9th Annual ESPAnet Conference

Sustainability and transformation in European Social Policy

Valencia, 8-10 September 2011

Stream 6: Labour market policy, activation and beyond

Stream convenors: Ludo Struyven (Leuven University) and Matthias Knuth (University of Duisburg-Essen)
Poor health as a cause and as an effect of unemployment: What can be done, what should be done in activating labour market policy? Experiences from Germany

“Sustainability and transformation in European Social Policy”  
9th Annual ESPANet Conference, Valencia, 8-10 September, 2011

Stream “Labour Market Policy, Activation, and Beyond”

Draft

PD Dr. Martin Brussig (martin.brussig@uni-due.de)*
PD Dr. Nico Dragano (nico.dragano@uk-essen.de)**
Dr. Sarah Mümken (sarah.muemken@uni-due.de)*
* Institut Arbeit und Qualifikation, Universität Duisburg-Essen, D – 47048 Duisburg

** Institut für Medizinische Informatik, Biometrie und Epidemiologie, Universitätsklinikum Essen, D – 45122 Essen
Introduction

The paradigm shift from “active” to “activating” labour market policies which occurred in Germany in the late 1990s was legitimized by rigidities in labour markets which seemed to need in particular more flexibility. Typical examples are employment protection legislation, the level of social security, but also the governance of labour market policy. Individual health as a main source of differences in individual labour market opportunities was largely ignored.

Our contribution discusses opportunities and restrictions to implement issues of health and well-being into labour market policy. For this purpose, we present in the first part results about the relations between health and unemployment. For instance, being unemployed has a negative impact on health. On the other hand, participating in labour market programs per se might have a positive health impact on the participants. In the second part, we present the institutional context in Germany which shapes labelling and treatment of individual health problems. In Germany, incapacity benefits are strictly linked to a medical assessment by approved doctors without considering labour market chances. As a result, many persons are not sick enough for an incapacity benefit, but are too sick to be employed. These persons remain in a status as “unemployed” and are subjected to activating programs. These programs usually are not sensitive to individual health. Since local actors in labour market policies such as PES begin to realize the importance of health-related integration problems, they start to try out innovative programs. In the third part of our presentation, we report first experiences of some local programs which try to influence the health and well-being of participants. Main questions are: What are the problems these innovative programs address? Which resources do they use, and what are the results? Which institutional obstacles exist, and which institutional structure would be appropriate to overcome some of the existing problems?

This paper is structured as follows: In the first section, we review the literature to extract the basic hypotheses about the relationship between health and unemployment. In the second section, we present the institutional structure of social policies aiming to protect against incapacity and unemployment (incapacity pensions and activating labour market policy) in Germany, and some problems for the activation of unemployed persons with health problems resulting from the institutional structure and the reforms of recent years. Third, we discuss results of pilot projects dealing with health problems of unemployed persons despite an institutional structure which is often not supportive. Methodologically, our paper combines literature studies (first part), with institutional analysis (second part), and results of original field work (third part).
An interaction between unemployment and health?

It is a well established fact that unemployed populations have higher disease and mortality risks as compared to the working population. For instance, a recent meta-analysis of 42 longitudinal studies from different countries estimates that unemployment is related to a 1.6 times higher mortality risk (Roelfs, Shor, Davidson & Schwartz 2011). Comparable evidence exists for incident diseases and for measures of psychological well being. Associations between health and unemployment have been systematically studied since many years and to date the main mechanisms linking the both domains are well known. In general they are distinguished into so called selection effects and causation effects.

