unemployment or years out of work. Our review, therefore, recognises weathering as a potentially valuable concept.



4. Work, sick pay and recovery

Our current review is concerned with how the conditions of work influence both exposure to illness and capacity for recovery. In the UK context, two institutional mechanisms are particularly important: access to sick pay and access to occupational health support. There are two main types of sick pay in the UK: Statutory Sick Pay (SSP) – the legal minimum that employers are required to provide – and Occupational Sick Pay (OSP), an employer-specific scheme defined in an employee's contract and often more generous than SSP. Access to adequate levels of sick pay, along with appropriate occupational health support, plays a crucial role in determining whether work protects or undermines health. These mechanisms also represent key points at which racial and structural inequalities may be reproduced.

The *Commission on Healthier Working Lives (2025)* offers one of the most comprehensive accounts of working-age ill-health in the UK, yet its analysis is notably race-neutral. It describes how the UK's SSP is among the lowest in the OECD as it covers only about 27 per cent of a full-time minimum-wage earner's income and how few workers receive early occupational-health support. But it does not consider how these deficits intersect with racism. Ethnicity appears largely as a descriptive variable rather than as a determinant of unequal access to protection.

> “Workers from Black, Asian and migrant backgrounds were disproportionately concentrated in roles with limited ability to work from home, lower levels of occupational sick pay, and higher exposure to infection

A related limitation is evident in the Keep Britain Working (2025) report, commissioned by the government to address rising health-related economic inactivity and published in November 2025. While the review advances a comprehensive set of proposals to support people with ill- health or disabilities to remain in work – including strengthened employer responsibilities, workplace health provision plus earlier intervention, its recommendations are developed without explicit consideration of how labour market inequalities shape experiences of ill-health and exit from work. In the absence of such analysis, the review offers limited insight into whether proposed measures will be effective for groups disproportionately concentrated in insecure or low-paid occupations, or for those facing additional barriers to disclosure. This constrains the capacity of the policy framework to address persistent racial disparities in work, health and economic security.

Evidence collected since the pandemic underscores why this is significant. Oskrochi et al. (2023) showed that workers from Black, Asian and migrant backgrounds were disproportionately concentrated in roles with limited ability to work from home, lower levels of occupational sick pay, and higher exposure to infection. These inequities made it more difficult for people to self-isolate or recover without financial penalty.

5. Work, ill-health and access to support

5.1 Overview and scope

The review aimed to identify UK and international evidence on how workplace protections related to ill-health, including sick pay, occupational health access, and return-to-work support, intersect with ethnicity and racial inequality. Alongside this, qualitative interviews and focus groups were conducted with 26 people from Black, Asian and other minoritised ethnic backgrounds who were either long-term unemployed or working in the service industries, public sector, or third sector. The qualitative sample was predominantly female (around four-fifths of participants) and included people identifying as Black African, Black Caribbean, South Asian and other minoritised ethnic groups, reflecting patterns of self-selection rather than any recruitment quota. Participants commonly reported multiple, overlapping health conditions – most frequently mental health difficulties, musculoskeletal and mobility-related conditions, and chronic physical illness – and many also identified as neurodivergent. Participants described how their health conditions and experiences of neurodivergence were shaped or exacerbated by work. As with all qualitative research, the findings are not intended to be representative; rather, they provide in-depth insight into how workplace protections and gaps in support are experienced by particular groups. The composition of the sample means that the findings may more strongly reflect the experiences of women and of Black and Asian workers and should be interpreted in that context. A detailed demographic breakdown of participants is provided in the Appendix.

> “Health conditions and experiences of neurodivergence were shaped or exacerbated by work

In terms of the identification of UK and international evidence, an initial scoping review was undertaken in October 2025. Nine structured Google Scholar searches using combinations of agreed terms (e.g., ‘racial inequality insecure work sick pay UK’; ‘ethnic minority return to work United Kingdom’) were conducted, supplemented by targeted searches suggested by collaborators. Approximately 64 sources were identified and reviewed using a structured extraction table to capture design, populations, and key findings.

> “Accounts from minoritised ethnic and migrant workers demonstrate that racial discrimination impedes access to workplace protections

The search strategy combined structured academic searches with targeted grey literature review (e.g., JRF, TUC, EHRC). Each article was screened for relevance using a colour-coded system (green for relevant, orange for semi-relevant, red for not very relevant but could be included for broader context, blank for not relevant), and entered into an extraction table capturing bibliographic details, population focus, study type, and key findings. Inclusion criteria required a focus on work, ill-health, and ethnicity in the UK or comparable high-income contexts; sector-specific or grey-literature analyses were included where they addressed relevant barriers or exposures.

The evidence base obtained through the scoping review is patchy: while there is abundant research on poor job quality, insecure work, and ill-health, few studies explicitly analyse racialised patterns within these dynamics. Most of the publications pre-date 2023 and rely on pre-pandemic labour-force data or COVID-specific analyses. Due to a number of factors, including declining response rates, confidence in labour market data such as that produced by the ONS to accurately track trends and support detailed analysis has also fallen since the pandemic.

The interviews and focus groups reinforce many of the findings identified in the review, while adding new insights. For example, accounts from minoritised ethnic and migrant workers demonstrate that racial discrimination impedes access to workplace protections. Older research participants were also more likely to report experiencing racial discrimination. This may reflect the intersection between age discrimination and racial discrimination. However, it may also be the case that cumulative exposure to discrimination over the life course increases older individuals’ sensitivity to racial bias and hence their ability to report it, rather than because younger workers do not experience discrimination.

Further, while the review of existing studies demonstrates that minoritised ethnic individuals disproportionately work in sectors which do not provide sick pay, occupational health support or return-to-work assistance, the interviews indicate that even when workers are eligible for these rights, they are often unable or unwilling to access them due to a lack of awareness, the low levels of financial support available – especially for those who are only eligible for SSP – and fears of negative repercussions. Fears of negative repercussions were particularly felt among individuals with insecure migration status, especially asylum seekers, most of whom do not have the right to work and hence have no access to workplace rights.

Across all sources, three consistent messages emerge:

1. Insecure and low-paid work is bad for health, increasing stress, mental ill-health, and the risk of long-term conditions.
2. Sick pay and occupational health coverage are highly unequal, leaving those in precarious jobs – disproportionately minoritised ethnic people – least protected.
3. Racism structures exposure to poor-quality work and barriers to recovery, but most studies treat ethnicity descriptively rather than analytically.

Overall, the evidence is strongest on exposure and experience – who is most likely to be in insecure, low-paid or unsafe work – and weakest on quantified health outcomes or service access by ethnicity. The review, therefore, presents conclusions as indicative rather than definitive, while identifying clear priorities for more systematic measurement.

