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UNEMPLOYMENT, HEALTH AND HEALTH SERVICES IN GERMAN-SPEAKING COUNTRIES

DETLEF SCHWEFEL
Gesellschaft für Strahlen-lund Umweltforschung m.b.H., München, Federal Republic of Germany

Abstract—The links between unemployment and health are manifold: The links between unemployment and health are manifold: *Employment may lead to illness*: health problems (that may lead to unemployment) often result from unfavourable working conditions of the (previous) employment. Another factor is job insecurity: feat to lose a job increases the incidence of disease, and this applies not only to people who are emotionally unstable. *Illness may lead to unemployment*: in many cases, unemployment is caused by previous health impairments, which, to a considerable extent, also explain the duration of unemployment. *Unemployment may lead to illness*: there is evidence that unemployment not only reinforces existing physical disease but also acts as a risk factor for new ones. This seems particularly true for problem groups such as the unemployed elderly as well as for infants and children of unemployed people. The relations between unemployment and mental health are strong, mainly in terms of depression and alcoholism. *Unemployment may lead to health*: short-time work and short-term unemployment may improve health by reducing previous stress, caused by employment or by an overload with social roles. Even in the case of long-term unemployment there are som positive health effects as long as a minimum of social security and alternative social roles are available and useful activities—minor agricultural jobs, illicit work—can be carried out.

The links between unemployment, work and society can considerably be loosened by a number of social factors and personal characteristics of the people affected.

Existing health services are not in a position to deal with disease stemming from employment or unemployment except through symptomatical and curative therapies. In addition to general medical care, which is guaranteed by the German health insurance system for the unemployed, too, therapeutical measures are especially important in cases of depression and alcoholism. As a rule, the medical profession has no knowledge of the links between health, work and unemployment; such knowledge, however, would facilitate prevention. Individual prevention and rehabilitation measures are of great importance to problem groups suffering from cumulative or indirect unemployment, i.e. to unemployed elderly as well as to children of unemployed parents. Since the unemployed tend to isolate themselves, extramural services are useful. Specific services for the unemployed only are certainly not as helpful as multi-functional social services, such as those being already rendered by some self-help organizations, churches and trade-unions. An anticyclical extension of these services is required; the existing health system may support them with professional expertise. The most cost–effective prevention of negative effects, side-effects and after-effects of unemployment and overwork comprises a 'fair' social organization of work as well as a socially 'just' distribution of the costs and benefits of work load and working time.

For more than a decade, partly as a consequence of the economic crises since the early 1970s, social science research has increasingly tried to examine the links between unemployment and health. In the beginning, it was mainly research from the US.A.—like the econometrical or epidemiological approaches of Brenner [1, pp. 27–80] and Kasl [1, pp. 338–370]—that helped to get research on this subject started in Europe. Gradually, however, various European regions developed their own approaches and research preferences in this area. Particularly in Britain, where the pressure of unemployment were strongly felt earlier on, research on unemployment had a head-start and, thanks to the wide-spread knowledge of English, it quickly received attention in many parts of Europe. In addition, there were several studies from Scandinavian and Iberian countries. Characteristic of this research is the very broad spectrum of approaches and methods it comprises. A host of academic disciplines participated in this collective endeavour: not only epidemiologists, sociologists but also economists, psychologists, psychiatrists, physicians and historians. Most studies examine the effects of unemployment on health, i.e. on physical, mental and social well-being. Topics such as the influence of health or illness on the occurrence and duration of unemployment or the fear of employed people to lose their jobs and its effects on their health status have so far been of minor interest only.

The purpose of this report is to review the recent research, conducted in German-speaking countries, on a large subject—unemployment and health—and the various methods to approach it.

UNEMPLOYMENT

In the Federal Republic of Germany, persons who are seeking work and are registered at the labour office, are officially classified as unemployed under the condition that

(a) they are not unable to work due to illness,
(b) they are not working, or working only to a

minor extent, as employees, homeworkers, family aids or self-employed, and
(c) they are not trying to get only a minor job or a job at a specified enterprise or a job as homeworkers (except those receiving unemployment benefits), or that they seek a job for not more than three months [2, p. 282].

The concept of long-term unemployment is not clearly defined. In some studies, long-term unemployment is assumed in cases where an unemployed is (still or again) jobless one year after his/her first interview with the researcher; this concept may disguise 'hidden' long-term unemployment as several short-term jobs could well have been held in the meantime. For some unemployed, continuing and renewed phases of unemployment may add up to an extremely long duration of unemployment overall [3, p. VII].

The official unemployment statistics do not include:

young people not registered as unemployed at the labour office,
women who have taken the role of housewives after having resigned from work,
those who, after qualifying for unemployment benefits, were declared incapable to work and now receive social welfare,
unemployed who work in schemes for job creation and rehabilitation measures,
institutionalized people,
vagrant people [4, p. 3].

'Disguised' unemployment is said to add up to an amount that equals about one-half of the official unemployment figure; so some sources estimate that in the Federal Republic of Germany today's actual unemployment rate is at about 15% [5, p. 9].

Major deviations from a traditional pattern of work—8 hours a day, 5 days a week, regular vacations—and from a three-phase life pattern—education, work, retirement—as well as from a socially determined definition of potential labour force' may be labeled as relative unemployment. This leads to highly relative definitions of unemployment. Seasonal work, underemployment, short-time work, long-term sick-leave, early disablement on the one hand, illicit work, additional (agricultural) activities and 'alternative' patterns of work, etc. on the other, demonstrate how unclear the limits between employment and unemployment are.

This unclarity often leads to an underestimation, sometimes to an overestimation, of the number of unemployed; in any case the real number is unknown. But there seem to be little doubt that since the employment crisis in 1974, and in spite of a reduction of foreign workers and the resulting relief of the German labour market [6, p. 226],

12.5 million Germans (or every third employed German) were hit by unemployment, and
the total length of unemployment accumulated to about one year per unemployed, and each phase of unemployment lasted, on an average, for about 19 weeks [7, p. 276].

Thus, unemployment is no longer a problem of fringe groups. Estimates put the figure of the unemployed in the Federal Republic of Germany to about 3.6 million in 1985 [5, p. 7] and predict 6 million for the nineties [8, p. 166].

Since the first oil crisis and the recession of 1974/1975, the traditional objective of full employment has apparently become Utopian. There seems to be a crisis of the labour society [5], a growing powerlessness of the labour force [8] as well a 'legitimation crisis' of the state [9, p. 3]. Although clear differences between the unemployment in the 1930s and the 1980s well exist [10, p. 62 *et seq.*], some authors speak of a new poverty and of a considerable change in the social climate [11, p. 50].

Although unemployment today is large-scale and obviously has a lot of causes beyond the control of individuals, it is still seen even by some unemployed themselves as the effect of insufficient individual adaptation and is labeled a psychological or even psychiatrical problem [8, p. 143 *et seq.*]. It is often attributed to characteristics of problem groups, or to an individual inability to compromise, or to other traits of personality [9, p. 9 *et seq.*]. Unemployment is therefore not only an 'objective' societal problem but also a 'subjective' individual one that creates a host of secondary effects.

RESEARCH ON UNEMPLOYMENT AND HEALTH

The purpose of the following section presents the main characteristics of major empirical studies on unemployment and health in German-speaking countries, including the Federal Republic of Germany, Austria and Switzerland, yet excluding the German Democratic Republic.

Studies

The first wave of German social science research on unemployment and health started in the 1930s, i.e. years after the peaks of unemployment during the Republic of Weimar. A second wave followed in the years 1976/1977, again some time after the new economic crisis had begun. Unemployment research is, it seems, a belated product of slumps [5, p. 19].

One of the first large research projects was carried out around 1950 by Schelsky and dealt with unemployment and occupational problems of youth; a control group was not used (according to [12, p. 34]).

Some of the most important cross-sectional research projects were the following:

ISO-institute (Institute for the Study of Social Chances): Survey of about 1300 unemployed and 1300 employed in North-Rhine Westfalia in 1976 [13–15].

Henkel: survey of 243 unemployed and 267 employed alcohol-dependent patients, in 18 special clinics [16, 17].

Bastiann: survey (1979) of the care personnel for 33 psychiatric patients in inpatient and 44 in (semi)-outpatient care [18].

Vagt: survey of 116 part-time, 509 short-time workers and 60 unemployed in 1978 [19].

Bahnmüller: survey of 89 unemployed and 73 employed men during 1977, focussing on work, identity, social relations, time structure, (personal) assessment of the causes of the situation [20, 21].