Selection describes a situation where ill or disabled persons are ‘selected’ into unemployment as a consequence of their impaired health. Such effects might occur at different stages of the employment career. First, chronically ill employees face higher risks of losing their job - despite the presence of worker protection laws in many countries, (Christensen, Kriegbaum, Hougaard, Mortensen & Diderichsen. 2008). Ill health determines absence rates and could have an impact on productivity and although such effects might not be apparent in many cases, persons with manifest diseases are often in disadvantage compared to other employees when decisions about dismissals are made (Varekamp & van Dijk 2010). Another form of selection takes place when already unemployed persons with chronic diseases try to gain reemployment. Impaired health is a major hindrance for the attempt to find a new job and it should be noted that employment rates among disabled are low in almost all western economies (Wynne & McAnaney 2005). Finally an indirect selection might occur (Bartley, Ferrie & Montgomery 1999). This kind of selection is characterised by the impact of a third factor which negatively influences both health and unemployment risks. An example for such a third factor is a low qualification level. Persons with a low qualification frequently work in precarious jobs with immanently high unemployment risks and at the same time, precarious jobs are often associated with a comparably high exposure towards health-adverse working conditions.

The second main mechanism linking unemployment and health is the direct health effect of unemployment itself, often called the causation effect. Unemployment is an important cause of material and social deprivation as well as a psychological burden for the affected individuals. Those consequences of unemployment are important determinants of health and could negatively influence the health of unemployed especially in a long turn. For example, poverty is known as a key determinant of health and life expectancy as it threatens many important resources such as a healthy diet, the living environment, participation in social activities or access to medical care (Marmot, Friel, Bell, Houweling & Taylor 2008). Accordingly, numerous studies report that initially healthy employees develop significantly higher morbidity and mortality risks after job loss (e.g. Voss, Nylén, Floderus, Diderichsen & Terry 2004; Reine, Jovo & Hammarström 2011).

Finally it is crucial to point out that the described selection and causation pathways are interrelated and could trigger a vicious circle of ill health, unemployment and blocked career perspectives. For instance, if a chronically ill person gets unemployed (selection), the negative
effects of unemployment (causation) might aggravate the disease status and prevent recovery which then further lowers the chances of re-employment. However, it is important to note that this interrelation is not necessarily negative because it implies that positive changes in one domain could have positive effects in regard to the other domain. It has been shown that health improves when re-employment is achieved and it is also plausible that re-employment chances get better when health is improved first. Thus, from a theoretical point of view, employment related strategies and health related strategies are both important when improving the health of the unemployed.

Social security in the case of inability to work in Germany: The institutional structure of incapacity pensions and its consequences

This section introduces the institutional structure of social security in the case of illness and work inability in Germany and discusses its potential for an integrative labour market policy for unemployed persons with health problems.

The most important system of social security for persons who are unable to work in Germany is the "benefit for reduction in earning capacity" (incapacity pension). Incapacity pensions are an integral part of the pension insurance. During its formation in the 19th century, pensions due to old age have even been regarded as a special case of the more general incapacity pension. Pensions due to occupational incapacity have been closed for persons born after January 1, 1961. For younger persons, the German pension fund offers only incapacity pensions in the case of lost overall – not restricted to the occupation – employability.

There are two basic requirements to qualify for an incapacity pension: contribution record and degree of (in)ability.

- Contribution record: Pension contributions must have been paid for at least three out of the last five years. Contributions will be paid for employed persons (by employers and employed) and for unemployed persons who receive unemployment benefit (by the unemployment insurance fund). Until 2010, contributions have been also paid for persons who receive the Minimum income benefit (Arbeitslosengeld II or Grundsicherung). From 2011 on, recipients of

1 In the case of sickness, the employer continues to pay wages or salaries for six weeks. In the case of sickness of more than six weeks, the health insurance pays a proportion of the lost income (sickness allowance). Permanent impairments due to work accidents are covered by the compulsory accident insurance.

2 The aim of the Bismarckian pension insurance was to provide some security in the case of incapacity. Incapacity had (and still has) to be proven individually. Only from a certain age limit (at that time: 70 years), an individual assessment was no longer required, because incapacity was assumed.
MIB are excluded from contribution payments. If they remain long enough on the MIB, they consequently lose eligibility for an incapacity pension. Unemployed persons without a benefit, or non-employed persons, such as housewives, are not insured in the pension insurance.

