Unemployment and its Health Effects: a Review
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‘Economic stressors lend themselves well to primary preventive intervention because they can, to some degree, be either managed or anticipated’. (Dooley, 1999)

This paper is not intended to meet the criteria of a team based systematic review. It complements the existing systematic reviews such as Platt et al 1999 and Waddell & Burton 2006 and focuses more on the possible causal links between the labour market, unemployment and health.

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1. Executive Summary

1. Unemployment is a matter of direct concern for health authorities and health workers and dealing with it is a necessary part of the achievement of any local or national health dividend.

2. Work is broadly beneficial but has its best effects when jobs are 'good quality'.

3. Despite the relationship between unemployment and ill health being multifaceted, unemployment is clearly associated with higher levels of physical and mental ill health for the unemployed, those close to them, and their communities. The exact nature and strength of this relationship, however, varies by type of unemployment and contextual factors.

4. Existing studies tend to miss part of this relationship because they do not properly analyse the types of employment, unemployment and non-employment and they do not allow for the link between unemployment and precarious employment.

5. The unemployment-health relationship is not separate from, but part of, a wider set of linkages structured by the inequality in circumstances, health outcomes and the social gradient of health.

6. Re-employment mitigates many of the adverse effects of unemployment but a significant number of the unemployed will experience a long term shift in their labour market position towards less secure employment and this too will have a longer term health impact.

7. In analysing the impact of unemployment earlier divisions between income and status effects and the association of these more with either manual or professional workers may not be helpful. A reconsideration of this may be even more important in terms of the nature of the UK benefit system and high levels of debt prior to unemployment.

8. There are serious possible (though not inevitable) effects for those not experiencing unemployment as they see others in their organisations and areas become unemployed. This not only complicates the analysis of the health effect of unemployment but is an issue that should be addressed in its own right.

9. Periodic mass unemployment shows some similar characteristics over time but each era of mass unemployment also has differences from the previous one. Predictions of the impact of mass unemployment therefore need to be based on more than a simple expectation of the past being repeated. The current crisis comes after a period of sustained economic growth, labour force change, a growth in personal debt and it is occurring in a culture where people had been led to believe that mass unemployment was a thing of the past. Moreover the apparently strong labour market of the last years hid, in the UK case, a disturbingly large number of people out of work on incapacity benefit and a disturbingly large number of young people who were neither in employment, education or training.
10. Mass unemployment is difficult to deal with in policy terms. The best solution is to ensure good work for all. Failing this, proactive measures to deal with restructuring can help but are more suited to a growing economy. When the economy weakens the burden will fall on reactive measures and not least from health care professionals. These will involve using NHS occupational health services and mental wellbeing services to ameliorate the effects of the fear of unemployment, unemployment and poverty; supporting anti poverty initiatives e.g. welfare rights, food and fuel poverty; using health service facilities to support communities and community groups etc. The health service also has direct responsibilities as a major employer and skills developer including assisting with youth unemployment, use of modern apprenticeships; supporting new technology innovation and development for job creation.
1. Unemployment – ‘a job for health authorities and health workers’?

In the last four decades there have been three major rises in unemployment – in the early 1980s; in the early 1990s and today. When the first rise in unemployment occurred in the 1980s there were the beginnings of a serious focus on its health effects. At this time the argument had to be strongly made that unemployment did have a health effect and that collective social problems could not be explained away in terms of the individual characteristics of the unemployed. Parts of this argument still needs to be made but responses today can be informed by a considerable accumulation of literature documented here about both the scale of the impact of unemployment on health and the mechanisms as well as its relationship to other socio-economic inequalities and the need to achieve a real health dividend.

The responses to this by the authorities, however, continues to be uneven despite the importance of the demonstrable negative health impact and the re-enforcement of this by the advice to undertake health impact assessments of all policy initiatives (or lack of them). In 1986 Richard Smith concluded his pioneering discussion of the health impact of unemployment with the argument that ‘improving the health of the unemployed’ was ‘a job for health authorities and health workers’. (Smith 1986) A year later a survey showed how patchy was the response of the then health authorities. More were doing something than had been imagined but what they were doing was not comprehensive or coherent and often was at the level of planning rather than practice. There was evidence that the response was linked to the local level of unemployment but this too implied a degree of complacency given that the average level of unemployment had risen significantly everywhere. (Harris and Smith 1987)

A similar piecemeal pattern emerged in the early 1990s when unemployment again rose. As Smith put it in an editorial in the British Medical Journal ‘here we go again – unemployment rising, evidence of harm strengthening’. (Smith 1991). It is important today to recognise that with a new surge in unemployment the harm remains serious. The psychological effect of unemployment is serious even if material need is limited. But in the UK the benefits system is in some respects harsher today than it was in the early 1990s or 1980s. Levels of job seekers allowance have not risen in line with the average wage – had they done so they would be around £110 a week. The complexity of the benefits system has also grown and the assessment process for continued benefit payment has been made more onerous. Additionally many workers have accumulated higher levels of debt than in the past so may be starting unemployment in a worse final state.

The health service needs to be prepared to respond positively to the growth in unemployment. As later sections of this document suggest failure to respond not only risks ignoring the shorter term problems created by unemployment but the longer term cumulative negative health pattern that is demonstrated in the literature. (Beale and Nethercott, 1987)

Figure 1 sets out some of the elements of what might be considered a minimum approach for a PCT drawing on the literature that does exist. It suggests a four level response.
1. PCT Advocacy Role

A PCT should see itself as having a major 360 degree role in terms of advocacy about both the health impact of unemployment and the need to ultimately address this by policies that can get people back into ‘good jobs’. This advocacy needs to be above – to central government; sideways towards partner organisations; and below. It also needs to support the arguments of other stakeholders putting pressure on central government. (Bell and Blanchflower, 2009).

2. PCT Information Role

Advocacy can only be effective if what is advocated is based on the best available evidence. In these terms a PCT must

1. Monitor - the unemployment and health situation in its area

2. Inform - the relevant groups working under it so that they may take this into account in their work.

3. Train – give appropriate training to its staff to recognise the role of unemployment in health matters and the ways in which negative health effects can be limited.
4. **Liaise** – between different groups within the PCT and externally to those regional and local bodies dealing with the non medical aspects of employment and the local labour market.

### 3. PCT Resource Allocation

The third level relates to the allocation of resources under the PCT control

1. Unemployment directly influences demand for health services and can be used as an indicator of area based socio-economic inequalities that also directly feed into health service demand. (Haynes et al 1996; Dominguez-Berjón et al 2005) But it is also important to allocate resources appropriately and to be sensitive to the need to have in place wider support measures as part of health provision that ‘encourage independence rather than dependency on prescription drugs’. (Smith 1991)

2. PCT’s are major employers and therefore have major responsibilities in two areas
   
   (a) in respect of their own staff they need to ensure that they follow the best employment practices
   (b) to support any central and local government initiatives in terms of job creation.

3. Support for broader public health measures – PCTs need to recognise that they also have a significant role in encouraging and supporting positive non medical community initiatives to reduce both the incidence of unemployment and to provide support for coping with its health impact.

### 4. PCT and General Practitioner Level

The first port of call for those suffering from the negative health impact of unemployment and related forms of precarious employment will be the general practitioner. This requires them to consider a number of different elements.

1. **Recognition** - general practitioners need to appreciate that many of the conditions that they are presented with have some or all of their roots in the precarious employment-unemployment situation of their patients.

2. **Recording** - this can only be meaningful if practice planning includes the recording and use of information about employment status.

3. **Referral** - GPs cannot be expected to act as social workers or benefits advisers but they must be aware that the complexity of the benefits system is such that it may defeat many applicants leaving them suffering from further stress and material need. The scale of under-claiming, delayed claiming, delayed payment increases with the difficulty of claiming. In these terms it is important to be able to refer patients as a *health issue* to appropriate benefits advisers and benefits rights advisers and to recognise the value of face to face encounters over phone lines and internet information. (Abbott 2002; Abbott & Hobby 2003; Adams et al 2006)
4. **Local Advocacy** - GPs also have a significant advocacy role in their local communities in overcoming the stigma of unemployment and making its costs clear.

Unemployment is a national problem and cannot be solved locally. But this does not mean that local initiatives have no impact. Research is now under way to explore why some disadvantaged areas have relatively low mortality rates and can achieve a better health dividend. (Tunstall et al 2007) Moreover, innovations have been undertaken which suggest that wider co-ordinated support measures do offer evidence of ‘more appropriate primary care for patients and more effective prescribing’ (Abbott 2000) which is not only to the benefit of budgets but, more importantly, to those experiencing the direct and indirect effects of unemployment.

2. **Unemployment and Health - Complexity and Controversy**

That a relationship exists between health and socio-economic conditions and the nature of society has long been recognised and this forms the basis of socio-epidemiological approaches which relate mortality and morbidity to social conditions. But this area remains controversial. It is firstly analytically complex – is it possible to demonstrate a close and direct relationship between health and society? Secondly, it is politically controversial. If there is a positive answer to the last question - if morbidity and mortality can be related to a factor like social inequality then this poses the question of what level of trade-off is acceptable and what, if anything, should be done to reduce inequality. The same questions arise if links can be shown to exist between health and employment status.

The larger issue of the link between health and society caused political controversy in the 1980s when the Black Report, commissioned in 1977 by the Labour government, but published in 1980 under the Conservatives, was sidelined as its strong link between social conditions and health provided uncomfortable reading for a government committed to markets and willing to tolerate growing unemployment. (Whitehead et al 1992) The 1998 Acheson Report fared better but these issues are still uncomfortable for politicians. (Acheson 1998; see also Black 2008).

The same difficulties arise with the more precise linkages that might possibly exist between health and unemployment. But here, alongside the unease such links might create for politicians, there is an additional problem that unemployment tends to be viewed as a necessary and positive adjustment factor by economists. There is therefore a temptation to minimise its potential human costs. Most economists, for example, argue that ‘labour flexibility’ is essential to economic success. One school insists that if benefit levels are too high, these act as discouragement to work search and perpetuate unemployment as a ‘voluntary’ choice. Another school suggests a trade-off between unemployment and inflation and traditionally has preferred low inflation to low unemployment. More generally, the process of economic adjustment has been termed a process of ‘creative destruction’, in which economists tend to emphasise the creative elements of restructuring, minimising the human effect either as fictional, or as a necessary evil.

However not only does a focus on health effects raise different concerns, it might also, in principle, be used to undertake a cost benefit analysis of the impact of change.
at either the national or organisational level using a social accounting framework. As an example of how controversial such an approach might be we can note Rowthorn and Ward’s analysis of the effect of closing a steel making plant in Corby in the late 1970s (Rowthorn & Ward, 1979). They estimated the direct and indirect economic effects of the preferred option, its labour market and public sector income effects. Then, following Brenner’s pioneering work in the US, they added an analysis of potential health and crime effects predicting, in the worse case scenario, over 1000 additional deaths including 353 from heart disease, 15 suicides and 3 murders. They also predicted 1300 additional cases of mental ill health and some 30 additional prison sentences. Published on the eve of the 1979 economic downturn and the return of mass unemployment, after the end of the post war boom, such a study was obviously deeply uncomfortable. Others were not only loathe to extend such studies but perhaps grateful when Brenner’s work, which formed the basis of the analysis of potential health effects, was questioned by other commentators. This interaction between political concerns and the health debate and policy in the 1980s was the subject of a study by Bartley 1992. More recently still the Whitehall II study of UK civil servants coincided with a period of major changes in job security, restructuring, privatisation etc. and this again allowed, in principle, some analysis of the connection between economic policy, organisational choices and health effects. (Ferrie et al 1998, 2001, 2002)

The sensitive political and theoretical nature of the employment health effect helps to explain the popularity of two counter- hypotheses in respect of health and unemployment

1. The good times effect – this argues that health actually improves during depressions and diminishes during ‘good times’. 
2. The health selection effect – this argues that ill health weakens employment opportunities and therefore leads to unemployment rather than unemployment leading to ill health.