5.2 Access to sick pay and financial protection

Across the UK workforce, access to paid sick leave remains highly unequal. Around one in four workers lack any form of employer sick pay, and the value of Statutory Sick Pay (SSP) is among the lowest in the OECD.

Recent research has begun to identify ethnic differences in access. Analysis from the Virus Watch cohort in 2021 found that South Asian and “other” minoritised ethnic workers were significantly more likely to lack paid sick leave than White British workers, even after accounting for occupation and income. This was a pandemic-specific snapshot, but it suggests that structural inequalities in the labour market translate into differential protection. Qualitative evidence from the *Virus Cohort* study also described how some minoritised ethnic and migrant workers continued working while unwell because of financial pressures and ineligibility for SSP.

The information gathered from the interviews and focus groups largely aligns with the findings from the evidence review. Accounts from research participants indicate that minoritised ethnic workers often fail to receive sick pay because their employers arbitrarily withhold it. Others, meanwhile, are unable to take sick leave – even when eligible for sick pay – because the level of sick pay provided is insufficient to meet their financial needs. As a result, these workers frequently continue working while experiencing ill-health.

Instances in which sick pay was withheld are illustrated by the following two quotations:

> *"…he stopped paying me sick pay, you know, because I was taking days off. And then he said, like, you know, if you're going to take a day off, I'm not going to give you any…sick pay. So, most of the time I will just, you know, be without any money."*

> *"I don't know how it worked out, but basically you had to prove there was a piece of paper that you had to take in, and they had to sign something off as well. And I think they just felt it was too much admin for them to send off that paperwork to get it done."*

In cases where sick pay was provided, the level of support offered was widely deemed to be insufficient:

> *"Oh, we paid you sick pay. I was like, you pay me 600-pound a...month. That's not enough."*

Consequently, several research participants reported having to depend on friends and family to meet their financial needs:

> *"Yeah, no, no, my, my daughter, she's working, she's paying the rent, she's paying the electricity, gas, everything, and I'm getting PIP [Personal Independence Payment] only."*

Even participants who were able to access supplementary forms of financial support, such as Universal Credit or Personal Independent Payment reported experiencing financial insecurity due ill-health-related absences from work.

> *"[T]he Universal Credit is not enough for me to cover everything, the bills, electricity and gas, the phone top up, and the food, toiletries and my winter clothes…it's not good, so I have to save money for the winter clothes now, and the travel expenses, yeah, the money is not enough for everything."*

Additional financial pressures were experienced by individuals navigating costly migration processes, as reflected in the following account, which probably illustrates how racism and insecure migration status intersect to shape economic precarity:

> *"I've been owing, owing, borrowing money or doing credit card, having to spend overdraft and things like that is really draining. I'm still owing, and we are still on the route. We are still on the route. Like next year now is going to be 10 years. I have to, I'm looking for like, 4000 pounds now. Today I'm going to do, I've done my life in UK. So I'm today, you know, I told I have exam I'm going to do English test. 160 pounds."*

Given the well-documented relationship between financial insecurity and adverse health outcomes, inadequate levels of sick pay are likely to exacerbate workers' existing health problems.

The interviews and focus groups also support existing evidence which demonstrates that some workers continue to work while experiencing ill-health. One participant, referring to their reluctance to take sick leave, explained:

> *"Yes, the bills, the bills. And of course, I've got a little one that is constantly wanting something. Oh, yes, the bills…most of the reason is because of the bills."*

Another participant remarked that:

> *"I guess the nature of the job was serving the local community, you know, there was pressures in that respect of, I felt that, this is a personal pressure that I put myself but still was very much there. I felt like I was letting people down, not being there."*

Taken as a whole, the evidence suggests that minoritised ethnic groups are more exposed to income loss when ill for two main reasons. First, minoritised ethnic workers are disproportionately concentrated in sectors with limited sick pay provision. Second, the flat rate of SSP is too low for individuals to be able to sustain themselves economically. It is important to note that the low rate of SSP affects individuals from all ethnic groups. However, minoritised ethnic groups experience higher levels of poverty (Marmot, 2020; Marmot 2025) than their White counterparts and hence are more likely to be negatively impacted. UK-specific evidence regarding the ways in which structural inequalities in the labour market translate into differential protections, however, remains moderate rather than conclusive.

Recent measures have expanded access to sick pay. Until the enactment of the Employment Rights Act 2025, access to sick pay was restricted by: the lower earnings limit (LEL), which required workers to earn at least £125 per week to qualify for sick pay; and the waiting period, under which employees had to be sick for four consecutive days to receive SSP, with the first three days unpaid. The Employment Rights Act has removed the waiting period and eliminated the LEL. Nevertheless, until the rate at which SSP is paid is significantly increased, many workers will remain 'too poor to be sick'.

Key Findings

- Low coverage sectors frequently cited included hospitality, social care, retail, cleaning.
- Workers from Bangladeshi, Pakistani, and Black backgrounds are overrepresented in jobs without occupational sick pay, including zero-hours, agency, and casual contracts.
- Migrant and minoritised ethnic workers in cleaning, hospitality, and social care are more likely to face financial penalties for illness, creating incentives to work while unwell.
- At the time the research was conducted, eligibility thresholds for Statutory Sick Pay (SSP), especially the earnings floor, exclude a disproportionate share of minoritised ethnic and part-time workers.
- Few employers provide top-ups or occupational sick pay in low-wage sectors; where they do, awareness and uptake are low.

Evidence Gap

While inequality in access is documented, no UK study quantifies differential health outcomes (e.g. recovery time, long-term sickness absence) linked to unequal sick pay by ethnicity.

