SICK OF BEING UNEMPLOYED

The health issues of out of work men and how support services are failing to address them

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MEN'S HEALTH FORUM

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"I am worse than e'er I was . . . and worse I may be yet"

King Lear

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INTRODUCTION

Unemployment is bad for your health. It can cause serious and long-term physical and/or mental health problems and worsen pre-existing conditions. Whilst the harmful effect of unemployment can be felt by both genders, there is evidence to suggest that men are overall more likely to suffer adverse health consequences than women (Jagger et al., 2008).

Poor health is not only a potential outcome of unemployment for men, but it is also a barrier to returning to and staying in work. Employment services in the UK appear to have made few efforts to address this issue, despite potential capacity within the Work Programme to provide specialist health support. As unemployed men are less likely to access health services, new ways to support the health needs of this group are urgently needed if both health and unemployment outcomes are to improve.

The recession and the resulting rise in unemployment over this period will have had an effect on many men's health. Between the beginning of 2008 and 2012 unemployment rose amongst men by 600,000, and inactivity amongst men by 579,000. Between 2008 and 2013, over two and a half million men (2,523,000) were made redundant, with redundancy rates spiking shortly in the early years of the recession. Reemployment rates continue to fluctuate. Whilst the situation is improving overall, steps must be taken to mitigate the health impact of this long period of increased unemployment amongst men.

Looking at recent research from both the academic and grey literature, this report will begin by bringing into focus the link between unemployment and poor health in men, before moving on to consider the gender differences in use of health services. The report finishes by addressing the lack of recognition that health receives in existing back to work support services, and the support that could be put in place in unemployment services to prevent and tackle poor health as a barrier to work.

Part One

ILL-HEALTH AND UNEMPLOYED MEN

Decades of research on the effects of unemployment on health has found that living without work is harmful for one's health. Unemployment is consistently associated with poor mental health (Kerr et al. 2012), and with common chronic conditions such as cardiovascular and respiratory disease (Calvillo-King et al., 2013) and musculoskeletal disorders (MSDs) (Virtanen et al. 2013). Why unemployment has such a detrimental effect on health is a complex question and will vary depending on individual circumstance – it has been suggested that the worsened financial circumstances for many who experience unemployment (Marmot & Wilkinson, 2005) and the physiological shock of becoming unemployed (Paul & Moser, 2009) contributes to poor health.

Men who have recently become unemployed are significantly more likely to engage in behaviour that will put their health at risk such as smoking and problem drinking, with both habits also associated with high cumulative unemployment - or frequent periods of employment built up over the course of lifetime. It is possible that this could have a long term impact on an individual's health as life long unhealthy habits are formed (Montgomery et al, 1998). Poor mental health is also commonly associated with unemployment. Even when taking into account pre-existing mental health conditions, becoming unemployed is clearly related to the onset of mental health symptoms. In one study, the relationship between recent unemployment and poor mental health was found to be stronger when prior tendency towards depression was controlled for, demonstrating the effect that employment status has on mental illness (Marmot & Wilkinson, 2005).

The risk to unemployed men's health

There is clear evidence that some of the negative effects of unemployment on mental health are more likely to manifest in men. It

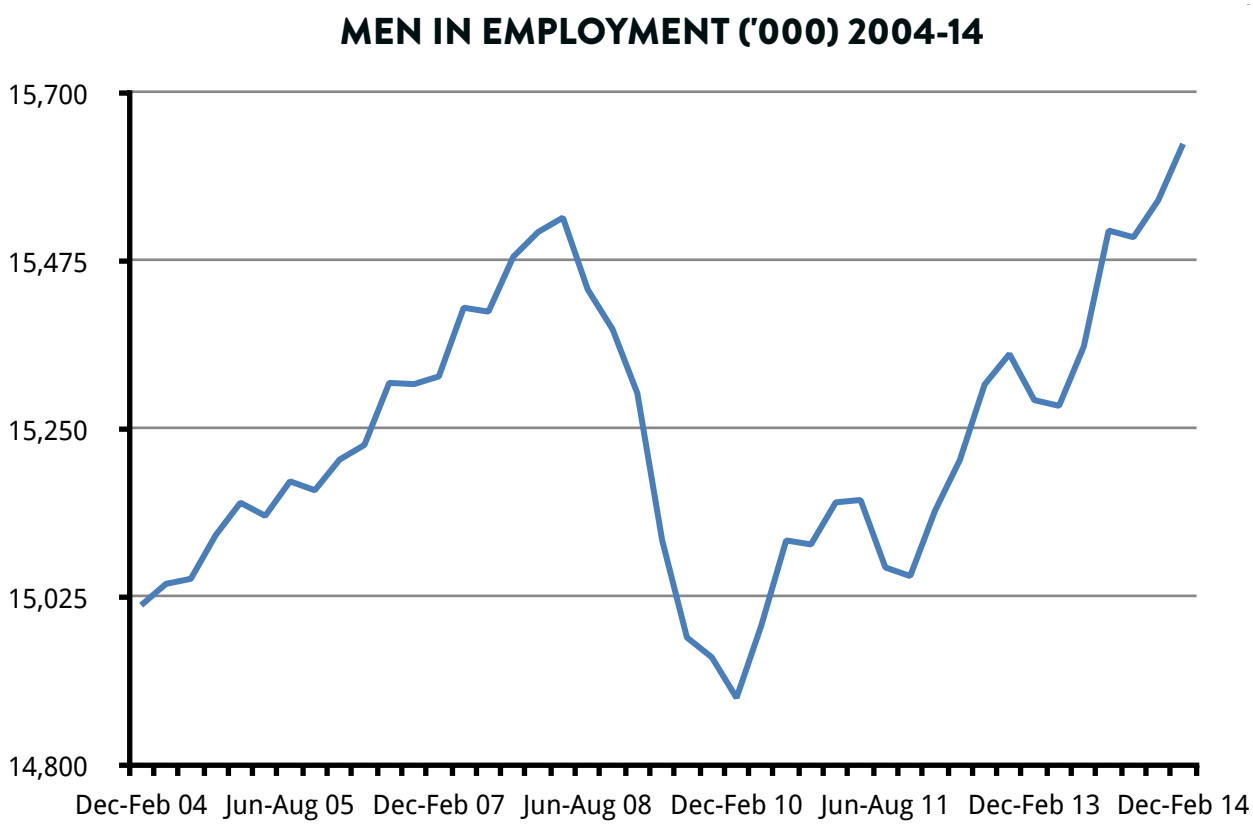
has been suggested that the strong cultural connection between work and masculine status means that the loss of employment may affect men's sense of well-being more adversely than it does women (Tiffin, Pearce and Parker 2005). It is believed that as many as one in seven men may develop depression within 6 months of being made redundant (Kivimaki et al., 2007). Research conducted by Ford et al. (2010) found that whilst a rise in common mental health disorders was associated with claiming unemployment benefit; it was the social, health and economic circumstances associated with this change, not claiming the benefit itself. This is corroborated by evidence to suggest that health can begin to be adversely affected before an individual becomes unemployed - studies of factory closures in the 1970s, '80s and '90s found that health began to be affected at the point an individual anticipated unemployment, even when they were still in work (Bambra, 2010). A large study of health inequalities in 25 European countries found that healthy life years, a composite measure of the remaining years that a person can expect to live without disability, were negatively associated with long-term unemployment, but the association was only found in men (Jagger et al., 2009).

