

Pan-European macro-drivers that impact on work, worklessness, social protection and health inequalities

Main issues, themes and futures scanning

18 June 2012

Health Action Partnership International



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Table of contents

1.Key points.....	5
2.Introduction.....	6
3.Overview of the current situation in Europe.....	8
4.Recession, labour markets and health inequalities	15
5.The economic crisis and health	18
6.ALMPs and health: overview of the evidence	20
7.Budgets cuts and health effects	21
8.Employment and mental health.....	25
9.Social investment and social protection: an overview	27
10.The role of international institutions and agencies	30
11.Key issues and policy options for the European Union and Member states	35
12.References	38



1. Key points

- Deprived individuals and communities and low skilled workers have been most affected in terms of health and their economic situation by the financial crisis and government policy responses.
- Austerity policies have been found to have severe health effects in a variety of countries, yet more monitoring across Europe is needed as the crisis continues.
- EU social cohesion is at risk as states and regions experience the crisis to different degrees of scale and intensity.
- There is strong evidence that participating in Active Labour Market Programmes (ALMPs) helps mitigate risks by improving resilience and the likelihood of job reintegration
- In the context of austerity, ALMPs offers strong public-investment value both for protecting public health and readying the economy for recovery.
- The research and academic community must make greater efforts to generate and sustain policy commitment to including the health equity in the design, delivery and effectiveness of all policies.
- The research and academic community must convince policy makers that health is an outcome that matters. They must also continue to strengthen the evidence base to demonstrate the social and economic value of health.



2. Introduction

- 2.1 The global financial and economic crisis has exposed major policy gaps in tackling health and labour market inequalities. As unemployment and job insecurity continue to rise across Europe, governments have resorted to austerity and efficiency measures, with little regard for equity, fairness and their effects on social cohesion, people's daily lives, health and well being. We are now at crucial juncture and a window of opportunity in how our societies will socially and economically develop over the coming decade. Indeed as the empirical evidence is beginning to demonstrate these austerity measures and budget cuts have had severe consequences of the health of populations across the European Union.¹⁻⁶
- 2.2 Prior to May 2010 the approach adopted by many European governments toward tackling the effects of the crisis and unemployment was one of Keynesianism stimulus packages. However, at the May 2010¹ meeting of European leaders and finance ministers, policies of stimulus, overnight became ones of austerity, 'contractionary expansionism' and a belief in what Krugman has termed the 'confidence fairies'. As various authors have recently noted the efficacy of these policies have been questioned given the lack of economic growth in a large proportion of Member States as well as the widespread social impacts that have arisen.
- 2.3 The crisis and government responses have raised a number of important ethical and social questions: Can government policy be designed to be more equitable and fair rather destructive? And how far do politicians and policy makers actually care about the social implications of their economic decisions?
- 2.4 This report provides an overview of the main issues and themes that arose from an expert meeting to discuss the current social and employment situation across Europe and which policy levers can be acted upon to affect positive health change.
- 2.5 There is an urgent need for the research community to create a cohesive and rigorous 'policy story' of how the economic crisis and more importantly government responses have and will affect the social conditions and health of populations. At the Brussels seminar the issue was raised as to whether it is necessary for academics and policy makers to embark upon establishing a 'Washington Consensus' type project and process in order to effect policy change. Importantly the research community must develop a better understanding of the policy process and policy 'entry points' in order to effectively influence the current debate and decision making.
- 2.6 As noted at the seminar the chair of the EU social protection committee is in talks with the finance committee about how social protection policies may be paid for across Europe. The common perception amongst academics and those outside the policy process is that that social protection has been completely abandoned in favour cuts and austerity. Without some pragmatic recognition of the constraints facing policy makers there may be little that researchers will be able to influence.
- 2.7 Indeed policy recommendations and options must be realistic for each context rather than trying to adopt policies and programmes from countries such as Germany and Sweden in an *ad hoc* fashion. As witnessed across Europe there have been differential effects on each country from the cases of Southern Europe (Greece, Spain and

¹ The Council and the Member States meeting May 9th and 10th 2010:
<http://www.reuters.com/article/2010/05/10/us-eu-greece-text-idUSTRE6490A820100510>



Portugal) to those of the UK, Germany and Scandinavia. Therefore it is important to recognise that there will not be a one size fits all policy response to the crisis, rising levels of unemployment and employment creation.

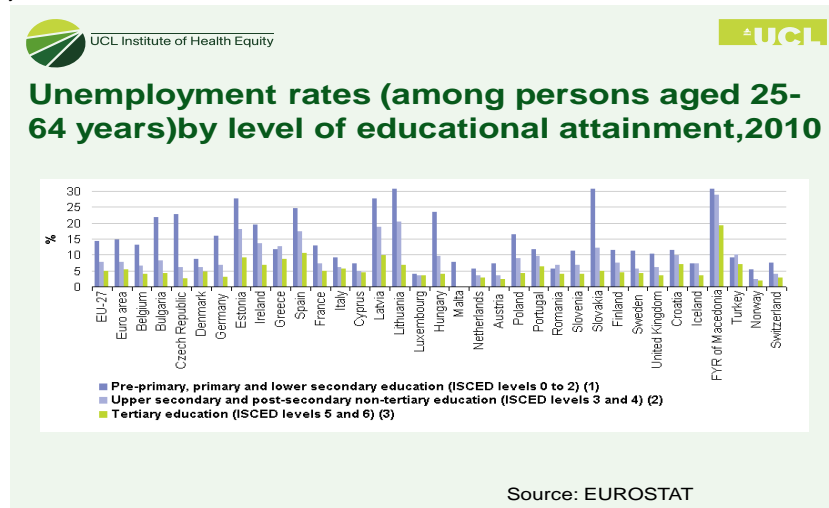
- 2.8 Although not explicitly discussed at the seminar it is vitally important to consider the wider macro-drivers of social and change across Europe such as the role of globalisation in that Europe is not be able to command as much of the 'global pie' as has been the case over the last 40 years. Added to this are the demographic and democratic deficits and the switch from a transition of baby boomers to baby busters which will have major impacts in terms of state dependency (pensions and social care) and the associated rates of welfare spending.



3. Overview of the current situation in Europe

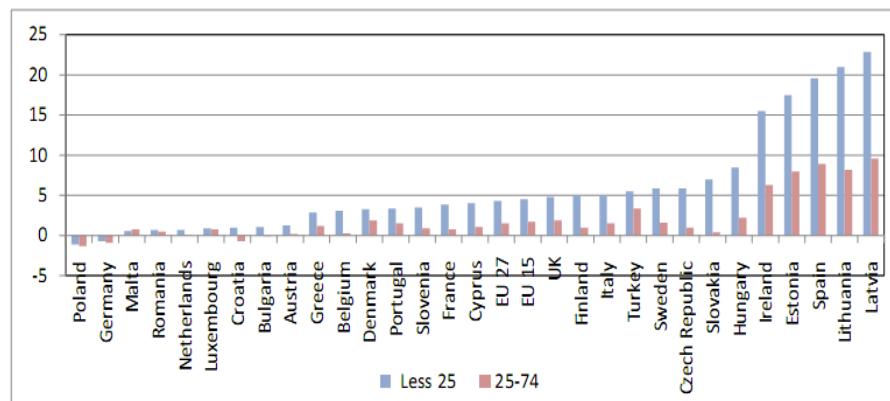
- 3.1 The financial crisis has significantly affected labour market conditions across Europe⁷⁻⁹. However, certain groups have been differentially affected. As various commentators at the seminar noted the financial crisis has had largely uneven effects especially on those with low levels of educational attainment (Figure 1). The evidence in this section highlights the major trends and policies over the past few years.

Figure 1 Unemployment rates (among persons aged 25-64 years) by level of educational attainment, 2010

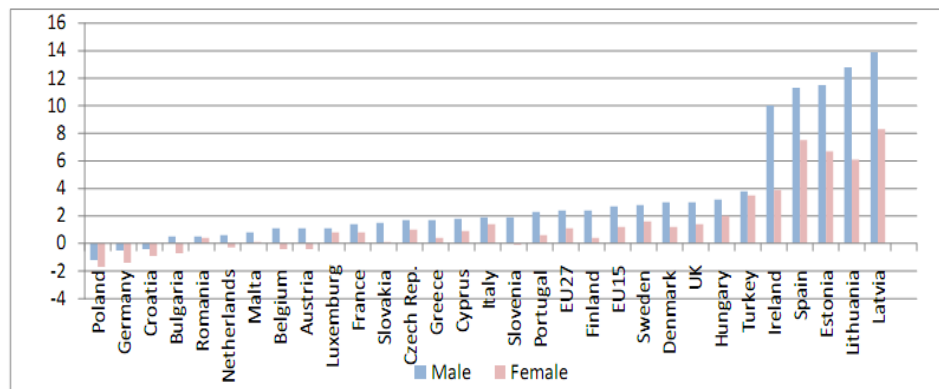


- 3.2 The crisis has reinforced long-term conditions of low pay and related poverty in Europe¹³. Currently, according to a recent ILO report 17.5 million people are experiencing 'in-work' poverty in the EU27⁷. Forty percent of workers report 'either some or great difficulty in generating a sustainable household income'⁸ which is particularly prevalent among non-permanent and self-employed workers⁹.
- 3.3 Labour market changes (that is employment adjustments and labour market churning) have substantially affected workers in non-standard arrangements -temporary or agency contracts¹⁰. Evidence from France, Spain and Sweden illustrates how temporary workers have functioned as an 'employment buffer' over the past two years¹³. In Spain, for example, approximately 90 percent of redundancies occurred among those occupying temporary contracts¹¹. The proportion of temporary contracts has declined rapidly for both men and women in almost all European countries¹⁰.
- 3.4 Young people have also experienced unemployment rates twice that of other age categories¹⁰ (Figure 2). Increasing youth unemployment has been particularly marked in the Spain, Greece and the Baltic States^{10 12}. According to latest Eurostat figures nearly half of 18-24 year olds in Spain and Greece are unemployed. Workers below 25 years have experienced unemployment rates 10-15 percent higher than those above 25 years^{9, 13}. This difference is due in part to the policy of 'last in, first out' that has applied in most countries over the past decade as well as a trend for young people to enter the labour market on temporary contracts. In Sweden, it is now a law that young people be hired on temporary employment arrangements.