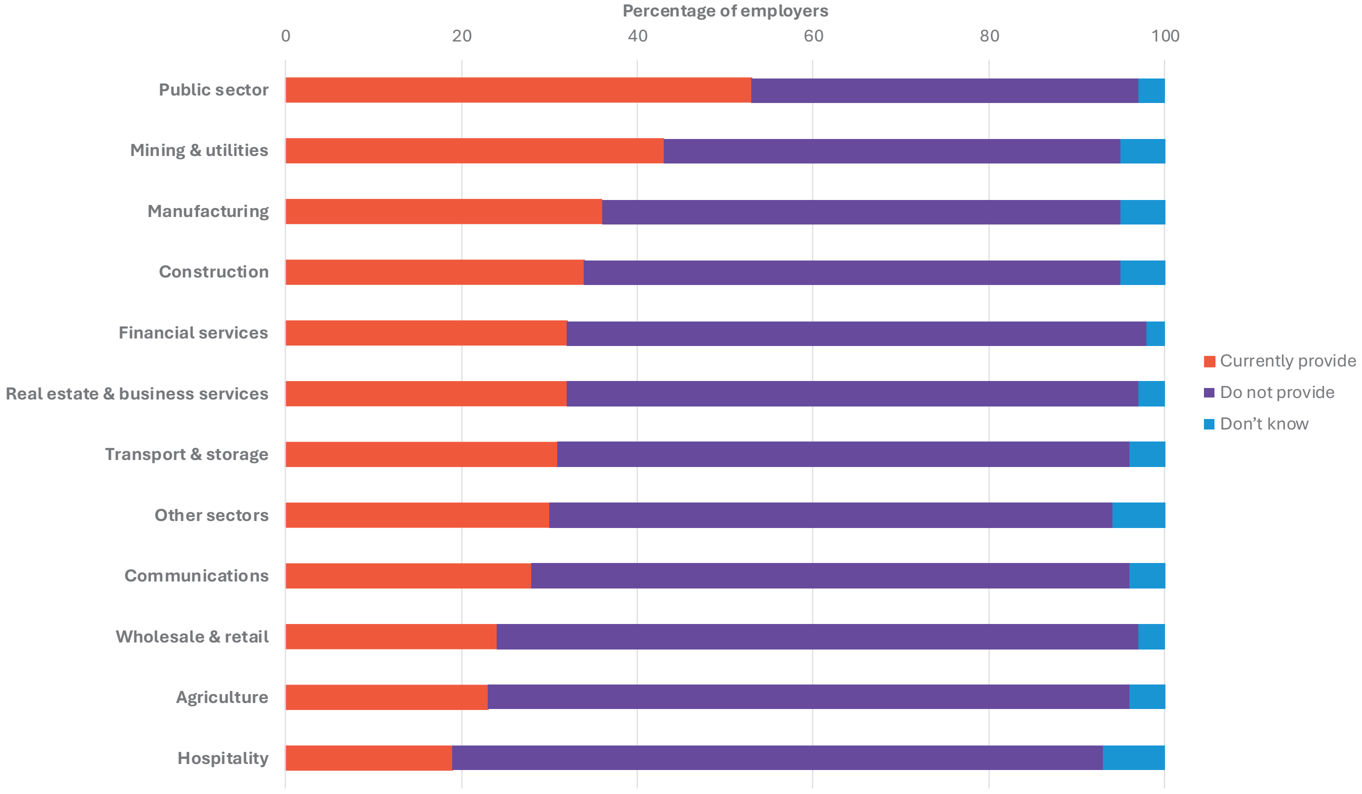
5.3 Occupational health and workplace protections

Access to occupational health (OH) services is highly uneven across the economy. According to the Department for Work and Pensions' (DWP) Employer Survey 2024, nearly two thirds of employers do not provide OH services; the services that are provided are concentrated in public sector organisations. The survey further (see figure 2) shows that access to OH services is particularly limited in the hospitality, agriculture and wholesale and retail sectors.

Studies in construction, health and social care, and the gig-economy highlight lower OH coverage and awareness among minoritised ethnic and migrant workers, but most are small or sector-specific. Evidence from social care and the NHS documents racialised patterns of bullying, harassment and stalled progression, which undermine confidence in seeking workplace health adjustments. Broader reviews of workplace health promotion find that interventions are rarely designed or evaluated with minoritised ethnic employees in mind.

Our interviews and focus groups bolster the findings presented in the reviewed studies while also yielding new insights. For example, accounts from research participants demonstrate that some workers are reluctant to request access to OH services for fear of negative repercussions, which may be related to racialised patterns of bullying and harassment. Others, meanwhile, described how their employers refused to implement OH recommendations due to the associated costs. Finally, several research participants reported that they were refused workplace accommodations due to racism and discrimination.

Figure 2: Percentage of employers that provide access to occupational health by sector



Source: DWP Employer Survey 2024 (accessed 16/12/2025)

In terms of limited awareness of OH services, one participant observed:

> *"First thing I think I'm going to ask everybody then, why nobody told me that there is this service [occupational health]? You know, do you know what I mean?"*

Among those who were aware of OH services, several felt unable to request the support they needed due to fears of negative repercussions:

> *"You shouldn't be...saying too much, because people usually will see you as, you know...this person is...always asking questions or could be a troublemaker, you know. That...is kind of, you know, in back of your mind. That thing is always there, you know. So, you always think 10, 10,000 times or 100 times before you open your mouth?"*

> *"Oh no. I was suggested a few times [to take time off] by my clinical supervisor, but I didn't have the courage to ask for that."*

As noted above, concerns about repercussions may be related to racialised patterns of bullying and harassment in the workplace. For other participants, no modifications to their working conditions were implemented even after accessing OH services and undergoing an assessment. Some also reported concerns regarding the OH service itself, expressing that the assessment was inappropriate:

> *"So I did have occupational health, but they didn't come into the workplace, but they called me to ask about my health and they then, they then told me that they were going to feed back to the school, that they needed to put some risk management in place for me…I didn't see any difference. Nothing changed."*

Further, several participants recounted instances in which employers withheld workplace support on the grounds that the required measures were considered too costly:

> *"[W]hat we found is, depending on the level of expenses needed for those reasonable adjustments, an employer will say yay or nay, and that's been my experience."*

> *"[O]h, I was just saying that. I think that the workplace and the obsession with money kind of prevents us from getting accommodations, so the stress is ultimately pushed onto us."*

Inadequate occupational health assessments and the withholding of occupational health support are likely to be experienced by individuals from both minoritised ethnic and White backgrounds. However, given the higher prevalence of ill-health among minoritised ethnic populations, these groups are likely to be disproportionately affected by limited access to appropriate occupational health services.

"I didn't have the courage to ask...

In some cases, refusals to grant workplace accommodations were explicitly driven by racial discrimination. As one participant noted:

> *"I think that also had a problem whenever I requested flexible working or even offered to work while being in the hospital bed, like, look, I have a laptop, I can work. This is something you can do virtually, you don't have to go in, but they just turned it down. Meanwhile, my colleague, who was Caucasian, was able to request flexible working."*

Another participant described the intersection of racial and disability discrimination in formal processes:

> *"When I sought formal agreements, my employer initially refused to engage with ACAS because they hadn't completed their formal grievance process. After completing it, they did not request any evidence from me. When they did, they focused excessively on the racial aspects of my complaint and largely ignored the disability-related issues."*

Key Findings

- Access to occupational health services is strongly stratified by sector and contract type.
- Minoritised ethnic and migrant workers, concentrated in small firms, self-employment, and agency labour, have lower coverage and less awareness of entitlements.
- Some evidence suggests racialised assumptions about 'resilience' or 'work ethic' influence managerial decisions to deny adjustments or light-duty options.
- Fears of negative repercussions prevent some workers from requesting OH support.
- Studies highlight the intersection of ableism and racism in how certain conditions, e.g. sickle cell disorders, are dismissed or mismanaged at work.