Although there has been an increase in the number and breadth of studies of the unemployment-health link, the attention paid to this appears to fluctuate with the level of unemployment. The existence of links between unemployment and ill health was first identified in the nineteenth century, but before 1914 most of the emphasis was on the problem of structural under-employment and poverty - what today would be called ‘precarious unemployment’. (Rowntree & Laskar 1911) The 1930s saw major economic crisis and the pioneering studies of the impact of cyclical and sustained structural unemployment. (Eisenberg & Lazarsfeld 1938; Jahoda, 1979, 1982; Webster 1982) In the 1950s and 1960s there was less interest in this problem but the return of unemployment led to a new surge of interest in the 1970s and 1980s. (e.g. Jahoda, 1979; Smith, 1987; Westergaard et al. 1989) Interest in the 1990s, except insofar as it involved the analysis of data from the previous decade, diminished as labour markets tightened. With the emergence of major economic crisis in 2008 and mass unemployment it seems likely that there will be a surge of renewed interest and a refocusing on the effects of mass unemployment.

The aim of the literature review that follows is to summarise the narrower debate on unemployment and health as it has been developed in epidemiological accounts and
the work of those interested in the sociology of medicine and disease. But inevitably the bigger issues will not be far away as the discussion proceeds.

3. ‘Good Times/ Bad Times’ and Overall Ill Health

If it is allowed that economic and social conditions influence health then it would seem intuitively obvious that bad conditions would produce ill health and good conditions better health. Unemployment is a negative economic and social condition in its own right and it is an indicator of a wider social malaise so hypothesis 1 might be that

H1. *Rising unemployment worsens mortality and morbidity*

A simple mechanism by which this might occur is shown in figure 3.1.

![Figure 3.1 Simple Linkages of Unemployment and Health Outcomes](image)

Unemployment impacts negatively on the material situation, the psycho-social condition through its impact on status and stress, and on health behaviours. The combined effects might therefore be a worsening of health outcomes. As we will see this is essentially what happens, though the mechanisms are more complex than this suggests.

But it is first necessary to deal with an argument that seems counterintuitive but for which there is considerable evidence. This is the argument that it is ‘good times which make you sick’. This argument was pioneered by Ruhm who showed that in the United States mortality seemed to rise during periods of economic expansion and fall during depressions, when unemployment rose. Ruhm’s work specifically rejected Brenner’s early attempt to support hypothesis 1 which had received considerable publicity. (Ruhm, 2000, 2003, 2005, 2006; Tapia Granados, 2005a) Similar patterns to that for the US have now been established for the OECD as a whole (Gerdtham & Ruhm, 2002, 2006) and analysed in detail for some other countries such as Spain (Tapia Granados 2003) , Germany (Neumayer 2003) and Japan (Tapia Granados 2008). This gives rise to hypothesis 2,

H2. *Rising employment leads to and worsens health and mortality.*

This is not an argument about the long term impact of economic improvement but rather the relationship between mortality, morbidity and short term economic indicators. How might we explain this pattern? How strong is it and, to the extent that it exists, is it compatible with the idea that the direct and indirect experience of unemployment has negative outcomes?
Ruhm’s analysis, and that of those who have followed him, focuses on aggregate mortality and cause specific mortality in areas which account for 80% of deaths in advanced countries. Ruhm also extended his analysis to show similar patterns in other health indicators including morbidity, reporting of medical problems and sick related absenteeism at work.

There are several problems that immediately arise here. The first is, as Gerdtham & Ruhm put it, ‘there is … no reason to believe that all types of health respond in the same way’, to economic conditions. Neumayer (2003) makes the same point ‘recessions lower (some) mortality rates’. We might expect divergent responses depending on the indicators we are looking at. No less we might also expect, as Ruhm acknowledges, that the impact will be different (if only in strength) depending on the group. Mortality and morbidity should not be expected to move in the same way for all indicators for all groups.

Ruhm’s causal mechanism is set out in figure 3.2. He uses a severe rational choice approach and suggests that good health has significant costs so that, if the opportunity cost of good health behaviour rises, as it might in an upturn (e.g. relative cost of exercise, a doctor appointment etc), then this could explain the negative health effects.

![Figure 3.2 Simple Linkages of Good Times and Negative Health Outcomes](image)

Ruhm and others then estimate health effects listed in table 3.1. From this it is apparent that most causes of death do rise in good times but some – most notably suicide – rise in bad times. Thus ‘the findings … illustrate that the epidemiological literature emphasising harmful effects of individual unemployment provides a misleading indicator of the overall health effects of economic downturns. (Gerdtham & Ruhm, 2006)

But the focus on the aggregate impact makes this apparently perverse result look more striking than it is. If we take accidental deaths on the roads, where the good times effect is the strongest, then to suggest that these rise as good times puts more traffic on the road is hardly a major insight. Similarly if more people are at work (and if as Ruhm notes vulnerable industries like construction exhibit stronger cyclical fluctuations) then we might again expect more deaths and accidents at work as employment grows. There is an interesting additional question which this research does not pose – this is whether ‘good times’ have a positive or negative effect on say
accidents per 100,000 miles travelled or accidents per 10,000 employed workers. Obviously a rate can increase but total numbers fall if there are fewer people on the roads or in work.

Table 3.1 Estimates of Impact of 1% Increase in Unemployment on Mortality Rate

<table>
<thead>
<tr>
<th></th>
<th>US</th>
<th>OECD</th>
</tr>
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<tbody>
<tr>
<td><strong>Total</strong></td>
<td>-0.5</td>
<td>-0.4</td>
</tr>
<tr>
<td>Infant deaths</td>
<td>-0.6</td>
<td>-0.1</td>
</tr>
<tr>
<td>Neo-natal deaths</td>
<td>-0.6</td>
<td>-0.2</td>
</tr>
<tr>
<td>Malignant neoplasm (cancer)</td>
<td>0.0</td>
<td></td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>-0.5</td>
<td>-0.4</td>
</tr>
<tr>
<td>Influenza/pneumonia</td>
<td>-0.7</td>
<td>-1.1</td>
</tr>
<tr>
<td>Liver disease</td>
<td>-0.4</td>
<td>-1.8</td>
</tr>
<tr>
<td><strong>External Causes</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Motor Vehicle</td>
<td>-3.0</td>
<td>-2.1</td>
</tr>
<tr>
<td>Other Accidents</td>
<td>-1.7</td>
<td>-0.8</td>
</tr>
<tr>
<td>Suicide</td>
<td>+1.3</td>
<td>+0.4</td>
</tr>
<tr>
<td>Homicide</td>
<td>-1.9</td>
<td>-1.1</td>
</tr>
</tbody>
</table>

Source: Ruhm 2000; Gerdtham & Ruhm, 2006

Equally while Ruhm is right to draw attention to the link between consumption, health and economic conditions that there might be an improvement in bad times is also plausible and widely documented. Budget studies have shown that as incomes fall so the amount of discretionary expenditure also falls. The relative price of smoking, drinking, and consuming large amounts of fast food, increases. There is thus a trade-off between psychological pressures leading to worse health behaviour and material restraints in terms of consumption possibilities.

Another factor that must be considered is the role of lags in links between economic conditions and health. Unemployment is itself notoriously a lagging indicator so that the first impact of crisis might not be measured by a speedy rise in unemployment. The possible health impact of unemployment too is a further lagging indicator as it will take different amounts of time for any health impact to work through. A close correlation between unemployment figures and health is not necessarily to be expected and if it existed it would be not be as convincing as might initially be thought. Nor will it be easy at the aggregate level to model any appropriate lags.²

Composition effects are also important. It is not disputed that the mortality rates of the unemployed are higher than the employed. But the employed is the bigger group so their experience will tend to mask the experience of the directly unemployed in any aggregate study. Further, the good times approach rests too much on a dichotomisation between being ‘in work’ and ‘out of work’. As we will see in the next section, once it was realised that unemployment might impact on health the next significant step was to produce a more sophisticated analysis of the work-non work
situation. This, to some degree, undercuts those studies which simply divide the population into two groups.

These comments are not intended to deny the good times effect, it is clear that it is real, but properly understood it is less startling or counter-intuitive than it seems at first sight. Moreover Gerdtham & Ruhm’s (2006) OECD study shows that the cyclical health effect is less marked in societies with stronger social insurance protection so that the analysis hardly leads to complacency (although this is how some want to interpret it, see Edwards 2005). Jäntti et al (2000) went further on the basis of Finnish data and argued that a proper social policy can smooth out the link between the economic cycle and mortality almost completely. Thus any good times effect is certainly not the basis for not focusing on health and bad times and developing specific policies to deal with the very real trauma that the threat and the reality of unemployment brings. Economic crisis is not a public health measure (Catalano & Bellows 2005).

4. Inadequate employment and the Danger of Dichotomising Employment - Unemployment and Health

There is now a wider appreciation that the analysis of the impact of unemployment cannot simply be reduced to a contrast between the employed and the unemployed. Labour market status is a complex thing and people do not simply move between states of being ‘in work’ and ‘out of work’. At one extreme there are those who have access to secure, ‘decent jobs’ whilst, at the other, there are those who become discouraged workers and fall out of the labour market. Between these two groups there are a multiplicity of other ways in which people are more or less anchored in the labour market. The health consequences of this are potentially important. Dooley, for example, suggests that ‘a mental health epidemiology that limits itself to a dichotomous measure of employment status seems likely to miss significant effects because of inadequate unemployment’. Measuring the impact of this, however, is difficult because, as he further notes, of ‘the complexity and arbitrariness of distinguishing subtypes of inadequate employment’ and the absence of ‘official statistics’ and ‘routinely reported statistics’ (Dooley, 1999)

This complexity has always existed but early researchers paid little attention to it. Today it is often claimed that the complexity of employment status has increased because of long run structural changes which have increased the need for a more flexible workforce. However the evidence for this is weaker than is often imagined and too many accounts assert as fact what is not clear in the data. (see OECD 1997; Taylor 2002) What is less ambiguous is that the pattern of labour market anchoring has a cyclical element to it. For example, in a depression there may be a rise in short time working which will complicate any analysis of the health impact of unemployment and the type of public health interventions that may be useful.

This can also be theorised in terms of labour market segmentation and divisions into core and peripheral work groups, primary and secondary labour markets etc. It is usually the case that workers on the periphery of the workforce are the most disadvantaged and employment security and health therefore declines as we move out from the core. As Bartley put it, (1994) ‘a relatively small proportion of the economically active population experience the majority of time unemployed’. But
Finnish data suggests it may also be necessary to allow for life style choices and selection effects as well with not all workers preferring permanent full time contracts. (Virtanen et al 2003)

Figure 4.1 Labour Market Segmentation and Core Periphery Relations in the Labour Force

This leads some analysts to suggest that we need to focus on a broader category of inadequate employment. This can then be used to subsume different employment and unemployment states. ‘Inadequate employment rates are substantial and exceed the official unemployment rate’ (Dooley, 1999; Ferrie 2001) Moreover the rates and nature of adequate employment can be expected to vary depending on gender, ethnicity, place etc.