Figure 2. Unemployment increases by age, 29 European countries, 2007-09⁹

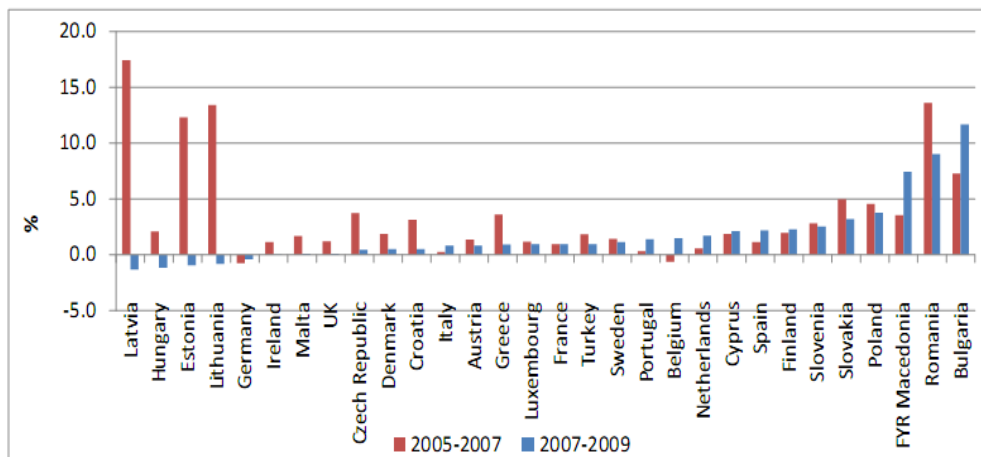
- 3.5 Low-skilled workers across most European countries have been badly affected by the crisis¹³. Initially, high-skilled jobs were the hardest hit, such as in financial services sector. However, unskilled or semi-skilled labour have subsequently suffered in manufacturing and construction¹². Elsewhere employment among high-skilled workers increased in Sweden, while unskilled employment fell sharply. The situation for ethnic minority groups deteriorated in the UK, a trend that is likely to continue, given public sector cuts, where ethnic minority groups are strongly represented^{9, 14}.
- 3.6 In all countries, the unemployment rate for men has been substantially greater than for women (Figure 3). In the Baltic States, Spain and Ireland this difference is significant and according to various commentators may have led to a reduction in gender unemployment gap⁹.

Figure 3. Male – Female unemployment^{7, 9}

Wages

- 3.7 In countries that experienced rapid wage growth before the crisis, falls in wages during the crisis have been much greater (Figure 4). This is the case in the Baltic states, Central and Eastern European countries, such as Hungary, Romania and Bulgaria⁹.



Figure 4. Wage rates (Source: ILO Geneva – social protection unit)^{9, 13, 15}

- 3.8 Wages reductions have occurred where working hours have been used as alternative policy response to redundancies. This has particularly affected women and young workers who occupy temporary, precarious and low paid employment⁹.
- 3.9 Despite large numbers of low paid workers being made redundant there is a continued increase in this work status (defined as earning less than two-thirds of the median wage)⁹. However, the percentage of low-paid workers has not increased in countries that have used minimum wage legislation as a social protection mechanism (such as in Poland, Portugal and Belgium)⁹. Wage differentials between the top and bottom have increased in Bulgaria, Hungary and the United Kingdom^{9,13}.

Labour market inequalities

- 3.10 Since 1980 socio-economic inequalities have been increasing across the EU amidst a period of economic growth and modernisation¹⁶. Low-paid workers have been subject to increasingly precarious and insecure working conditions, while professional and managerial workers have gained from productivity increases¹⁰. Increasingly employment can no longer be considered a reliable pathway by which to reduce poverty which previously formed a key element of the European Employment Strategy (EES) and social mobility policies¹⁶.
- 3.11 EU countries with large socio-economic inequalities have experienced greater social problems than those with flatter socio-economic gradients¹⁶. These inequalities look set to increase given the policy responses of austerity and pose serious challenges to the implementation of the EU 2020 strategy, limiting the potential of economic growth and the social inclusion of large groups of society^{16, 17}. A combination of factors (including economic restructuring, the shift towards a knowledge economy, and changes to welfare regimes) have also contributed to labour market inequality over the last three decades¹⁶.

Earnings and wage inequalities

- 3.12 The largest increases in earning inequality occurred between 1979 and 2000 in the UK and Northern European countries¹⁶. In contrast, only modest increases occurred in continental Europe. However, the gender wage gap has remained largely unchanged¹⁸. In addition to this is the imbalance between pay and productivity. Low-paid workers have not benefited from increased productivity over recent decades¹⁶. In fact, a large proportion of European workers have experienced a decline in total income¹⁶.



- 3.13 Various policies have been put forward for reducing differentials in earnings via social transfers, taxes and benefits⁹. Hungary, for instance, has a high level of income inequality, but in terms of disposable income it is within the middle of the distribution¹⁶, indicating the presence of redistributive policies. Sweden and Denmark have low earnings and disposable income inequalities, despite the sharp increase in earnings inequality over recent decades¹⁶. Western European countries (such as Austria, France, & Germany) have comparatively low levels of inequality, while Southern European states, and the more market-oriented ones such as the UK, and the new member states, are the most unequal¹⁶.

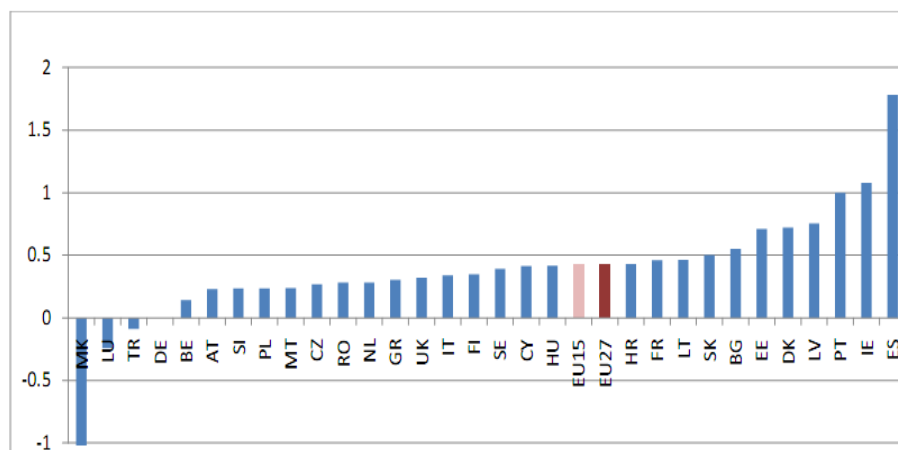
Working conditions

- 3.14 Various commentators have argued that work intensity and working conditions more broadly have risen among employees left behind after large-scale redundancies⁸. In Turkey increased rates harassment and bullying have been reported and in Spain and Croatia overall working conditions have deteriorated. Previous government and employer policies directed towards promoting a healthy work-life balance have dwindled over recent years¹⁶.
- 3.15 Individual businesses have reduced training and apprenticeship programmes. However, in countries such as Denmark training opportunities for the unemployed and activation measures are currently being promoted. In contrast, Spanish firms have reduced vocational training, instead preferring to utilise the large pool of flexible and temporary labour. The overall trend in reduced training expenditures and reduced use of ALMPs is likely to have significant effects skills supply and the long-term sustainability of the labour market^{7 10}.

Polices and institutions

- 3.16 Policies and institutions are crucial influences of employment conditions⁷. Some European countries have experienced steep increases in unemployment, whilst others have maintained employment despite significant declines in GDP¹⁶. The combination of stimulus packages, subsidies to maintain employment stability, and social dialogue have helped to limit redundancies and negative impacts on social welfare and social cohesion¹⁰. However, the large differences between European countries demonstrate the elasticity of employment losses to GDP during the crisis (Figure 5).

Figure 5. Employment losses to GDP. Source: Eurostat 2010⁹



- 3.17 The observed trends may be attributed to the onset of the crisis in certain countries, but also to the labour market and welfare regimes in place¹⁰. The impact of unemployment has been highest in the Anglo-Saxon countries that rely on labour market flexibility (especially Ireland), but also in Spain and Central and Eastern Europe (Estonia, Latvia & Lithuania)^{7, 13, 15}.
- 3.18 In addition, governments have adopted a range of policy responses to deal with economic downturn. As noted above changes in working hours have been an important buffering mechanism in Austria, Germany, Cyprus and the Czech Republic. In 2009, 1.1 million German workers had their working hours shortened⁸.
- 3.19 There are several best-practice examples of policy or institutional responses. Germany has instituted significant public investment and social dialogue to stimulate short-time working schemes¹⁰. These programmes, as well as extensive active labour policies were in place pre-crisis and have helped mitigate negative impacts. The length of participation in ALMPs has also increased from six to 24 months in 2009 and governance has also been considerably simplified, enabling greater coverage and uptake^{7 10}.
- 3.20 Social dialogue between government, employers and employees has made it possible in Germany and France to negotiate alternatives to layoffs either through wage and/or working time reductions¹⁰. In countries with limited wage bargaining mechanisms, such as Estonia, Latvia and Lithuania, wage cuts were immediate and substantial. In France, the crisis has highlighted the polarisation and inequalities present within the labour force. Workers at the lower end of the labour market were the first affected by employment cuts. The majority of the labour force has, however, remained protected and benefited from a series of institutional arrangements^{7 10}. As noted above, the social impacts of such policies have yet to be properly evaluated, especially in light of the long-term adverse effects on the employees' career and pay.
- 3.21 Economies with strong internal flexibility have fared better with respect to unemployment and spreading the distribution of risk¹⁰. As the IMF states, "these programmes can spread the burden of the downturn more evenly across workers and employers, reduce future hiring costs, and protect workers' human capital until the labour market recovers"¹⁹.
- 3.22 A number of countries, as well as employers' organisations have increased in the use of temporary contracts to offset labour market shocks¹⁰. The use of temporary contracts has increased rapidly in 2010⁷. This trend was reversed in Portugal, Romania, France, Italy, Cyprus, Turkey and Hungary, and also Finland and Sweden. In Germany and Italy institutional arrangements, such as shorter working times, were extended to workers in non-standard forms of employment. Sweden has combined training with external flexibility as a social protection mechanism⁷.
- 3.23 The 'public sector shock' continues to have severe social and economic consequences, although little research on the effects of such policy responses exists²⁰. Several socio-economic effects are already observable across Europe, such as reduced consumer demand, declining quality in the delivery of public services; an expanding informal sector, migration between member states, and reduced investment in training and education programmes^{7 10}. Current austerity policies aimed at reducing expenditure in sectors such as health care, training, and ALMPs could potentially limit progress towards improving working conditions and job quality across Europe^{7,9}.