Evidence Gap

- No large-scale quantitative studies explore ethnicity-linked differences in occupational health uptake or outcomes in the UK.
- Qualitative accounts exist but remain fragmented and sector-specific (construction, care, food production).

The evidence reveals barriers of trust, cultural fit and discrimination, but do not yet provide reliable population-level measures of differential access. The implication is clear: occupational health systems reproduce wider inequalities, but the evidence base remains partial and qualitative.

5.4 Insecure work, precarity and health

The link between insecure work and ill-health is well established. Zero-hours, temporary, agency and gig contracts are associated with higher levels of stress, poorer physical health and increased risk of long-term conditions. Minoritised ethnic and migrant workers are disproportionately concentrated in such jobs.

Recent syntheses, including Walcott and Nightingale (2025), situate these disparities within a wider framework of structural racism. They argue that racism shapes the building blocks of health – employment, income and housing – through discrimination in hiring, progression and pay, and through occupational segregation. These analyses help to explain why exposure to poor-quality work remains racialised, although they rely largely on secondary data and conceptual reasoning rather than new empirical studies. The overall picture is one of strong descriptive evidence that minoritised groups experience more insecure and hazardous work but limited causal analysis of racism itself as a driver of these outcomes.

The association between insecure work and ill-health was also apparent in our analysis of the interviews and focus groups. Several participants reported that their health deteriorated as a consequence of their working conditions, which included having to undertake lengthy commutes, extended working hours, exposure to workplace hazards, and high levels of work-related stress. For instance, some healthcare workers were exposed to hazardous chemicals detrimental to their health, while employees engaged in repetitive factory work for 60 hours a week reported developing conditions such as carpal tunnel syndrome. Furthermore, racism exacerbated some workers' health conditions. For example, one older participant, the only Black employee in their workplace, reported that they experienced a deterioration in their health consequent to being subject to racist and discriminatory behaviour. Some workers also reported encountering dismissive or even punitive attitudes and behaviours upon disclosing that they were experiencing health difficulties.

> “Minoritised groups experience more insecure and hazardous work but limited causal analysis of racism itself as a driver of these outcomes

The health-harming effects of working in sectors which require a high level of physical labour also emerged strongly from the interviews and focus groups, as illustrated by the two quotes below:

> *"I have to go up flights of stairs, which is often a killer, because my knees are just like they're dying… I'm expected to sit down with the kids, sometimes on the floor, and then getting up is like, I have to crawl and look for a table to then get me up."*

> *"...what I've told you, what I've gone through, has really affected my body… and my heart's problem as well. I can't really do something that is strenuous."*

Some of our research participants also explained that their health deteriorated consequent to spending long hours in front of a computer.

> *"But I'm very good in technical line [of work] and that is not helpful, because I cannot sit in front of a computer for long, long hours because of my neck issues and my shoulder pain and back issues."*

Meanwhile, in relation to the link between stressful working conditions and ill-health, one research participant explained:

> *"...you know, pressure on me, and that added stress affected my health and my condition worsened because of the stresses which are beyond my control, although I tried my level best."*

The interviews also suggest that women from minoritised ethnic groups may be disproportionately affected by workplace-related stress due to the need to balance occupational demands with caregiving responsibilities, which continue to fall primarily on women. Structural inequalities in both the labour market and the domestic sphere can compound these pressures for minoritised women.

> *"[W]ork-life balance. I had caring responsibility at home as well. It's not just going out to put bread on the table, but caring responsibilities. So, trying to juggle all the balls in the air was not easy, yeah... I am like an Iron Lady, so I just continued working, but it obviously affected my health."*

“Employees with visible health conditions reported encountering unfair treatment, including disciplinary action...

Another significant theme emerging from the interviews was the dismissive and punitive attitudes of employers toward employee ill-health. Such practices affected individuals with both visible and invisible health conditions and disabilities. The following two quotations illustrate the experiences of individuals with invisible disabilities and highlight the intersection between racism and disablism in creating disadvantage:

> *“I have conditions that aren’t like...I guess you call them invisible disability. So, it’s not like completely obvious, but I find that sometimes when you do ask for support, you are made to feel a little bit like a burden, so now I kind of try my best to conceal that as much as I can.”*

> *“[Be]cause I was immunocompromised, basically. So obviously, seeing patients like I’m going to get quite sick anyway, so I don’t think there was that understanding, or they [employers] didn’t understand how the condition sort of affected me.”*

Even employees with visible health conditions reported encountering unfair treatment, including disciplinary action, upon disclosing their illness. Additionally, some employers required inappropriate burdens of proof from workers when they reported being unwell, as demonstrated by the following two quotations:

> *“I remembered being in hospital because I had a really horrible crisis, and my manager at the time basically requested for me to send a photo to prove that I was in hospital. Obviously, at that time, I didn’t know anything about employment law. I believe I was about 23-ish, so I…sent the photo over, and then she asked me to get the same day newspaper and hold it up to my face and take a picture, which obviously, at the time, I thought it was normal, so I did that.”*

This participant’s experience suggests how the intersection of age discrimination and racism can compound vulnerability in the workplace. The speaker, a young worker in their early twenties, describes being subjected to extreme and invasive demands from a manager while hospitalised – a situation that exploits both their youth and lack of knowledge about employment rights.

Another participant described a similar experience of having an inappropriate burden of proof placed upon them:

> *"I had to call the ambulance. It came to pick me up, and that's the reason why I got a disciplinary, basically, because she said that I didn't give her a call, even though everyone else did give her a call to say she's going in, like there's blood all over the place."*

Research participants also explained that they were compelled to resign from their positions because their work was adversely affecting their health or ability to manage their disability. Individuals forced to resign reported experiencing financial insecurity and social isolation as a result, both of which exacerbated pre-existing mental and physical health conditions. The following quotations illustrate these findings:

"It was sort of challenging, because at the time, I had a mortgage, etc, so I don't think they, you know, they didn't take anything else into consideration. So the more time I ended up sick, the worse it was, basically. And I think you then spiral to the, you know, you're not good enough, you can't and because I've never been in that situation."

"When you become disabled, and you feel like your, your whole worlds crashed around you, and then like you can't do anything, you're sitting in the house. I couldn't eat, I couldn't cook. I couldn't, you know, the first weeks or so, I couldn't cook, I couldn't, you know, I couldn't sleep. I couldn't. There was all these things that was quite difficult to manage in those six weeks that I think is a disabled person."