Once it is recognised that analytically we are dealing with much more of a continuum we might suggest relationships such as those illustrated in figure 4.1. One possibility is a simple linear relationship where, as employment becomes less adequate, health worsens. However there is much evidence to suggest that when the threat of unemployment grows there might be a weakening of health so that levels of stress for example, fall once the person becomes unemployed. Equally re-employment may not resolve problems if a person is forced to take a job that is less secure than before and in which there is a mismatch in skills and aspirations. Moreover there may be a cyclical element in the degree to which jobs become precarious as pay and job security, safety etc are impacted on by profitability. (Catalano 1991; Wanberg 1995; Platt et al 1999; Quinlan et al 2001; Ferrie 2001; Scott 2004; Virtanen et al 2002; Virtanen et al 2005; Artazcoz et al 2005; Benach et al 2004; Dooley & Prause 2004; Benach & Muntaner 2007)

This needs to be related to the disproportionate incidence of employment disadvantage (Nylén et al 2001) and its persistence in the UK. Women and mothers are argued to be less disadvantaged than in the past but still vulnerable. Older workers saw a serious deterioration in the 1970s and 1980s but some slight improvement in the 1990s which may disappear again. The disabled continue to have long term problems. Disadvantage and ethnicity varies by group but can be especially serious for some and can combine with other issues e.g. gender. One of the most disadvantaged
employment groups is Pakistani and Bangladeshi women. (Berthoud & Blekesaune 2007)

**Figure 4.2 Seeing health in terms of an employment – unemployment continuum**

![Diagram showing health and employment status]

Out of labour force
- Incapacity
- Unemployment
- Intermittent employment
- Involuntary part-time
- Low wage
- Skills mismatch
- Adequate employment

**Figure 4.3 Labour Market Status and Health Outcomes**

The most important consequence of failing to properly consider the different forms of employment- unemployment is that this will tend to lead to an understating of the health impact of unemployment.
5. Measuring Unemployment

Measured unemployment is based on arbitrary concepts and it is therefore dangerous to use unemployment statistics as a measure of the group at risk of ill health because of unemployment. The crudest measure of unemployment is the monthly claimant count. (ONS 2008) This is a product of the benefit system. It therefore reflects (a) those claiming benefit; (b) the eligibility rules, which may be subject to change. In the 1980s and early 1990s eligibility rules changed frequently. Since October 1996 the claimant count has been more stable being based on the Job Seekers Allowance system. However entitlement to benefit is limited and this means that the claimant count is only a partial measure of labour market flows and unemployment.

| Claimant count | 0-6 months | 6 months +
<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Basic JSA – means tested</th>
</tr>
</thead>
<tbody>
<tr>
<td>No eligibility</td>
<td>Contributions based JSA</td>
<td>No eligibility</td>
</tr>
<tr>
<td>Voluntarily left employment</td>
<td></td>
<td>Partner working but registering for nat. insurance</td>
</tr>
<tr>
<td>Students seeking part time vacation work</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 18 refusing training place</td>
<td>Means Tested JSA</td>
<td>No eligibility – Not counted</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Partner working and not registering</td>
</tr>
</tbody>
</table>

Labour Force Survey Measures

<table>
<thead>
<tr>
<th>Employed</th>
<th>Unemployed</th>
<th>Economically inactive</th>
</tr>
</thead>
<tbody>
<tr>
<td>One hour’s paid work a week</td>
<td>No job</td>
<td>Out of work</td>
</tr>
<tr>
<td>Training scheme</td>
<td>Wants to work</td>
<td>Not looked for work in past four weeks</td>
</tr>
<tr>
<td>Unpaid work for family business</td>
<td>Actively seeking work</td>
<td></td>
</tr>
</tbody>
</table>

Figure 5.1 Unemployment Measures

Unemployment Rate = \[
\frac{\text{unemployed}}{\text{employed + unemployed}} \times 100
\]

The second and more substantive measure is the Labour Force Survey measure which uses international definitions. The ILO definitions of employment and unemployment were first adopted in the UK in 1984 and have been the basis of a continuous Labour Force Survey since 1992 for Great Britain and a 3 monthly survey since April 1998. The survey is effectively a 1% sample of the population.
Even the ILO definition is problematic. For example, an unemployed worker who goes on a training scheme under these definitions will now be considered employed for the duration of the scheme but there is much evidence that such schemes may not lead to permanent employment. Research has also shown that such labour market programme participants will have worse health than those normally employed. (Novo et al 2001)

More controversial still is the relationship between unemployment and labour force inactivity. For example, some have argued that governments have sometimes used education to help ‘mop up’ youth unemployment. No less there is the question of what it means to be registered long term sick and disabled? These groups are often excluded from a discussion of unemployment and ill health on the grounds that here a health selection effect is more evident. But there is strong evidence that long term incapacity has been used as a way of moving people from the unemployed category to an inactive category. UK inactivity rates are high (20%+ at the peak of the boom) and especially so for older workers. In 2003 40% of inactive males aged 25-34 were registered as long term sick and disabled; 60% of inactive males aged 35-49 and 42% of 50-59/64. (Bacon 2002; Barham 2003) Additional evidence that the unemployed have been moved between categories is available in the geographical variations in the numbers on incapacity benefit which seems to follow the spatial pattern of unemployment and decline. (Beatty & Fothergill 2005; Beatty et al 2007) Retired workers can also be a problem as here too there may be an element of unemployment being manifested in the involuntary or quasi-voluntary taking of early retirement.

Table 5.1 Economic Inactivity by Reason 16-59/64 in 000s

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Student</td>
<td>1,848</td>
<td>1,958</td>
<td>2,051</td>
</tr>
<tr>
<td>Carer</td>
<td>2,038</td>
<td>2,276</td>
<td>2,256</td>
</tr>
<tr>
<td>Temporarily sick</td>
<td>200</td>
<td>189</td>
<td>169</td>
</tr>
<tr>
<td>Long term sick</td>
<td>2,066</td>
<td>2,038</td>
<td>1,988</td>
</tr>
<tr>
<td>Discouraged</td>
<td>42</td>
<td>34</td>
<td>49</td>
</tr>
<tr>
<td>Retired</td>
<td>611</td>
<td>603</td>
<td>598</td>
</tr>
<tr>
<td>Others</td>
<td>810</td>
<td>807</td>
<td>745</td>
</tr>
<tr>
<td>Does not want work</td>
<td>5,785</td>
<td>5,759</td>
<td>5,737</td>
</tr>
<tr>
<td>Wants work</td>
<td>2,101</td>
<td>2,106</td>
<td>2,121</td>
</tr>
<tr>
<td>Total</td>
<td>7,885</td>
<td>7,904</td>
<td>7,858</td>
</tr>
</tbody>
</table>

Source: ONS, Labour Market Statistics First Release – February 2009
Table 5.2 Beatty et al’s Estimates of Real Unemployment Rate in West Midlands in 2007 at the peak of the boom

<table>
<thead>
<tr>
<th></th>
<th>Claimant Count</th>
<th>Real Unemployment</th>
<th>Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Total</td>
</tr>
<tr>
<td>Birmingham</td>
<td>8.8</td>
<td>2.9</td>
<td>6.0</td>
</tr>
<tr>
<td>Coventry</td>
<td>6.0</td>
<td>2.1</td>
<td>4.2</td>
</tr>
<tr>
<td>Dudley</td>
<td>5.2</td>
<td>2.0</td>
<td>3.7</td>
</tr>
<tr>
<td>Sandwell</td>
<td>7.6</td>
<td>2.7</td>
<td>5.2</td>
</tr>
<tr>
<td>Solihull</td>
<td>3.3</td>
<td>1.3</td>
<td>2.4</td>
</tr>
<tr>
<td>Walsall</td>
<td>6.8</td>
<td>2.6</td>
<td>4.8</td>
</tr>
<tr>
<td>Wolverhampton</td>
<td>7.4</td>
<td>2.9</td>
<td>5.2</td>
</tr>
</tbody>
</table>

Source: Beatty et al 2007

Unemployment Types and Re-employment Issues

The simple division that economists use of frictional unemployment, cyclical unemployment and structural unemployment is helpful in further exploring the social and health dimensions of unemployment. Frictional unemployment refers to the normal day to day movements in the economy as workers change jobs and firms expand, contract or fail. A market economy always needs some level of frictional unemployment. Cyclical unemployment refers to the longer term, economic cycle which pushes the overall rate of unemployment up and down. Structural unemployment refers to the unemployment created by structural economic change – the impact of technological change, trade and changes in policy, which lead to a weakening and collapse of activity in particular economic sectors and geographical areas.

Workers experiencing cyclical unemployment have a good chance of regaining employment using their existing skills with a smaller impact on long term pay and prospects. This will mean less for some than others since one group might be trapped in what Fryer (1997) calls ‘careers of labour market disadvantage’, experiencing a cycle of employment, unemployment and re-employment in precarious jobs. For the other group the hope and achievement of re-employment in a similar job means that the long term implications of job loss may also be less extreme.

This is not the case where structural unemployment occurs. Here the workers become displaced, in American terms, go ‘in the skids’, as they experience a fall in their relative and absolute position which is sustained even after re-employment. Serious structural unemployment has been a permanent condition in the British economy since the 1970s but it grows in economic crisis as the destructive element of ‘creative destruction’ is concentrated by falling profits in industries that are already underperforming.

There is much discussion of seeing unemployment as a chance for a positive life change (e.g. the banker who becomes teacher on lower pay but with greater job satisfaction) and that workers should be encouraged to develop flexibility and life skills for ‘portfolio employment.’ But the evidence is that this is not how most displaced workers experience unemployment and re-employment. Permanent
structural change tends to give rise to permanent displacement and the majority do not return to comparable or better work situations. They lose their skills and the positive elements that went with the earlier job. – pay, tenure, seniority etc. This group of workers experiences longer periods of unemployment in the short to medium term. They see their ‘human capital’ devalued. It is in this group that we are likely to see much higher rates of incapacity as what in America is called ‘displaced worker syndrome’ takes hold. When displaced workers take new jobs these tend to be at lower pay rates and these lower rates are maintained in the long term. Re-employment may also involve a higher level of part time working. Job satisfaction may also be adversely affected with a low quality ‘match between the worker and the job’. There is evidence to suggest that the minority of displaced workers who regain employment in their former sector experience fewer losses than those who are completely displaced. This may help encourage the majority to delay adjusting in the hope that they may become one of the fortunate minority. Equally, moving area may increase the chances of re-employment but it may not be sufficient to restore earlier earnings. The scale of long run income declines in re-employment depends on the group observed but US studies suggest at least +/-15%. (Daniel 1983; Fallick, 1996)

Of immediate interest here is an analysis of the impact of the closure of the MG Rover plant at Longbridge in April 2005. This was the largest industrial failure in the UK for twenty years and it led to 6000 direct job losses (7% of whom lived in Sandwell) and an unknown number in the supply chain. A major ESRC funded study analysed the subsequent experience of a sample of directly redundant workers in July and December 2005 and again in April 2008. Although the sample is not without its problems the resulting analysis is one of the most detailed we have for the UK of the impact of unemployment and the process of the return to work and whether those made redundant can obtain, what the then Prime Minister (Tony Blair) spoke of in 2005 as, ‘full and fulfilling jobs’.

The plant closure occurred in an already disadvantaged region but its national context was an economy that was still growing strongly. The ‘success story’ was that three years on, 90% had found work – three quarters in full employment, 11% self employed and 5% in part time employment. But within this, redundancy had led to a significant long term shift on the situation of the redundant employees along the lines already suggested.