Lagged impacts and the need for monitoring

- 3.24 Policy shifts to austerity measures may also serve to have long-term differential impacts particularly on women, skilled, older, disabled, and ethnic minority groups. Many of these effects have already occurred in Bulgaria, Greece, Hungary, Ireland, Romania, and the UK⁷.
- 3.25 When examining the potential effects and designing monitoring mechanisms of the crisis on labour market conditions, it is necessary to consider the likely time-scales. For instance, the decrease training and apprenticeship expenditures, combined with the reduced state funding and use of ALMPs, will have long term-effects on human capital, skills supply and the quality of employment⁷.
- 3.26 The European Commission launched a consultation on the future Europe 2020 Strategy, with a formal Communication addressed to the European Council with three mutually reinforcing priorities. The Europe 2020 agenda aims to “help Europe recover from the crisis and come out stronger, both internally and at the international level”. The strategy is based upon three key pillars:
- Smart growth – developing an economy based on knowledge and innovation;
 - Sustainable growth – promoting a more resource efficient, greener and more competitive economy;
 - Inclusive growth – fostering a high-employment economy delivering social and territorial cohesion.
- 3.27 One of the five EU targets of the Europe 2020 strategy is to raise the employment rate to 75% by 2020. Current indications are that the EU will fall short of this target by around 2%. The EU 2020 strategy establishes a number of initiatives, such as a new skills and jobs agenda. This aims to increase the effective functioning of labour markets through various reforms such as:
- Working contracts that allow people to enter the labour market and progress;
 - Adjustable unemployment benefits;
 - More individually-tailored help for people looking for work;
 - Better incentives to take up learning opportunities;
 - Equipping people with the right skills for employment;
 - An 'EU skills panorama' will be created to help identify future skills needs;
 - Improving job quality and working conditions;
 - Job creation.
- 3.28 Since the 1990s, linking unemployment benefits to job search or mandatory work activities has become more explicit in almost all countries. There has been a move from ‘passive’ to ‘active’ labour market policies. This trend also includes stricter eligibility for unemployment benefits claims. The policy shift largely comes from the



belief that passive unemployment policies and social insurance contributes to benefit dependency and low rates of social mobility.

Under activation policies the emphasis is on intensive job search, as well as participation in short training or work experience schemes. Many EU countries invest considerable resources into improving labour market outcomes through a variety of ALMPs (with notable exemptions such as those employing austerity measures to social welfare budgets such as the UK, Greece and Spain), but little is known about how and why ALMPs may protect the health of the unemployed particularly during times of crisis². The following sections explore some of the possible mechanisms responsible.

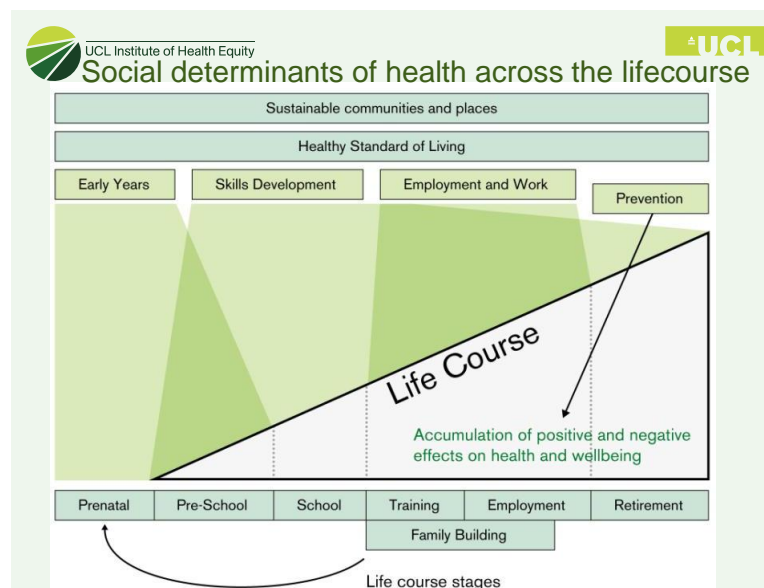
² Stuckler et al [24] demonstrated a health protection effect of ALMPs during rising rates of unemployment. However, the mechanisms responsible for these health changes have not been fully explored. See Coutts 21. Coutts A P. Active Labour Market Programmes and health: an evidence base.; 2009.



4. Recession, labour markets and health inequalities

- 4.1 Throughout the seminar there were various discussions on the empirical evidence linking labour market status and health / health equity. In relation the role of the welfare state and social protection (investment) policies and how programmes can help to offset and prevent the social, economic and health disadvantages acquired across the life course was noted as being a useful policy approach to addressing health inequity. A number of guiding questions were raised such as: will the social, economic and health situation improve across Europe? And is there 'light at the end of the tunnel' and what policies and programmes can be adopted in order to get there?
- 4.2 Professor Michael Marmot highlighted a number of the recommendations from the English Review of Health Inequalities. He noted that a life course approach to addressing health inequalities must be adopted, that is, policies should be in place to tackle prenatal conditions, moving through to early years education followed by training and employment (Figure 6 below). Employment and work in particular form critical transition phases within the life course and have significant impacts upon health and well being.

Figure 6: Life course approach. Review of health inequalities, England



- 4.3 Research demonstrates that the mental and physical health disadvantages induced by unemployment are primarily related to the combination of psychosocial and material factors. Material pathways include low income and financial strain, whereas psychosocial health impacts occur indirectly through the perception of social isolation, loneliness and social exclusion^{22 23}.
- 4.4 Longitudinal research has shown that changes in a number of aspects of health can occur after redundancy, extended periods of unemployment, or negative changes in job attributes. The most health damaging effects are related to the duration and frequency of unemployment. Long-term unemployment (six months plus) and labour market churning wherein an individual moves in and out of the labour market at frequent intervals (usually between unemployment and temporary work) has been found to have severe health impacts. These health impacts include increased risk of

mortality or morbidity from a range of physical diseases, notably heart disease, as well as mental health issues suicide (This report does not provide a systematic review of this evidence but see for example ²²⁻²⁴ for comprehensive reviews). However, it is not simply the case that unemployment, by itself, causes poor health because the negative psychosocial attributes of insecure 'bad' work and employment are also health damaging.

- 4.5 In reaction to this evidence base, policy makers have assumed that mechanisms designed to move people from unemployment to employment are the key factors in tackling poverty and improving health.

Labour market, working conditions and health

- 4.6 Researchers have used various theoretical constructs in order to examine how the psychosocial characteristics and attributes of employment in terms of the vitamins, latent and manifest functions of employment may affect health^{17, 30 25}. These relate to such features as: security; satisfaction; demands and control; effort reward balance; supervisor and peer support; and perceived financial strain. These psychological/psychosocial attributes of work have been related to various psychological and physical health impacts such as general ill health, depression, cardiovascular disease, coronary heart disease and musculoskeletal disorders.
- 4.7 Various conceptual frameworks are used to link employment quality (i.e., labour market –aggregate/ecological level indicators) and job quality, (which refers to specific aspects of a job at the individual level) to health (See for example ^{26-28, 29, 30, 31, 32}). There is currently a need to develop a robust model to examine the job quality and links to individual health outcomes.

Box 1: Distinction between employment and job quality

Employment quality

- Who does the job? Slavery, child-labour...
- The quality of the job itself (7 components)
- The Welfare State (Unemployment Insurance, ALMPs ...)
- The Legal framework (Employment Protection Legislation, minimum wage, level of inspections, size of informal economy)
- Supply/demand factors (local Unemployment, Participation rate, vacancies)

Job quality

- Earnings
- Working Time Quality (long hours, unsocial hours)
- Prospects of job (including job security)
- Intrinsic Quality
 - Skills and Discretion
 - Good Social Environment
 - Good Physical Environment
 - Work Intensity

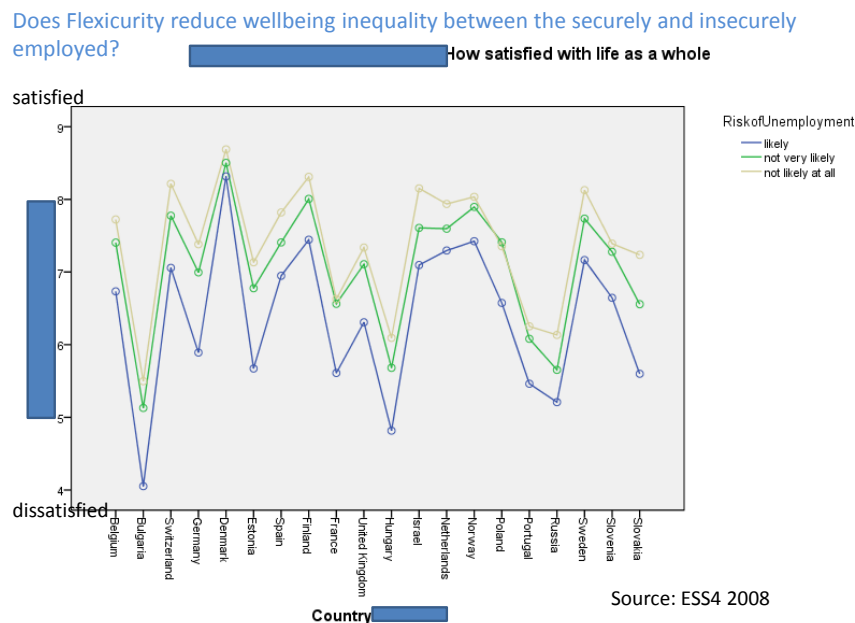
- 4.8 A forthcoming report for the Eurofoundation has examined job quality in EU27 and candidate countries in 2010, and changes in job quality since 2005. There is clear evidence that there have been significant improvements in many aspects of working time between 2005 and 2010. 'Prospects of Job' (see Box 1) deteriorated



considerably with the economic crisis. There is little evidence that the other aspects of job quality changed systematically across Europe in this time period. Differences between countries in 2010 were sometimes predictable, for instance with Nordic countries having high quality jobs. Other results were somewhat surprising; for instance France had the worst social environment of all the EU countries. It is hoped that the regular monitoring of job quality will provide an incentive for improvements in job quality.