Migrants with precarious migration status also described how having to navigate harsh immigration practices – including practices involving the detention of asylum seekers – harmed their health and led to their exit from the workforce:

> *"I just work in the restaurant in the UK… I have a problem with my immigration status, my they, they detained me in detention centre for a long time, nearly six months. And after I was released, my mental health problem. Have very serious mental health problem, and after that, they give me permission to work, but I'm unable to work due to my mental health illness."*
>
> *"…things went down the hill for me when, due to the policy I wasn't able to, like it made me realise that, no, I am helpless. Nobody is able to help me out the support that I need. I can't get it. I think there was, there was that realisation was where I think it impacted me very, very deeply."*

These experiences illustrate the disadvantages created by the intersection of racism and precarious migration status, especially for asylum seekers.

Moreover, several participants, especially older participants and recent migrants, reported encountering explicit and systemic discrimination when attempting to re-enter the workforce. One participant explained:

> *"…because when after I explained to them my immigration status, they revealed that they do not like migrants. I felt discriminated against because of racism, yeah."*

Another participant recounted:

> *"[T]hey asked me why I'm coming here. I come here for the money. They asked me that question, and I felt they discriminate against migrants. They don't need to ask when employing staff why someone had to flee their country to come here."*

Key Findings

- Insecure work – zero-hours, agency, gig, and temporary contracts – correlates with higher self-reported stress and poorer physical health.
- Black and Asian workers are consistently more likely to hold insecure contracts and to experience dismissal or penalisation for illness.
- Case studies of migrant workers (Chinese, Eastern European, and African) reveal patterns of wage theft, lack of holiday/sick pay, and dismissal for being unwell, sometimes compounded by immigration insecurity.
- Precarious employment restricts access to routine health care and leads to presenteeism (working while ill).

Evidence Gap

Although racialised patterns are described, most analyses stop short of identifying racism as a causal mechanism; instead, they attribute inequalities to sector, contract type, or migration status.

5.5 Return to work and recovery from illness

Very little UK research examines whether return-to-work (RTW) outcomes differ by ethnicity. An international systematic review, covering studies mainly from North America, found strong evidence that ‘non-White’ workers are less likely to return to work after injury or illness, even after controlling for diagnosis and severity (Jetha et al., 2023). However, differences in labour-market institutions and welfare systems mean that these findings cannot automatically be generalised to the UK.

Within the UK, indirect evidence points to potential disparities. Primary care providers are responsible for facilitating sick leave certification and coordinating referrals to rehabilitation. However, Hayanga et al (2024), using data including The GP Patient Survey for 2018-19, report that people from most minoritised ethnic groups with multiple long-term conditions report poorer experiences of primary care: less time, less involvement in decisions, and lower satisfaction.

The interviews provide further evidence of inadequate primary healthcare provision for minoritised ethnic workers including due to racist attitudes on the part of healthcare providers. A substantial number of participants reported a range of concerns regarding both access to healthcare and the quality of support received. Some participants were even unable to request an appointment from their GP due to the recent digitalisation of access channels. As one participant explained:

> *“We can’t go there directly to book an appointment. We have to do it on the phone, and I’m not good at booking through the app. They have the app, and we have to book on the app. That’s something I never do.”*

> **“People from most minoritised ethnic groups with multiple long-term conditions report poorer experiences of primary care**

Participants also frequently reported that their health concerns were dismissed or inadequately addressed during appointments. They described experiencing various forms of discrimination, including being tone-policed, misdiagnosed, or having mental health concerns inappropriately attributed to neurodivergence. Minoritised ethnic participants additionally reported being characterised as 'aggressive' by healthcare professionals – a racist stereotype. Additionally, participants with mental health conditions highlighted a lack of holistic care, observing that clinicians appeared to rely predominantly on pharmacological interventions rather than considering a broader range of therapeutic options. In terms of experiences of being dismissed by medical professionals, one research participant reported:

> *"I'm not medically qualified to know every medical term, but sometimes, if you're not able to express the medical term, sometimes the doctors switch off, and that is the kind of thing that I would really expect them to say, you know, every layperson should get the same treatment."*

Another participant described delays in receiving appropriate care:

> *"If you're not really that sick, initially, they were like, well, you know, just a couple of Ibuprofens, you'll be fine. So, I think it took at least six weeks or six attempts to go to the GP to figure out something's not right. Then it took another four A&E visits for them to realize there's actually something wrong here."*

Participants also highlighted a lack of clarity and communication from healthcare providers, reporting issues such as misdiagnosis or frequent changes to their diagnoses:

> *"I'm now aware of, because of the investigations around me going into functional seizures and like them investigating that, that things are always going on behind the scenes. I know this. No one communicates it… getting random emails, letters and phone calls each month. It's just jarring. It's just jarring. You're like, oh yeah, change your diagnosis. I'm like, what?"*

As noted above, primary care plays a key role in sickness certification and referral to rehabilitation. Therefore, the patterns described above – which align with existing evidence demonstrating that minoritised ethnic individuals receive poorer care than their White counterparts – may partly explain ethnic differences in recovery and work retention, but this remains a plausible inference rather than a tested association.

> **"Minoritised ethnic participants additionally reported being characterised as 'aggressive' by healthcare professionals – a racist stereotype**

Alongside the provision of high-quality healthcare, the implementation of appropriate RTW practices by employers is essential for supporting employees to successfully reintegrate following a sickness-related absence. There is little secondary research pertaining to the adequacy of employers' return to work practices as applied to minoritised ethnic workers. However, one study found that individuals with sickle-cell disease – a condition which disproportionately affects individuals of African and Caribbean heritage – are not adequately supported to return to work. Further, the interviews indicate that minoritised ethnic workers experiencing a multiplicity of health conditions fail to receive adequate return to work support.