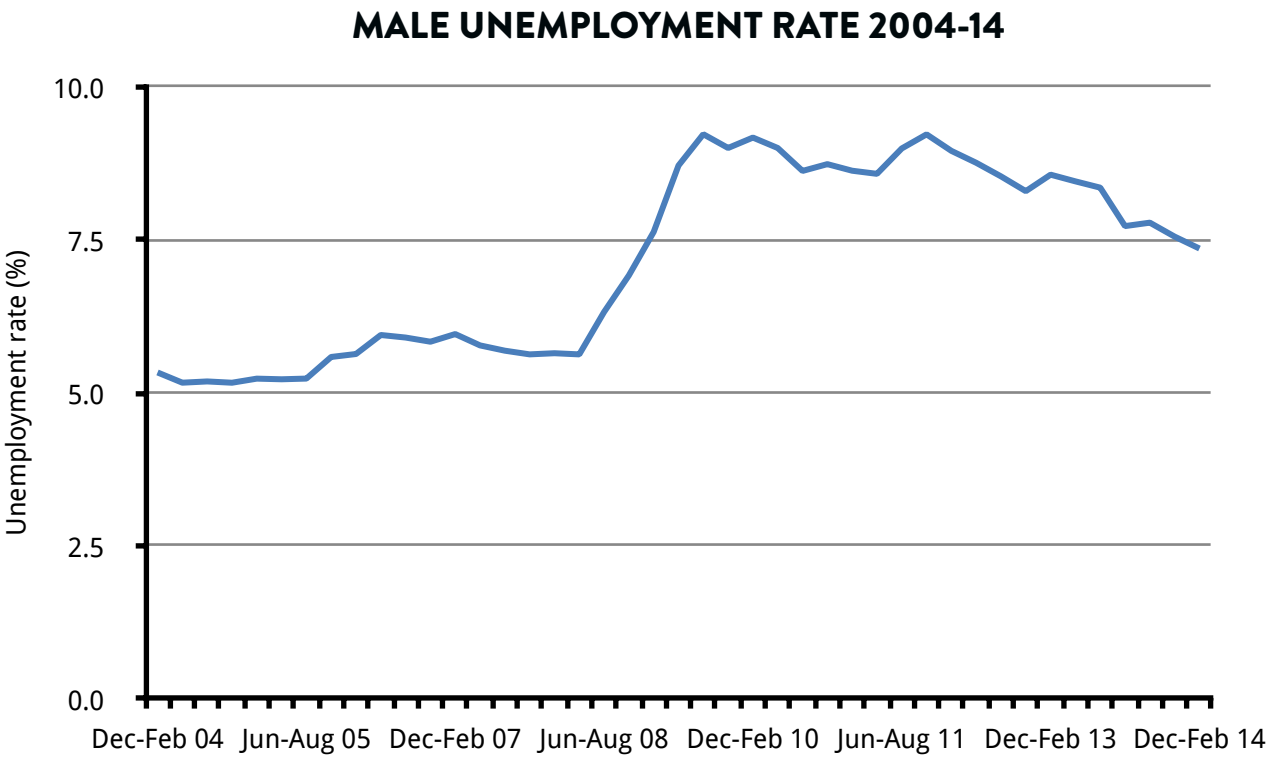
It is well established that unemployment may double or even triple the risk of male suicide (Gunnel, Platt and Hawton, 2009). Overall, men are more likely to experience a quick, sharp rise in mortality and general poor health than women, followed by a plateau during medium term unemployment and another steep rise when moving into long term unemployment (Garcy & Vågerö, 2012; Paul & Moser, 2009). In relation to men's overall risk of death, the 2005 evidence review by the Health Development Agency (HDA), Worklessness and health – what do we know about the causal relationship?, noted that mortality rates were higher among unemployed men than employed men. It cited earlier research that estimated a "20% excess risk of death for [unemployed] men actively seeking work". The review concluded that "the evidence supports a strong association between increased mortality and unemployment at an aggregate level" (Health Development Agency, 2005). Whilst unemployment has a negative effect on men's health, there is evidence that returning to work negates these effects. The HDA

review notes that ". . . there is a strong association between unemployment and psychological and psychiatric morbidity . . . Upon re-employment, there appears to be a reversal of these effects" (Health Development Agency, 2005).