- 4.9 An integrated flexicurity approach was adopted in various countries order to generate various social and employment gains^{33 7}. Flexicurity policies and initiatives address labour market conditions, labour relations, , employment security, and social protection¹⁶. The Commission also recommended that member states combine adequate income support and access to quality services for unemployed people³³. As Figure 6 (below) shows in particular the case Denmark that flexicurity policies can protect workers during a recession.
- 4.10 Flexicurity is primarily concerned with promoting active labour market policies in combination with also maintaining levels of social security and social protection. It possesses three main components: Flexibility in hiring and firing; a social welfare system which provides income security and active employment policies. It attempts to reconcile employers' need for a flexible workforce with workers' need for security – confidence that they will not face long periods of unemployment (EU 2007).

Figure 7: Does flexicurity reduce wellbeing inequality between the securely and insecurely employed?



- 4.11 Indeed, the approach adopted by the Commission of the Social Determinants of Health, and the PROGRESS project is that it is important to recognise that any simplistic dichotomy between employment and unemployment is rather more complex than viewing unemployment as 'bad' and employment as 'good' for health. This is particularly pertinent given recent European evidence that the declining employment opportunities available to the 'labour market weak' and those furthest from labour market entry may be characterised by high levels of insecurity, in-work poverty and limited sustainability.



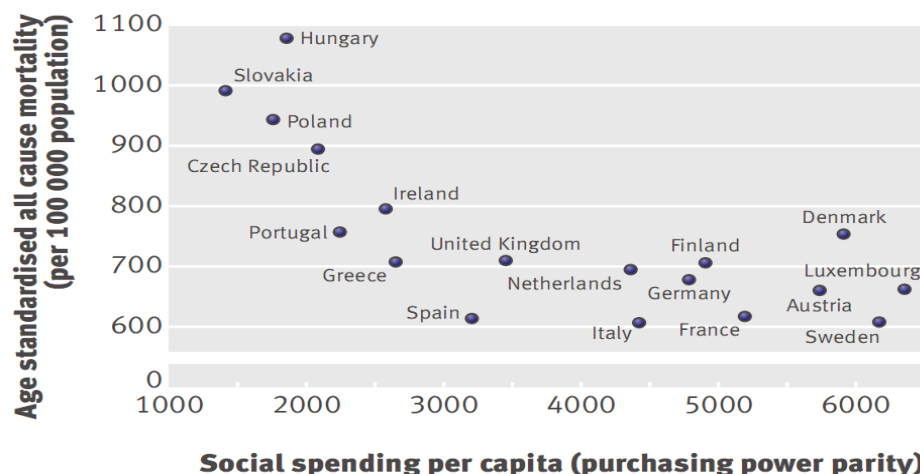
The economic crisis and health

- 4.12 Across Europe in countries such as Spain and Greece public-health spending has declined and a commitment to ensuring health equity³ has fallen off the political agenda. Policy inaction is having devastating social and human consequences despite recent high-level commitments of European health ministers to the Tallinn Charter on Health and Wealth³⁵, which acknowledges health as a powerful means for promoting economic growth and stability.
- 4.13 The financial crisis of 2008 has raised serious concerns within the public health community that health would suffer across the globe. In 2008, WHO director-general Margaret Chan stated that “health problems would increase as people struggle with unemployment and poverty. It should not come as a surprise if we continue to see more stress, suicides and mental disorders”³⁶.
- 4.14 In January 2009, the WHO released the report, Financial Crisis and Global Health, suggesting that poor people would be hardest hit as employment declined across European countries³⁷. Indeed, emerging evidence shows that access to care and preventive services has declined and the deprived face higher risks of ill health and premature death^{38, 39}.
- 4.15 Marmot noted how this situation is not new. Using evidence by Peter Goldblatt from the 1980s recession in the UK he showed how social class and unemployment were significantly linked to mortality. He also described the reaction of British policy makers and politicians at the time who were unprepared to believe that unemployment would cause ill health. Rather it was proposed that sickness led to unemployment. Politicians were unprepared to believe ‘that government policy was killing people’.
- 4.16 A large proportion of the literature on economic cycles and health has focussed on the United States⁴⁰, with recent studies conducted in European countries^{3, 38, 39}. There is a developing evidence base examining the role of institutions and social protection systems in buffering the impact of economic crises and employment on health. Importantly, Stuckler, et al^{3, 38} showed that rises in unemployment are associated with short-term increases in suicides and homicides, but these effects are mitigated by increased spending on social welfare, particularly investments in ALMPs and welfare-to-work interventions. Further evidence⁴¹ finds that negative health effects of economic downturns are more pronounced in countries with weak social protection systems and low social expenditure. Marmot noted that government policy, welfare generosity and social investment spending can protect people from the negative effects of unemployment.

Figure 8. Social spending and all cause mortality⁴²

³ By health equity we refer to Marmot’s definition: systematic inequalities in health between social groups that are deemed to be avoidable by reasonable means. Therefore any policies that retard action to reduce these avoidable health inequalities are unfair³⁴. Marmot M. Policy Making With Health Equity at Its Heart. *Journal of the American Medical Association*. 2012; **307**(19): 2033-4..





- 4.17 More precisely, Stuckler and colleagues have found that ‘for every US\$100 investment in ALMPs there was a 0.038% lower effect of a 1% rise in unemployment on suicide rates in people younger than 65 years (95% CI 0.004–0.071, $p=0.028$). When spending was greater than US\$190 per head per year, rises in unemployment had no adverse effect on suicide rates’⁴². See Table 1 and
- 4.18 Table 2 below for details

Table 1. Effect of \$100 of income, social welfare spending, and healthcare spending on cause specific mortality in 15 EU countries, 1980-2005 (purchasing power parity in \$ for 2000)⁴²

Covariate	All cause	Alcohol related	Malignant neoplasms	Cardiovascular disease	Suicide	Tuberculosis
\$100 in income per capita	-0.14%** (0.035)	-0.21% (0.12)	-0.034% (0.034)	-0.31%** (0.084)	0.19% (0.20)	-0.59%*** (0.14)
\$100 rise in social welfare spending (excluding health care)	-0.99%*** (0.11)	-2.80%*** (0.46)	-0.065% (0.18)	-1.23%** (0.31)	-0.62% (0.49)	-4.34%** (1.27)
\$100 rise in healthcare spending	-0.01% (0.43)	0.97% (0.90)	-0.82% (0.47)	-0.28% (0.95)	-3.15% (1.50)	2.11% (2.32)
No of country-years	320	319	319	319	319	318
R ²	0.906	0.773	0.535	0.901	0.239	0.716

Countries were Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, Spain, Sweden, and United Kingdom. Robust standard errors in parentheses clustered by countries to reflect non-independence of sampling.

Table 2. Effect of \$100 of income, social welfare, and general government spending on all cause mortality for 15 EU countries, 1980-2005 (purchasing power parity in \$ for 2000)⁴².

Covariate	Statistical model			
	Social welfare spending	Income	Income and general government spending	Social welfare spending and income
\$100 rise in social welfare spending (including health care)	-1.19%* (0.068)	—	—	-0.80%* (0.098)
\$100 in income per capita	—	-0.28%* (0.041)	-0.24%* (0.050)	-0.11%* (0.025)
\$100 rise in general government spending (excluding social welfare spending)	—	—	-0.27% (0.15)	—
No of country-years	320	320	258	320
R ²	0.865	0.792	0.787	0.900

Countries were Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, Spain, Sweden, and United Kingdom. Robust standard errors in parentheses clustered by countries to reflect non-independence of sampling.



5. ALMPs and health: overview of the evidence

- 5.1 ALMPs and the interventions used to deliver them are an intermediate stage within the process of labour market reattachment that aims to provide the unemployed and economically inactive with the human capital 'steps' towards employment. Coutts^{21, 43, 44} has highlighted how participants are neither employed nor unemployed but occupy an intermediate labour market status, that is, participants in such programmes continue to receive welfare benefits, i.e., they remain materially poor/constrained whilst at the same time they are exposed to the psychosocial attributes of the employment experience and the intervention itself, which are used to reinsert them into the labour market.
- 5.2 In comparison to the (un)employment and health literature as previously outlined, there is considerably less evidence available on what happens to health when there is an apparent amelioration in aspects of labour market deprivation, especially that embodied within this quasi-employment condition of return-to-work schemes and ALMPs. The small body of international evidence that is available indicates that various positive health gains and reductions in health disadvantage can be anticipated from the changes likely to flow from these processes and interventions^{21, 42, 43}.
- 5.3 As research by Stuckler and colleagues recently shows social protection policies in the form of ALMPs and return to work interventions can have a protective health effect in times of economic downturn and rising unemployment. European Union (EU) mortality trends during recessions in the past three decades indicate that member states can avoid a rise in suicide rates by spending US\$200 per capita a year or more on active labour-market programmes, designed to improve people's chances of gaining employment and protecting those in employment. In those spending less than \$70 — such as Spain and a deteriorating economy correlates with a rise in suicide rate. But in Finland and Sweden, which spend at least \$300, economic change and aggregate unemployment has no discernible short-term effect on overall population health. However, the causal mechanisms or pathways responsible for these effects have not been fully examined.
- 5.4 Using the unemployment-and-health models propounded by Jahoda²⁵, Warr⁴⁵, and Fryer⁴⁶ as well as Bandura's⁴⁷ self-efficacy model as noted above, it is suggested that training programmes have the potential to improve health, in particular mental health and psychosocial functioning, through the provision of the latent psychosocial functions such as social support and time structure which may become unmet during unemployment²⁹. Indeed, a small body of research originating from Scandinavian studies of Finland's Työön Job Search Training Programme⁴⁸, a now country-wide vocational rehabilitation ALMP, and the University of Michigan's Institute of Social Research⁴⁹ has identified positive health impacts of training programmes using these theoretical frameworks. These include reductions in psychological distress and depression^{44, 48-54}; increased subjective wellbeing⁵⁵; higher levels of control/mastery⁵⁶; improvements in motivation and self-esteem through feeling needed^{44, 57, 58}; having something meaningful to do, somewhere to go and meet people; less stigma of being unemployed; and improved social support^{44, 59}. In a new qualitative study of unemployment training programmes in Bradford, Giuntoliet al.⁶⁰ suggested that the health and wellbeing of unemployed participants could be protected through the provision of the psychosocial and material needs disrupted by unemployment, as proposed by Jahoda, Warr and Fryer.