In this regard, one research participant explained:

> *"[T]here was no sort of, like reintegration, reinitiation, yeah, like making you familiar with the systems. If they've changed all that kind of stuff, some of the things had changed, like new equipment got bought in, and then I think you're just expected to sort of just be able to pick it up and just use it straight away."*

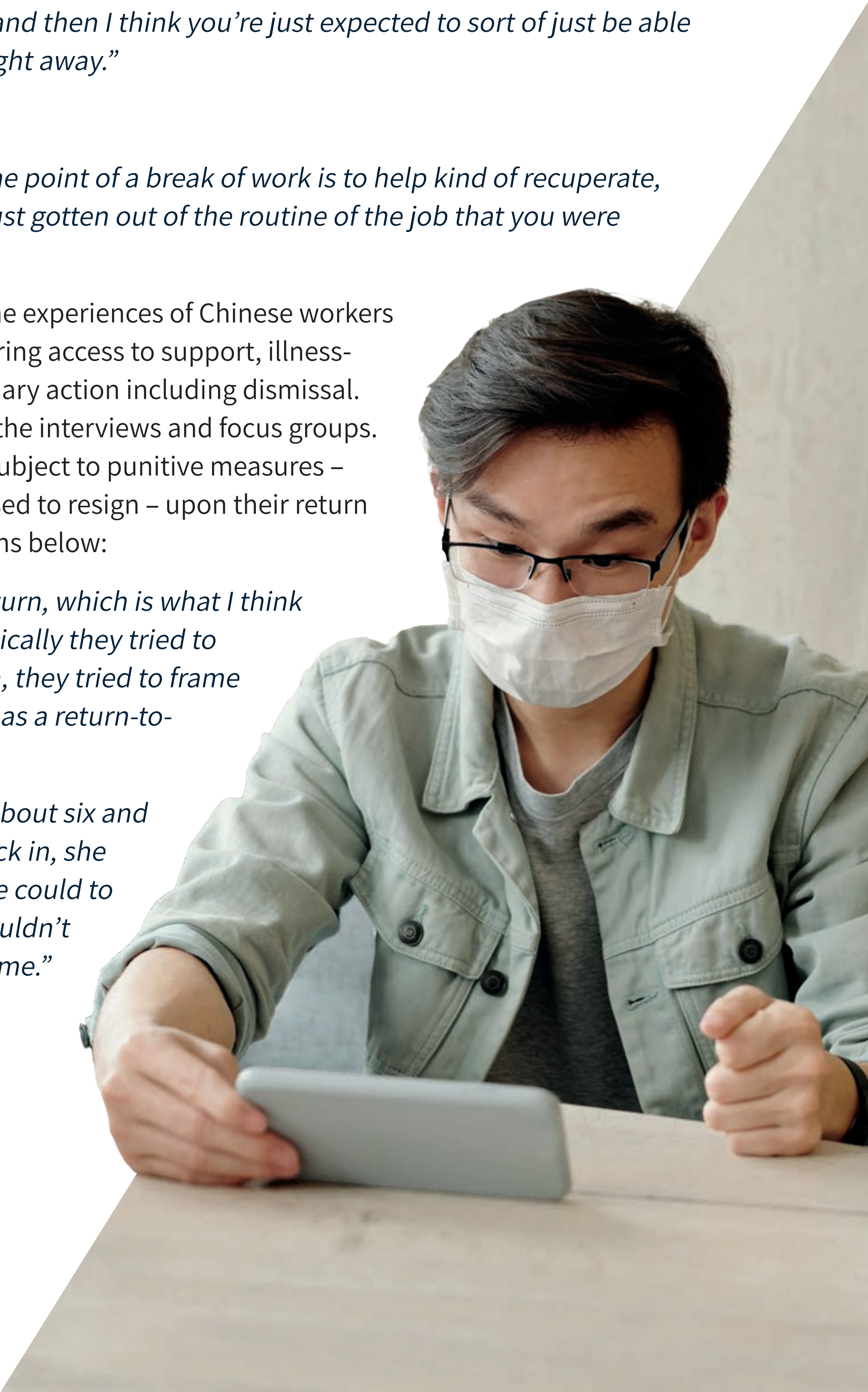
Another participant remarked:

> *"I find that when you, I mean, the point of a break of work is to help kind of recuperate, but sometimes you've kind of just gotten out of the routine of the job that you were doing."*

The sickle-cell study and a study of the experiences of Chinese workers in the UK found that instead of triggering access to support, illness-related absences can lead to disciplinary action including dismissal. These findings are also borne out by the interviews and focus groups. Several participants reported being subject to punitive measures – including being demoted or pressurised to resign – upon their return to work as illustrated by the quotations below:

> *"The whole issue around my return, which is what I think my discrimination was, was basically they tried to frame a return to work as a, as a, they tried to frame a demotion and a pay decrease as a return-to-work process."*

> *"[I] was in hospital for roughly about six and a half weeks, and when I got back in, she basically did everything that she could to make sure that I quit, so she wouldn't approach me, she won't talk to me."*



Key Findings

- International evidence shows that workers from racialised minorities take longer to return to work after injury or illness, even after adjusting for occupation and severity, linked to discrimination and poorer workplace support.
- UK data are sparse; however, Hayanga et al. find that multimorbidity is more common and more limiting for Black, Pakistani, and Bangladeshi adults, suggesting potential downstream effects on labour-market exit.
- Qualitative work on sickle-cell and similar conditions shows systemic lack of reasonable adjustments and frequent disciplinary action for health-related absences.

Evidence Gap

No UK studies explicitly analyse ethnicity in fit-note use, sickness certification duration, or employer-initiated return-to-work schemes.

> “Research tends to conflate race, migration, and socioeconomic status, masking the operation of institutional racism

5.6 Conceptual and methodological observations

- Most studies treat ethnicity as a demographic control, not as a structural determinant.
- Evidence focuses on specific sectors e.g. care, hospitality, construction.
- Research tends to conflate race, migration, and socioeconomic status, masking the operation of institutional racism.
- Evidence from the U.S. ‘weathering’ literature (e.g., Simons et al., 2021) and UK public-health studies (Stopford, et al. 2023; Hayanga et al. 2024) shows the biological and psychosocial pathways through which racism harms health, but these frameworks are rarely applied in labour-market studies.
- No single study connects the full causal chain: racism ▸ job quality/insecurity ▸ unequal access to sick pay/ occupational health ▸ delayed recovery or economic exit.

5.7 Synthesis and implications

- Structural racism operates through occupational segregation, earnings thresholds, and employer discretion, yet is largely invisible in existing analyses.
- Minoritised ethnic and migrant workers are disproportionately concentrated in forms of employment that deny basic protections and increase exposure to health risks.
- Policy and employer reforms around sick pay, occupational health coverage, and early intervention must integrate a racial-equity lens, not just generalised deprivation metrics.
- There is strong rationale for future mixed-methods research combining quantitative linkage of ethnicity and sick-pay data with qualitative accounts of lived experience.

6. Cross-cutting patterns

Across the reviewed literature and the information gathered through the interviews and focus groups, several consistent patterns emerge:

1. Racialised exposure to insecure work

Black, Pakistani, Bangladeshi and other minoritised workers are more likely to hold insecure or low-paid jobs with limited rights and protections.

2. Differential access to protection

Limited evidence suggests lower access to sick pay and occupational health support among minoritised workers, especially in small firms and self-employment.