Re-employment – those who found jobs soonest tended to step sideways into similar jobs using the same skills. But only 30% of the group were re-employed in any kind of manufacturing industry. Those who found jobs more quickly, even if they involved long distance commutes, were less anxious and suffered less of a salary fall. But only one third of the group felt that their new jobs were better than the old. 60% had had some retraining and the longer the period of unemployment, the more important this had been. Especially disturbing and symptomatic of redundancy leading to more precarious long term labour market positions was the number of people who had had more than one job within the three years. This included one third of the fully employed group and a higher proportion of the unemployed and non-employed. Successful re-employment search was heavily dependent on individual initiative, family and friends networks etc rather than formal services. Older workers and those with a longer work history at MG Rover found it harder to get jobs, as did women.
Table 5.3 Main Employment status of Redundant MG Rover Group at 3 months, 8-9 months and 24-25 months

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-employed</td>
<td>2.2</td>
<td>4.5</td>
<td>10.8</td>
</tr>
<tr>
<td>Employed full time</td>
<td>22.7</td>
<td>52.3</td>
<td>73.5</td>
</tr>
<tr>
<td>Employed part-time</td>
<td>2.2</td>
<td>3.4</td>
<td>4.4</td>
</tr>
<tr>
<td>Still at MG Rover</td>
<td>4.3</td>
<td>2.3</td>
<td>-</td>
</tr>
<tr>
<td>Full time education and training</td>
<td>4.9</td>
<td>4.5</td>
<td>1.0</td>
</tr>
<tr>
<td>Part-time education and training</td>
<td>2.2</td>
<td>0.6</td>
<td>1.5</td>
</tr>
<tr>
<td>Unemployed and looking of work</td>
<td>58.4</td>
<td>28.4</td>
<td>4.9</td>
</tr>
<tr>
<td>Unemployed and not looking for work</td>
<td>1.6</td>
<td>0.6</td>
<td>2.0</td>
</tr>
<tr>
<td>Caring</td>
<td>-</td>
<td>-</td>
<td>0.5</td>
</tr>
<tr>
<td>Retired</td>
<td>-</td>
<td>0.6</td>
<td>0.5</td>
</tr>
<tr>
<td>Other or incapacity/ disability</td>
<td>1.6</td>
<td>2.8</td>
<td>1.0</td>
</tr>
</tbody>
</table>

Finance – one third of the group had improved their incomes but these were concentrated amongst more senior managers and those who moved into the construction industry. 66% were worse off with the average, inflation adjusted, salary decline being £5,640 – approximately 20%. In this new situation 36% said that they were just managing and 25% were still in debt, using savings.

Health Effects – the sample was asked about self-rated health. ‘Most people reported feeling healthy, but felt that their health was generally poorer than when at MG Rover’. More serious self-reported health concerns were apparent amongst the longer term unemployed. Training appeared to have reduced potential health effects for all and the role of family and friends in terms of support was rated highly.

6. Measuring the Health Impact of Unemployment

The general effects of unemployment on health have been subject to various, more or less systematic, reviews over time including Kasl 1977; Jahoda 1979; Hakim 1982; Jahoda 1982; Fryer & Payne 1986; Smith 1987; Catalano 1991; Wilson & Walker, 1993; Bartley, 1994; Jin et al 1995; Dooley et al 1996; Shortt 1996; Mathers and Scofield 1998; Platt et al 1999; Kasl and Jones 2000; Bartley and Ferrie 2001; Saunders & Taylor 2002; McLean et al 2005; Bartley 2005; Waddell and Burton 2006.

6.1. Selection Effects

In the early days of research into any possible link between unemployment and health one of the most controversial areas was the possible existence of a health selection effect. (Bartley, 1992) Consider two hypotheses:

H3 Ill health leads to unemployment

H4 Unemployment leads to ill health
Clearly both elements exist and their contribution is now known to vary. For example, in a period of low unemployment health selection effects are potentially more important than in periods of rising unemployment when it makes little sense to see poor health as an explanation of a systemic problem. Most accounts today, however, stress the role of unemployment as a health determinant rather than health selection. Moreover, even if health selection is a significant factor, it needs to be treated carefully.

1. Ill health is not randomly distributed but a reflection of accumulated disadvantage that starts in the womb and is then manifest throughout life not only in a greater incidence of morbidity but also differential resources to deal with it. This process is partly material but more a psycho-social one. (Marmot 2003; Artazcoz et al 2005; Wilkinson and Pickett 2009; Yuill 2009)

2. The impact of ill health is constructed by the power relationship. Employers are known to alter (despite the law) selection criteria as economic circumstances change. This can lead to some workers losing jobs and then finding it hard to gain re-employment. This affects not only those suffering from physical and mental illness but the disabled, prisoners etc.

3. Even if there is a selection effect, unemployment may well exacerbate health problems and cause a further deterioration.

4. The specific causation between unemployment and health may well vary depending on the type of physical and mental ill health being discussed.

In these terms it is perhaps best to heed Fryer’s warning that

*It is a gross over simplification to dichotomize causation [unemployment] and drift [selection] as part of a dynamic process. In the lives of real people social causation and social drift processes are usually inextricably intertwined and the preoccupation with separating them may be misguided.* (Fryer 1997)

This also points to the limits of those quantitative (and qualitative) studies which pay insufficient attention to multi-level causation, feedback etc.

### 6.2 Unemployment as a Determinant of Ill Health

The debate on the health impact of unemployment involves four measures of health

1. Mortality
2. Morbidity
   (a) Physiological
   (b) Psychological
3. Self-rated health
4. Access to medical services

Measuring mortality is relatively easy given the requirement to register deaths and establish their cause. Morbidity is more problematic as this requires patients to attend for medical treatment and have their symptoms and illnesses recorded. There is
therefore a tendency to under-report (which varies by group as well) and especially for the less acute conditions. Self-rated health is usually assessed by standardised health questionnaires but is also subject to reporting bias. The possibility may also exist that self-reporting will be affected by ‘fashion’ and issues of acceptability e.g. stress is now widely recognised as a legitimate symptom and may therefore be used as a cover to report other work related problems. Access to medical services has tended to focus on use of GPs, hospital services and measures of medical consumption e.g. medication.

Figure 6.1 sets out the basic causal mechanism by which unemployment may have an impact on health outcomes. Unemployment is argued to give rise to three types of risk which we will briefly consider.

**Financial Strain**

It is commonly hypothesized that the greater the fall in income, the worse the health effects. (Starrin et al 1997; Nordenmark & Strandh 1999) The size of the fall will be determined by the gap between the previous income and the benefit levels and other entitlements (e.g. pensions in older workers). This is known as the income replacement level. On this basis UK benefit levels are low compared to a number of countries and they have been so since the 1980s. Unlike in some countries, initial unemployment pay is not earnings related. Obviously then the lower the employment pay then the smaller the income replacement gap. But the higher the previous employment pay, the greater the gap.

Financial strain may have a secondary effect in reducing the means by which people can maintain their social interactions leading to greater isolation. (Roberts et al 1997) As an example in the UK it would currently cost someone on job seekers allowance 8-10% of their monthly income to buy a daily morning and evening newspaper and maintain internet access. Direct social intercourse will add to these costs.

A third issue is the possible development of a vicious circle of debt. Where employment is bound up with significant debt and additional forced borrowing there is evidence to suggest that the health effects are greater. It is important therefore to consider the ways in which personal debt has built up in the UK. The weight of housing debt is especially important given the limits on the period when assistance becomes available and its amount. Unsecured debt levels are also high. A significant number of the unemployed will therefore be beginning unemployment with serious debts which may serve to differentiate some of the problems in this recession.
Self-esteem and stress

The status/esteem effects of unemployment have been a major concern since the 1930s, leading possibly, according to some critics, to an under-estimating of the financial issues. A concern with this aspect has also led studies to ask whether some groups (e.g. higher status workers) are more prone to experience unemployment as a status/self esteem trauma than a financial one.

Status and self-esteem effects have been shown to be a factor even where the financial strain is light (including in those societies such as Sweden which have traditionally had a high benefit-income replacement level). A common, if unsophisticated, way of thinking about this is in terms of the psychological contact.\(^8\) Unemployment is seen as a violation of this contract and a betrayal.

This can be accentuated where unemployment leads on to a loss of life structure – time structures weaken, physical and mental inactivity may increase and social networks become diminished. There are serious issues, however, in the extent to which income and status effects can really be separated. (Fryer 1990; Rantakeisu et al 1999)
Health Related Behaviour

The impact of unemployment on health related behaviour is more subtle than may appear at first sight. As is evident in figures 3.2 and 3.2, a balance needs to be drawn between pressures to both worse health behaviour and to better.

There is evidence, as we noted in the discussion of the good times hypothesis, to suggest that on balance health related behaviour might even improve. The income losses of unemployment can lead to a reduction in smoking and drinking because of their high costs (note however the recent sharp declines in the real cost of alcohol in the UK). Diet may also improve with more time for better cooking. There is no significant evidence of a relationship between unemployment and increase in illegal drug use. The time cost of medical attention can also be reduced.

Some commentators however argue that an average effect might be misleading. There is speculation, for example, that unemployment may create a more dichotomised response – encouraging some to become heavier drinkers, for example, and others new abstainers. (Morris et al 1992)

The most dramatic link between unemployment and health related behaviour is in terms of suicide and para suicide. Unemployment does contribute to a higher suicide rate but the mechanism is not necessarily direct. Intervening events need to be involved such as debt, loss of family home, divorce etc, what Bartley calls ‘an unfortunate synergy of increased frequency of life events and reduced support’. (Bartley, 1994)

Types of Studies Linking Unemployment and Health

In assessing any link between employment status and health status it is important to compare two methods – cross sectional and longitudinal.

Cross sectional

Cross sectional studies compare the employment and health status of different groups at the same point in time e.g.

- General population to unemployed
- Employed to unemployed
- Sub sample of above to sub sample of above

Cross sectional analysis is the easiest to carry out in terms of cost but analysing the results is difficult because of sample problems and the need to properly take account of confounding and mediating factors.

Longitudinal

This involves comparing groups over time. It is more complex and costly to do but the results may be more reliable since it is potentially easier to control for confounding and mediating factors. As examples of longitudinal research we may note
• Comparing a sample of the general population and unemployed at one point in time (e.g. census) and then tracking subsequent health history
• Tracking the impact of plant closure on health history of a group of victims and survivors
• Tracking young starters and comparing the health history of those who quickly gain employment and those who do not.

Nature of relationships

In each case the focus of discussion involves trying to establish a number of issues including:

• Nature of the casual relationships between employment and health status
• Direction and extent of any influence
• Relative weight of different components in model
• Role of contextual factors e.g. overall unemployment rate
• Role of mediating factors e.g. gender, age, class, education, duration of unemployment
• Efficacy of any policy responses

| Examples of more specific studies exploring and showing health links of unemployment |
|-----------------------------------|---------------------------------|
| Mortality                         |                                 |
| Suicide – Platt 1984; Blakely et al 2003. |
| Morbidity                         |                                 |
| All Cause – Beale & Nethercott 1987; Mathers et Scofield 1998; Keefe et al 2002 |
| Cardio-vascular – Weber & Lehnert 1997(sceptical); Sundquivst et al 2006 |
| Cancer – Lynge 1997 |
| Health Behaviour                  |                                 |
| Smoking – Morris et al 1992      |
| Alcohol – Morris et al 1992; Dee 2001 |
| Self Rated Health                 |                                 |
| All studies Ferrie 2001           |
| Health Service Usage              |                                 |
Duration

An obvious consideration in the relationship between unemployment and health is the question of the duration of unemployment. Is duration a product of health selection? (Stewart 2001) Does longer duration lead to an intensification of health problems or is there a process of adaptation? Duration is partly a function of the scale of the unemployment problem. Duration will be longer for a greater number, the more intense the cyclical crisis and the more intense the structural adjustment problems. Duration data can be analysed using UK unemployment statistics as in table 6.1. It can also be analysed in terms of longitudinal studies as in the MG Rover one.

Table 6.1 Unemployment by Duration in Nov-Jan of year

<table>
<thead>
<tr>
<th></th>
<th>Unemployment</th>
<th>Months unemployed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>%</td>
</tr>
<tr>
<td>2007</td>
<td>1,696</td>
<td>5.5</td>
</tr>
<tr>
<td>2008</td>
<td>1,608</td>
<td>5.2</td>
</tr>
<tr>
<td>2009</td>
<td>2,029</td>
<td>6.5</td>
</tr>
</tbody>
</table>

Source ONS, Labour Market Statistics, March 2009 First Release

For most workers, even in a deep crisis, unemployment will be a more or less temporary phenomenon with them finding work within six months. But the share of long term employment will be significant. The long term unemployed will be made up disproportionately of those who are disadvantaged and less strongly anchored in the labour market. There will also be a more significant health selection effect in this group although again the complexity of causation should not be underestimated.