- 5.5 The evidence is equivocal, however, on the extent and duration to which these health gains may persist after intervention. Psychological health benefits may persist for up to four months^{53, 58}, or rapidly decline after participation^{51, 55, 56}.
- 5.6 The evidence suggests that certain intended outcomes of training programmes can have immediate and beneficial health effects, arising directly from participation. The most widely cited and robust evidence comes from the JOBS program^{61, 62}. These studies have replicated randomised field trials involving unemployed workers and their partners to examine the mental health outcomes of moving the unemployed into ALMPs and employment^{53, 59, 62}. Using a combination of self-efficacy training and job-search skills, the programme returned unemployed workers to new jobs more quickly, into jobs that paid more, and reduced mental health problems (e.g. depression) associated with prolonged unemployment^{62, 63}.
- 5.7 Numerous studies (e.g.^{48, 51}) demonstrate that job search is a significant predictor of entry into paid work. Therefore, many ALMPs, and return-to-work interventions, consider it a fundamental component of their training. However, training and support given by job-search trainers and advisors can be haphazard, resulting in various health outcomes^{64, 65}. Various authors⁶⁶ suggests that job seekers could be helped by the provision of counselling to enhance⁶⁷ their expectations of success in job search. This, in turn, may activate the intensity of job search and lead to an increased likelihood of finding a job. However, repeated experiences of failure can undermine personal efficacy and lead to reduced psychological wellbeing^{47, 67, 68}. Consequently, it could be argued that, in terms of health, it would be unwise to motivate people to look for employment given that employment demand may be quantitatively and qualitatively 'bad' in terms of the pay and sustainability that is available. It may be considered, as Westerlund et al.^{54, 69} and Creed et al.^{56, 70} point out, that for the 'labour market weak' training programmes may merely become a 'healthier alternative' to unemployment, enabling them to cope more effectively with the negative psychosocial characteristics of unemployment.
- 5.8 In light of this, a number of researchers^{56, 70, 71} have recommended that ALMPs should be based upon enhancing personal development, rather than focusing entirely on occupational skills and supply-side factors. Academics at the Institute of Social Research (Michigan) have pursued this idea by developing ALMPs based on the self-efficacy model – the JOBS programme⁶². They aim to 'immunise' and help the unemployed cope with the debilitating effects of unemployment by developing their self-efficacy^{53, 59}. This is achieved through role-play on how to carry out effective job searches, by anticipating potential barriers and setbacks in job searches and developing strategies to enhance resilience in coping with these setbacks. Evaluations have highlighted how participants develop higher levels of self-efficacy and mental health, leading to employment in good quality jobs⁵³.

6. Budgets cuts and health effects

- 6.1 Cuts to social welfare budgets have affected the incomes of workers in health services (such as in Slovenia, Latvia and Lithuania) or as in Spain –expenditure on pharmaceuticals⁷². In a number of countries, policies have been bolstered to protect spending for the most vulnerable⁷³. For instance Austria, Czech Republic and Estonia have increased health insurance using tax revenues to cope with the increased demands on health insurance⁷³. However, countries such as Sweden and France have directly increased spending on healthcare and social policies - active labour market interventions to mitigate the potential health risks of unemployment⁷³.



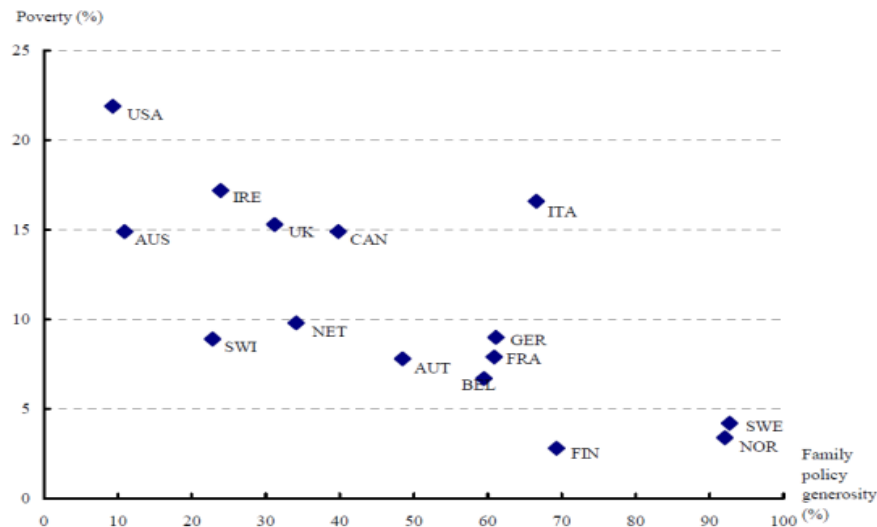
- 6.2 Recently, detailed research on European countries⁴ undergoing major economic downturns, particularly Greece, demonstrate the increased risks to health from budget cuts, and economic adjustments³. In Greece, suicide has been found to have increased by 17% between 2007 and 2009. Unofficial data indicate a 25% rise in suicides in 2010, and a further 40% rise during the first half of 2011. A 2011 survey found a 36% increase in people reporting suicide attempts since 2009⁷⁴. In 2011 a significant rise of 52% in HIV infections was demonstrated⁶. Kentikelenis et al⁶ attribute over half of this surge to intravenous drug use with heroin use increasing by an estimated 20% in the same period. New infections among drug users increased tenfold over first 7 months of 2011⁶.
- 6.3 Access to health care has also declined. Hospital budgets have been cut by about 40%⁶, and it is estimated that 26,000 public health workers (including 9,100 doctors) will be made redundant⁷⁵. An analysis of the EU Survey of Income and Living Conditions in Greece found that between 2007 and 2009, there was about a 15% increase of people reporting that they did not seek medical treatment, despite feeling that it was necessary⁶.
- 6.4 Waiting times have increased due to understaffing in hospitals. As patients have become less able to afford private care, admissions to private hospitals decreased by about 24% in 2010 compared with 2009, and admissions to public hospitals rose by about 30%. It appears that budget cuts to social welfare and health have exacerbated these pre-existing problems⁶.
- 6.5 Greece provides a significant warning to other European countries that are undergoing significant fiscal austerity. As is noted throughout this report monitoring of the health situation is required to respond rapidly to potential unintended consequences of budget cuts and minimise risks to health.
- 6.6 Estonia also provides a specific contextual view of the effects of the crisis which apparently seems to go against the general trend in terms of health effects observed in other European countries. Economic change and policy responses within Estonia were extreme, i.e., the government fully adopted austerity policies and budget cuts early on. Highly qualified workers in the public sector switched to the private sector as the public sector was badly affected with mass redundancies. In terms of health it was noted how those in work particularly part-time work and the self employed rated their health as being worse than that of the unemployed. It was proposed this was due to rise in job insecurity. It was demonstrated that the crisis had a number of beneficial health effects for the population as well as encouraging the government to think seriously about public health. For instance given reduced incomes levels of alcohol consumption reduced which led to a decline in the number of deaths from alcohol related violence and cirrhosis. Taxes on alcohol increased over the period which generated revenue. In addition relative income inequality (gap between rich and the poor) reduced over the crisis. Life expectancy also increased over the crisis despite a significant gap between men and women remaining. Recent statistics show that 64% of men die before the age of retirement. The observed increase in life expectancy has important implications for the design of the pension system and retirement age.
- 6.7 Professor Marmot raised the question and debate between 'budget cutters' and 'social spenders' of those countries such as Germany promoting investment to

⁴ There is some unofficial evidence that life expectancy in Germany has declined over the past three years as a result of the crisis.



increase growth as opposed to the 'contractionary expansionists' and Krugman's 'confidence fairies' who are endorsing the adoption of austerity. He proposed that it is necessary to look at the impact these measures have upon the lives people are actually able to lead, their health and the intergenerational effects such as child poverty. The example of the Nordic approach to family policy was highlighted. Countries with generous family policies have lower child poverty rates (Figure 9). This association is mainly due to policies that support dual earner families. The contribution may be direct through the amount of benefits paid, or indirect by supporting two earners and thereby raising the market income of the household

Figure 9. Source: Lundburg et al 2007 CSDH Nordic Network



- 6.8 A number of important issues were raised particularly whether social protection is affordable. In a time of economic crisis policy makers may say: 'we can't afford social protection...' However, health evidence suggests social protection needed to protect workers and unemployed.
- No evidence austerity measures actually work economically or socially.
 - Possible split in national European country approaches - austerity (Germany, UK, Greece etc) versus social protection (France, Estonia) and the need for monitoring of health impacts not just financial/economic outcomes.
- 6.9 Various commentators provided an 'insiders' overview of the policies currently being adopted by governments across Europe to tackle unemployment and worklessness. In particular what is currently worrying policy makers is that the crisis is no longer just affecting the periphery but has moved to the centres of power and money. Brussels is a just as much a 'pawn' and an observer of as other key players / institutions. Further the policy responses to the crisis have become more than just about designing policies from an evidence base but rather about political economy and ideology. Indeed a similar situation has occurred before. In the 1980s the Conservative government in the UK tried to keep the unemployment and health debate out of the public sphere. The question was raised regarding the nature of the debate now and whether the unemployment/health relationship is accepted by policy makers but has been allowed to slip off the political and policy agenda. Is it our role then as academics and policy makers to keep this on the agenda and strengthen the evidence?