- Degree of (in)ability: The degree of incapacity will be assessed by a medical exam. The doctors who examine candidates for an incapacity pension are appointed by the pension insurance. The doctors have to determine the individual ability to work as an amount of hours which a person is able to work on a daily basis. Persons with a daily ability to work for less than three hours fulfil the requirement for an incapacity pension. Persons with a daily ability to work for at least three, but less than six hours fulfil the requirement for a partial incapacity pension. The benefit at the partial incapacity pension is only half of the benefit for a (full) incapacity pension. The assumption is that a person with a partial incapacity is able to earn an income based on the remaining work ability. For the definition of individual work ability, neither the labour market situation nor the former occupation is taken into account. Only when a person is unemployed – and the assumption that he or she can earn an income with his or her remaining work is obviously fictitious – a partial incapacity benefit can be transformed into a (full) incapacity pension.

Before an incapacity pension is granted, normally rehabilitation will be undertaken to restore work ability. Normally, an incapacity pension will be granted for a fixed term of only three years. After three years, a new medical assessment takes place. Only after two other assessment procedures (after six and after nine years), an incapacity pension will be granted until the age of 65, when it is transformed into an old-age pension.

In international comparisons, gate keeping into the incapacity benefit in Germany is strictly focused on individual medical conditions without paying much attention to the labour market situation. The incapacity pension does not serve as an escape from unemployment; quite to the contrary, it sets incentives to work even with health impairments. The work orientation of the incapacity benefit is laid down in principles as “rehab before pension”, the fixed time limit of the benefit during the first years, and the opportunities to earn from own work without damaging the entitlement. These provisions contain the fiscal costs of the incapacity pension, but these provisions can be justified additionally by the assumption that being employed improves individual well-being, provided that the job is adjusted to the specific individual impairments.

Rehabilitations have to be applied for as well and will be approved after an individual assessment. It is plausible but not investigated yet that requests for rehabilitations by unemployed have lower chances to be approved because their chances for employment after rehabilitation are lower than those of sick, but employed persons who might return to their job or their firm.

Persons with an incapacity pension who earn above the exempted level receive a lower benefit, but will not lose their entitlement to the pension. If the income is lost, then the old level of the pension will be paid again. This provision reduces fears to lose entitlements when a person picks up a job but is uncertain whether he or she will sustain.
Whereas the incapacity pension is “work-friendly”, labour market policy is not “health sensitive”. Among the unemployed in Germany, many persons are too sick for employment but not sick enough to be unable to work in the sense of the pension insurance (see section 1). In a survey among recipients of Minimum income benefit, 8.8 percent said that they can work less than six hours daily on a regular basis (and rated their health as “poor” or “very poor”) (see Brussig & Knuth 2010, p. 315). If these subjective self-assessments would have been officially acknowledged, then these people would find themselves in the wrong benefit system. Strict gate-keeping before incapacity pensions is reflected in international comparisons as well. The chance of persons with otherwise similar characteristics to describe themselves as “unemployed” instead of “incapacitated” is in Germany 15.4 times higher than in the Netherlands, and 20.8 times higher than in Great Britain (see Erlinghagen & Knuth 2010, p. 83; see also Börsch-Supan 2011).

Public employment services (PES) are hardly prepared for the fact that many jobseekers have significant health problems. In the labour market policy reform discourse, health impairments and the consequences of the erosion of health in the labour process didn’t play an important role. Health problems have not been discussed neither as a cause of getting unemployed, nor as a barrier to be re-employed. “Causation” and “selection” as the main mechanisms how health and unemployment interact (see section 1) have not found their way into the mainstream design of labour market policy in Germany. There was, however, an innovation in labour market reforms by integrating psychosocial services into the realm of labour market policy.\(^5\) It was innovative, because psychosocial services were accepted as an element of labour market policy despite the fact that these services do not lead directly into a new job. Rather, they would work to improve preconditions of individual employability.