6.3. Employment/ Unemployment/Re-employment Transitions and Ill Health

As section 4 stressed it is important to have a more sophisticated appreciation of the employment-unemployment relationship. This means that any analysis cannot begin with job loss but the anticipation of job loss. Figure 6.2 sets out three stages in which any health effect might be different.
Stage 1 Threatened unemployment

It is a commonplace that the anticipation of a problem often produces more stress that the problem itself and this appears to be the case with unemployment. ‘One of the most consistently replicated findings in this area is that health begins to be affected at the time when people anticipate unemployment but are still at work.’ (Bartley, 1994) Evidence that a threat to job security may be as harmful psychologically as the reality of unemployment is offered by many researchers. (e.g. Cobb & Kasl 1977; Lazarus 1991; Burchall 1996; De Witte 1999, Ferrie 2001). By extension, since people in work still have an income, we might also expect that the threat of unemployment might worsen income related negative health behaviours (e.g. smoking, drinking etc).

The possibility of unemployment can be anticipated in sectors of the economy where there are known to be difficulties or in major economic downturns. But it can also come as a shock. Where a firm is struggling to survive this may be reflected in public measures such as short time working but managers will sometimes try to hide the scale of the problems for fear that a loss of confidence will precipitate immediate financial collapse.

In this context it is helpful to distinguish between employment uncertainty - affecting the employed and the unemployed – which relates to the inability to foresee if a job is to be lost or whether a new one can be obtained and job insecurity – the threat of potential and imminent job loss. Job uncertainty will be greater the higher the level of threatened unemployment. (Mankter et al 2005)

Stage 2 Unemployment

Once unemployment begins there is some suggestion that physical ill-health may stabilise. The response of psychological ill health is less clear. Either stabilisation would appear to be at a lower level. But Manter et al 2005 in a study of ‘high tech’ unemployed in Canada after the collapse of the dot.com boom suggest a more complex relationship in which unemployment may bring some immediate relief but
stress levels rise again with duration. Their study is unusual in trying to track comparable groups in the same industry.

**Stage 3 Labour Market Exit/Re-employment**

Stage 3 comprises a move either back into work or *de facto* labour market exit. It is usually argued that the prime responsibility of the health service is to encourage people back to work. (Wanberg 1995; Vinokur et al 2000) Re-employment in these terms is seen as a solution and any job is better than no job. But, in the light of the argument that has already been made, this may not follow for health if the new position continues to be precarious. (Broom 2006) Health problems will then continue to be present both as a legacy of the past and a manifestation of the current inadequate employment. (Westin 1990)

Labour market exit is likely for those who present serious health problems during a period of unemployment, this has been especially marked amongst older men. Once on incapacity benefit there is then only a limited chance of labour market re-entry (on one calculation this is no more likely than for retired people). (Bacon 2002, Barham 2003) The interaction of health and labour market position here remains problematic. As the economy boomed in the middle of this decade the high numbers of people on incapacity benefit seemed to be a constraint on the labour supply. With rising unemployment this may again appear as a socially acceptable way of managing it although this cannot be admitted publically. For those in the health service there is a conflict between the desire to encourage people back into good work and health and the need to manage demoralisation, employer prejudice and intolerance, the benefit system etc. This poses real problems on the ground that need to be more openly discussed. (Mowlam & Lewis 2005)

**6.4. Unemployment and Social Characteristics as Health Modifiers**

**1. Gender**

Possible differences between men and women in relation to unemployment and health arise from the gendered nature of society in which women, as a whole, have less power to influence their situation than men (Doyal 1995; Rogers & Pilgrim 2005) and the specific mechanisms of the labour market. This is reflected in different overall participation rates; segregation by occupation with more male or female dominated sectors; and segregation by level with fewer women in senior positions. (Klumb & Lambert 2005) Two possibilities arise from this. One is that women might be disproportionately affected by job loss. This would arise if the sectors in which they worked were disproportionately affected; if (despite equal opportunities legislation) they were more likely to be dismissed; if they found it harder to get re-employment. There is fierce debate as to whether any differences here are explained by gender or other factors. The second possibility is that women might feel the health impact of unemployment more. There is evidence to show that this is the case (Novo et al 2001) and that women find adaptation harder (Jackson and Warr 1987) but there are differences in how this is measured and might be explained.
2. Age

Age is an obvious moderator of both the physical and psychological effects of unemployment. Jackson and Warr argued that unemployment stress is probably greatest in middle age (Jackson and Warr, 1984). Stress here arises from the way that unemployment relates to financial problems, family responsibilities, career interruptions and pessimism about the future. Since many of the studies of unemployed groups are dominated by the experience of this group as the largest in the workforce their situation is already heavily weighted into aggregate studies.

Youth Unemployment

Youth unemployment is of interest in its own right but it is also significant because there are generally a higher proportion of young people unemployed than adults (Hammarström 1994; Gaetz et al 1993; Morrell et al 1998; Hammarström & Janlert 2002). Evidence suggests that the young do not suffer disproportionately more ill health (especially mental) from unemployment. But it has long been argued that the stress created by unemployment for the young might be longer lasting. In their classic account of unemployment in the 1930s Eisenberg and Lazarsfeld suggested

\[\text{In general we obtain the same effects upon the personality of unemployed youth as on that of unemployed adults but because of the greater susceptibility of youth and because they are going through a transition period between childhood and maturity these effects are probably more lasting.}\]

Subsequent research has focused on the school-to-work transition and shown that the health gap between employed and unemployed youth grows (Dooley 2003). It is less clear, however, whether this gap can be explained by a rise in mental health problems amongst the unemployed youth or a fall amongst employed or a combination of both. The key mechanism here appears to be stress related rather than finance related as, unless unemployment results in homelessness, even with limited welfare benefits there may not be material impoverishment (low benefits may even lead to an improvement). (Lakey et al 2001; Bjarnason & Sigurdardottir 2003).

It has also been shown that the anticipation of unemployment by secondary school pupils also leads to increased stress in the same way that it might with the employed. It is an unresolved question as to whether these arguments can be applied to college graduates. There is some suggestion that stress here might be less and it might be related to financial status (Fryer, 1997) but (Novo et al 2001) suggest that employment anxiety does affect students.

There is also a question as to why, if the health effect is less serious for unemployed youth, there is apparently greater concern for their situation? One explanation is that while older groups might be ‘out of sight and out of mind,’ younger groups are treated more as a social problem because of their perceived street visibility as NEETS – ‘neither in employment, education or training.’ (Prince’s Trust 2007).
Older Workers

Older workers continue to be at a disadvantage in the labour market so that in terms of re-employment gaining a new job may be harder. The redundancy process is supposed to favour them in economic terms if they obtain access to full or enhanced benefits. Voluntary redundancy programmes in these terms can seem attractive but there is evidence that older workers may feel pressure to leave in order to save jobs for younger workers. Health effects appear to depend heavily on circumstances. For those leaving with enhanced pensions and significant redundancy packages unemployment effectively becomes a form of more prosperous early retirement (Kasl et al 2000; Gallo et al 2000). For those without these terms (or who had them and lost them in pension fund collapses) the situation is more serious. Studies of the health effects of unemployment amongst older workers show that they are more evident the less financially strong the position of the older worker. This may also help to explain gender aspects such as the health impact on older unmarried women.

3. Ethnicity

The 2001 census showed that 8.1% of the population of Great Britain defined themselves as part of an ethnic minority. Research has focused on an ethnic penalty in terms of labour force participation, an occupational penalty and a degree of spatial segregation (Smith 2000). The marked incidence of ethnic disadvantage for some groups in the labour market is reflected in higher levels of inactivity and higher levels of unemployment. Unemployment rates for Chinese and Indian ethnic groups are comparable to white groups but this may be distorted by higher levels of self-employment. For other groups male unemployment rates may be up to three times those of white males. Activity rates are lower for ethnic minority women in these groups but the unemployment penalty is similar to males (Simpson et al 2006; Heath and Cheung 2006). In so far as unemployment leads to ill health we may therefore expect to find that this will fall more on ethnic minority communities which experience labour market disadvantage.

4. Previous Occupation

This argument suggests that the causal mechanisms and scale of health effects will differ depending on the group from which the unemployed come. As an example we might contrast the unemployed worker, the unemployed professional and the failed business man (Jahoda 1982; Payne et al 1984). The arguments derive from possible differences between the manifest and latent aspects of the unemployment experience. A number of commentators have suggested that whereas workers experience unemployment primarily in terms of income effects, white collar workers, professionals and managers experience it primarily through a loss of status.

If this argument is correct it might be important since it is commonly argued at the moment that the current rise in unemployment is disproportionately affecting the 'middle class’. This has also led to various targeted policy responses designed to offer something to the professional unemployed. However there is a need for great caution here.
1. The social incidence of unemployment at the start may not be the same as the crisis develops.

2. There is considerable dispute over the way in which the issue of manifest and latent impacts are discussed for all groups. Some critics argue that there is too much \textit{a priori} reasoning here rather than engagement with the texture of the life of the unemployed.

3. It is not clear that in any case the alleged differences are real. While professionals might have more to lose in status than the unskilled manual workers it is not clear that this is true of skilled workers who are displaced. Income falls for both may be considerable given the low-level of income replacement through benefits in the UK.

4. The division of the workforce into these groups is somewhat arbitrary. The UK, for example, has a larger managerial group than comparable advanced societies but this is better explained by the overuse of the title manager than real differences.

This is not to say that the issue of sub groups can be discounted. But it does need careful thought than it is usually given.

**Failed employers**

Business and organisational failure not only affects employees but owners and senior managers. There has been much less research on the impact of this, in part because the literature on business tends to focus on success and interest ceases when the business ceases. The entrepreneurial focus of much discussion also stresses a positive view of entrepreneurship and leadership, emphasising the alleged conditions of success. But most small firms sooner or later fail. Family businesses rarely survive two generations. If not through retirement, the end comes through bankruptcy, take-over or merger and this type of failure increases in times of economic crisis.

There appears to have been no systematic quantitative study of the health impact of failure on employers that is comparable to the studies of employees. Two arguments are strongly made in the limited literature that does exist. The first is that in owner controlled firms personal commitment encourages owners to over-commit to avoid failure. This can take the form of pressure on employees but also personal over-commitment in terms of effort and resources of the owner, with negative effects for themselves and those closest to them (Shepherd, 2009b). There is some division as to whether this is worth it in its own terms. Some commentators speculate that this stress is a necessary part of search, learning and adaptation which can help lead to business recovery. Others stress ‘threat rigidity’ where the quality of decision making decreases inhibiting necessary change.

The second argument is that owners experience business failure (to a degree like employees experience unemployment) as a form of grief similar to the loss of a loved one (Shepherd, 2003, 2009a). The limited research that has been done tends to depend on qualitative interviews and see this process from the perspective of the failed business person (Singh et al, 2007). Whether it would be possible to go beyond
this to look for systematic evidence of the health impact of failure, relating it to the nature of the losses (e.g. the role of limited liability in limiting economic losses), issues like director disqualification and so on remains unclear but these are issues that would need to be taken into account in any research design.

6.5. Coping, Blaming and Individualising

In analysing any aspect of life there is a question about the level at which causation occurs and what type of intervention might be appropriate. As individuals we all have a degree of ‘freedom’ or ‘agency’ but we are also constrained and conditioned by society and social processes. The balance between these two aspects of life remains the subject of fierce debate but impacts directly on the analysis of health and unemployment. A strong focus on individual agency can lead to the view that the unemployed can be ‘masters of their own fate’ and that it is within their means to solve their own problems. This focus on individual responsibility was captured by Norman Tebbit’s urging in the 1980s that the unemployed should ‘get on their bikes’ to find work. It also finds expression in some of the more detailed discussion on unemployment and health. Figure 6.3, from Waddell and Burton, for example, individualises the relationship and, followed to its conclusion might suggest that an individual remedy is sufficient for a collective problem.