- 6.10 Most of the macro forces that drive social conditions are becoming less linked to political democracy and the policy process. There has been an expansion of the demographic deficit across Europe. For example the adoption of austerity policy responses occurred overnight. Before May 2010 there was not a government who did not warn against cutting social welfare budgets too quickly. The necessity of bailing out of Greece complicated this situation for the major contributors of the EU. Ministers of finance met on the 9th and 10th. As noted 'ministers flew in with policies of stimulus and flew out with policies of austerity'. Angela Merkel and Nicholas Sarkozy had convinced themselves that austerity policies were necessary in order to ensure the continuation of the European social project. Member states have bound themselves to policies of austerity, contraction and financial markets. However, there was discussion about the nature of debt (national public debt is not the same as private debt) in that it may not require to be paid back immediately for growth to occur as the case of the United States post World War II and the Japanese government which currently is running a debt of 200%. It is therefore a fallacy to use the necessity of clearing public debt as justification for austerity policies.



7. Employment and mental health

- 7.1 With 23 million people currently unemployed and set to increase across the EU being fit and healthy have become increasingly important attributes of job readiness. Preparation and fitness for work has traditionally been thought of as primarily associated with the influence of school years and university education. However, with the ageing demography of Europe and the changing nature of work people are increasingly required to be prepared to enter work or switch employment at different stages of their lives.
- 7.2 In examining readiness for work for new workers of all ages it is necessary to take a life course approach. The current culture is that the life-course still has three stages (0-25, 26-50 and 50+) and that the last of those, 50+, is very much about 'deterioration'⁷⁶. With recent changes in retirement age, it may be better to think in terms of four stages (0-25, 26-50 and 50-75 and 75+). Increasing employment and supporting people into work are key elements of public health and welfare reform agendas across Europe. Work readiness can be viewed as both a process and a goal that involves developing workplace-related attitudes, values, knowledge and skills. This enables new workers to become increasingly aware and confident of their role and responsibilities, usually as entry-level workers in enterprises where customer satisfaction, operational performance, and frequently financial return, are vital⁷⁶.
- 7.3 Preparation for working life and acquiring resilience are crucial stages in young people's lives, often having a lasting impact on future financial security and their long-term health and wellbeing. Long-term youth unemployment (between the ages of 16 and 23) significantly increases the likelihood of subsequent unemployment in later life and reduces income from wages by up to 12% to 15% some 20 years later⁷⁷.
- 7.4 Mental health and wellbeing have a fundamental impact on life chances, including employment⁷⁸. As noted throughout this report, being employed is generally good for people's mental health and wellbeing. The workplace is a context that can provide opportunities for people to build emotional resilience develop social networks and develop their own mental capital. However people with mental health problems may find gaining employment challenging. Many mental health problems start early in life, identification and early intervention is important⁷⁸. Half of those who experience mental health problems over the life course exhibit symptoms by the age of 14⁷⁹. Around 90% of people with the most complex mental health conditions are unemployed. Supporting someone with their employment aspirations is a key part of the recovery process⁸⁰.
- 7.5 Mental illness is increasingly recognised as the most significant health concern for children and adolescents in developed countries, with an estimated prevalence of 8%-23% of the child and adolescent population in European countries^{80 81}. It is not only a significant health issue, but also affects many other spheres of life, including the individual but also family and friends and society at large. Prevalence rates seem to be rising, particularly in psychosocial disorders among young people⁸⁰. Prevalence and is well documented, however, there is an urgent need to monitor the economic costs of mental illness for the labour market, as well as the economic return of interventions^{80, 82}. As various reports note 'the presence of mental illness during childhood may lead to up to 10 times higher costs during adulthood, which indicates that early intervention may be particularly effective and necessary'⁷⁸ 180.
- 7.6 Various large employers have taken a strong view on health and well being. Airbus and Eon have introduced a variety of measures to reduce sickness absence. Growing



body of knowledge that helping people / employers to develop resilience in the work place can be very effective strategies for coping with job changes and insecurity. It is also cost effective to introduce these programmes. However, these programmes are often introduced in high end blue chip companies. In relation to equity these policies may be having a negative impact as those who are already benefiting from higher wages are also benefiting from these psychosocial interventions. Perhaps a useful policy proposal would to offer these types of programmes to those who are unemployed or occupy temporary alternative employment.

Germany

The German government is planning a back-to-work scheme outlined in a White Paper to bring millions of mothers and retirees back into industry and trade. To sustain both the economy and Germany's welfare state, an action plan to call in mothers who have not worked before is proposed. Engineering, nursing, IT specialists, care-workers and semi-skilled workers are among those most needed. The paper states: "Women and older workers represent a significant potential which could be quickly mobilised." An estimated 1.2 million professionals could be tempted back to the workplace if the options to combine child care and work were improved". 'Operation Mama', as it has become known, is aimed first at close to 500,000 mothers with children aged between six and 16. Studies show they are eager to become workers if some practical child-care programme were in place. Germany is also focusing on the elderly. BMW recently opened a factory in Bavaria tailored to the older employee, with special non-slip floors, better lighting, tools designed for hands that have lost their strength and so on. The raising of the statutory retirement age from 65 to 67 will boost the numbers of workers by a million by 2025. Only 56 per cent of over-55s currently work, and the goal is to increase that to 70 per cent. In tandem with both schemes is a plan to reduce the number of students who drop out of their course, currently running at 7 per cent. The goal is to halve it, thus adding 300,000-plus professional-level workers to the job market.

Portugal Telecom-Menssana in carporesano

The company has a large health promotion programme directed towards a range of health issues with a number of different awareness campaigns. The aim of these programmes is to maintain and improve physical and mental health and wellbeing. Their general approach is to promote physical activity and good nutrition as key components in keeping fit, healthy and happy. Specific campaigns include raising awareness on how to protect your heart and reduce obesity.



8. Social investment and social protection: an overview

- 8.1 The issue of affordability of social protection was debated throughout the seminar. The discussion focused on the actual role of social protection and how its use is often misunderstood by economists and politicians. Social protection was noted ‘is an unavoidable ingredient of capitalism that helps the unproductive become productive such as childcare to allow women to work and pensions to get the unproductive older person out of the labour market. It is, however, delivered at lowest cost. For the foreseeable future policy makers/politicians are in the mind frame of paying less for such policies’.
- 8.2 The rationale of social protection is to promote cohesive and stable societies through increased equity and security⁸³. Social protection is about alleviating absolute deprivation and vulnerabilities of the poorest, helping people cope with external shocks, social risks and life-cycle events, and the promotion of self-reliance and labour force participation¹⁵.
- 8.3 The social investment perspective in the social policy literature focuses on the ways in which public welfare institutions provide people with resources to help them assume control of their lives, and thereby progress society^{84, 85}. It opposes the idea that welfare – as argued by Titmuss – is solely about altruism and redistribution. This may be the positive side effect of welfare, but it is not the primary purpose of a new and updated approach to welfare. Rather, this perspective aims to formulate “a conception of social policy as ‘productivist’ and investment oriented, rather than redistributive and consumption oriented”⁸⁶.
- 8.4 There are multiple intellectual sources of this approach. After the war, social development theory emerged as a means of promoting and reconciling economic growth and social development in developing countries. The basic idea was that welfare could enhance economic growth, not hamper it, and at the same time contribute to social development and wellbeing. Social policy could, and should, be guided by principles related to productivity and social investment. There was no necessary contradiction between growth and welfare. The state was assigned the prominent role as the conductor of the modernisation project^{84, 86}. Midgley states, the proponents of social investment “advocate interventionist strategies that create employment, raise incomes, and contribute positively to improved standards of living”⁸⁶.
- 8.5 Like Midgley, Jenson⁸⁷ draws a demarcation line between Keynesianism on the one hand and neo-liberalism on the other. Keynesianism is criticized for being preoccupied with ‘passive’ income protection, whereas neo-liberals are accused of relying too much on market forces and policy measures that lack investment properties (e.g. punitive workfare programmes). The social investment perspective, as laid out by Midgley and Jenson, identifies a set of policies based on the requirements of post-modern societies. Strong claims are made that a new welfare architecture is needed to meet the demands of the post industrial society, and that social investments policies can address these new challenges. Chief among these challenges are (new) social risks associated with the labour market; for example, precarious, non-standard life-course transitions, new skills requirements, and changes to the family (higher divorce rates, the rise of single households and lone parenthood). Social investment policies aim to increase social inclusion and labour market participation (e.g. by removing barriers), prepare people for more demanding employment conditions,



minimize intergenerational transfer of poverty, and build social capital. It is argued that policy measures need to meet the challenges of post-industrialism by investing in children and families (e.g. subsidized childcare and parental leave), life-long education, and health. Wages and benefits need to be maintained, and communities and neighbourhoods mobilised^{86, 87}

- 8.6 Another stimulus to the social investment perspective is Titmuss' notion 'command over resources over time' (although Titmuss elsewhere put heavy emphasis on need)⁸⁸. This notion has several advantages and virtues. Resources (not only money) are seen as the basic requisites for people's welfare and life chances. Resources may include psychological (self-efficacy), individual (health), and collective (clean water) resources. In a social policy perspective, perhaps the most interesting resources are those that welfare states provide, which compensate for the lack of resources among vulnerable individuals and families. The emphasis on resources implies that the fulfilment of needs is not the essential purpose of welfare provision. Rather, resources are the main prerequisites for the fulfilment of need, happiness and individual welfare.
- 8.7 This resource perspective was adopted by the Scandinavian living-conditions approach,^{89, 90}. Three components are central to this model: Resources, arenas, and outcomes. The basic idea is that people invest their resources (labour) in different arenas (labour market) to achieve a desired outcome (income). Different kinds of resources are the key to wellbeing and life chances. Since resources are unevenly distributed, the welfare state may intervene by compensating for a shortage of crucial resources (e.g. by restoring work ability through rehabilitation). Sen launched the influential notion of equality of capabilities, which has a strong affinity with the Nordic living conditions approach. In a discussion of the relationship between these two approaches, Ringen⁹¹ states that the concept of capabilities captures both the concept of resources and the concept of arenas in the Nordic living conditions approach. There are many links between this resource perspective and an asset based health approach.
- 8.8 Finally, social investments have the possibility to enhance the resilience of deprived individuals and communities with resources that are closely associated with the social determinants of health, thereby reducing exposure to adverse health risks. Social investments, therefore, have the potential to enhance public health and reduce health inequalities.