In the course of the reform of labour market policy, new staff has been hired into the PES. This “window of opportunity” was used mainly by the PES to hire persons who worked already for the PES on a fixed-term basis, persons who worked in the area of further training in private organizations, and (some) HR-managers in local enterprises. Few of them, if any, have competences or received trainings in sociomedical or sociopsychological questions. Consequently, case managers are “health sensitive” only to a very limited degree. Moreover, case managers do not have enough resources. Very often, the caseload of case managers is higher than initially promised by the supporters of the reform. Case managers often don’t have sufficient time to build up trust in their talks with jobseekers. But trust is necessary to come to very personal matters in job talks, such as depressions or alcohol dependency. The work of case managers (and of local PES-branches, and consequently of local PES-managers) is

\(^5\) A prominent example for such psychosocial services is counselling for drug and alcohol addictions. However, gaps in the regional coverage with these services result in long queues for those who need this service; due to financial pressure in PES, they can cover the costs for only a few of them (and consequently PES hold back information about drug counselling); and a relative low prevalence of addictions – at least compared to health problems in general – give this innovative enlargement of labour market policies rather a symbolic than a practical value.
evaluated foremost against integrations into employment. This carries the risk of “creaming”, i.e. to concentrate on jobseekers who are easily integrated into jobs.

Therefore, it isn’t surprising that jobseekers with limited health are less activated than jobseekers without health problems.\(^6\) This supports the “creaming”-hypothesis. And since activation improves job chances, jobseekers with limited health have lower integration chances. However, multivariate analysis shows that even jobseekers with health problems benefit from activation, but they need a “higher dosage” before a significant impact on job chances is measured. For instance, a significant activation effect can be shown for jobseekers without health problems who have a personal integration plan or received a job offer, while jobseekers with health problems need a personal integration plan and a job offer to improve their chances (see Brussig & Knuth 2010). This is of course only a statistical relation without a causal explanation. It provides, however, support for the hypothesis that a linkage between labour market policies and instruments on the one hand, and rehabilitation or – more general – improvement in subjective health is useful. Such linkages are tested in several regions and different projects.

**Experiences in the implementation of health promotion for long-term unemployed**

The German health insurance funds have a legal mandate to improve the health status of the population, particularly with regard to health inequalities produced by social causes (§ 20 SGB V). The standard procedure concerning such ‘preventive’ measures is that a member of an insurance fund may choose from fitness programs recommended by the fund but offered by various providers. Participants will first have to pay admission fees out of their own pockets and will only later receive a full or partial refund from their health insurance. Together with low affinity to ‘wellness’ as a middle class concern, liquidity problems inherent in such an advance payment and refunding procedure may explain why unemployed persons’ usage of such prevention services offered is below average (Robert Koch-Institut 2006), despite the fact that this group would have above-average needs for health promotion. In order to overcome social distance, health insurance funds, in promoting “preventive” measures, follow a so-called “setting approach”, which aims at taking people’s living conditions into account. These measures are mainly focused on settings like child day-care facilities, schools, urban districts and workplaces. Unemployed people, their special needs and their financial condition, however, are rarely considered (Hollederer 2009).

The public employment service too is required by law to preserve, improve or restore the ability to work (§ 1 SGB II), which implies the absence of serious health restrictions (§ 8 SGB II) respectively a certain degree of health. Unlike the health insurance system, the PES is using

---

\(^6\) Activation is here measured as being invited for a personal job talk, having a personal integration plan, and receiving a job offer.
health promotion and prevention as a means to an end, trying to achieve re-employment. But still the interests of the unemployment and the health insurance system basically point in the same direction. The Advisory Council on the Assessment of Developments in the Health Care System\(^7\) stressed in its report of 2007 the need to link these two pillars of the social system (Deutscher Bundestag 2007). However, practical experiences show that this recommendation is not always easily complied with. The areas of responsibility do not seem to be clearly defined at the interface of the two ‘pillars’ of social insurance concerned and hence, the success of the cooperation heavily depends on the willingness of the involved representatives to make use of their freedom of action. For this reason, it is not really surprising that negotiations between these actors can be very tedious and only lead to locally or regionally limited agreements. In order to remedy this problem, the guideline for prevention in its current wording, published by the associations of the statutory health funds, advocates that the health insurance companies should work together with jobcentres and suitable educational institutions (GKV-Spitzenverband 2010). Furthermore, co-financing of appropriate and health-oriented measures targeted at recipients of unemployment benefit II is suggested as an alternative to the advance-payment and refund procedure which tends to exclude people with tight budgets.