Unemployment, health and the recession

In the context of the recent recession and the resulting cohort of men who became unemployed during this period, and the many who remain unemployed, it seems probable that there will have been an increase in overall levels of poor health amongst this group. The recent economic crisis saw a rapid fall in male employment rates, with a decline of 3.7% between January-March 2008 and January-March 2010, compared to a 0.5% decline for women. Whilst male employment rates are slowly recovering, they have yet to reach their pre-recession levels.[1] Between the beginning of 2008 and 2012 unemployment amongst men rose by 600,000, and inactivity amongst men rose by 579,000. Between 2008 and 2013 over two and a half million men were made redundant, with redundancy rates spiking shortly in the early years of the recession. Reemployment rates continue to fluctuate.





Source of both graphs: ONS 2014 [A03: Summary of employment, unemployment and economic inactivity for men aged from 16 to 64 and women aged from 16 to 59. Date of Publication:16 April 2014. (Excel sheet 754Kb)]

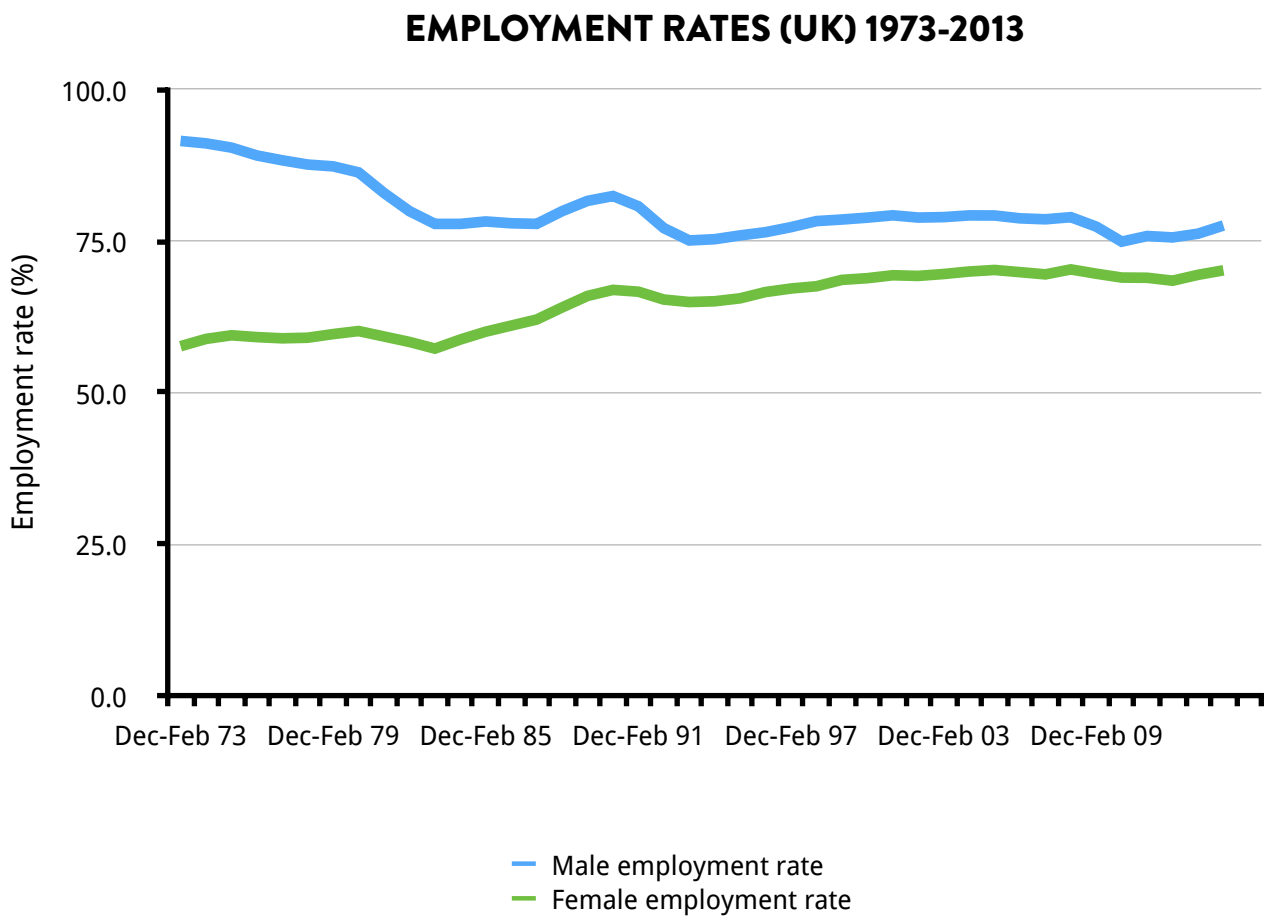
Whilst there is some evidence that overall population health in wealthy countries may actually improve during a period of recession (due to reductions in personal expenditure on unhealthy activities such as alcohol consumption), this is not the case for already disadvantaged sub-groups within the population. Research suggests that health inequalities will widen during periods of recession, and that individuals who have fewer qualifications or education are more likely to experience a decline in health during periods of unemployment. Moreover, whilst not the subject of this report, it is probable that many negative health outcomes associated with the recession will not manifest until some time after the period of the crisis. For example, an

increase in the number of lung cancer cases caused by more people smoking to counteract recession-related stress would not be evident until some years down the line (Suhrcke & Stuckler, 2012).

However, many negative health outcomes will become evident relatively quickly. The recession has already had an impact on suicide rates among men: there were significantly more suicides among men between 2008 and 2010 than would have been expected based on historical trends (Barr et al., 2012). It should be noted that the link between suicide and para-suicide (a suicide attempt or gesture) and unemployment may not be a direct one. It has been argued that unemployment increases the likelihood of other adverse life events and lessens the psychological and social resources that are necessary to cope with them (Marmot & Wilkinson, 2005).