Figure 6.3 Individualising Work and Health Relationships? (Waddell & Burton 2006)

Coping strategies have been broadly defined as either problem focused or emotional (which can then be divided into expression or avoidance). (Waters & Moore 2002) It is well established that lower levels of stress are associated with problem based coping and the highest with emotional avoidance. The problem here is that the unemployed lack the same resources as the employed to engage in realistic problem solving.
Support mechanisms in the form of carrot and stick approaches (job clubs, support groups, CV planning, threats to benefits etc) have therefore been implemented to overcome these gaps.

After a period of unemployment, benefit-recipients enter a period of grey resignation where any change can appear dangerous. Their “tastes” change. It is the role of the employment office to push people out of that state and into meaningful activity. If we could mobilise more of Europe’s unemployed, these extra employees could find jobs and at existing rates of pay. (Layard, 2005)

But attention is also being focused on the emotional aspects of coping and the ways in which failure to cope may lead to longer term illness. This has been at the centre of Layard’s arguments about happiness which have followed on from his role in developing UK government policy in respect of the ‘New Deal’ and ‘Welfare to Work’ and it is reflected in the Centre for Economic Performance’s 2006 study, The Depression Report A New Deal for Depression and Anxiety Disorders of which Layard was part author.

According to this view sufficient measures existed (in 2006) to deal with unemployment but not with those who become discouraged and for whom mental illness then becomes a route to long term incapacity. 10 For Layard, and those who support this position, a key solution is therapy and it is claimed that this can ‘lift at least half of those affected out of their depression or chronic fear’. And the central therapy is Cognitive Behaviour Therapy which, if offered on a mass basis, proves extremely cost effective (Proudfoot et al. 1997). 11 This argument has now had a significant impact on UK policy but it has also provoked fierce debate, including most recently within the therapeutic community itself as a result of the attempt to further regulate relationships.

Several issues can be noted. The first is the fallacy of composition. In the competition for jobs the more optimistic, problem focussed and active are likely to succeed. But if there are fewer jobs than applicants then this is not a remedy for all. It does not make sense analytically, just as it does not make sense at the level of the individual, to generalise a collective solution for all, from the successful experience of some.

The second issue is the debate over the extent to which CBT is theoretically sound and whether there is systematic evidence it actually works (or that such evidence is methodologically sound) (Pilgrim 2007). The third problem is the way in which this approach contributes to (and derives from) an understanding of unemployment and ill
health that Fryer and Fagan attack as ‘fundamentally myopic, inauthentic paradigm driven and usually irrelevant to the lives of most unemployed people or complicit in their problems’ (Fryer and Fagan 2003).  

To this we can add a fourth point in terms of a social justice perspective. Not only is unemployment itself unjust but its incidence may compound other elements of injustice. For example, racism has been argued to be a contributor to ethnic variation in health. ‘Individuals who had higher levels of lifetime exposure to discrimination are more likely to experience new episodes as threatening and potentially harmful’. This has been extended to the argument that amongst the long term unemployed and marginal groups greater perceptions of social injustice may add to worsened health outcomes. The question then is whether the injustice is real and if so whether the solution is to ‘re-programme’ the individual to ignore it or to work with them to address the social injustice at what ever level is necessary (Friedl et al 2007).

7. Unemployment and ill health and the wider impact

7.1. Business organisations and survivor effects

Survivor effects refer to the impact that redundancy has on those left behind in organisations, ‘it is a generic term that describes a set of attitudes, feelings and perceptions that occur in employees who remain in organisational systems following involuntary employee reductions’ (Noer, 1995). Interest in this partly arises from the perception that restructuring by redundancy often does not seem to produce improved organisational performance (Mirabal & Young, 2005) and the related perception that redundancy might have a negative emotional and psychological impact leading to a health effect on those who survive. In the US Trevor and Nyberg (2008) show that for major companies a 0.5% lay-off rate results in a 2.6% increase in the turnover rate of non laid-off staff to 13% (i.e., turnover increases at 5 times the number laid-off) with each increase in the lay-off rate leading to a even high turnover rate.

Although speculation about survivor effects goes back a long way most of the analysis has focused on restructurings in good times. (Zietlin 1995; Vahtera et al 1997; Appelbaum et al 1997; Kaye 1999; Baruch & Hind 1999, 2000; Grunberg 2001; Hemp 2004; Sahdev 2004) The rationale for using redundancy as a means of organisational restructuring is that it addresses immediate cost issues and can make an organisation ‘leaner and meaner’ i.e. increasing productivity and profitability. There is, however considerable evidence that suggests that this may be wishful thinking.

Survivor effects have been identified at all levels from the most senior managers, who appear as ‘corporate executioners’, to those at the bottom. (Hallier & Lyon 1996)
<table>
<thead>
<tr>
<th>Alleged positive effects</th>
<th>Alleged negative effects</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Direct effect</strong></td>
<td>Individual Survivor</td>
<td>Organisational</td>
</tr>
<tr>
<td>Reduced wage bill</td>
<td>Demotivation</td>
<td>effects</td>
</tr>
<tr>
<td>Decreased overheads</td>
<td>Distrust</td>
<td>Reduced</td>
</tr>
<tr>
<td><strong>Secondary effects</strong></td>
<td>Reduced commitment</td>
<td>organisational</td>
</tr>
<tr>
<td>Increased efficiency</td>
<td>Reduced job satisfaction</td>
<td>skills</td>
</tr>
<tr>
<td>Faster decisions</td>
<td>Presenteeism</td>
<td>reduced</td>
</tr>
<tr>
<td>Increased effort</td>
<td>Goal displacement (from</td>
<td>organisational</td>
</tr>
<tr>
<td>Increased focus</td>
<td>organisation to individual)</td>
<td>knowledge</td>
</tr>
<tr>
<td></td>
<td>Fear of job security</td>
<td>Staff turnover</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Recruitment costs</td>
</tr>
</tbody>
</table>

**Figure 7.1. Contrasting Views of Benefits and Losses of Organisational Restructuring through redundancy**

The longitudinal *UK Quality of Working Life* survey which examines opinions of a sample of middle and senior managers who are members of the Institute of Management is used by its authors to document a widespread managerial perception of extensive survivor effects by dividing managers into three groups – those in organisations restructuring with redundancy; those restructuring without redundancy and those not restructuring at all (Worrall and Copper, various). Similar results have been reported for the US ([http://www.leadershipiq.com/index.php/news-a-research/recent-studies/150-layoff](http://www.leadershipiq.com/index.php/news-a-research/recent-studies/150-layoff)).
Figure 7.2 Thinking About Survivor Syndrome in an Economic Crisis

<table>
<thead>
<tr>
<th>Total Collapse</th>
<th>Unemployed Group</th>
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<table>
<thead>
<tr>
<th>Employed Group</th>
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<table>
<thead>
<tr>
<th>Downsizing</th>
<th>Part restructuring</th>
<th>Intra organisation survivors</th>
<th>Way dealt with</th>
<th>Survivor Syndrome and Survivor Effects</th>
<th>Managers &amp; Employees</th>
<th>Health effects</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Individual effects</td>
<td>Stress Effects</td>
<td>1. Aggravation pre-existing conditions</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>1. Nature of Crisis</td>
<td>Morale Effects</td>
<td>2. New conditions</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2. Selection procedure</td>
<td>Political effects</td>
<td>□ 1. Health Status</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3. Post Reorganisation assistance</td>
<td></td>
<td>Clinical depression/affective disorders</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Inter Org survivors</td>
<td></td>
<td></td>
<td></td>
<td>2. Health behaviours</td>
</tr>
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<td></td>
<td></td>
<td>□ Workplace Effects</td>
</tr>
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<td></td>
<td></td>
<td>Sector Survivors</td>
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<td></td>
<td>Presenteeism</td>
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<tr>
<td></td>
<td></td>
<td>Community Survivors</td>
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<td></td>
<td></td>
<td>Absenteeism,</td>
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</table>
However not all workers seem to suffer from survivor syndrome. Baruch and Hinds (2000) talk of it as being management myth drawing for their evidence on an employee opinion survey in a UK financial institution subject to 'sequential significant restructuring'. But Sahdev in a comparison of the experience of Barclaycard and a manufacturing firm did uncover negative survivor reactions in the former. This was explained by the weaker management of the Barclaycard programme and the confusion in which staff were left (Sahdev, 2004).

Unemployment Context

The issue of context would appear to be a significant issue in determining the health impact of unemployment but it has been subject to much less analysis, possibly because of the difficulty of modelling the different elements. Context is usually argued either to provide a buffer against the worst health impacts of unemployment or to intensify them (Béland et al 2002). Figure 6.3 provides a simple example of some of the key contextual elements that have been discussed.

Figure 7.3 Possible Contextual Elements in the Health Impact of Unemployment

The Business Cycle and Community Unemployment

These two elements may be taken together. To what extent does the health impact vary according to the level of unemployment and the degree to which a community is trapped in structural unemployment and underemployment? (Blake Turner 1995; Tausig & Fenwick 1999; Nvo et al 2001) Here contrasting hypotheses are debated

H5 is that the selection effect will be less at a time of/ in an area of mass unemployment.

H6 is that the health effect of unemployment will be lower the higher the level of unemployment.

H7 is that the health effect of unemployment will be higher the higher the level of unemployment.
As we have noted earlier H5 is a logical deduction from the discussion of selection, for which considerable supporting evidence exists. More interesting is to confirm H6 or H7. Here the evidence is more ambiguous. Is an individual more or less badly off if lots of people are in the same boat? Different studies have found different results and the debate seems to remain completely open (See, for example, Beland et al 2002). One reason is the difficulty of separating out this aspect from other variables.

7.2 Families and Children

There is considerable evidence of the negative impact of unemployment on families and children. (Fagin & Little 1984; Voydanoff, 1984, 1990; Winefield et al 1993) Figure 6.4 shows the possible linkages that have been considered.

![Diagram of possible impact of family unemployment on family and children]

**Figure 7.4 Possible Impact of Family Unemployment Family and Children**

**Partners and Family Stress**

Research has tended to follow the gendered nature of society and assumed, or directly investigated, the loss of the male breadwinner job (Voydanoff 1984, 1990; Rook et al 1991). This will be the main issue but it is no longer the only one that needs to be considered. So far as marital relations are concerned account must be taken of family structure, size, composition and stage in the life cycle. Studies make an important distinction between partnership stability and satisfaction. Separation and divorce are major incidents in people’s lives with significant health costs. But there is less evidence than might be imagined that unemployment in itself leads to marital break-up for the unemployed. However there is strong evidence to suggest that it increases marital stress and reduces marital satisfaction which can then relate to health problems (including, for example, sexual dysfunction where a link to unemployment is widely hypothesized but not necessarily supported by systemic survey) (Rook et al 1991). On the other hand there is also strong evidence that family resilience exists and that this can be a significant factor in reducing unemployment stress and its health effects (Conger et al 1996). Sleskova et al 2006 review some of this literature as a preface to their own study. They point out that short term unemployment may not be a problem for families and may even lead to integration.
Children

Following Sleskova et al, the difficulty for children appears to be pre-unemployment family tensions and longer term unemployment. This seems to make sense with length of unemployment also related to the degree of family hardship and an increase in family stress levels. There is evidence to show that family unemployment impacts negatively on children producing a higher level of illness and a lower sense of personal well-being. It is also thought to have negative behavioural effects and to reduce aspirations (Madge 1983).