Some cross-sectional research projects were extended to longitudinal studies:
Infratest [22–27]:

1977: representative interviews with 1637 unemployed and 1236 reemployed.

1978: 12–14 months after the first sampling, a second interview was carried out with 1125 and 823 persons of the respective groups.

1978: representative study on the attitude of employed persons towards further training and mobility.

1982: last interviews with all three samples [3, 27].

Institute for Labour Market and Occupational Research:

1975: retrospective survey of a representative group of unemployed who had registered at the labour office the year before, including a survey of 1000 unemployed youth [28, 29].

1981: survey of about 8000 unemployed in 25 representatively selected labour offices; personal interviews with about 2800 of them, written interviews with about 2000 others as well as 2500 unemployed under the age of 25 [30].

1983: panel study on 1600 participants of the 1981 survey [31]. Results were compared with a sample of employed people in cities [32].

Wilhelm-Reiss:

Surveys of 272 young people in 1976 and 252 in 1977; 29 unemployed youth participated in both surveys [12].

Frese:

Surveys of unemployed workers over 45 years of age in 1975 an 1977 [33, 34].

Heinemann combined several studies in order to assess the effects of youth unemployment:

Standardized personal interviews with 293 male German youths aged 15–20 as well as 277 employed young people,

content analysis of records of delinquent youths in the years 1973 to 1976,

semi-standardized interviews with employers,

expert meetings and group discussions [35].

Schwefel *et al.* are presently involved in research on unemployment and heatlh at different levels:

inventory of the most current international research and its publication in a newsletter [36–38], application of the MEDIS health indicators to, for example, the longitudinal studies of the Institute for Labour Market and Occupational Research [32].

time series analyses of highly aggregated data on mortality and economic development [39, 40],

'comparisons' between micro- and macrostudies [1, 41–43].

For research on unemployment [44] the following data were also used: routine investigations of the Federal Employment office into the structure of unemployment (since 1973), routine data of the Statutory Sickness Funds including, for example, statistics on insured people, sick-leave, old age pensioners [45–48] as time series from other official statistics [40].

Case studies were used either on an individual basis in a quasi depth psychology manner [49–52] or as community-oriented case studies, e.g. to analyze consequences of plant closures [53, 54].

A survey of privately practising physicians on the health effects of unemployment was undertaken by Thomann [55, 56]. Recently, BOSOFO interviewed other experts on the same subject [57].

In Austria, Strotzka and Leitner were able to carry out a community study during an economic crisis in a small rural industrial town with about 5000 inhabitants [58]. Action research was the core of the so-called Hamborn Project taking care of about 130 unemployed young people [59]. Group discussions (see also [60]) and in-depth interviews with 311 youths were carried out by Burger *et al.* in 1975 [61].

Up to now, German research lacks monographic family studies, community studies, as well as studies on the relation between highly aggregated time series on economic development, unemployment, morbidity and mortality, as were carried out by Brenner [62].

Concepts, data and methods

All these studies deal, directly or indirectly, with the subject of 'unemployment, illness and health'; the concept of health used here includes physical as well as mental health and social well-being.

Many different procedures to assess health status and health impairments are applied. Examples include:

questions as to whether a specific illness is officially acknowledged as a barrier to earning any income or practising any profession [15, p. 158; 63, p. 31; 64, p. 13],

registration of health problems at the labour Office [63, p. 31],

sick-leave certificates issued by physicians [65],

self-assessment of 'subjectively' experienced health status and of chronic impairments [13, p. 300; 66, p. 168],

listing of complaints and diseases during the last 3 months [63, p. 31; 64, p. 13],

open questions on occupation-impeding diseases and handicaps [15, p. 158],

MEDIS-scale of complaints [32; 66, p. 168].

Operationalizations of mental health and of personal characteristics, currently used, are manifold:

MEDIS-scale on emotional balance [32; 66, p. 168],

Zung-scale on depression [67],

Rosenberg-scale on self-esteem [67],

Kaufmann-scale on fatalism [15, p. 45 *et seq.*],

scales (of about 20 or more items) on nervousness, aggressivity, depression, irritation, sociability, relaxedness, domination, inhibition, openness, extraversion, emotional lability and masculinity [12, annex],

statements on the subjective experience of unemployment [15, p. 45 *et seq.*], achievement motivation, expectations of failure [63, p. 28] and anomia [13, p. 301].

individual statements on anxiety in social situations [64, p. 13], occupational orientation [32, p. 379 *et seq.*] and self-esteem [29, p. 76 *et seq.*].

With respect to operationalization of social well-being, single statements or questions regarding time budgets, frequency and quality of social contacts and social relations, are used [68].

Notwithstanding all the problems of registering unemployment correctly [69, p. 172 *et al. seq.*] and despite the misuse of the unemployed status [70, 97 *seq.*], unemployment is usually operationalized by its official registration and by the consequent self-assessment of the interviewee as an unemployed.

As a rule, results are analyzed descriptively; common are phenomenological approaches to interpretation. Items from lists or scales are, in the main, analyzed one by one. Multivariate statistics are as rare as scalographic procedures and time models (but see [12, 13, 44, 71]). Approaches at different levels—micro- vs macrostudies—are underrepresented [1, 41, 42].

Frequent sources of error and bias in study designs and analyses are:

confusion of long-term unemployed with temporarily short-time reemployed when comparing two points of time,

underestimation of unemployment effects in the interview situation,

effects of anticipating unemployment during the first interview (in longitudinal research) or in the control group [2, p. 285 *et seq.*].

When comparing a control group with the unemployed, the fact that unemployed people tend to be younger and proportionally more of female sex than the employed is often overlooked; this may lead to an underestimation of health problems caused by unemployment [64, p. 2].

HEALTH, WORK AND SOCIETY

Causes of unemployment

Except when dealing with illness-induced unemployment, the wider causes of unemployment, and its changing meanings over time [72], will not be dealt with in this report whose main subject are the effect of unemployment. In general, the causes of unemployment may be characterized as a complex problem related to population dynamics, economic crisis and to the transition towards intensive economic growth [5, 8; 73, 75; 76].

Effects of unemployment

When the more recent research on unemployment started off, it first tried to understand the present situation by going back to, and using, the results of former studies on the effects of unemployment. Looking back into history held the promise of helping to generate relevant hypotheses [77, p. 191 *et seq.*]; so, among others, the Marienthal study, the Warsaw study and the Detroit study were reviewed [78, p. 36 *et seq.*].

In the beginning, results of foreign research were prominently adopted which, rather in a cookbook-like manner, emphasized effects of unemployment such as the following:

anticipatory fear, and the shock, of becoming unemployed,

hopelessness, depression, general loss of control, helplessness, anomia, suicide, passivity, resignation, pessimism and reduced self-confidence,

problems in the social sphere, social isolation and matrimonial difficulties,

alcoholism,

psychosomatic disorders: hypertension, high cholesterol level, high values of noradrenaline, or uric acid, and of creatinine in the serum, indisposition and days of reduced activity due to indisposition [2, p. 288 *et seq.*].

The work of Brenner and Kasl and Cobb ranged high on the list of foreign studies that have been dealt with here [1].

Some attempts to systematize the effects of (long-term) unemployment were made, resulting in classifications such as:

Problem groups: directly affected unemployed, indirectly affected family members, people indirectly affected by their fear of job loss [79, p. 223].

Adaption of activities or attitudes to the situation of being unemployed: combining an 'intrinsic/extrinsic dimension' with an 'individualistic/collective dimension' to form four groups of reactions:

intrinsic/individualistic: extreme reaction is suicide,

extrinsic/individualistic: extreme reaction is criminality,

intrinsic/collective: extreme reaction is illegal drug consumption,

extrinsic/collective: extreme reaction is labour disputes [12, p. 67].

Degree of effect intensity: selection according to health status, intensification of existing diseases, and development of new diseases, due to unemployment [32, p. 378].

Theorems and theories

Depending on the sort of problem stated, on profesional socialization, academic discipline and theoretical orientation, some of the following constructs to investigate and understand the links between unemployment and health are preferably used:

Stress: unemployment is considered a stressor; yet, there are arguments against approaches that are too much oriented towards individuals and pathologies as they tend to individualize problems [8, p. 160 *et seq.*].

Life-event: arguably, to think of unemployment only as a critical life-event, seems one-sided and too simple; rather, one should look into the processes of psychological adaptation and accomplishment, and thereby take into account two opposite hypotheses: the duration-of-exposition vs the initial-effect hypothesis [80; 81, p. 371 *et seq.*]. Some results of life-event research are also criticized for being correlational only [82, p. 1].