Practical implementation has generally taken place in pilot programs so far. For example, the aim of the pilot program “JobFit” was to develop and test a successful link between health and employment promotion (BKK Bundesverband 2010). On the one hand, jobcentres participating in the programme will offer individual health competence consulting, and on the other hand the health insurance funds will finance a prevention course for jobseekers run by a provider of educational courses. Both elements must be embedded in the on-going activities to bring the unemployed into work. Staff of jobcentres and providers involved receive an extensive training which enables them to conduct the health consulting and the prevention course. The first step is to talk about individual health-related issues and to motivate people to solve their problems. Together, health practices should be reflected and strategies of improvement should be found. The main purpose of the prevention course is to show how to cope with stress, which is not insignificantly caused by “unemployment” itself. Turning intention on the specific situation of unemployed persons, the course tries to sensitize for the importance of health and provides relaxing methods and techniques for dealing with stress. Healthy and price-conscious nutrition is also picked out as a central theme. Examples and possibilities for health-conscious behaviour should be demonstrated, and, at best, their positive effects should become directly perceivable for the unemployed through the integration of elements of physical activities (e.g. Nordic walking). The JobFit pilot programs were scientifically monitored and evaluated. The majority of the providers observed lower absence rates due to sickness, lower programme drop-out rates and – even though this was not a primary goal – an improvement in employability. Moreover, the participants rated their ability to work after this training significantly better; they reported better nutrition behaviours and more physical activity (Faryn-Wewel, Roesler, Schupp & Bellwinkel 2009; BKK Bundesverband 2010).

\(^7\) Sachverständigenrat zur Begutachtung der Entwicklung im Gesundheitswesen
Another approach connecting health and employment promotion on an equal footing is called “AmigA” developed for unemployed and jobseekers suffering from impaired health (Toumi & Braunmühl 2009). The concept utilised cooperations and networks between different specialisations going beyond financial aspects. Involved are for example health insurance funds, pension insurance funds, health professionals and psychological psychotherapists. Based on detailed diagnostics, further steps towards integration are planned in an interdisciplinary perspective. Since the pilot-phase has brought up good results, this concept is continued.

An additional approach to improve the health of unemployed persons is offered by “AktivA” (Rothländer & Richter 2009), although it is not explicitly focused on common funding and immediate re-employment. This approach likewise relies on the education and training of disseminators in educational institutions that work with unemployed persons. After the training, the measures’ conductors should be able to assist unemployed persons in planning activities and in constructive thinking as well as enhancing their social skills and contacts. Systematic problem solving supported by relaxing methods is trained to reduce the daily exposures. Evaluations indicate that the psychological and physical well-being can be improved.

“Perspective 50plus – Employment pacts for older workers in the regions” is a national programme, issued by the German Federal Ministry of Labour and Social Affairs, which promotes the (re-)entry in the labour market of older long-term unemployed. Since 2010, this programme has placed emphasis on unemployed persons handicapped by diverse placement obstacles. Given that poor health is often a hindrance, many regions gave considerable importance to health conducive measures. To some extent, providers used approaches as described above or at least elements of these.

One important finding in monitoring an integrative health and employment promotion is that the principle of “promoting and demanding” – a basic idea of the SGB II – is not completely transferable into this domain. Health can only be promoted but not demanded; if someone is not convinced of the need to improve one’s health, it will not be successful to force it.

Conclusion

It could be demonstrated that unemployment and health are linked. Furthermore, in Germany a relatively large number of unemployed persons suffer from health problems without having access to incapacity benefits. This makes it all the more important to implement health related strategies into activating labour market policy. However, such approaches are still only in their pilot stages. Further research is needed to facilitate reliable conclusions about the effectiveness of health conducive measures.
References