Social protection and the welfare state

- 8.9 The role of the welfare state in determining the variability of health inequalities raises important political and policy questions regarding the actual purpose of the state. Is it to improve the status of those at the very bottom of society, or to promote the general equality and wellbeing of the entire population?
- 8.10 This is a pertinent question given that governments across Europe are reducing their coverage of social protection, despite evidence that demand for social protections is increasingly needed. As Stuckler and colleagues have repeatedly demonstrated if countries hope to maintain their present level of social protections, including mechanisms like ALMPs, social welfare spending will have to increase^{2, 3}.
- 8.11 In developed economies, poor health and prior unemployment are major risk factors for unemployment and cycles of insecure work and benefits receipt. In combination with other labour market disadvantages, such as low education, poor health can compound the risk of health-related worklessness⁹². As research over the past decade



has demonstrated the role and type of welfare state regime can moderate the effect of these risk factors^{93, 94}. The assumption that the Nordic countries with more egalitarian welfare states have 'flatter' health equality gradients (in terms of morbidity and mortality). However, recent research by various authors is challenging this finding^{94,95 92 95 92}. The developing evidence suggests that the type of welfare design has a profound effect on the social determinants of health moderating the relationship between unemployment, non-employment and health. Consequently the differential size of inequality in egalitarian compared to less egalitarian welfare states has become a point of substantial debate in the field of social determinants of health.

- 8.12 In analyzing links between welfare states' structure and their public health, researchers have used indicators, such as disease (mortality) and illness (self-rated health). Recent research such as⁹² have used supposedly more sensitive indicators to examine health inequalities between countries with different welfare state arrangements. These indicators focus upon 'sickness' – the ability of an ill or disabled person to fulfil his or her social roles⁹². Sickness is related to the broader 'social consequences' of illness or disease which are influenced by the interaction between individual characteristics and differing social circumstances. The research has examined whether there are different patterns of absolute and relative social inequalities in sickness can be observed.

Empirical evidence

- 8.13 Employment rates of people with an illness or disability have consistently been found to by welfare state typology. Health-related worklessness is lowest in the Scandinavian welfare states, where the worklessness rates of people with a limiting long-term illness is 30.3% in Iceland, 33.1% in Sweden, 41.6% in Finland and Denmark, and 42.4% in Norway, with a welfare state regime average of 37.8%⁹². Health-related worklessness is highest in the Anglo-Saxon countries of the UK and Ireland, where 49.9% and 64.3% respectively of people with limiting long-term illnesses are unemployed / economically inactive. Significant cross-national differences in terms of the magnitude of socio-economic inequalities in employment related ill health have been found⁹². Educational inequalities in worklessness are higher in the UK (and, to a lesser extent, in Canada) than in the Scandinavian countries.
- 8.14 In an analysis of 25 countries, using data from the European Union Survey of Income and Living Conditions⁹² labour force participation by educational status and health was compared. The authors found that in all countries, people with health problems have lower employment rates than those who are healthy, and that worklessness rates are accentuated in people with a combination of both a health problem and a low-level of education attainment. However, surprisingly they found that employment rates of those with a health problem and a low levels of education are higher in the Social Democratic welfare states (that is, those who invest more per capita in ALMPs), and which provide more generous welfare benefits. There are smaller educational inequalities in non-employment in countries that spend more on active labour market policies⁹².
- 8.15 Employment rates were consistently higher, and absolute and relative inequalities in sickness were lower in countries that provide generous unemployment benefits and spend more on ALMPs⁹². This echoes the findings of Stuckler and colleagues. As the authors note 'even if benefit morale may be lower in more generous welfare states, it does not seem to affect sickness levels or sickness inequalities in any way that threatens the sustainability of the welfare state, when compared to less comprehensive welfare states'.⁹²



The role of international institutions and agencies

- 8.16 Various international organisations and agencies have played a vital and often controversial role in the responses taken by Member States to the economic crisis. An overview of their role and various recommendations are outlined below.

World Trade Organization (WTO)

- 8.17 The World Trade Organization (formerly GATT) oversees implementation, administration and operation of trade agreements, provides a forum for negotiation and settling of disputes, and reviews national trade policies to ensure coherence and transparency for its 153 members. Its activities have an immense impact on global health, by determining which (health) issues are part of trade agreements and by setting the scope for trade among WTO members (Ervik et al., 2009). Two agreements, in particular, shape national provision of health care:
- 8.18 1. Agreements on Technical Barriers to Trade: covers issues such as trade in biotechnological and pharmaceutical products, and equal access to - and sharing the benefits of - health resources.
2. Trade-Related aspects of Intellectual and Property Rights (TRIPS): agreements decisive to issues of medical patenting.
- 8.19 Lee et al. (2009) outline three main concerns about the WTO's role in health. The first is that the major trading partners (the EU, USA, Japan, and Canada) dominate restricted bilateral meetings, with many low and middle income countries lacking the resources to sufficiently monitor or influence negotiations. Whilst the average size of a delegation from a low-income country consists of two representatives, the EU sends over 140 in addition to capital-city based officials. As a consequence, the priorities of those with the most resources dominate proceedings. A second concern is about the settlement dispute process, which is central to the WTO's rules-based trading system. On this, Lee et al. claim that it fails to adequately balance commercial and health interests and doesn't permit sufficient public health measures based on the precautionary principle. The third main concern relates to the low status accorded to health policy in comparison to commercial interests. For example, health representatives only sit in on two of the 16 advisory committees, and 93% of the 742 advisors represent commercial interests.
- 8.20 Given that, the WTO is criticised for subsidising richer countries at the expense of developing ones, favouring richer countries in trade agreements over poorer ones, creating barriers to the use of drugs and medicines in the name of intellectual property rights, having an overly complex and expensive legal system favouring richer litigants and deterring poorer ones, and failing to respond swiftly with trade concessions to countries hit by natural disasters.

The World Health Organization (WHO)

- 8.21 The WHO has been very vocal on the health effects of the economic crisis and how governments should respond. However, few governments have adopted any of these recommendations particularly the need for monitoring systems as the crisis progresses.
- 8.22 For many decades GATT/WTO and the WHO operated in isolation, co-operating infrequently. The growth and expansion of world trade and economic globalisation increased the importance of health issues, bringing the two into more frequent



contact (Lee et al., 2009). In 1997 the WHO reacted to the potential effect of the TRIPS agreement on access to drugs, noting that negotiations were largely dominated by industrialised countries, sometimes forcing developing countries to accept commitments running counter to their economic and social development (WHO, 1998). Essentially a defence of public-health over free-trade principles, this initial dispute prompted the WHO to strengthen its engagement and show leadership on trade issues. The WHO currently has observer status at the WTO in the committees on sanitary and phytosanitary measures and technical barriers to trade, and ad hoc observer status on the TRIPS Council and the Council for Trade in Services, allowing it to contribute to discussions even though it does not enjoy official decision-making authority.

- 8.23 The WHO has been increasingly active on the social determinants of health, establishing the Commission on Social Determinants of Health in 2005 in response to worldwide persistent and increasing health inequalities. The Commission's final report (WHO, 2008) argued that "social justice is a matter of life and death", and proposed actions in three main areas: 1) improving daily living conditions, 2) tackling the inequitable distribution of power, money and resources, and 3) measuring and understanding the problem and assessing the impact of action. Work is currently on-going into a review of health inequalities in the European Region, which is due to report in 2012 and will inform the WHO's Health 2020 Strategy.
- 8.24 Most EU member states have endorsed the equity principles and values articulated by the WHO, and the EU and WHO generally co-operate with each other on issues relating to public health, though the role of the EU is growing in this respect.

International Monetary Fund (IMF)

- 8.25 The International Monetary Fund (IMF) works to provide financial assistance to countries experiencing serious financial and economic difficulties. It claims that low-income countries which borrow from the IMF under its Poverty Reduction and Growth Facility generally increase spending on health and other social programmes. However, research demonstrates that countries participating in an IMF programme experience a 16.6% increase in tuberculosis deaths, with each additional year of participation in an IMF programme associated with an increased tuberculosis mortality rate of 4.1% (Stuckler et al., 2008) though it should be noted that countries in receipt of IMF assistance already have difficulties financing their health and welfare systems.
- 8.26 The IMF has been widely criticised for advocating austerity programmes, supporting military regimes, and for impoverishing countries, and as a result has been the subject of numerous protests and demonstrations around the world. A recent book by Rick Rowden (2009) argued that the IMF's approach stopped developing countries from increasing public investments, resulting in chronically underfunded health systems, dilapidated health infrastructures, inadequate training of health workers, and demoralising working conditions, helping contribute to the aforementioned 'brain drain'. Östlin et al. (2011) note that international institutions including the IMF have increased emphasis on market-based and privately-financed health care, and that research is needed on how to redesign institutions for global decision-making "so that these institutions address not only trade and economic crises, but other global issues... that have important social and health consequences".

The World Bank



- 8.27 The World Bank is an international financial institution with 186 members, providing low-interest loans to developing countries for public and private investments in education, health, administration, agriculture and environmental and natural resource management, alongside technical and financial assistance.
- 8.28 Although its stated intention is to reduce poverty, critics assert that it is dominated by richer countries, that its policies have actually increased poverty, and that it has been detrimental to the environment, public health and cultural diversity. Lumped alongside the WTO and the World Bank, critics such as George (1988) argue it promotes a neo-liberal agenda: an example being its demand that Bolivia privatise its water supply in 2000, resulting in massively increased water bills for local people and widespread social unrest⁴⁶. Worse, the World Bank's approach to health 'exacerbates poor health outcomes by reducing access to health services for those unable to pay for care in newly privatised systems... with recent programmes aiming to help the poorest actually ignoring structural deficiencies in social services' (Birn & Dmitrienko, 2005).