Labeling approach: this approach, chosen to understand the negative consequences of unemployment, builds on the concept of stigma and the processes of stigmatization [12, p. 79 *et seq.*].

Socialization: some authors interpret unemployment as a learning process, an experience of socialization, etc. [83, p. 171 *et seq.*].

Strain models: a coherent and operational concept of strain seems still missing [29, p. 75]. More attention should be given to the multi-factorial ethiology of diseases. Complex models of strain would be neces-

arry in which, for instance, society could be conceived as a 'specific totality' [8, p. 159].

Course models: a sociological analysis of the dynamic process of becoming and being unemployed is advocated for: entering an insecure segment of the labour market, becoming unemployed, situation during unemployment, ending of unemployment and consequences for professional careers [84, p. 63 *et seq.*].

Society: the point is also made that, increasingly, the labour market can no longer be considered the crucial mechanism to distribute opportunities for social participation and life [84, p. 54], and that the meaning of work, social integration and working morale undergo rapid changes [78, p. 21 *et seq.*]. Therefore, a comprehensive analysis of society is required.

Economics: economic essays on unemployment often refer to trade-offs between inflation and unemployment, to problems of equilibrium assumptions and to the theory of voluntary unemployment [85, p. 21 *et seq.*] as well as to theorems on the segmentation of labour markets [86, p. 228 *et seq.*].

Psychology: psychological and psychoanalytical interpretations stress the emotional meaning of job loss in terms of time perspectives and inability to act, of deprivation and 'Trauerarbeit', of identity crises and social stigmatization as well as of confidence and system loyality [78, p. 109].

Neomarxism: some authors visualize unemployment in terms of capitalistic crises, mechanisms of competition, and of disposable alienated labour in highly developed capitalist systems were labour is not distinguished from work or activity. The distinction between labour as a value-in-use and an exchange value has been drawn [5, p. 120].

Relativity: as compard with the situation in developing countries or in Western Europe during the 1930s, the relative meaning of today's unemployment in this region is stressed and put against its absolute meaning in terms of poverty, catastrophic life-events, etc. [71].

Chance: unemployment is also considered to be a new chance of personal development [78, p. 9], a 'creative unemployment' to open up alternative forms of living [87, p. 51 *et seq.*], one step in an individual and lifelong development towards a change in lifestyle [6, p. 220 *et seq.*; 88, p. 69 *et seq.*].

In conclusion, a coherent theoretical conception that would help to grasp the topic unemployment and health intellectually is still not available.

The role of work

In order to understand the effects of unemployment, many authors refer to the positive functions of labour and work. Freud regarded work as the strongest link to reality, and the ability to work as a measure for the absence of neurotical disturbances (cf. [89, p. 5]. According to Jahoda, labour and work have five main functions: experience of time, social contacts, participation in collective objectives, status and identity and regular activity [10, p. 70]. According to 'Work in America', the importance of work lies in: social contacts, feeling of competence, sense of usefulness, social frame for self-esteem, individual concept of reality and personal identity (cf. [9, p. 24 *et seq.*]). Work and labour are therefore praised to guarantee income, acceptance, security and utility of life, although—as many polls show—professional roles have been considerably depreciated [5, p. 34], and wage labour seems to have lost a lot of its power [8, p. 175 *et seq.*].

Various sources of strain, heavily destructive for body or mind, are still characteristic of many jobs, especially in the industrial sector [10, p. 74]. 'Learned helplessness' as a consequence of low control over strong stressors are still typical of the work situation of the underprivileged [9, p. 48]. Increased rationalization and even more intensive labour may lead to further health problems [90, p. 117]. The high percentage of ill people among the unemployed is often indicative of the strains sustained during the last job [63, p. 22]. As Büchtemann and von Rosenblat concludes: "Unemployed with health problems suffered in their last jobs more than it is usual from strains such as uncomfortable and rigid posture, dull and uninteresting work, unfavourable weather conditions, increased risk of accidents, noise, polluted air, physically heavy labour as well as shifts and/or on-line production" [63, p. 31]. The determination of the health status by the last occupation is shown in many studies [64, p. 58 *et seq.*]. Psychosomatic complaints of unemployed are frequently caused by jobs held just before [63, p. 31 *et seq.*].

In conclusion, it could well be expected that people, after having worked under very unfavourable conditions, might experience the loss of work as an improvement of their status of health [68, p. 130 *et seq.*]. Classical authors, too, (e.g. Hufeland) suggest that 'unhappy overwork', just like physical passivity and boredom, may reduce life expectancy (cf. 55, p. 205).

Economic recession and health

In a period of mass unemployment and economic recession, both the suffering from work and the suffering from being jobless seem to increase [5, p. 10]. Economic crises do not only hit the unemployed but all people [91, p. 366]—a fact that makes unemployment research all the more difficult.

During the economic crisis with its mass unemployment, the rate of early disablement in the Federal Republic of Germany increased considerably; this was particularly true for psychiatric cases. At the same time, public rehabilitation services were cut down so that the chances of rehabilitation worsened [18, p. 77]. Work (unhealthy working conditions, selection of the less healthy) seems to be the main factor for the increase in early disablement [92, p. 559]. It is mainly the blue-collar female workers and the psychically disabled who are hit by early disability [93, p. 83; 94, p. 92 *et seq.*]. Cardio-vascular diseases, diseases of the musculo-skeleton system and the connective tissue as well as neoplasms are major causes [92, p. 555]. While the rate of early disablement increases, the age of entry into early disablement decreases [92, p. 552].

Officially registered illnesses usually decrease in economic crises; insecurity of job seems to lower the number of sick-leaves [95]—hence the argument that people tend to protract their illness out of fear to lose their job [96, p. 2783]. Yet, there is empirical evidence

that, even in times of economic recession, the ill do go to see a doctor, only certificates of illness are not issued to the same extent as before; "recessions lower the number of sick persons, not the number of contacts with physicians" [65, p. 502].

Preiser and Schräder suggests that, during long-term economic crisis, employed people with health problems, and with an above average number of sick-leaves, are prominently forced out of the labour force [47, p. 276]. This is explained by

a reduction of the labour force quota of persons of 55–63 years of age,
an increase in the number of early retirement due to disablement,
an increase in unemployment due to health problems,
an increase in hospital cases and hospital days per retired.

This, however, must be considered a hypothesis as long as some inherent data problems and the influence of the jurisdiction on these interrelations are not satisfactorily coped with [45, p. 226 *et seq.*; 48, p. 234 *et seq.*]. Besides, the sick-leave frequency of the unemployed has the same procyclical variations as that of the employed [45, p. 228]. Nevertheless, up to now, the relation between absenteeism, illness behaviour and unemployment has not been explored sufficiently [97, p. 184 *et seqq.*].

Threatening unemployment—even if only assumed—changes health. Strotzka and Zeitner reports a marked increase in psychogenic diseases during economic crises: "The most interesting finding was that among 30 cases not one was directly hit by dismissal"; "an uncertain threat has stronger pathogenic consequences than the real strain" [58, p. 198 *et seq.*]. Wuggenig found a relationship between increased emotionality and anticipated unemployment [98]. Pelzmann *et al.* conclude: "Among those employed who had reason to worry about their jobs, we observed a significant increase in so-called dispositional diseases during the phase of their anticipating unemployment" [99]. Such findings highlight the danger of confounding objective unemployment and subjective handling of (threatening) unemployment in longitudinal] studies on employed and unemployed people [2, p. 285 *et seq.*; 8, p. 156].

In conclusion, complex interrelations exist between unemployment and health

(anticipated) unemployment interferes with health
health interferes with unemployment and employment
employment interferes with health
health effects of (un-)employment may be buffered or increased by socio-economic conditions.

Thus, a review cannot only deal with the topic of unemployment-induced disease; it has to approach the much wider connections between society and economy on the one hand, and physical, mental and social well-being on the other. This is why in the following chapters a distinction is to be made between

the influence of health on unemployment, and
the influence of unemployment on health.

THE INFLUENCE OF HEALTH ON UNEMPLOYMENT

In this section, the influence of (ill) health on unemployment, on its duration and its ending will be dealt with. Here, illness is regarded as one of the determinants, not as an effect of unemployment.