Long term trends in the UK labour market for men: implications for health

The male labour market has changed in a number of different ways over the last few decades which potentially have significant implications for men's health. Long term trends in male labour markets will also have had an impact on the nature of the relationship between men's health and unemployment in the UK. Over the last few decades the overall male employment rate has steadily decreased, going from 91.6% in 1973 to 77.6% in 2014.[2] These changes are in part a consequence of the decline of a number of traditionally male dominated industries such as manufacturing and mining. For example, between September 1981 and March 1994 the total workforce of British Coal fell from 279,200 to 18,900 employees (Beatty & Fothergill, 1996).



Source: ONS 2014 [A03: Summary of employment, unemployment and economic inactivity for men aged from 16 to 64 and women aged from 16 to 59. Date of Publication:16 April 2014. (Excel sheet 754Kb)]

The decline of traditionally male-dominated industries has been coupled with a number of other changes to the labour market which have had a detrimental effect on the employment and health of men. Nationally there has been a hollowing out of the labour market, with significant loss of middle-income jobs requiring mid-level skills, also known as the 'hour glass effect'. This has pushed some people into lower paid and sometimes less stable jobs (Sissons, 2011). This has occurred during the same period as the rise of what is known as the 'low-pay, no-pay' cycle, in which people churn in and out of employment. Whilst, overall, women are more likely to be affected by the low-pay, no-pay cycle, research from the Joseph Rowntree Foundation (JRF) (Shildrick et al., 2010) found that men are increasingly affected by unscrupulous private employment agencies which encourage temporary work with the promise of long term work in the

future. Individuals may suffer further as result of being unwilling or unable to claim out of work benefits, and the additional uncertainty of their situation. This can lead to increased stress and anxiety as individuals take on loans to get them through the times between jobs, pushing them into debt. Debt is a major risk factor for common mental health conditions, with adults in debt being three times more likely than those not in debt to experience this (Meltzer et al., 2012). This cycle is difficult to escape, as the short periods of unemployment may mean that they are unable to access the often more intensive back to work government support that long-term unemployment brings.

Shildrick (2010) also emphasises the impact of the informal jobs market in fuelling the low-pay, no-pay cycle. Such jobs are less likely to offer preventative interventions such as proper health and safety practices or suitable sickness absence policies, or to implement legally required reasonable workplace adjustments for people with a long-term health condition or disability. This will no only make it more likely that they will drop out of work due to ill health, but will affect their experience of unemployment. As Bambra (2010) puts it 'workers currently experiencing a daily existence of low paid, high strain, temporary employment may be ill prepared for, and least resilient to, the additional negative health premium of unemployment'.

Poor health is not only a likely outcome of unemployment, but can be a barrier to returning to work as well - creating a "negative feedback loop" which can trap an individual and prevent him from attaining and sustaining employment. In a study of the long-term effect of the closure of the MG Rover factory in 2005, poor health was considered to be one of the top five factors preventing a return to work for those who lost their job, and had deteriorated significantly amongst those unemployed for longer than a year (Armstrong, 2006).

Overall these changes to the labour market mean that any policy that attempts to tackle male unemployment and male health in an integrated fashion must take into account the increasingly precarious labour market, the role of temporary jobs and the 'low-pay, no-pay

cycle'. The pursuit of flexible labour market policies, whilst not in themselves harmful if implemented carefully, has the potential to create a more precarious labour market and be harmful to men's health. Many individuals who may appear to have been unemployed for only a short period of time may have been cycling in and out of employment for quite some time. For health and employment interventions to be effective, they will need to be innovative in nature and must be implemented at an early stage. We know that mortality rates amongst unemployed rise sharply during the early stages of being out of work. Interventions need to be timed at this period, before that steep decline in health occurs.

Part Two

HEALTH SERVICES AND UNEMPLOYED MEN

Not only are men more likely to become ill as a result of unemployment, but it is widely recognised that men tend to be less likely to use health services. Men are 30% less likely than women to visit their GP and 40% less likely to do so between the ages of 21 and 40 when the gap in GP visits between the sexes is greatest. There are only small differences in childhood and none amongst elderly patients, suggesting attention on this issue should be focused on the working age population (Wang et al., 2013). This difference in younger adulthood is partially explained by female patients attending GP surgeries in connection with their reproductive health but even when these consultations are removed from the data a significant difference in consultation rates still remains.

The pattern of poor GP attendance is repeated across many other areas of the health service. Men are less likely to have regular dental check ups for example, and less likely to have eye tests (Labeit, Peinemann and Baker, 2013). Men are also more likely to fail to attend scheduled hospital outpatient clinic appointments (Ellis and Jenkins, 2012) and less likely to take up the offer of bowel cancer screening, despite being at greater risk of developing the disease (Logan et al., 2011).

Use of health services also varies by economic status, although the picture is not straightforward. Men and women with lower socioeconomic status are less likely to use some targeted services (for example bowel cancer screening, and screening programmes generally) but are more likely to take up primary care services – most notably GP services. This is expected since there is a clear "social gradient" in health for both men and women - that is to say, the less well off an individual is, the poorer his or her health is likely to be. There is however a marked interaction between gender and deprivation in relation to GP consultation rates, with consultation rates

increasing in parallel with deprivation for women but not for men. This has the inevitable effect of increasing the gender gap in consultation rates among the least well off (Wang et al., 2013).

If men overall are less likely to use health services than women, and if unemployment has a harmful effect on male health, we can argue that a more innovative approach to tackling the health of unemployed men must be taken to improve both the health and employment outcomes for men. In order to access and support the health needs of unemployed men, different approaches to reach this group should be considered. The featured case study of Tomorrow's People and the James Wigg Camden GP surgery is an example of such an approach. Employment is increasingly recognised as an outcome within the NHS, and we support this. However, given that men are less likely to use health services, a broader net may need to be cast in order to identify and support this groups' health needs. This will be explored in the following chapter.