International Labour Organization (ILO)

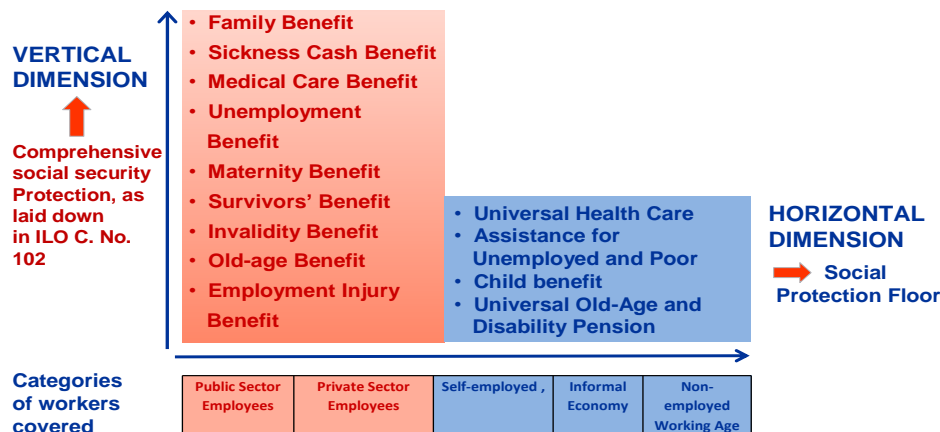
- 8.29 The International Labour Organization (ILO) is the specialised agency of the United Nations (UN) responsible for drawing up and overseeing international labour standards⁴⁷. It is the only 'tripartite' ²⁷
- 8.30 UN agency bringing together representatives of government, business and labour to jointly shape policies and programmes concerning labour. The ILO's standards directly influence EU member states' policies on workplace health and safety, and ILO recommendations help determine the strategies of the European Agency for Safety and Health at Work⁴⁸.
- 8.31 In recent years the ILO has put forward a proposal for a Universal Social Protection Floor, which aims to provide a guaranteed minimum level of social security by combining income transfers, access to health, education and active labour market programmes to act as safeguards against the negative social and economic effects of unemployment, job insecurity and poverty⁴⁹. As discussed at the seminar the SPF may be more applicable to developing countries who have yet to achieve any form of social welfare. In the case of the European Union, the SPF can be used as a lobbying against the dismantling of social protection policies under the guise of austerity and claims by Member States that they do not possess the required finances to introduce such as packages often stating that social protection and social security will face cuts within austerity packages. However, as evidence shows the rapid extension or introduction of social transfers is one of the most powerful tools to effectively cushion the impacts of economic downturns, through limiting the negative social effects of the crisis and helping to stabilize aggregate domestic demand^{42, 96}. It is widely recognized that labour market and social effects are lagged in comparison to the economic / financial impacts and will continue to be felt in years to come. The United Nations system as a whole and many of its agencies have devised coping mechanisms in this regard⁹⁷.

Social Protection Floor (SPF) The two dimensional strategy

- 8.32 The basic principles underlying the ILO approach to social security coverage can be thought of as two-dimensional in nature, namely the horizontal and the vertical dimensions (Figure 10).



Figure 10: Social protection – two dimensional strategy



- 8.33 The horizontal dimension: Four essential guarantees – social transfer component of the Social Protection Floor¹⁵
- 8.34 The horizontal dimension, includes the extension of some income security and access to health care (basic social security guarantees), even if at a modest basic level, to the whole population. The horizontal dimension aims at providing minimum income security to all, including protection against catastrophic health expenditure. Thus, the set of basic social security guarantees aim at a situation in which: all residents have the necessary financial protection to afford and have access to a nationally defined set of essential health-care services, in relation to which the State accepts the general responsibility for ensuring the adequacy of the (usually) pluralistic financing and delivery systems; all children have income security, at least at the level of the nationally defined poverty line level, through family/child benefits aimed at facilitating access to nutrition, education and care; all those in active age groups who are unable to earn sufficient income on the labour markets should enjoy a minimum income security through social assistance or social transfer schemes (such as a minimum income guarantee for women during the last weeks of pregnancy and the first weeks after delivery) or through employment guarantee schemes; and all residents in old age and with disabilities⁵ have income security at least at the level of the nationally defined poverty line through pensions for old age and disability.
- 8.35 The four social security guarantees, together with essential services, constitute the social transfer component of the Social Protection Floor, promoted by the United Nations as one of the nine initiatives to confront the recent financial and economic crisis, accelerate recovery and pave the way for fairer and more sustainable globalization.

⁵ This means a degree of disability that excludes them from labour market participation.



- 8.36 The vertical dimension: Social security benefits protecting people's standard of living across the life cycle. This dimension seeks to provide higher levels of income security and access to higher quality health care at a level that protects the standard of living of people across the life course when faced with problems such as unemployment, ill health, invalidity, becoming a widow and old age. It should provide range and level of benefits at a level that is described in Convention No. 102. Policies can be introduced along the vertical axis as a country acquires more fiscal space and is able to provide higher levels of protection. However, policies and principals of social security should be pursued along both axis and adapted to fit national circumstances/contexts.



9. Key issues and policy options for the European Union and Member states

The role of Active Labour Market Programmes

- 9.1 Today, social protection is a crucial investment in economic development, helping individuals and communities to be resilient against economic crisis and constrained fiscal budgets^{98 1, 3, 73}. It is widely understood that, without social protection, no society can fully develop its full productive potential or achieve 'healthy' levels of welfare for all its members.
- 9.2 The global financial crisis has added a sense of urgency for countries to implement national social protection policies. However, it also provides a window of opportunity to get evidence into policy. As noted throughout the seminar and this report many governments claim that they do not possess the required finances to introduce such packages, often stating that social protection and social security will face cuts within austerity packages. As McKee and Stuckler have recently noted there is worrying trend within certain European countries are rapidly dismantling their welfare systems^{99, 100}.
- 9.3 However, as the evidence shows social protection and in particular ALMPS are powerful mechanisms that can mitigate the impacts of economic downturns, by limiting negative social and health effects and helping to improve individual resilience⁹⁶. However, these policies and interventions must be sustained; it is widely recognized that the social and health effects lag in comparison to the immediate economic and financial impacts. This will help to ensure that health inequalities are not further accentuated and compounded for certain population groups.
- 9.4 One of the main proposals from the seminar is that health equity must be incorporated into national and EU level economic decision making in order to help offset the impacts of unemployment and job insecurity on health. Currently no such mechanism or policy tool exists to facilitate this. Over the past ten years there have been attempts to include Health Impact Assessment (HIA) techniques and methodologies into the policy making process. HIA should form an essential component of in design, delivery and measurement of policy effectiveness.

Enhancing the evidence base

- 9.5 Given rising unemployment and economic inactivity across Europe, a number of EU countries are putting resources into improving labour market outcomes through a variety of welfare-to-work programmes and ALMPs, but as noted earlier in this report the evidence regarding their health impacts needs to be strengthened. ALMPs have shown variability, with some programmes having considerable success (in terms of health protection and resilience development) in one country or context, but not in another. This highlights the importance of evaluating the effectiveness of these programmes by measuring improved labour market and social outcomes.
- 9.6 In addition the evidence base surrounding policy interventions is currently heavily biased towards studies carried out in the USA, Scandinavia and the UK. In the US examples these studies are the those established by the Manpower Demonstration Research Corporation (MDRC), where social welfare interventions are applied in a specific sub-population and compared, using Randomised Controlled Trials (RCTs). Given this there is an urgent need to generate primary evidence from a wider European context particularly eastern and southern European states undergoing large-scale social and economic change as a result of the financial crisis and



government responses. It is often the case that EU government policy makers have adopted lessons and made inappropriate generalisations on the basis of such international evidence.

Health: an outcome that matters

- 9.7 Most policy research and evaluation has focused upon the more tangible outcomes of policy interventions, such as rates of job entry. There is a developing evidence base that health, particularly psychological health, is also measurable and tangible, with respect to training programmes and social interventions. Numerous studies have noted how psychological health is a necessary part of an individual's portfolio of employability and a 'step' towards labour-market entry. Psychological health includes self-esteem and self-efficacy, which can affect an individual's job search motivation and behaviour and, therefore, influence job outcomes. Therefore, this report recommends that health should be included in the monitoring and evaluation of government social interventions. Essentially this entails creating a method of measuring policy process outcomes (as a result of participation in a programme or policy) in addition to outcome-based commissioning (i.e., job entry rates).
- 9.8 Indeed, the evidence generated by examining the health effects of interventions such as ALMPs can be fed into current work on measuring and valuing the employment outcomes of various labour market policies/interventions. This would include the social value of moving someone into work, and how their health and wellbeing can be effectively be valued (monetarised) as an employment outcome^{101 102}. This entails demonstrating the cost savings to the treasury and also to the individual. In the UK there are moves within policy circles to monetise the health outcomes of ALMPs. The Department for Work and Pensions (DWP) has recently has started to use measures of wellbeing to attach (monetised) values to employment. Traditional Cost Benefit Analysis (CBA) methods which assess the value of employment outcomes generated by ALMPs are underestimates of the values of these programmes because the impact on quality of life of participating in these programmes is ignored. Understanding of the impacts on health and psychological wellbeing of participating in ALMPs provides a fuller picture of the effectiveness of welfare policy interventions which, by attaching monetary values to these impacts CBA, can be improved. The DWP aims to incorporate the value of these wellbeing outcomes into CBA and – where differential wellbeing impacts exist (say for different demographic groups or programmes) – make an impact on policy decisions by helping the Department to channel money where it has the greatest social impact.
- 9.9 The EU has good measures of the quantity of employment (eg participation rates, unemployment rates), permitting analysis of the relationship between these variables and wellbeing. However, there are few good measures of the quality of employment, despite the considerable evidence that health and wellbeing are linked to job quality. Furthermore, the increase in unemployment might, in some countries, lead to a decrease in job quality. Agreed indices of job quality are an important step towards monitoring these trends which will be necessary before the drivers of job quality are better understood, which will in turn lead to policy options



**Creating sustained policy commitment for the social determinants of health -
Understanding the policy process**

There is still further work to be done by academics and the research community in order to place health equity and the SDH approach at the heart of social and economic policy making. Generating and sustaining policy commitment, requires a number of components such as promoting a joined-up approach to policy design and delivery, recognising that health is a cross-cutting issue and outcome that matters across the whole-of-government. This means reaching outside of the health ministry to social affairs, labour, agriculture and trade for example by demonstrating that health is of social and economic value to their policy agendas. It also means thinking long-term, which extends beyond the short-term political cycles which govern current policy thinking and ultimately lead to inefficiencies and shallow policy change. Finally, it involves building policies, programmes and interventions based on evidence and setting up a cycle of monitoring and evaluation to identify successes or failures and, where possible, extend successes throughout the community, region, or entire society. As noted above evidence should, where possible, demonstrate both economic and social value, particularly in terms of whether the health of individuals and communities is protected and improved.



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i For downloadable publications from the Michigan Prevention Research Centre and JOBS programme, see: <http://www.isr.umich.edu/src/seh/mprc/public.html>