Illness and the entry into unemployment

Sick persons run a higher risk of becoming unemployed [63, p. 31]. The risk of being sacked increases with the frequency and duration of illness [100]. In 1978, every fifth dismissal in private businesses, and every third in industry were due to illness [101]. One study showed that health problems accounted for 56% of all dismissals on personal grounds; 29% of all official explanations of dismissals referred to health problems [21, p. 51]. Several authors report on this link between ill health and dismissal [64, p. 38 *et seq.*; 102, p. 1047; 103, p. 562 *et seq.*]. 11% of those unemployed who had given up their job of their own will mentioned health problems [103, p. 563].

Illness is one determinant of unemployment. Social selection processes are at work; people with health problems are pressured out of the labour market [84, p. 63. *et seq.*; p. 111; 101, p. 226]. "In most cases, ill health was the main reason for terminating the last job" [101, p. 225 *et seq.*]. One-third of unemployed men—but only one-quarter of the women—indicated that their present illness was caused by their previous jobs [15, p. 159].

Selection processes especially hit foreign workers, blue-collar workers in extremely strenous jobs as well as women [104]. In particular, elderly and disabled people run this risk [90, p. 112] *et seq.*]. The unemployment rate of the heavily disabled was twice the total unemployment rate in September 1979 [105]. Thomann reports a "weeding of the weakest from the labour process" [96, p. 2783].

Illness and the duration of unemployment

Persons with health problems run a very high risk of continued unemployment [63, p. 31]; their unemployment lasts three times as long as that of the healthy unemployed [64, p. 41 *et seq.*]. In addition, of all unemployed people the share of those who have health problems increases [63, p. 32].

A contrast group analysis to 'explain' the duration of unemployment by health impairments shows a variance reduction of 9.3% in the first analysis step; health problems rank as the first of the 27 variables to explain the duration of unemployment [44, p. 275; 106, p. 182]. Moreover, health status tends to deteriorate during unemployment [107]. Health problems play an even more important role during unemployment than at the beginning of it [32, p. 379].

Illness and reintegration of the unemployed

According to employers, health problems are not the biggest obstacle to the reintegration of unemployed; more important were qualification, reliability, the number of previous jobs [64, p. 49]. By way of contrast, employment offices give health problems as the prime factor of the refusal of unemployed job applicants [63, p. 32; 84, p. 80 *et seq.*]. Routine

data anlyses of the Federal Employment Office show that every third unemployed suffered from health problems in September 1980, and that for every fifth person the chances of getting a job were considered low because of his/her health problems [101, p. 226]. "The occupational reintegration of unemployed with health problems is primarily thwarted by the increasingly severe selection criteria applied by the enterprises" [101, p. 225]. Nevertheless, the main determinant of occupational reintegration is the situation of the labour market [30, p.413].

According to an analysis of the determinants of continuing unemployment, health problems explained 3.19% of variance; civil status, sex, payment of financial benefits by the Federal Employment Office, occupational status of the spouse and duration of unemployment explained more of the variance [106, p. 187]. Next to age and duration of unemployment as explanatory variables for the re-integration into the work force, health problems rank third with a variance reduction of 1.64% (106, p. 187]. Because of strains at the new job, occupational reintegration does, however, not lead directly to a marked improvement of health status [63, p. 34].

"In most cases, occupational reintegration of unemployed with health problems to professional degradation and dequalification, but generally also to a diminished strain at the job as compared with the time before unemployment" [101, p. 225 *et seq.*]. "Unemployed with health problems . . . have, more frequently than others, to accept changes in occupation, professional degradation and dequalification" [84, p. 85 *et seq.*]; they have to accept jobs at a lower level, change of occupation and of industry, and a decreasing income [64, p. 50 *et seq.*]. A typical result is the destabilization of the professional career [84, p. 87].

"People with unstable reintegration patterns (show) a significant deterioration of health when compared with long-term unemployed" [63]. Such instability is not rare. Specific measures to increase job perspectives of the unemployed are often interrupted; 32% of people withdrawing from those programmes mention health problems [108, p. 428].

Unemployment is often brought to an end by retreat into other social roles: the role of the ill, the retired, the housewife [84, p. 84; 109, p. 120 *et seq.*; 110, p. 33].

THE INFLUENCE OF UNEMPLOYMENT ON HEALTH

This section will deal with the influences of unemployment on health. Although it is not contended that unemployment by itself causes illness, some evidence or plausibilities will be shown which suggest a sort of quasi-causality that exists in this relationship. At any rate, a lot of physical, mental and social effects of unemployment will be present.

It is an indisputable fact that a high proportion of the unemployed is burdened with health problems. In 1979/1980 when about one-third of the male unemployed was affected by illness, this percentage was higher than in 1982 (21% only); yet, this figure is expected to increase in the future [32, p. 378]. The crucial question is whether those unemployed had been ill before, or fell ill during, unemployment.

Intervening factors

There is no single form of unemployment nor of health. Individual attitudes and social conditions lead to a lot of different reactions towards unemployment.

Thomann gives the following list of factors which are assumed to increase illness connected with unemployment:

previous health status,
financial situation of the unemployed,
duration of unemployment,
additional strains (e.g. family problems),
social or family support,
position of the unemployed in society,
values, ideals and social norms,
socially accepted possibilities of conflict management,
class-consciousness of the unemployed,
importance of work in the life of the unemployed,
age of the unemployed,
general level of education and occupational qualification of the unemployed,
previous jobs,
existence of a health insurance for the unemployed,
psychic structure of the unemployed [55, p. 196 *et seq.*].

In addition to this almost complete list of factors possibly influencing the state of health of the unemployed, other studies on unemployment and health mention the following factors alleviating or reinforcing illness connected with unemployment:

Long-term unemployment seems to have effects mostly on those people who spent their time inactively. Running a smallholding, moonlighting and stopgap activities—with or without payment—prove to be a protection against some effects of unemployment [99].

The effects of unemployment are less negative when other roles can be adopted: the role of a housewife or a retired [26, p. 66 *et seq.*; 29, p. 85 *et seq.*; 63; p. 33]. Persons who had to retire early did not show to be more depressive than employed people [110, p. 33].

Status—whether as a (once more) unemployed or a housewife or a retired—is a more important predictor of psycho-social and psychosomatic strain than is duration of unemployment [63, p. 22]. "The subjective health status of unemployed is less impaired by long-term unemployment and steady job-seeking than by their status and the behavioural requirements related with it" [101, p. 225 *et seq.*].

Social support eases the psychological burden of unemployment on women [111]. Support of the spouse alleviates the effects of unemployment [112, p. 44 *et seq.*]. A favourable family situation has a protective effect [12]. Social support is experienced as moderating the impact of unemployment [78, p. 10].

"The public system of unemployment insurance and of social welfare (still) prevents unemployment from having a full impact on the individual existence" [113, p. 11]. The same is true for health insurance.

The effects of unemployment are less incisive when unemployment is seen collectively as a wide-spread

reality (as for example in the case of plant closures) or is experienced as a mass phenomenon in the neighbourhood [35, p.9].

Depending on the general meaning of work, or on the specific importance of the last occupation, for the personal identity of the unemployed, the loss of job as a potential stressor varies considerably [5, p. 34; 8, p. 156 *et seq.*; 13, p. 293 *et seq.*; 112, p. 33 *et seq.*].

Unemployment and anticipation of unemployment become greater problems when, after the loss of job, forced passivity is to be expected [114].

Sociability, provided it is a stable trait of character, can act as a buffer against the immediate impacts of unemployment [112, 20].

Many factors contribute to the interrelationship between unemployment and health; by no means is there a unilateral linkage. That is why highly differentiated research on unemployment is necessary.

Unemployment and physical health

The links between unemployment and physical health are relatively unknown. Research approaches are predominantly interpretative; ethiological models have hardly been developed at all [55, p. 199].

From 1975 to 1978, the percentage of unemployed with health problems rose from 20 to 34% [44, p. 264]; early disablement and early retirement also increased during the 1970s [90, p. 113]. However, the overwhelming part of the unemployed cannot be classified as disabled [64, p. 2]. Likewise, in the 1930s, somatic impairments were less than was expected for the unemployed themselves, but had rather affected their children [8, p. 148].