Recommendations

- Employment needs to be considered a clinical outcome of healthcare, at all levels. Whilst we were encouraged by the announcement in the Disability and Health Employment Strategy that employment will be a measured outcome for people with a mental health condition in the Clinical Commissioning Group Outcome Indicator Set, it is unclear why this has not been extended to all long-term conditions.
- Men, in general, interact with health services in a different manner to women. All stakeholders must look both at how men as a group use health services, and how these services could be improved and made more accessible to encourage greater accessibility and effectiveness among all groups.

Case studies

TOMORROW'S PEOPLE AND JAMES WIGG CAMDEN GP SURGERY

With the right resources and initiative, employment support can be made available through health services. Between 2001 and 2011 Tomorrow's People, a specialist employment charity focusing on supporting the hardest to help back to work, and the James Wigg Health Centre, based in Camden, took an innovative approach to providing integrated health and unemployment support. The idea was simple; James Wigg Health Centre agreed to have a Tomorrow's People employment advisor situated within the practice. The Employment Advisor quickly became integrated within the Surgery's team, receiving referrals from both GPs within the centre and the reception staff.

Importantly, the service was open to anyone who attended the practice, so long as they planned to be working at some point in the future. Around 70 per cent of those who were helped by the service were registered as unemployed, with 85 per cent of this group having been unemployed for over 6 months.

Support was one-to-one and informal, with a focus on building the individual's self-confidence, which was considered as important as employment-related activities. The sessions lasted around an hour and were held once a week, with participants receiving 'homework' to do in their spare time. Tomorrow's People described the service as taking a 'softly' approach to encouraging people to return to work. They believed that the service was trusted due to its independent status and not being tied to any form of welfare benefit, and by being situated within a GP service.

The results from the Practice were positive both in helping people return to work and in terms of health outcomes. An evaluation of the first four years of the project found that people who had been referred to the service had lower average monthly GP consultation rates, as well as lower referrals rates to in-house counselling. The number of anti-depressants prescribed to those who received support fell markedly after registration to the service.

The employment outcomes were positive, with 87% entering employment, a volunteer or training placement, or some form of education. Of this group 36% entered a job, while 54% took on a voluntary or training placement.

Overall, Tomorrow's People estimated that the service resulted in a social and economic return on investment of between £40,270 - £73,870, This was as a result of reduced GP consultation, lower prescription rates, savings from people moving off out of work benefits, and increased tax revenue as a result of people entering into employment. Considering the project cost £33,503 over 39 months, this was a significant rate of return.

The project was popular, replicated by 80 other GP surgeries in London. At one point, there were over 400 GPs on the waiting list to introduce a similar project to their own practice. Due to a lack of funding in 2011 Tomorrow's People closed down the James Wigg practice employment service, as well as the other services that had been inspired by it. Finding funding for the service, a representative from Tomorrow's People told us, had always been an issue. Being neither fully within the realms of health or unemployment, obtaining funding from either the DWP or DfH was difficult. With the introduction of the Work Programme many of the funding streams which had previously been available dried up.

STATUS EMPLOYMENT AND THE MENTAL HEALTH FOOTBALL LEAGUE

Status Employment, a charity focused on helping people with severe mental illness return to work, has taken a practical approach to tackling the issue of health. They have set up a football team open to any of their clients who are being supported by a Community Mental Health Team and are currently not in employment. The football team links back to Status Employment, with referral to an Employment Advisor and potentially IPS (Individual Placement and Support – a method for supporting people with a mental illness into sustained employment), being offered through the team.

Robert Elston, Chief Executive of Status Employment, argues that being a part of a football team brings considerable health benefits - providing an opportunity for people with a mental health problem to engage in regular exercise within an open and comfortable setting. As well as the numerous benefits that exercise has in terms of physical health, he suggests that team sports also have considerable positive psychological and social effects. Regular sports activities help people bounce back quicker, and remain confident that they will be able to find a job. It builds up individual resilience, self-confidence by 'changing their language' and helping to remove the self-stigma that many people with mental illness experience.

With training provided by Charlton Athletic Football Club, Status Employment football team plays against other teams whose members also are experiencing mental health problems. Playing as part of a competitive football league - the South London Mental Action league in this case - is also important, says Robert. Playing competitively, rather than purely in friendlies helps people to become more motivated and engaged. Tapping into the enthusiasm and interest that many people have for football is a useful way of encouraging people to partake in regular exercise.

The social aspect of a football team also has important implications, building up friendship, a network of support as well as contacts. Being involved in a wider circle of people may also alert people to job opportunities via word of mouth. Being a part of a football team helps people to become engaged with the outside world, perform activities that they would not normally do and meet people they wouldn't have otherwise met.

Individuals also have the option of a more structured programme of support - the 'Work Preparation Course with Sport Activities'. This programme combines two days of work preparation skills and one morning a week participation in a variety of sports with Charlton Athletic FC's coaches.

Part Three

GOVERNMENT OUT OF WORK SUPPORT AND HEALTH

Back to work support should be considered as a potential avenue of support for health interventions. As the previous sections have demonstrated, men, and especially unemployed men, are less likely to access health services.

Poor health is a potential outcome of unemployment and can also be a barrier to returning to work. For those with existing health conditions support is particularly ineffective. The UK labour market struggles to support people with disabilities and long-term health conditions who are claiming benefits. Not only does the UK have a high rate of in-flow to disability benefits at twice the OECD average (OECD, 2014), it also has a low out-flow.

A study looking at those flowing in and out of Jobseeker's Allowance (JSA), Employment and Support Allowance (ESA) or Incapacity Benefit, and their job status 7 to 8 months later, found that half of those who had left for paid employment were no longer in work. Even though men are more likely than women to leave JSA for paid work, they were also more likely to have a temporary contract. People with a long term condition were also more likely to have a temporary or casual job and also on average earned less. Individuals with long-term health conditions were found to be more likely to move off from JSA for temporary or casual employment, with 40% of this group doing so compared to 31% of the overall cohort. They also earned less, earning an average of £11,050 compared to £14,050 in other groups (Adams et al., 2012).