7.3 Social capital, communities and support services

The issue of communities, support services and formal and informal forms of social capital is a growing research area (Kawachi & Berkamn 2000; Islam et al 2006; L Poortinga 2006). The argument is that the density of social networks will offer more or less support and therefore significantly moderate the health impact. ‘The impact of unemployment on the health of individuals in supportive social contexts may be less than its effect on individuals living in less supportive contexts.’ (Beland et al 2002).

Figure 7.5 The Argument about Social Capital, Organisation, Disorganisation and Health Outcomes

This argument relates to popular discussions about social capital with the suggestion that community cohesion, and individual with communities, are better the higher levels of social capital. But this is not just an argument that allows for a comparison between two communities. There is a longitudinal issue with the argument that there has been a long run decline in community cohesion and a weakening of social capital in the western world but especially the US/UK. This has led to a greater degree of social atomisation which might be predicted to worsen the health impact of unemployment, if this argument is correct. There is some support for this in cross sectional data but no real attempt has been made to test the longitudinal claim in a sophisticated way.
It is important here to allow for a degree of feedback. Social nets are themselves affected by the level of unemployment so a simple linear relationship cannot capture the complexity of this issue. The idea of the 'run down' community suggests a situation where economic failure and unemployment feed back into lower community cohesion and levels of social capital (Muntaner et al 1999).

7.4 Assessing Public Health Interventions to Deal with Unemployment

Evidence-based practice in terms of public health interventions to deal with the health impact of unemployment is weak. This is partly because of the dominant concern with unemployment as a health determinant but also because of the intrinsic difficulty of assessing such public health interventions.

> We lack good research strategies for analysing public health interventions. Unemployment studies are good examples of the inadequacy of the existing research design, especially randomised controlled trials. The evolution model tends to favour individually focused studies, imitating experimental situations. (Hammarström & Janlert, 2005)

Table 6.6 follows Hammarström & Janlert’s suggestions and sets out three different levels of prevention, following the standard division into primary, secondary and tertiary intervention and three different focuses – the national, community and individual.

<table>
<thead>
<tr>
<th>Primary (reducing unemployment incidence)</th>
<th>Secondary (reducing unemployment prevalence)</th>
<th>Tertiary (facilitating life and managing impact)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>National</strong></td>
<td><strong>Community</strong></td>
<td><strong>Individual</strong></td>
</tr>
<tr>
<td>Economic policy</td>
<td>Work and educational opportunities</td>
<td>Education</td>
</tr>
<tr>
<td>Labour market policy</td>
<td>Work and educational opportunities</td>
<td>Work environment</td>
</tr>
<tr>
<td>Education policy</td>
<td>Job creation</td>
<td>Retraining, Mobility, Rehabilitation</td>
</tr>
<tr>
<td>Social policy</td>
<td></td>
<td>Job seeking skills</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Unemployment Benefits</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Economic compensation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Social support</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Coping strategies</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Stress alleviation</td>
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<td></td>
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</tbody>
</table>

Table 7.6. Examples of Primary, Secondary and Tertiary Unemployment-Health Interventions by levels

The table helps to contextualise where more localised and individualised interventions can operate, their possibilities and limits. The major boxes in this table clearly relate to national labour market and social policy areas. If the labour market is buoyant and unemployment problems are localised then we might expect local and individual interventions to be more successful. But if there is mass unemployment than they will inevitably be less adequate. It is important therefore not to allow an economic and social problem to be overly medicalised either in narrower public health terms or doctor/therapist relationships. This raises the issue of what incentives there are to decrease unemployment. We can see here that there may be a serious paradox. At the national level where intervention might be most effective there may be few political
incentives to deal with unemployment. Lower down the incentives might be greater even though the collective effect may be less (e.g. targets for helping people find jobs, improving local health indicators etc).

What the table does not address is the question of who should be the subject of intervention and when? By default past interventions have tended to focus on the long term unemployed – i.e. a smaller group after a prolonged period. But given the arguments about the potential health impact of unemployment it may make theoretical sense to focus on a much larger group earlier. However ‘early interventions are rare’ (Hammarström & Janlert, 2005) and as unemployment grows in scale there will always be a gap between the numbers of unemployed and those being offered and taking advantage of assistance.

8. Responding to the risks of unemployment – evidence of good practice

The Wanless Report argued that ‘every opportunity to generate evidence from current policy and practice needs to be realised’. Unfortunately in the area of unemployment and health there has only been limited analysis of policy/practice impact, not only in the UK but internationally.

A major difficulty here, raised in the previous section, is the question of at what level of intervention the greatest health impact will be had. In the first decades after World War 2, it was assumed that full employment was a major goal of any government and that governments had the tools available to achieve this. In the last decades, full employment has been seen as a fanciful goal and it has been argued that governments do not have the tools to achieve it. The formal focus has therefore been on market enhancing supply side measures which it has been hoped would indirectly help reduce unemployment. There is a shift at the moment towards a pragmatic but disorganised form of counter-cyclical policy, but one constrained by the ideas of the recent past. There have, however, been strong elements of hidden demand intervention (e.g. lottery spending in the UK). Moreover supply side measures have often been costly. Urban regeneration programmes in the UK are estimated to have cost £11 bn 1980-2002 (Thompson et al 2006). There is, therefore, a major political argument about the extent to which unemployment levels can and should be left to market forces which then becomes even more controversial if the idea of health impact assessment is added to the debate. It is not surprising then that the enthusiasm for ‘evidence based policy’ and ‘good practice’ at this level has been muted. Such a health impact assessment would have to consider

1. The health impact of macro-economic decisions (or non decisions)
2. The health impact of medium level initiatives to deal with unemployment on a proactive-reactive basis.

Health impact assessment tends to be preferred as a more local tool partly because it is more manageable but also because this limits the degree to which controversial issues are brought in. But the limited results that are available are not encouraging in terms of being able to separate the local from the national and even the international.16
Business Organisations and Good Practice

Before looking at the issue of evidence of good practice in the response of the health services it is worth noting that there is some organisational literature giving rise to good practice recommendations for ‘downsizing’, which take the form of ‘don’t but it you must ...’ (Briner & Reynolds 1999). Critics would argue that such recommendations are based on a degree of wishful thinking and window dressing for policies driven by other motives, rather than real evidence-based practice. These approaches relate to the best way to make people redundant and the best way to avoid survivor syndrome. (Gandolfi 2008)

Redundancy

Here, despite the discussion of good practice, it is argued that ‘evidence around ‘poor practice abounds’ (Baruth & Hind 1999). Obviously a continuing organisation is obliged to meet the minimum legal requirements, though sanctions are limited if they do not and not least in the UK where the regulatory framework regarding redundancy is looser. 17 Figure 7.1 sets out the minimum legal requirements for redundancy in a continuing firm and good practice measures suggested in the human resource argument literature.

Figure 7.1 Legal Minimum of Redundancy

Redundancy situation

<table>
<thead>
<tr>
<th>Redundancy situation</th>
<th>Consultation</th>
<th>Employment Tribunal</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;20</td>
<td>TU or employee reps</td>
<td>Protective Award</td>
</tr>
<tr>
<td>20-99</td>
<td>1. ways to avoid</td>
<td>Unfair dismissal</td>
</tr>
<tr>
<td>&gt;100</td>
<td>2. agreed procedures</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Information</td>
<td>Employment Tribunal</td>
</tr>
<tr>
<td>&gt;100</td>
<td>1. Reasons</td>
<td>Protective Award</td>
</tr>
<tr>
<td></td>
<td>Numbers</td>
<td></td>
</tr>
<tr>
<td>Good time</td>
<td>2. Selection procedures</td>
<td>Unfair dismissal</td>
</tr>
<tr>
<td>&gt;100</td>
<td>3. Method</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Calculation redundancy payments</td>
<td></td>
</tr>
<tr>
<td>20-99</td>
<td>Information</td>
<td>Employment Tribunal</td>
</tr>
<tr>
<td>30</td>
<td>1. Reasons</td>
<td>Protective Award</td>
</tr>
<tr>
<td>days</td>
<td>Numbers</td>
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<tr>
<td>20-99</td>
<td>2. Selection procedures</td>
<td>Unfair dismissal</td>
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<td>Calculation redundancy payments</td>
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<td>1. Reasons</td>
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<td></td>
<td>Selection procedures</td>
<td>Unfair dismissal</td>
</tr>
<tr>
<td></td>
<td>Method</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Calculation redundancy payments</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Employment Tribunal</td>
<td>Protective Award</td>
</tr>
<tr>
<td></td>
<td>Unfair dismissal</td>
<td></td>
</tr>
</tbody>
</table>

Select Criteria

- People making selection must have right skills

Confirm Redundancy

Reasonable time off for job search

Redundancy pay
Survivor Syndrome

It might be argued that firms have more of a self-interest in following good practice here since survivor syndrome can affect the success of any restructuring. Moreover, although no case has gone before the courts, there is a view that a failure to offer support might be grounds for legal action on a statutory employer breach of the duty of care under UK law (Davies, 2008).

Again, however, arguments about good practice here are often speculative and whatever the views of ‘HR’ about how to proceed they may be sidelined by actions dictated on other terms. Organisations which use redundancy as a matter of short term policy are not well placed to deal with survivors and denial may end up intensifying the problem through claiming that ‘it is business as usual’ and that ‘all is well’ when it is not. In this situation, as Curtin put it, ‘in a spectacular display of faux loyalty to the organisation, managers (who may be suffering from survivor syndrome themselves) end up looking like Mafioso’ (Curtin 1996). It might be argued that positive survivor programmes etc only increases the ease with which remaining staff may leave but this may be a necessary price to pay in order to mitigate wider survivor effects (Trevor and Nyberg 2008).

Figure 8.2, however, sets out the standard approach in the limited literature on what might constitute good practice.
Figure 8.2 Typical HR View Best Practice of Organisation/ Management Handling of Redundancies

<table>
<thead>
<tr>
<th>Redundancy</th>
<th>Alternatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use Redundancy as ‘the last resort’</td>
<td>Cost cuts</td>
</tr>
<tr>
<td></td>
<td>Early Retirement</td>
</tr>
<tr>
<td></td>
<td>Wastage and recruitment freeze</td>
</tr>
<tr>
<td></td>
<td>Job share</td>
</tr>
<tr>
<td></td>
<td>VR</td>
</tr>
<tr>
<td></td>
<td>Wage cuts</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Union involvement</th>
<th>Perspectives</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Credible long term plan Avoid redundancy as a short term fix</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Collective decision</td>
</tr>
<tr>
<td>2. Transparent decision</td>
</tr>
<tr>
<td>3. Identify stakeholders</td>
</tr>
<tr>
<td>4. Training/ support for senior managers</td>
</tr>
<tr>
<td>5. Truthful information</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Announcement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Explain rationale</td>
</tr>
<tr>
<td>2. Be truthful</td>
</tr>
<tr>
<td>3. Be specific e.g. dates</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dismissed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Fair exit package</td>
</tr>
<tr>
<td>2. Job search aid</td>
</tr>
<tr>
<td>3. Counselling</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Selection ‘open, rigorous and fair’</td>
</tr>
<tr>
<td>2. Speed</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Survivor programme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aftershock effect</td>
</tr>
<tr>
<td>1. Survivor training</td>
</tr>
<tr>
<td>2. Career counselling</td>
</tr>
</tbody>
</table>

**Government and Local Government Policies**

The MG Rover study considered policy issues and recommended two types of response to plant closure. (Bailey et al 2008)

1. Proactive
2. ‘Intelligent’ reactive

**Proactive**

Proactive measures tend to be thought of in terms of ‘supply side’ initiatives to better enable industries and companies to compete and to enable workers to deal with the changing labour market through skill improvement and flexibility. Even in their own terms these policies work best in a stable or growing economy. They are less relevant and likely to be overwhelmed in a strong economic downturn.
When MG Rover closed in 2005 measures were already in place at the level of the regional development agency (AWM) and some local councils. A special task force and funding of some £170 million was made available for various forms of assistance so that it was possible to ‘hit the ground running’. The review of these measures suggested that positive policies should have a triple thrust:

1. encouragement of long term economic diversification
2. support for modern manufacturing, especially at the level of continued education and training for high quality skills
3. use of information and consultation rights ‘to minimise job losses and to avoid complete closure overnight’

Although not without problems the MG Rover experience has been argued to show the value of having in place a ‘permanent capacity’ to foresee and deal with such plant closures on the basis that ‘it is unlikely that a future closure would happen without at least some prior warning’ (Bailey et al 2008). Unfortunately, within the next months of this case being made large scale redundancies were announced with little warning in a number of key sectors.