When comparing the unemployed with employed people, twice as many unemployed are affected by health impairments; the rate is: 18% for male and 11% for female unemployed [15, p. 159]. In particular, the unemployed more often suffer from sleep disorders and circulatory ailments, whereas the employed mention headaches and fatigue more frequently [64, p. 29 *et seq.*]. But the unemployed, too, often report nervousness, sleep disorders and tiredness [63]. Main complaints of unemployed males are: colds (21%), circulatory disorders (20%), headaches (18%), spinal disorders (16%), nervousness (15%) and flu (15%); women's complaints range from headaches (34%), circulatory disorders (28%) colds (21%), nervousness (20%), to flu (18,), cough (16%) and spinal disorders (16%) [64, p. 19]. Quite a few of these complaints are by no means specific to the unemployed. 21% of the interviewed unemployed were not suffering from any complaints or diseases during the three previous months; those who reported any complaints had about four complaints on an average; employed people reported more complaints than others [64, pp. 19, 29]. Predominantly, the health status of the unemployed remained the same as compared to when they were employed; for 21% of them, the health status even improved after becoming unemployed (especially when their previous work had been very strenous), in the case of 24% it deteriorated [13, p. 301; see also 3]. Case studies on plant closures (no control-group) report of nervousness, aggressivity, sleeplessness and gastric pains [54, p. 75]. At the level of highly aggregated health indicators such as general and infant mortality rate, significant relationships could only be shown between unemployment and the infant, but not with general, mortality rate [40, p. 113 *et seq.*].

The interaction between sympatic and parasympatic leads Müller-Limmroth to assume that a reduction of activities by unemployment negatively affects the activity regulation through the vegetative nervous system. The result of unemployment could be that there are no marked phases of activity and recreation which, in turn, could lead to vegetative dystonia with symptoms like nervous heart complaints, circulatory instability, nervous gastric disorders, sleep disorders, cold sweat, etc. [9, p. 50]. "By causing financial, social and occupational problems, unemployment works as a psychical and social stress-factor which, physiologically, produces an increased level of activation by means of hormonal control, with no change of simultaneous motoric release. If such a situation persists, increased arteriosclerosis, fatigue and digestive disorders might follow" [9, p. 50 *et seq.*]. Moreover, stress increases blood sugar, blood lipids and hyperacidity resulting in diabetes, arteriosclerosis, circulatory disorder and myocardial infarction as well as gastric and duodenal ulcers [115, p. 671 *et seq.*]. Pflanz also found a higher probability of ulcer incidence in the unemployed (in [55, p. 220]). Effects of unemployment in terms of 'ACTH-hormone' production are mentioned by Thomann [96, p. 2777] who, however, points out that unemployment is an unspecific burden; pathological effects are to be expected at the weakest point—"there is no specific unemployment disease" [55, p. 196]. A generally higher morbidity is much more probable than specific diseases of unemployed [55, p. 209]. Unemployment is only an external stimulus for the manifestation of diseases or for the intensification of previously existing but latent disease [63, p. 32].

During the first 3 months of unemployment, recovery outpaces effects of strain; the health status of the unemployed equals that of the employed, in special groups (e.g. young women) it is even better [32, p. 383; 99]. Similar results are reported from Austria: "During the first four months of unemployment, diseases decreased and were about as frequent as in times of job security" [99]. A 'recuperation and recovery factor of unemployment' is also reported by Brödel *et al.* [116].

The effects on health of long-term unemployment are not totally clear. Brinkmann reports a deterioration in all the indicators of the MEDIS-complaint scale (with marked effects on mental health) in cases of long-term unemployment. His panel survey with unemployed quite strongly indicates that unemployment leads to a deterioration of health: 30–40% of the diseases of long-term unemployed result from changes in health status during unemployment; the rest is said to be a structural effect of selection processes; so, long-term unemployment worsens existing diseases or causes new ones [66, p. 170]. Cross-sectional data of Fröhlich also seem to indicate a deterioration of the health status due to long-term unemployment [13, p. 310]. An Austrian research project shows that long-term unemployed report a worse health status than the re-employed; 18.7% of the unemployed males, as compared to

2.6% of the employed, reported ill health [57, p. 20]. Psychosomatic and cardiovascular problems, in particular, seem to increase during long-term unemployment [66, p. 170; 107]. An Infratest study, however, found out that the health status of long-term unemployed, though worse than that of short-term unemployed and employed, had been similarly bad even before unemployment, implying that afterwards no deterioration took place [64, p. 9 *et seq.*]. According to this source, long-term unemployment does not produce a bad health status [64, p. 45]. It is also said that persistent unemployment has no direct impact on the subjective health status [63, p. 32]. These results strongly contradict the following statement: "In the long run, the burden of unemployment leads, for a considerable part of the affected, to the development or promotion or deterioration of a mental or physical disease" [96, p. 2774].

A strong link can be found between age, health and unemployment [90, p. 115]. Occupational ability and health decrease with the age of the unemployed [64, p. 22]. In the case of unqualified blue-collar workers—despite their release from poor working conditions—health deteriorates very significantly during unemployment; their rate is at 29.1% as compared to an average of 24.3% for all unemployed men whose health status deteriorated during unemployment [68, p. 133 *et seq.*]. The level of deterioration of physical health status increases with mounting economic deprivation [13, p. 308].

"Among patients in institutions for consultation, therapy and rehabilitation, a marked increase in dependence on alcohol can be found since mass-unemployment started in 1974. Today, about 50–70% of all alcoholics in inpatient care are unemployed" [16, p. 2]. So far, very few studies deal with the realtionship between unemployment and alcoholism, although unemployment may well be considered a psychosocial risk factor of alcoholism [16, p. 1 *et seq.*; 117]. A study of Henkel shows that unemployment increases the risk of alcoholism and, in the case of addicts, reinforces their problem. According to the Trier-Alcoholism-Test, unemployed and employed differ quite significantly in the form and severity of alcoholism [16, p. 3 *et seq.*]. Owing to financial problems, unemployed alcoholics tend to favour strong drinks; there is also an increase in the consumption of substitutional tranquillizers and sleeping drugs. As Henkel demonstrated, intensified and extended forms of alcoholism are rather a consequence of unemployment than a symptom of selective filter-processes [16, p. 4 *et seq.*]. Somatic secondary effects of alcoholism might as well increase [17, p. 10). Given unemployment after discharge from a clinic, relapses into alcoholism increase dramatically and occur earlier in people who are not in a stable work situation [17, p. 9). Unemployment seems to lead to a higher probability of relapses, but the empirical results are not totally convincing [118].

Unemployment and mental health

Research on mental health of the unemployed has used different constructs and produced divergent results [8, p. 154]. In comparison with the situation of 1930s, the impact of unemployment today seems to be more of a psychological nature [119, p. 179], a fact apparently entails some problems for research [120, p. 93 *et seq.*].

A higher degree of nervousness and depressiveness and a lower degree of conviviality than in the population at large have been found among the unemployed by Wilhelm-Reiss [57, p. 13]. The results of Gnengel/Mohr, admittedly achieved without using any controls, suggest a high share of depression, aggressivity and sleep disorders [57, p. 13]. Henkel reports of psycho-social changes during unemployment in 30–50% of the unemployed, especially in terms of growing worries about the future, nervousness, sleep disorders, depression and helplessness, and even suicidal tendencies among 30% of unemployed (alcoholic) patients as compared to 3% of employed ones [16, p. 3]. "None of the patients related their complaints, which were subjectively experienced as purely physical ones, to the conomic crisis" [58, p. 198].

For Müller, the self-esteem of unemployed is being imperiled by the underutilization of personal capabilities, causing long-term physiological reactions [9, p. 51 *et seq.*]. An awareness of general powerlessness has been shown by the work of Bahnmüller [21, p. 190]. According to Fröhlich, there is a correlation relationship between the state of health and the feeling of worthlessness [68, p. 143].

Fröhlich also shows that 38% of the unemployed have low anomia, 35% middle anomia and 27% a high degree of anomia [13, p. 301]. Bahnmüller links frustration and self-attribution of the blame with unemployment [21, p. 116 *et seq.*]. But, according to Hentschel, employed and unemployed do not differ significantly on a fatalism-scale [29, p. 99].

Wacker presupposes a relationship between unemployment and aggressivity, caused by emotional blocking, transfers into irrationality, self-hate and self-defence mechanisms [91, p. 369 *et seq.*].

Lauterbach points to the feeling of the unemployed not to be able to control negative life events [82, p.4]. Self-stigmatization has also been reported as a way to personally deal with unemployment [121, 122].

Comparing employed and unemployed, Infratest finds a lower achievement motivation and a higher expectation of failure among the latter [64, p. 33 *et seq.*]. During unemployment, the achievement motivation increases smoothly [63, p. 28 *et seq.*].

Most evidence has been gathered on the linkage between unemployment and depression. Based on the depression model of Seligmann and his concept of 'learned helplessness', Frese and Mohr are doing particular research on this relationship [119, p. 181]. Their hypotheses are:

unemployment leads to depression
unemployment leads to a subjective feeling of non-control
there is a relationship between non-control and depression [119, p. 183 *et seq.*].