Overall, people with a long-term condition or disability were less likely to still be in employment by the end of the 7-8 month study period, with only 28% doing so compared to 59% overall. Five percent of JSA leavers who had found work left it for health reasons, compared to 52% of people leaving the job due to its temporary nature.

Back to work services must adapt to effectively prevent poor health developing in men as a result of unemployment, to support the health needs of men with pre-existing conditions or disabilities and support men with disabilities or long term health conditions to find and sustain employment. The following section will evaluate the two primary forms of back to work support available in the UK - Jobcentre Plus and the Work Programme.

The Jobcentre Plus Offer

The majority of back to work support will first be accessed through the Jobcentre. A recent evaluation of Jobcentre Plus (JCP) found that the JCP has responded well to policy changes and fluctuating claimant figures, including the increasing flexibility for individual centres to experiment with different ways of structuring support which has resulted in a range of delivery models. In theory this has allowed a greater degree of personalisation and a reduction in the constraints on when claimants are eligible to access certain forms of support (TNS BMRB / DWP, 2013). This should have made it easier for Jobcentres to take account of an individual's current health conditions and respond quickly if a health condition develops, but the extent to which this has happened is unclear and appears less than positive. There has been some concern that the current JCP offer places an emphasis on mainstream JSA claimants to the detriment of more vulnerable groups, such as those claiming ESA and people with more complex needs. Certainly, there are some concerns that ESA claimants are not receiving the same level of support. A recent evaluation of JCP provision, for example, found that ESA claimants saw their advisor less often than JSA claimants, and were less likely to receive advice on job-searching (TNS BMRB / DWP, 2013). The Work and Pensions Committee (2014) estimated that there is only one Disability Support Advisor (DSA) for every 600 ESA claimants. A representative from the DWP providing evidence to the Committee argued that this is mitigated by the number of ESA claimants who are in the Work Programme and do not therefore need the support provided through JCP. However, given the high

percentage of ESA claimants still with JCP this should raise concerns and should be investigated by the relevant bodies.

Poor health as both an outcome of unemployment and barrier to returning to work often goes unrecognised, even for claimants with a formally diagnosed health condition or who claim a health related out of work benefit, such as ESA. Only half of ESA claimants and a quarter of JSA claimants with a disability or health condition discussed health support options with their Jobcentre advisor, and this discussion did not always consider the potential suitability of job or job type. This suggests that the advisor may not have the confidence, knowledge or capacity to tackle these issues when interacting and advising claimants with health needs (TNS BMRB / DWP, 2013). JSA claimants with a mental health condition were more likely than those without a diagnosed mental health condition to feel that their JSA advisor had not spent sufficient time with them for their needs, and were more likely to have only seen their advisor once a month. They were also much less likely to feel that advisors treated them with understanding - with 44% feeling this way compared to 28% of JSA claimants overall (TNS BMRB / DWP, 2013). Given the likelihood of men developing poor mental health in the early stages of unemployment, this should be of concern (Kerr et al. 2012).

There is little provision within the Jobcentre to properly assess health barriers to work, although there is some scope for individual advisors to do so on an ad hoc basis. The new claimant interview has been criticised by witnesses interviewed as part of the Work and Pensions Committee's investigation. They argued that this interview, which outlines the conditionality of claiming benefit and tries to build a picture of the claimant's employment support needs, includes very little about the barriers that jobseekers face in returning to work. Instead the interview focuses on personal characteristics such as gender, age, claim history, income and capital (Work and Pensions Committee, 2014). Whilst important this does little to enable personalised support that takes into account barriers to returning to work, in particular health.

There are examples of good practice at a local level, with individual Jobcentres using the flexibility now available to them to provide health focused support. One anonymous district contacted as part of a DWP evaluation of Jobcentre Plus used the funding available through the Flexible Support Fund to provide a claimant with access to a specialist health consultation support helpline for advice on self-management. The Flexible Support Fund is generally used to tackle a single barrier to returning to work, such as transport to an interview, making this an unusual case. Applying to the Flexible Support Fund can be a difficult and time-consuming process, and its use is limited. The lack of health provision is a concern to many of the staff working in Jobcentres, who felt that claimants needed more widespread access to support services for mental health conditions and related problems, such as low self-esteem, anxiety and depression. There was also some concern among the staff that vulnerable groups were less likely to meet benefit conditionality and as a result, be sanctioned (TNS BMRB / DWP, 2013).

It should be noted that jobseekers are able to access Work Choice; a programme designed specifically to help people with disabilities and long-term conditions. This programme has seen some success, with a six-month job outcome cohort rate of 45.9%.[3] However, this service is only available to people with a recognised disability, and excludes people with a non-diagnosed health condition or with general poor health. Moreover, there is currently a cap on the number of referrals that can be made to the service, limiting its use. A number of health and disability charities have called for its expansion, and have also raised concerns regarding the referral process - pointing to the large number of people whose health conditions is marked as 'unknown' in governments statistics and the low number of ESA claimants on the scheme, suggesting that this programme has not been targeted correctly (Trotter, 2013).