Crisis Management and Intelligent Reactive Policy

This suggests that much of the burden will fall on reactive services. Here the argument is the need to combine a universal baseline set of policies, and not least speedy registration into the unemployment system, with tailored approaches to help the unemployed find work and to limit labour market polarisation. Even in good times though, the unemployed report limited help from formal employment services. Less than 40% of the MG Rover group found this support useful and most, as we noted earlier, got jobs using their own contacts and networks.

A number of forms of tailored support were identified as being positive though there was evidence that, despite the high profile of support initiatives, their availability was not as widely known about as might have been expected. Measures that it is argued should be developed on the basis of this experience include:

1. Specific immediate help to locate similar jobs and assist in mobility e.g. transport costs
2. Training and educational opportunities, especially in relation to ‘transformational assistance’ for those who cannot step sideways.
3. Support to enable mobility, physical and transport
4. Counselling in relation to finance and debt issues
5. Support to help partners of the unemployed, including training opportunities—this aspect has hardly been developed at all.

Longer Term General Area Policies and Good Practice

One of the most important issues here has been the health impact of area based initiatives of community regeneration. Making a direct impact on health has not been the main stated purpose of such initiatives but big claims for their potential impact have been made. But Thompson et al 2006 note that little evidence is available of a health impact assessment. Their review of the few studies that have been made of
urban regeneration and health suggest that at best the effect has been ‘small and positive but adverse impacts have occurred’. They also suggest that it is difficult to see an effect size different from national trends. This again points back to the issue of the level at which intervention can be appropriate.

**Health Service Response and Good Practice**

By contrast with the literature on unemployment and health there is limited literature on how the health care system can best react. This was noted in an Australian survey in 1998 although some progress has been made since as noted in section 1 earlier. Casual evidence, however, suggests that there is bad practice at all levels – for example, the indifference at the level of state policy is manifest lower down and may lead to the unemployed being treated prejudicially as when drugs may be overprescribed in general practice to this group as a ‘quick fix’ (Harris et al 1998).

<table>
<thead>
<tr>
<th>Advocacy Health and Employment Security to State and Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) for individual e.g. benefit claims, debt negotiation</td>
</tr>
<tr>
<td>(2) for group - against stigmatisation e.g. scrounging, lazy, workshy</td>
</tr>
<tr>
<td>(3) to argue for good jobs for all</td>
</tr>
</tbody>
</table>

| Identify /record Own family employment status               |
| Physical / Mental health                                    |
| Assess                                                      |
| Risk Factors Assessment                                     |
| Manage – including education. Recognise financial constraints |
| Life style support                                           |
| Referral                                                    |
| Patient capacity strengthening to deal with health-related problems |
| 1. Identify areas of difficulty (e.g. motivation, lack of structured daily routine) |
| 2. Offer support, teach problem solving skills (e.g. how to structure day) |
| 3. Help and support with family and other social problems   |
| Recognition of role of Health Service as an Employer        |

**Figure 8.3 Recommendations for Practice Management**

One way of thinking about a response is set out in figure 8.3 which follows Harris et al 1998 in theorising a base for good practice for general practitioners. They suggest that, whatever the exact scale of unemployment risk, ‘differences in the presenting health problems of unemployed and employed people are not subtle’. The first stage is to recognise that unemployment may be a significant factor and then to assess and
manage it in the light of the risk factors. Management also has to be undertaken in association with other health service and community workers focusing on mitigating the immediate effects of unemployment and ensuring that ill health does not develop to such an extent that it becomes a barrier to a return to work. What the detailed content of this may involve, however, remains as with the debate on CBT.  

**Community Intervention**

Community intervention too is caught up in contradictions. Radical approaches see community intervention – e.g. youth work, community psychology etc as part of a politicised process which should aim to restore some of the lost power and agency of the unemployed by working closely with them from the bottom up. But much of this work takes a top down form where the presumption is that resources and knowledge exist to be given out – an approach that is said to lead to further alienation and passive processing. Work in the community may not be work with the community.

**Health Service and Good Practice as an Employer**

Harris et al 1998 also argue that health service concerns need to go beyond simple reaction and management back to work when opportunities arise. This is not the place to discuss in any detail the role of the health service as an employer. But it must be noted that the NHS still claims to be the largest employer in Europe and therefore its own policies are important in themselves and as a model for other organisations. Yet redundancy is not unknown in the NHS as a management tool, nor is all NHS work good work – indeed some jobs fall, into the category of ‘precarious work’. There may therefore be an obvious contradiction if a health service is seen to argue for a policy to be guided by a concern with health impacts but does not ensure that its own policies reflect this.

**Health advocacy**

The final issue noted by Harris et al 1998 can serve as a conclusion to this survey. This is the need for health advocacy in general and specific health advocacy from professionals in terms of national employment policy making. This report has surveyed the literature which does show a significant link between unemployment, mortality and forms of ill health, but it has also shown that the efficacy lower level responses is necessarily constrained. Health service professionals have to be seen to argue for more jobs, indeed jobs for all, but this has to be more than a demand for any jobs. A decent work-life relationship based on good quality work is a basic human need and without it, health problems will continue.

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1 For the link between publication rates and the level of unemployment see Hammarström & Janlert 2005 generally and Dooley 2003 for psychology literature.
This has important implications for this review, namely that the unemployment rate at any one moment may not be the best indicator of the challenge that unemployment presents to health.

Good jobs have been defined in terms of 8 characteristics – (1) autonomy and task discretion; (2) control; (3) lack of monotony; (4) appropriate use of skills; (5) balance between reward and effort; (6) fairness; (7) Support; (8) opportunity for development and progression. (Fauth et al 2008)

The US government attempts to measure displaced workers based on more specific definitions.

This is linked to the new work undertaken, the loss of trade union premiums in pay bargaining since new work tends to be less unionised, the loss of seniority pay etc.

This means that cross sectional studies will give different results about the role of selection depending on their context.

The income replacement level of state benefits is notoriously difficult to calculate in a single index. Eligibility varies, so does length of entitlement, availability of different benefits e.g. housing benefits, part time working, number of dependents etc. The normal way to compare benefit levels is to compare hypothetical individuals. See Scruggs & Allen 2006; Scruggs 2006.

The psychological contract has been typically defined as ‘the unspoken promise, not present in the small print of the employment contract, of what the employer gives and what the employee gives in return’. (Baruch and Hinds, 1999 299)

Catalano 1991 discusses possible ‘decision rules’ to establish how significant a linkage might be. Unemployment might double the odds of reporting a health symptom, for example. This is a significant effect but smoking increases the odds of getting lung cancer by 20-30 times.

This is a waste of people’s lives. It is also costing a lot of money. For depression and anxiety make it difficult or impossible to work, and drive people onto Incapacity Benefits. We now have a million people on Incapacity Benefits because of mental illness – more than the total number of unemployed people receiving unemployment benefits. At one time unemployment was our biggest social problem, but we have done a lot to reduce it. So mental illness is now the biggest problem, and we know what to do about it. It is time to use that knowledge. (CER, 2006)

The CER report suggests that ‘at least half of … [the chronically depressed] … could be cured at a cost of no more than £750’ per head.

Fryer suggests that too much research and intervention on unemployment and ill health involves ‘passive processing’ which adds to disempowerment, treating the mental states and behaviour of the unemployed as ‘problems’ rather than focusing
on collective strength and resources. Fryer’s community based action research with
the unemployed leads him to question the appropriateness of questionnaire type
studies; the preference for arguments about the latent impact of unemployment on
status as against income issues; and the failure to respond to the realities of life for
the unemployed. A powerful example here is the role of working on the side in the
black economy. Viewed from the top down this is an example of benefit fraud
which as citizens (and in some instances representatives of authority) we are asked
to deplore and report. Viewed from the bottom up this is more widespread than may
be imagined and significant not only in income terms but more importantly as a
measure of status and self-respect and pride. Support mechanisms which engage
with the unemployed at a tangent to the real texture of their life are therefore at best
irrelevant and at worst ‘part of the problem rather than the solution’. (Fryer 1999)

13 Although a firm can immediately save on its wage bill and overhead costs, there are
redundancy package costs and new recruitment costs to set against this. It is often
claimed that the use of redundancy has been driven by financial metrics and the
share price but that there is no systematic evidence that the rate of return on equity,
sales to total assets, etc improves.

14 If we distinguish between the ‘main’ and ‘secondary’ or no-income we can
analyse partner relations in terms of male-female; female-male and same sex.

15 Pierre Bourdieu defined social capital as ‘the aggregate of the actual and potential
resources which are linked to possession of a durable network of more or less
institutionalised relationships of mutual acquaintance and recognition’. But there is
no single accepted definition.

16 While in theory health impact assessment might be applied to ‘virtually any area of
public policy’ (Lock 2000) Davenport et al 2006 note its limited and uneven
impact. Employment policy does not figure in their listing of areas subject to an
HIA. Some simple toolkits are being designed for lower level HIAs but data
sources, methods and weightings remain problematic. The policy role of an HIA is
an even more fraught issue. Thomson’s 2008 evaluation suggests that earlier hopes
for HIAs are not being justified but this may not rule out future limited successes.

17 UK law gives workers fewer rights than in many countries thus reducing
redundancy costs. The MG Rover study suggests that the cost of making a car
worker redundant in France in 2005 was 3 times that in the UK.

18 US approaches tend to focus on encouraging individuals in organisations to adjust
their personalities. A typical discussion distinguishes positive SOBBO survivors
who are ‘staying on but building options’ from HOBBOS ‘hanging on but bummed
out’. The latter are said to be characterised by being passive, reactive, and
resistant and having feelings of anxiety, victimisation and lack of commitment. The
aim of counselling, mentoring and even therapy, should therefore be to encourage
these individuals to become realist, proactive, self managing and development
minded in terms of their own futures. (Kaye 1999). This approach can also be
found in some UK literature which emphasises employee responsibility over
employer responsibility. (Baruch & Hind, 1999)
Harris et al suggest the following general strategies to prevent or reduce the health impact of unemployment

- Providing accessible, appropriate and high quality preventive care and management of health problems in unemployed people;
- Developing the skills and capacity of the healthcare system to address these issues;
- Working with other agencies to reduce the impact of unemployment on health and increase the chances for unemployed people finding work;
- Acting as advocates for people who are unemployed to government and the wider community;
- Continuing to research the impact of unemployment on health and to evaluate interventions; and
- Providing training, work experience and jobs within the healthcare system for people who are unemployed.

Community psychologists aim to work in a collaborative way with people to shift the balance of power in their direction believing that disadvantaged people frequently have the expertise and insight relevant to prevention and reduction of mental health problems in their own community’. (Fryer & Fagan 2003)

Prioritising market values in the public sector is clearly problematic in these terms and can be argued to have been shown to systematically prejudice employees, patients and citizens. Health targets that are designed to mimic the market rather than substitute for it, then intensify these problems. See Rustin 2007.
References


Kaye, B (1999), 'The Kept on workforce’, Training and Development, March