After checking these hypotheses in the existing literature, a longitudinal study (with only a few interviewees, though) showed that unemployment evoked depressive states of health [33, p. 222 *et seq.*; 110, p. 22 *et seq.*; 119, p. 183 *et seq.*], which are "characterized by passivity, resignation, planlessness, apathy, hopelessness, missing self-confidence, feeling

of worthlessness and the like" [34, p. 675]. The average unemployed seems to be in a state of medium-depression, which means that a considerable number of unemployed is very depressive and in need of clinical treatment [34, p. 677; 123, p. 12 *et seq.*]. There is a strong relationship between the financial situation and depression [34, p.677]. Long-term unemployment contributes to depression [34, p. 678]. "Long-term unemployment or renewed unemployed leads to heavy depression in the case of persons who still long to the able to control their future, whereas people who have lost this hope or desire are no longer heavily affected by long-term unemployment or new unemployment" [33, p. 239]. Depression lessens when a new job is found or pension is granted (in [57, p. 12]). Other studies have so far not revealed such trends [8, p. 155]; Balz, using the same Zung-scale on depression, could not find significant differences between unemployed and employed [67].

As depression is one of the main causes of suicide [34, p. 678], an increased suicide rate caused by unemployment should be expected. But John, using macro-data, could not support this theis [39]. Friessem also doubts that there is a linkage between suicide and unemployment [124, p. 56 *et seq.*], while others—rather hypothetically—assume that occupational conflicts (i.e. also unemployment) play an important role, e.g. for male suicidals [125].

A further deterioration, caused by unemployment, of the health status of mentally ill people is reployment, of the health status of mentally ill people is reported by Bastiaan: for 37.2% the disease was protracted, for 30.8%, new psychic problems developed, and for 26.9% the treatment period had to be prolonged. Only in the case of 32.1% of the affected, no additional effects could be found [18, p. 80 *et seq.*]. Work can be a therapy for the mentally ill [18, p. 75].

The emotional health of the unemployed is closely related to their financial problems [34] as well as to their income-oriented attitude towards work [57, p. 8]. In contrast to that, Frölich states that only work attitude is significant factor of psychosocial strain, but not so (as an indicator of economic deprivation) consumer behaviour [13]. Personality variables such as individual strategies of management, ability to activate social support, openness and help—seeking behaviour, help to moderate the effects [126].

To understand the different phases of the emotional affection by unemployment, models are rarely used. However, in its initial phase—as was shown by Brinkmann and Potthoff—unemployment is felt quite strongly as a mental strain in terms of low morale, inner nervousness, and fear of the future. This is particularly true for young unemployed males when compared to an employed control group [32]. According to Strotzka and Leitner [58, p. 199], flash-in-the-pan effects can be seen in the case of emotionally unstable people. Later on, psychosocial strain seems to lessen, yet this may be an artificial effect of statistics as housewives and pensioners retreat from unemployment [29, p. 86]. In the end, psychosocial burdens seem to increase again, though less, for the long-term unemployed than for those who lost their job several times [3]. Due to the steadily diminishing chance of success for their own activities, the long-term unemployed show clearly marked phases of reaction [127]. Wacker speaks of a special sequence: shock, optimism, pessimism, fatalism [128].

As early as in the 1930s, some typologies of the unemployed were developed distinguishing, for instance, between apathetic and stable personalities among the unemployed [8, p. 148]. WAL has not found any clear-cut types of unemployed [129], whereas Heinemann has constructed the following typology of activities of the young unemployed:

instrumental-economical oriented type of activity,
interest oriented type of activity,
self-value oriented type of activity,
social oriented type of activity,
leisure time oriented type of activity [35, p. 226].

In his action research with unemployed youths, Opaschowski developes the following typology:

the hopeful: about 10%
the apathical: about 10%
the pragmatical: about 50%
the resigned: about 30% [130, p. 29 *et seq.*].

In 1978, the associations of German psychologists concluded: "Tendencies towards 'giving up oneself' are strengthened (by unemployment), especially in the area of addiction; attempts of suicide in depressive symptoms increase. A multitude of other psychological strains and impairments are also worsened by the effects of unemployment" [9, p. 45]. In contrast to this, other research comes to somewhat milder results; it is unclear, however, whether this is only further evidence of the non-effect problem of evaluation research.

Unemployment and social well-being

Usually, the employment of time, the degree of social isolation and of social prestige are the crucial criteria for assessing the social well-being of unemployed [34, 41, 52, 68]. Again, a complex of psychosocial strains, rather than a series of individual social strains, has to be dealt with [131].

Fröhlich has found that unemployed more often intensify social contacts (41%), instead of reducing them (17%) [13, p. 301]. Brinkmann points out that adult unemployed experience the social strains of unemployment—even those that affect other members of the household—as more pressing than the financial burden [107; see also 9, p. 54 *et seq.*]. Additionally, a higher rate of trouble and conflict is found in the families of unemployed [8, p. 157]. In contrast to that, Fröhlich argues that unemployment actualizes problems of partnership, but does not create them [112, p. 44 *et seq.*].

Obviously, the time consumption pattern of unemployed changes during unemployment, but the results of research on this are contradictory [112, p. 69 *et seq.*; 132, p. 87 *et seq.*].

Increasing financial constraints change the life style of unemployed. Sometimes, with no social net given they find themselves on the verge of starvation [5, p. 35; 133, p. 321 *et seq*].

Some studies deal with the question as to whether and how the unemployed organize themselves; so far, the results have been rather disappointing [134, p. 265 *et seq.*].

Bahnmüller shows that unemployment more often leads to an aversion strategy than to a conflict strategy; apparently, the unemployed do not tend to politicize [20, p. 132]. Likewise, Bonss *et al.* sees an inclination towards adaptation, resignation and apathy, i.e. a trend to 'depoliticization', in times of mass unemployment [8, p. 147]. Unemployment has no great impact on political awareness and attitudes [9, p. 3]. A great potential of conflict does not seem to exist among the unemployed [21, p. 15 *et seq.*]. Unemployment does not activate the electoral behaviour of the concerned [135, p. 273 *et seq.*].

Contrary to frequent allegations that young unemployed tend to criminal behaviour, there is no evidence at all of an increase of criminality as an effect of unemployment [4, p. 6; 136, p. 241 *et seq.*].

There is an argument between Brinkmann and Fröhlich as to whether the unemployed welcome their situation as giving them more leisure time. Brinkmann criticizes Frölich for his retrospective study design and a biased sample [137, p. 15]. The fact that 37% of long-term unemployed say to have more time for their families, and 33% to have more time for things they like, may well be attributed to rationalizations [8, p. 157]. On the other hand, unemployment—provided a minimum of social security is given—might also be experienced as a liberation from labour and the routine of daily life [8, p. 164 *et seq.*].

Financial effects of unemployment

There are quite a few intriguing studies on economic deprivation during unemployment [15, p. 99 *et seq.*; 138] but, occasionally, the tendency is to play down the "actual processes of impoverishment" [8, p. 145 *et seq.*]. The financial problems of some unemployed are, despite a basic level of material security, astonishingly high [31, p. 1 *et seq.*; 34, p. 678]. As a maximum, the unemployed receive benefits which amount to about 62% of their last net income (singles about 7.5% less), and this is for a period of 12 months only [8, p. 151].

Fifty percent of the unemployed receive unemployment benefits, about 16% are only entitled to unemployment relief, and 34% get no subsidy at all [8, p. 151]. According to Hentschel, 40% of the unemployed (according to Fröhlich: 34%) have severe economic problems [68]. 39% of long-term unemployed pay bills late or are indebted [139, p. 3]. Savings are used up [131]. Attempts to cut down on expenditure are mostly made in the area of durable consumer goods and to high quality products. The longer unemployment lasts, the more areas of consumption are affected [137, p. 13]. First, expenses for holidays, cars, etc. are reduced [21, p. 94], then for clothing and, in 20% of the cases, even for food [140]. As for the latter, most savings relate to the quality and diversity of food as well as to the frequency of eating-out [78, p. 63]. Still, for most of the long-term unemployed, the risk not to subsist in terms of housing, nutrition and clothing seems actually not to be immediate and overwhelming [8, p. 151]. "The financial burdens of long-term unemployment are generally not heavier than those of short-term unemployment, as is often alleged" [29, p. 72]. 30% of the unemployed have financial difficulties already in the initial phase of their unemployment [29, p. 99 *et seq.*].