3. Barriers to support and recovery

Experiences of discrimination and poor communication in healthcare and workplace systems, alongside ill-health-related dismissals, hinder early intervention and return to work.

4. Conceptual clarity but data gaps

Frameworks such as structural racism and weathering help explain observed patterns, but UK-specific quantitative evidence remains thin.

These findings point to a complex but coherent picture of racialised disadvantage across the continuum of work, ill-health and recovery, underpinned by structural features of the labour market and welfare system.

7. Implications for policy and research

The evidence reviewed supports a clear conclusion: **people in poor-quality work are more exposed to ill-health and less protected when it occurs, and these vulnerabilities are patterned by ethnicity. However, the strength of UK data varies substantially across topics.**

Policy and practice should therefore proceed on a precautionary and equity-by-design basis—acting on the plausible risks while improving the evidence base. Key priorities include:

Measurement

a. Incorporate ethnicity and migration variables into national data on sickness absence, sick-pay eligibility, occupational-health provision and return-to-work outcomes.

b. Quantify racial disparities in sick-pay access, fit-note use, and return-to-work rates.

c. Develop linkage between labour-market and health datasets to allow longitudinal analysis.

Design and evaluation:

a. Ensure forthcoming and future reforms to Statutory Sick Pay and to occupational-health provision are assessed for differential impact by ethnicity and employment type.

b. Encourage co-production of policy and guidance on sick pay, occupational health services and right-to-work provision with minoritised ethnic workers and communities.

Mechanisms and lived experience:

a. Support mixed-methods research that investigates how racism and discrimination operate through employment practices, benefit eligibility and healthcare navigation.

Framing and accountability:

a. Recognise racism as a determinant of health within work and welfare policy, while avoiding over-attribution where evidence remains limited.

FURTHER QUANTITATIVE ANALYSIS USING ROUTINE HEALTH DATA

A clear gap identified through this study is the lack of robust, ethnicity-disaggregated quantitative evidence on pathways into sickness absence and labour market exit. One priority for future research is therefore to explore whether routinely collected primary care datasets could be used to examine patterns in the issuing of fit notes (formerly sickness certificates), as a proxy for sickness absence and work-limiting ill-health, and whether these vary by ethnicity.

Initial scoping suggests that this may be feasible using the Clinical Practice Research Datalink (CPRD). While CPRD does not contain a single explicit “fit note” variable, previous researchers have successfully identified fit note issuance using established sets of clinical codes recorded in GP systems, which can then be categorised (for example, as indicating “not fit for work” or “may be fit for work”). Ongoing, as-yet unpublished (Wynne-Jones et al, 2021) work using CPRD demonstrates the technical viability of this approach, including for people with musculoskeletal and mental health conditions. If combined with ethnicity coding within CPRD, this could allow longitudinal analysis of whether certain ethnic groups are more likely to receive fit notes, experience repeated certification, or receive different types of recommendations.

> “Linking fit note data to ethnicity, health condition, and subsequent employment outcomes could significantly strengthen the evidence base...

There may also be complementary opportunities through the OpenSAFELY platform. OpenSAFELY has already been used to analyse sick note issuance in the context of COVID-19 (Schaffer, et al, 2024), with publicly available code lists (https://github.com/opensafely/long-covid-sick-notes) and analytic pipelines that could potentially be adapted for non-COVID conditions. While access to non-COVID OpenSAFELY data is still subject to permissions and timelines, this approach offers strengths in scale, transparency and reproducibility, and could enable large-scale analysis across multiple conditions and demographic groups.

Together, these approaches point to a promising future research agenda. Linking fit note data to ethnicity, health condition, and subsequent employment outcomes could significantly strengthen the evidence base on how ill-health, work, and racial inequality intersect. Such analysis would directly address limitations identified in this report and support the development of more targeted, equitable policy interventions on sick pay, occupational health, and employment support.

8. Conclusion

Record numbers of people in the UK are out of work and not looking for work, with ill-health a significant driver. Consequently, economic growth is being held back, and people's life chances are being diminished. The health of the UK workforce is, therefore, high on the political agenda.

Between 2002 and 2018, most of the net growth in the labour force came from Black, Asian and minoritised ethnic groups. With continuing demographic change, it is likely that these communities will constitute an ever-greater percentage of the workforce in Britain. Nevertheless, evidence on the interaction between work, health and structural racism remains scarce, particularly research which understands racial discrimination as a driver of ill-health. This scoping review appraised the available evidence, identifying the key findings in and limitations of the existing literature. It also collected new qualitative evidence on the lived experiences of Black, Asian and minoritised ethnic workers which deepen our understanding of the daily practices minoritised ethnic groups are subjected to, and the ways these intersect with other identities.

The evidence from this scoping review is strongest in three interconnected areas. The first is the concentration of minoritised ethnic workers in sectors characterised by low pay, precarious contracts and poor working conditions, a pattern that can be explained by structural racism. This not only contributes to ill-health among minoritised ethnic workers; it also restricts their access to workplace protections such as statutory and occupational sick leave, occupational health services, and return-to-work support. Workplace protections are not only a right to which everyone should be entitled – they are also mechanisms which mitigate the progression of ill-health and support work retention.

> “Even when workplace protections are formally in place, their implementation is shaped by workers' financial resources, racial discrimination and discretionary decision-making

Second, evidence from the interviews and focus groups indicates that even when workplace protections are formally in place, their implementation is shaped by workers' financial resources, racial discrimination and discretionary decision-making. Participants described being arbitrarily denied sick pay, subjected to unfair occupational health processes, and refused reasonable workplace accommodations. These dynamics contribute to the under-utilisation of available protections and to delays in seeking care, thereby exacerbating the severity and duration of ill-health.

Third, the findings indicate that these patterns are cumulative. Poor-quality work, discrimination, financial precarity and impeded access to workplace protections do not operate as independent risk factors – rather, they form a mutually reinforcing system which accelerates the onset and progression of ill-health. This is consistent with the concept of weathering, which describes how chronic exposure to stressors – including racism, job insecurity and poor-quality working conditions – generate physiological deterioration and hence premature biological ageing.

An intersectional analysis further demonstrates that racism interacts with other axes of disadvantage, especially insecure migration status, sexism and disablism to shape the probability of entering sectors with poor quality work, the ability to secure support when unwell and the consequences of illness for future employment.

> “Chronic exposure to stressors – including racism, job insecurity and poor-quality working conditions – generate physiological deterioration

This scoping review also identified substantial evidence gaps. Analysis of key datasets is rarely disaggregated by ethnicity, limiting the capacity to understand inequities across sickness absence, fit-note use, access to occupational health services, workplace accommodations, and return-to-work trajectories. These gaps in and of themselves reflect structural racism because the monitoring of workplace health, protections and outcomes are maintained in ways which obscure the experiences of minoritised ethnic groups. Few studies quantify differential outcomes related to workplace conditions and access to workplace protections while racialised patterns are routinely treated as a demographic control, with existing studies stopping short of identifying racism as a causal mechanism.