The Work Programme

The Work Programme is the government's flagship employment scheme, to which jobseekers are referred usually after a year of claiming an out of work benefit, although this varies depending on a

number of factors including benefit type. The Work Programme was intended to have greater flexibility and capacity for personalisation than had previously been possible through JCP, being a more linked up approach with smaller and specialist provision due to its supply chain model of provision. This model, in which large 'Prime' providers use a supply chain of commissioned sub-contractors, is intended to provide a programme of tailored and specialised support that takes account of individual needs, with no government-specified requirements. Due to its flexibility, such a model has the potential to tackle the issue of health in terms of unemployment, and there are a number of different sub-contractors who specialise in this area. Despite this the job outcome rates[4] in the Work Programme for men with a disability or long-term condition are low. The cumulative job outcome rate for this group is only 5.5%, compared to 18% for men without a recorded health condition.[5]

One of the issues in assessing the effectiveness of the Work Programme in helping prevent ill health or addressing pre-existing ill health or disability is a lack of information. The Work Programme operates a 'black box' model indicating that Primes have few minimum requirements which means that service providers can design and implement back to work support as they see suitable, and are under little obligation to reveal what services they actually provide. Although we have a basic idea of the subcontracted organisations they might be using[6], data is not available on the number of referrals subcontracted organisations receive. We therefore have no indication of the number of specialist health-related services that are accessed. This is an area that requires further research.

Anecdotal evidence however indicated that many voluntary sector organisations, including many specialist health charities, have not received the referral numbers they expected. If verified, this would suggest that jobseekers are not getting the health support that they might need to return to work.

The job outcome rates for people with a long-term health condition remain low, and a number of health and disability charities have

gathered evidence indicating a lack of specialist support being provided through the Programme. It is possible that 'the payment by results' structure tied to benefit type rather than level of need may discourage Primes from commissioning health support. Moreover, if a person has a health issue but is not claiming a health-related form of benefit, there may be fewer incentives for providers to help the individual. Anecdotal evidence indicates the increasing likelihood that 'creaming and parking' is taking place in certain areas of the Work Programme. This term refers to the concern that providers prioritise support for jobseekers who are more likely to get a job quickly, motivated by financial incentives paid for a successful job outcome; and park those unlikely to enter work and for whom the cost of supporting them may outweigh the financial incentives. As a result, for someone in poor health but claiming a type of benefit which comes with a relatively small financial incentive for Work Programme providers, the risk/cost ratio of a health intervention is not felt to be justified.

It is also possible that even for those claiming a disability related out of work benefit the higher job outcome payment attached to them may not be sufficiently high enough to compensate the effort resources and risk to get them back to work. Moreover, whilst outcome payments are framed as being attached to individuals, in practice they must cover the cost of providing support for all jobseekers in the Work Programme. With the attachment fee (worth £400-£600 in the first year) being gradually phased out over the first four years of the Work Programme, successfully supporting someone back to work must also cover support for those who do not get a job. To put it another way, Prime providers are expected to support all of those in the Work Programme, but they will only receive payment for those who return to work- in practice this means that job outcome and sustainment payments must fund all individuals which the Prime are supporting, meaning that 'parking' individuals, and not investing large amounts of money that they may not see a return on, may be the most financially viable option. This may be the case even for benefit groups with higher outcome fees attached to them - given the smaller percentage of the

cohort likely to return to work the risk of providing intensive support to the whole group and may outweigh the potential gain of getting the smaller predicted portion back into work. This creates an extremely tight funding model. This may encourage providers to provide the bare minimum of support to account for this, with health being seen as an 'extra' rather than an important aspect of returning to work. For an externally contracted employment scheme such as the Work Programme to be successful in helping disadvantaged groups it is essential that it is financially viable for the organisations carrying it out.

How can back to work support prevent poor health and tackle pre-existing conditions in men?

Given what we know about the specific issues faced by men, and particularly men in low socioeconomic groups in unstable forms of employment, there is an obvious and potentially harmful gap in current Jobcentre Plus and Work Programme provision. Many will have undiagnosed health conditions either caused by or made worse by periods of unemployment. This group are currently too often unrecognised and unsupported by current provision. A number of organisations such as the Association of Chief Executives of Voluntary Organisations (ACEVO), the Shaw Trust and the Employment Related Services Association (ERSA) have argued that some form of assessment at the beginning of a claim would be a useful tool in identifying an individual's barriers to returning to work and the level and type of support that they need (ACEVO &Shaw Trust, 2013; ERSA, 2013). The new Disability and Health Employment Strategy makes mention of the possibility of a 'Gateway' tool which would assess the level of support needed to aid an individual to remain in or return to work. Details regarding this service, however, remain vague, and it is unclear to what extent this will be open to all claimants with a previously identified health condition or disability. A potential focus on pre-existing health conditions also ignores the high number of claimants who will develop a health condition as a result of being unemployed.

The Work and Pensions Committee have recommended that JCP implement something akin to Australia's 'Jobseeker Clarification

Instrument'[7], which is used to measure a jobseekers relative difficulty in gaining and maintaining employment, and identifies the level and type of support that they will require (Work and Pensions Committee, 2014). However, the Committee noted that the DWP had piloted a similar tool in 2010 but had been unhappy with the results. Despite this it would be recommended the DWP continue to look further into this issue, as the use of such a tool could have a number of benefits for this group. Firstly, it would help to identify individuals who habitually cycle on and off of benefits as a result of poor health, helping to target support and break this cycle. Currently this group are difficult to identify, and may only claim benefits for short periods of time. Such an assessment tool may have some benefits for jobseekers in the Work Programme as well. The Work Programme is based on a 'payment by results' funding model with the amount of funding attached to each claimant based on the type of benefit the individual is claiming. As organisations such as ERSA (2013) have pointed out, this is a crude proxy for the actual level of need. In such a scenario the assessment tool could be used as a basis for more accurately assessing the support that an individual will require to return to work, and could identify both pre-existing health conditions and the probability that an individual will develop health conditions. This information could then be used to help prevent the 'creaming and parking' we currently see within the Work Programme. A future iteration of the Work Programme could also consider linking payments to progression towards the labour market as well as job outcomes, helping to prevent the 'parking' of individuals less likely to return to work.

We look forward to the Work and Pensions Committee returning to the issue of specialist employment support for people with disabilities later in 2014.