The risk of impoverishment tends to increase with unemployment [86, p. 219 *et seq.*]. In German-speaking countries, only very few studies deal with the extent and impact of poverty on health [141, p. 5; 142]. Brennecke shows that the spectrum of health complaints is different for poor and rich people. The poor suffer more from exhaustion, tirdness, sleeplessness, colds and kidney diseases, the rich more frequently have diabetes, digestive trouble, cardiovascular diseases and hypertension [141, 14 *et seq.*]. There seems to be a U-shaped relationship between complaints and poverty/wealth [141, p. 26].

PROBLEM GROUPS

As the results of unemployment research are generally too diverse to be consistent, it seems wise to develop typologies of the unemployed and to concentrate the investigations on specific 'problem groups' among them.

Social and mental problem groups

Several studies speak of cumulative unemployment [143, p. 300 *et seq.*] or of a "cumulative reinforcement of social inequality in terms of opportunities and risks at the labour market" [84, p. 61 *et seq.*]. Apparently, unemployment is the burden of labour market risks among different social groups is accompanied by unequal capabilities to manage without employment, constituting, for example, different mental groups [84, p. 53 *et seq.*; 90, p. 106 *et seq.*].

In the main, these groups are composed of elderly and young, foreign, disabled and less qualified employed persons [84, p. 76; 144, p. 149]. Health problems are more often found in blue-collar than in white-collar workers, more in male single than married women, and more often among the elderly than the middle-aged unemployed [63, p. 31]. Cumulative unemployment especially hits the sick [145]. 'One-sided cumulation of burdens' is characteristic of long-term unemployed [63, p. 22]. Long-term unemployment weighs most heavily on men, individuals between 45–55 years of age, singles, and young people [8, p. 157 *et seq.*].

According to Opaschowski, some segments of the unemployed become problem groups as a consequence of their specific personality: e.g. the resigned and the apathical unemployed [59].

Unemployed youth

About 10% of the unemployed are youth under 20 years of age [146, p. 375]. There is no room here to report on the determinants, and the extent, of youth unemployment; only some effects will be mentioned [but see 79, 98, 147–162].

According to Wilhelm-Reiss [57, p. 10], young unemployed are more aggressive and have more psychosomatic symptoms than young people in training courses. The Hamborn Project found a continued change from more positive to more negative attitudes in young unemployed; it also showed a tendency towards isolation, increased money insteady of job orientation, and towards the family as a possible retreat [12, p. 40 *et seq.*]. Compared with young

employed, unemployed youths "are more handicapped in somatic and psychosomatic terms, are more depressive and doubtful, more reactive, aggressive, less open to contacts and social affairs" [12, p. 226 *et seq.*].

The impact of youth unemployment on physical health is rarely mentioned in the literature. Interestingly enough, more than 8% of school leavers have health impairments "which have to be regarded as factors that reduce their capacity of physical work": postural disorders of the spine and various other anomalies of the skeletal system in addition to visual impairment and vegetative disablements [102, p. 1046].

There are parallel developments between increasing youth unemployment and an increased consumption of hazardous, illegal drugs by young people [163, p. 1]. The empirical evidence of the proletarization of drug consumption as well as the theoretical assumption of a declining capability consciously plan for the future lead Schneider and Weber to the conclusion that young unemployed become easily disoriented and are highly inclined to misuse drugs [164, p. 53]. Misuse of alcohol and drugs in the context of unemployment is often assumed [165, 241]. Henkel finds the highest percentage of people who run the risk of becoming alcoholics in young unemployed [16, p. 2]. By way of contrast to this, the Hamborn Project did not find any escape into alcoholism, drug consumption or criminality [59, p. 44 *et seq.*].

"Spectacular forms of deviant behaviour such as organizing gangs, alcoholism and criminality" are frequently assumed [12, p. 76]. Youth unemployment and criminality, however, are no cause–effect relationships but are parallel developments only [35, p. 168 *et seq.*]. The analysis of official statistics does not reveal any relationship between unemployment and criminality among young people [166, p. 7 *et seq.*].

Youth unemployment changes self-esteem [12, p. 1 *et seq.*] and leads to a somatization of conflict management [165, p. 246].

Unemployed youth more often show boredom, helplessness, doubtfulness and hopelessness [61, p. 115 *et seq.*; 167, p. 576 *et seq.*]. Boredom affects unemployed young women less than men [59, p. 27].

In young age, unemployment is a permanent situation of high individual stress [114, p. 139 *et seq.*]. It blocks personal development [168, p. 693] and generates, at least from some, an irreversible retardation of the process of becoming socially mature [59, p. 40].

Unemployed women

Whether negative impacts of unemployment are particularly strong for women, is a moot point [32, p. 378 *et seq.*; 111; 169; 170; 171, p. 14 *et seq.*]. After a phase of felt relief from the previous double burden, their sense of self-worth decreases markedly, and resignation grows in extrovert persons [172]. Resignative moods are typical at the beginning of unemployment [172, p. 200]. Female singles are especially affected [172]. Long-term unemployment furthers the acceptance of 'traditional role playing'; in the end, those women do no longer regard themselves as being unemployed [172, p. 201]. "Not unemployment itself but the . . . intended professional and family activities constitute the identity and mental condition of women" [172, p. 104].

Unemployed white-collar workers

Uncertain are the effects of unemployment on highly qualified and white-collar workers. Wuggenig found more social problems and emotional stress with persons of higher qualifications. Fröhlich shows that people of this category suffer less when unemployed [13, p. 316; 173]. There seems to be a strong tendency among unemployed white collar-workers to hold on to a world of illusion [174, p. 335 *et seq.*]. Results of special research projects are still waited [52, p. 167].

Unemployed elderly

For most of the elderly, unemployment is the preliminary (last) stage of a hard and relatively underprivileged occupational career [27, p. 19; see also 175; 176; 177, p. 517 *et seq.*]. For them, once dismissed, long-term unemployment is typical; they clearly show chronic diseases, caused by physical attrition [27, p. 16]. "Large differences between the unemployed and employed elderly can be shown as to health status and the deterioration of work capacity. Old employees with relatively poor health are highly likely to become unemployed. About two thirds of the interviewed unemployed stated that they suffered from heavy chronic diseases—rheumatism, spinal, gastric, cardiac and circulatory disorders, etc.—during the last three months; these can be interpreted as a symptom of a continued deterioration of their individual working power" [27, p. 16]. "Older unemployed and/or unemployed having health problems who take over a new job after unemployment, are frequently forced to accept incisive professional losses for their reintegration into the work force. Especially for the older, not healthy unemployed, . . . re-employment often coincides with a change of profession and branch of business, professional decline and dequalification" [27, p. 160].

Children of the unemployed

The impact of unemployment on family members, especially children, was dealt with much more intensively in the 1930s than today. Then it was found out that children of unemployed, as compared to employed parents "more often and more severely developed nervous symptoms, hyper-sensibility and functional impairments without clear organic causes" [178]. The only topical research project of recent date revealed that 14–16 year old school boys and girls of unemployed parents showed considerable differences in terms of psychologic symptoms, yet very low differences in their motivation to learn, and no differences as to the problem of professional orientation, when compared with children of employed parents [179]. Another study shows that unemployment reduces the rate of participation in prevention programmes [180]. It must be stated that the indirect effects of unemployment are underinvestigated. Results of macro-level studies on the link between unemployment and infant mortality suggest that research on this problem group should be much more intensive [40; 181, p. 258 *et seq.*; 182].

Short-time workers

Short-time workers are not identical with part-time unemployed. "They do not differ much from the employed with a normal working time pattern. The tendency is rather a positive one: They seem to benefit from additional leisure time in contrast to the unemployed" [19, p. 513 *et seq.*]. However, systematic and comprehensive analyses of the health effects of short-time work are still missing.

DIAGNOSIS

Some of the main results can be summarized as follows:

Unemployment and overwork can induce similar psychosomatic impairments [115]: the obvious afflictions caused by unemployment should not lead to overlook those caused by employment. In both cases, the effects of stressors are considerably modified by personal capabilities to manage the situation.

More than 20% of the unemployed—in some groups up to 35%—regard unemployment as 'not so bad' [131]. "Nevertheless, the manifold problems of the overwhelming part of the unemployed should not be disregarded even if some unemployed, including long-term unemployed, see some aspects of unemployment in a positive way" [107].