The available evidence also tends to conflate racism, migration and economic status, thereby masking the operation of institutional racism. Most importantly perhaps, no single study connects the full causal chain: racism ▸ job quality/insecurity ▸ unequal access to sick pay/occupational health ▸ delayed recovery or economic exit. There is, therefore, a strong rationale for future mixed methods research combining quantitative analyses with qualitative accounts of lived experience.

APPENDIX: METHODOLOGY

This appendix outlines the approach used for the scoping literature review and the qualitative engagement with participants. It also explains why the original plan for three group workshops evolved into a combination of workshops and individual interviews, and provides a narrative summary of participant demographics, to be accompanied by charts in the final report.

APPROACH TO THE LITERATURE REVIEW

The project began with a structured scoping review of UK evidence on racial and ethnic inequalities in work and in access to workplace protections. The aim was not to assess the strength of causal claims but to map what is known, where gaps remain, and how these gaps limit policy understanding. Searches were conducted across academic databases such as Scopus, Medline, Sociological Abstracts and Google Scholar, as well as organisational repositories including the Health Foundation. The review focused on material published within the past decade. A set of inclusion criteria guided screening, and relevant studies were reviewed in full before being coded thematically.

The resulting synthesis was organised using the Commission for Healthier Working Lives' framework, covering prevention, early support and employer incentives. This process highlighted significant gaps in evidence, particularly around access to occupational health and the interaction between discrimination, ill health and job loss. Findings from this review informed the design and focus of the engagement activities.

WORKSHOPS AND INTERVIEWS

In the original design, the research team intended to carry out three group workshops. However, at the start of recruitment we made a deliberate decision to offer participants a choice between taking part in an online group interview (workshop) or an online one-to-one interview. This was to ensure that those with fluctuating health conditions, caring responsibilities or concerns about discussing sensitive issues in a group setting could participate in a way that felt comfortable and accessible to them.

> “The aim was not to assess the strength of casual claims but to map what is known

In total, twenty-six people took part. Both interviews and workshops followed a semi-structured format, exploring participants' backgrounds, experiences of ill-health, challenges at work, access to support and views on returning to work. All discussions were recorded with consent using Zoom and transcribed using Otter AI. An inductive thematic approach was employed, with transcripts analysed using an iterative process of familiarisation, coding and theme development. Codes were organised into thematic areas aligned with the project's aims, such as barriers to work, barriers to healthcare access, pressure to keep working, employer support, etc. with themes checked against the evidence from the scoping review to ensure consistency and depth. Due to the size of this project, apart from the transcription, analysis was conducted by hand utilising Excel and word processing software to categorise and order data collected into codes and themes.

PARTICIPANT DEMOGRAPHICS

Participants represented a broad cross-section of people living with ill-health while in work or seeking work. The group was predominantly female, reflecting patterns of self-selection rather than any recruitment intention (Female: 21; Male: 5). All participants were from Black, Asian or other minoritised ethnic backgrounds, including Black African, Black Caribbean, Black British and Asian or Asian British communities (see figure 3).

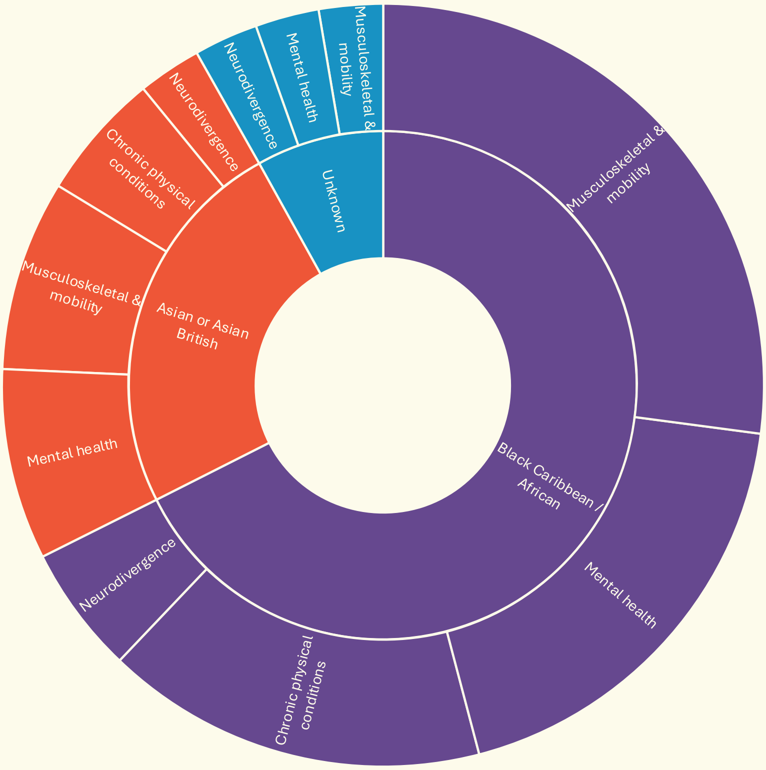
Figure 3: Gender and ethnic make-up of participants

Participants lived with a wide range of health conditions, often multiple at the same time (see figure 4). Musculoskeletal problems and mobility issues were the most common, followed by mental health conditions, chronic physical conditions and experiences of neurodivergence. Many explained how these conditions interacted and how symptoms fluctuated over time, shaping their ability to work or seek work.

Geographically, participants were based mainly in London and the Midlands, with a small number from the North West.

Employment backgrounds were similarly diverse. Some participants were long-term unemployed as a direct result of their health, while others worked across health and social care, retail and service industries, the voluntary sector, education, creative roles and public-sector jobs. Several held multiple jobs or combined part-time roles to manage their health or financial pressures.

Figure 4: Participants' ethnicity and health conditions



ETHICS AND LIMITATIONS

Participation was voluntary and all contributors received a thank-you payment. A trauma-informed, flexible approach was used throughout, including the option of individual interviews for those who preferred not to speak in groups. All data were anonymised for analysis and reporting.

As a qualitative study, findings cannot be generalised to all people of Black, Asian and minoritised ethnic backgrounds. However, the depth of insight, combined with the scoping review, provides a strong foundation for the recommendations in the main report. The shift from three workshops to a mixed-method model is a limitation in terms of comparability but strengthened inclusivity and allowed richer participation from individuals who would otherwise have been excluded.

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