Recommendations

- The introduction of an assessment of barriers to returning to work when an individual claims an out of work benefit could be a useful tool in quickly identifying individuals with current health conditions or who are at risk of developing poor health as a

result of unemployment. This could help Jobcentre advisors target support at an early stage, and could help prevent health-related 'churning' on and off from benefits.

- Work Programme providers need to be given greater incentives and support to tackle the health issues which can prevent returning to work, or develop during a period of unemployment. Linking job outcome payments to level of need rather than benefit type, as recommended in both the ACEVO/NCVO and ERSA reports, might be an effective method of encouraging a greater focus on health when the next version of the Work Programme is commissioned in 2015. The level of need could be decided through the use of the assessment tool mentioned previously.

Preventing poor health

As this report has demonstrated, men and especially men from lower socio-economic groups in low-skilled or unstable jobs, have a higher risk of poor health when becoming unemployed. Men are more likely than women to experience poor health during the initial stages of unemployment and especially if they remain unemployed for over a year (Paul & Moser, 2009). Given that many men will cycle in and out of unemployment, and that even a short period of unemployment can impede returning to and sustaining employment, encouraging Jobcentres to take preventative steps could play an important role in helping people return to work and stay in work.

The creation of a Local Support Services Framework, a database for JCP advisors detailing local services, organisations and other forms of support available to jobseekers, should be implemented as soon as possible, and should include interventions, organisations and services which have a health and wellbeing focus. As some case studies have demonstrated, small and focused health interventions can be successful in helping people find work, and should be accessible through Jobcentres where they deem it appropriate. This has already

been recommended in the Work and Pensions Committee report on Jobcentre Plus (Work and Pensions Committee 2014)

This could be complemented through innovative use of the Flexible Support Fund, encouraging and enabling Jobcentres to easily use this source of funding to engage with health barriers. As discussed, some Jobcentres are already doing this, in one case enabling one jobseeker to use the fund to access a self-management helpline.

Recommendations

- The government should consider how ill-health in unemployed men could be prevented, and should be a part of back to work support provided through Jobcentre Plus. As this paper demonstrates, not only does unemployment lead to poor health outcomes amongst men, but poor health hinders returning to work. Action to prevent poor health as soon as an individual claims an out of work benefit has the potential to be a cost-saving intervention.
- Local government should work in partnership with Jobcentres, health care providers and charities to create a Local Services Framework. This would provide a comprehensive guide to local specialist services available to Jobcentres, and should include organisations able to tackle health related barriers.

CONCLUSION

Men, and particularly men who were previously employed in temporary or unstable positions and have a lower socio-economic status, have a higher risk of developing poor health as result of becoming unemployed than other groups. Moreover, men overall are less likely to access health services. Poor health can be a barrier to an effective and sustained return to work, and the government should consider utilising innovative pathways to address the health needs of unemployed men. Enabling Jobcentres to take greater action to prevent poor health amongst unemployed men, helping back to work support providers identify men at risk of developing poor health or already suffering from it and incentivising and supporting Work Programme providers to address this issue are all changes which would contribute to tackling this issue. We call on the government to ensure that both preventing ill health and addressing existing health conditions that are barriers to returning to work are priorities within back to work support services.

However, there is also an urgent need for further research in this area. Whilst there is much evidence to suggest that unemployment leads to poor health, particularly in men, little recent primary research has focused on this within the context of the UK benefit system, and particularly the Work Programme. The impact of changes to the welfare system such as increasing conditionality and payment by results financial incentive structures should be considered, as well as considering the health of the growing number of individuals unemployed but not claiming out of work benefit.

Summary of recommendations

- The introduction of an assessment of barriers to returning to work when an individual claims an out of work benefit could be a useful tool in quickly identifying individuals with current health conditions or who at risk of developing poor health as a result of unemployment. This could help Jobcentre advisors target support at an early stage, and could help prevent health-related 'churning' on and off from benefits.

- Work Programme providers need to be given greater incentives and support to tackle the health issues which can prevent returning to work, or develop during a period of unemployment. Linking job outcome payments to level of need rather than benefit type, as recommended in both the ACEVO/NCVO and ERSA reports, might be an effective method of encouraging a greater focus on health when the next version of the Work Programme is commissioned in 2015. The level of need could be decided through the use of the assessment tool mentioned previously.

- The government should consider how ill-health in unemployed men could be prevented, and should be a part of back to work support provided through Jobcentre Plus. As this paper demonstrates, not only does unemployment lead to poor health outcomes amongst men, but poor health hinders returning to work. Action to prevent poor health as soon as an individual claims an out of work benefit has the potential to be a cost-saving intervention.

- Local government should work in partnership with Jobcentres, health care providers and charities to create a Local Services Framework. This would provide a comprehensive guide to local specialist services available to Jobcentres, and should include organisations able to tackle health related barriers.

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ENDNOTES

1 ONS, 2014. Summary of employment, unemployment and economic inactivity for men aged from 16 to 64 and women aged from 16 to 59. http://www.ons.gov.uk/ons/rel/lms/labour-market-statistics/march-2014/table-a03.xls

2 A03: Summary of employment, unemployment and economic inactivity for men aged from 16 to 64 and women aged from 16 to 59. Date of Publication:16 April 2014. (Excel sheet 754Kb)

3 https://www.gov.uk/government/publications/work-choice-official-statistics-february-2014 Accessed 22nd April 2014

4 The job outcome rate is created by dividing the number of job outcomes (when an individual has been in employment for 3-6 months depending on benefit type) by the number of attachments to the Work Programme. A cumulative job outcome rate includes all individuals attached to the Programme, including those only recently referred at the time of the statistics. Unfortunately cohort analysis is not available broken down by health condition.

5 DWP Tabulation Tool, http://tabulation-tool.dwp.gov.uk/WorkProg/tabtool.html. Accessed 22nd April 2014

6 http://www.dwp.gov.uk/docs/wp-supply-chains.pdf

7 http://employment.gov.au/job-seeker-classification-instrument

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