Compared with the massive impoverishment in the thirties, stress and distress seem to be much less for today's unemployed [8, p. 145]; unemployment is rarely felt as a catastrophe or vital threat [68, 112, p. 72]. Comparing the 1930s and the 1970s/1980s, Jahoda speaks of a change from absolute physical deprivation to only relative damages [10, p. 70]. The unemployed suffer from fewer physical health problems than was expected by many [64, p. 80 *et seq.*]. Present research results are quite modest in comparison with the most prominent health effects of unemployment stated by Moses in 1931 [55].

Normally, unemployment causes more financial and psychological than physical burdens [137, p. 10 *et seq.*]. "Certainly, we cannot assume that unemployment always and necessarily leads to health disturbances. Financial constraints and psychosocial stress during unemployment play an important role, but vary depending on the individual case" [32, p. 388].

Comparisons with the situation of the 1930s are misleading, as they disregard the progress in social security that has taken place in Europe. At least in relative terms, there is a process of degradation and demoralisation affecting the unemployed [51, p. 10; 130, p. 16]. However grave the health impacts may be, the unemployed have to carry their consequences individually, although they may not be personally blamed for their unemployment situation [71]. The right to work implies the right to physical and mental integrity [34, p. 679]. The latter might well be limited by the effects of both employment and unemployment.

THERAPIES

Proposals for a strategy to overcome unemployment or to smoothen its effects may look quite limited at present. There are too many open questions about the causes of unemployment and, therefore, about the right way to deal with it. Reform of a single insitution or a single sector will certainly not help to overcome the problems cost–effectively.

Policies

Activities to combat unemployment or to soften its effects, have to start on different levels: creation of new jobs, 'fair' distribution of work and working hours among the members of society, economic relief for the deprived and overburdened, minimization of physical and mental impairments caused by employment as well as unemployment. The need to change the organization of labour and to cut down the working hours seem to be inevitable [6, p. 288 *et seq.*]. Short-term employment schemes may rather lead to the construction of Keynesian pyramids than to a solution of the problem.

Case-oriented social policies are needed, as for example:

securing jobs for underprivileged groups [35, p. 184],

stop-gap relief in critical life situations for those members of problem groups who suffer most [4, p. 9],

deployment of unemployed in social services which are labour intensive and need personnel [143, p. 309],

creation of, and support for a second labour market [143, p. 309],

measures to faciliate the mobility of people [183, p. 76],

reform of the rules of 'reasonableness': when assessing the acceptability of professional degradation for re-employed people, the demands of the new job have to be taken into account, both in regard to the present state of health of the re-employed and to the long-term consequences on health and work performance,

special programmes for the reintegration of the unemployed elderly to help them overcome their occupational isolation [183, p. 77 *et seq.*]

Quite a number of organizations offer training programmes to improve job opportunities by requalification, further education and personality training [88, p. 69 *et seq.*; 108, p. 426; 183, p. 78 *et seq.*; 184, p. 39; 185]. Most prominent are schemes of additional qualification as well as social-pedagogical and psychological training programmes to enhance self-management abilities on the cognitive, social, emotional and motivational level [11; 186, p. 1251 *et seq.*]. Such offers are used more frequently by unemployed middle-class people than by those in more urgent need of support [51, p. 10].

In view of the labour market situation, such training programmes often lead to quite unrealistic hopes [2, p. 320]. West German associations of psychology therefore recommend political rather than psychological solutions [187, p. 372 *et seq.*].

Health policies

In times of economic crisis and increasing unemployment, the need for advice as well as the number of contacts with physicians increase [58, p. 198]. Simultaneously, the supply of specialized social service diminishes [51, p. 9]. There has been a consid-

erable decrease of rehabilitation measure per retired person since 1974 [94, p. 97]. But the most important dilemma concerns the possibilities of medical rehabilitation and the low chances of reintegration due to high chronic unemployment [188]. The small labour market implies that psychiatric and psychosocial therapy has no real perspective in cases where work is needed as a means of rehabilitation [18, p. 80]. On the other hand, schemes to improve qualification or measures of social support or therapy may provoke unrealistic expectations [110, p. 28 *et seq.*]. Increasing the supply of consultation may also add to the individualization of the problems and even reinforce the stigmatization by unemployment [51, p. 11; 189, p. 11 *et seq.*].

Surveys of physicians about the link between unemployment and health show that only a few physicians are interested in this topic, and that the relationship between unemployment and illness is unclear to many of them [56, p. 486]. A more 'clinical' perception of the problem creates new tasks and more work for the helping professions [190]. Yet, instead of persuing a need- and employment-oriented budget policy in order to increase the number of medical staff, social workers and trainers, the present policy is to reduce personnel. While demand and need increase, the awareness of the problems is small, and so is effective supply.

It is proposed that the health services of Austria, Switzerland and West Germany may improve their curative and preventive functions in the following ways:

A prerequisite is the information and training of health personnel with regard to the results of psychological and medical research on unemployment [4, p. 9; 51, p. 9 *et seq.*; 56, p. 481]. The training of general practitioners, internists and gynaecologists would be particularly important. Knowledge of the need for, and the supply of, advice as well as of the facilities available for the training of the unemployed should enrich the spectrum of therapies offered by physicians.

"The sick-leave problem is mainly a problem of morbidity; an adequate solution, therefore, requires intensified efforts to improve health care. Of special importance would be a higher emphasis on rehabilitative and prophylactic measures against cardiac and muscular-skeletal disorders as well as psychogenic diseases" [46, p. 1]. This concerns not only office-based physicians but also the services of confidential medical officers, who are to quarantee early rehabilitation in cases of relapses.

Psychological prevention is recommended mainly for young (unemployed) people. Essentially this means an improvement of the medical and psychological measures of prevention and care in (pre-)school age as well as further education for physicians who are in charge of monitoring the youth protection laws concerning employment and working conditions. Usually, these physicians have little knowledge of the particulars of vocational training and of the special requirements for working places of youth. Improvements in this area may yield some results in terms of prevention [102, p. 1046 *et seq.*].

Healthy working conditions can be an important protection against early disablement. If it is true that the link between unemployment and health is, to a large extent, conditioned by the effects of hazardous jobs, then a prevention-oriented occupational medicine and 'humanization of work' seem to be essential [92, p. 562; 191, p. 130 *et seq.*; 192, p. 176 *et seq.*].

The unemployed are in great need of advice; they badly need help [31, p. 16; 32]. If, as is proven, unemployment leads to depression, the unemployed is entitled to therapies like any other patient [110, p. 31]. Because the pesonal problems caused by unemployment vary from person to person, individual forms of consultation and care are needed, as are offered, eg. in the Phealth park' of the Munich Volkshochschule [193]. Counselling should help persons to stablize and reduce the effects of their situation [11, p. 46 *et seq.*]. But advisory boards exclusively for the unemployed are not be recommended; rather, it would be cost–effective to have agencies that comprehensively deal with all psychosocial problems which develop in the context of family, alcoholism, drug consumption, unemployment and life management. To establish such services may not primarily be the task of the health care system but of voluntary organizations; the latter, however, need professional support from the former. Prevention of unemployment and its consequences may preferably take on the form of 'empowerment strategies' [126].

The unemployed, especially the most affected, tend to self-isolation, quite a few to self-disclosure [51]. Psychosocial advice is not only needed by those who look for help [51, p. 19]. For problem groups, e.g. the mentally ill, outreach ambulatory services are necessary [18, p. 93].

In times of economic decline more than ever, the consolidation of the institutions of rehabilitation is important [18, p. 79], likewise the extention of psychosocial advice in existing organizations [51, p. 19].

Preventive and curative measures against alcoholism and depression, and special assistance for the unemployed young and elderly seem to be the most cost-effective services the health sector can provide to reduce or, at least, smooth the effects of unemployment. One other problem group deserves special attention: the children of unemployed.

Self-help

Self-help activities of adult unemployed are still rare; the same applies to initiatives of young unemployed [107; 143, p. 314 *et seq.*; 194, p. 37 *et seq.*; p. 331 *et seq.*]. To the extent that organiztions of the unemployed exist, nearly all of them—as surveys show—were created from outside [196]. Centres for the unemployed are offered mostly by social, religious or trade-union related organizations. They often have advisory services for health problems [197, p. 178 *et seq.*]. Help for self-help seems to be the one essential measure of personal prevention against unemployment although this would mean a boost for the shadow economy.

Research

Intensified and more diversified research—further publications not quoted in the preceding sections may be also good points of departure [198–269]—could be helpful to design cost–effective therapies to reduce, and to offer relief from, the effects of unemployment.

It will be most important to design scientific models on how to possibly minimize the strain of work and the stress of unemployment, and how to change the human organization of labour and the social distribution of working time.

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