

**Active Labour Market Programmes (ALMPs)  
and health: an evidence-base**

**Review prepared for the Strategic Review of Health  
Inequalities in England Post 2010 (Marmot Review)**

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**May 2009**

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Active Labour Market Programmes (ALMPs) form a core component in the delivery of welfare-to-work policy, the New Deal programmes and broader policies of urban regeneration. The long-term unemployed, youths and lone parents have been the focus of government attention with emphasis on work as the best form of welfare and route to prosperity and mechanism of social mobility for deprived individuals and communities. Over recent years they have become a valuable feature of both domestic and international labour market policy and social development interventions. OECD countries, in particular, have a long and extensive experience with ALMPs which are often targeted at the long-term unemployed, workers in poor families, and particular groups with labour-market disadvantages. ALMPs and programmes such as the New Deal are used to increase employability and reduce the risk of unemployment. Such interventions include job search assistance, training as well as wage and employment subsidies which aim to enhance labour supply and improve the functioning of the labour market.

There is, however, little evidence particularly from the UK examining how these policies and social interventions affect the quality of life, in particular the health and well-being of those they intend to help. Evidence on the effects of ALMPs and the government training programmes used to deliver them deal almost exclusively with labour market outcomes such as earnings, re-employment opportunities and the cost-effectiveness of programmes. Further public health policy in Britain has recently promoted the potential to improve health and reduce health inequalities through changes in the social determinants of health such as employment and working conditions.

The evidence presented in this review would suggest that participation *within* ALMPs, specifically government training programmes can have a positive effect on the well-being (psychological health) of the participants compared to those who remain unemployed and economically inactive. In addition it may be stated that ALMPs can be designed and delivered to have a 'double' effect in terms of improving participants basic skills and education thereby increasing their potential for entering the labour market and securing employment. But also that programme participation prior to labour market entry can improve their psychological health / subjective well-being. Making a substantive claim for the potential of ALMPs to reduce health inequalities more broadly is problematic given the individual level and context specific nature of the evidence available. However, this evidence does demonstrate that health improvements can occur via participation *within* ALMPs,

despite material circumstances remaining poor, via psychosocial mechanisms such as an increased social contact, social support, and generating feelings of control and self-worth.

ALMPs and welfare to work policies in general should be viewed as offering 'steps' toward reducing the health burden and negative social circumstances that individuals endure as a result of unemployment, social isolation and poverty. These 'steps' involve increasing employability in terms of developing individual hard and soft skills but also helping to reduce the incidence of psychological ill health amongst the unemployed and economically inactive. ALMPs should form a core component in the 'family' of social interventions and measures that are required to address the multiple forms of deprivation that individuals experience and which are linked to poor psychological and physical health outcomes.

## What evidence is there?

There have been various calls – most notably by Richard Smith (1992) in a now dated editorial of the *British Medical Journal* – to fund research on the health effects of welfare to work policies. Furthermore, the Acheson Report recommended ‘...assessing the impact of employment policies on health and inequalities in health’ (Acheson et al 1997, Recommendation 9.2). And more recently the Employment Conditions knowledge network of the Commission on the Social Determinants of Health (CSDH) examined the evidence on various employment conditions and more specifically on the ‘effectiveness or potential effectiveness of employment related policies and interventions on health’. However, only one mention is made to ALMPs and no evidence is provided regarding their impact on health and well-being. It appears that policy and academic proposals have largely gone unheeded and consequently, as a result there is a evidence ‘void’ regarding the ‘unintended’, i.e., the health impacts of governmental social interventions such as Active Labour Market Programmes (ALMPs).

The empirical evidence that does exist on labour market status and health has tended to focus on the health damaging effects of unemployment and employment (Bartley *et al* 1999; Benach *et al* 2007; McKee-Ryan *et al* 2005; Murphy and Athanasou 1999). In comparison, 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 the quasi-employment status or condition of ALMPs<sup>1</sup> (Coutts 2005a). The small body of evidence that is available is equivocal about how much positive health gain and reduction in health disadvantage one can anticipate from the changes likely to flow from such interventions (Coutts 2005b; Curtis et al 2001). Furthermore, the evidence that does

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<sup>1</sup> Evidence does exist in relation to the health impacts of labour market programmes targeted at the disabled and those receiving incapacity benefits. See Corden and Thorten (2002) and Waddell and Burton (2006) for evaluations and reviews.

exist tends to focus upon the more 'traditional' unemployed groups such as youths and redundant older workers.

The lack of empirical evidence is surprising given the current policy ethos of the application of progressive values and political commitment to increasing personal well-being. Furthermore, work, health and well-being are considered fundamental in the delivery of welfare to work and the broader policies of neighbourhood renewal, reduction of income and health inequalities, as well as social exclusion and the improvement of life satisfaction (New Economics Foundation 2004; Strategy Unit 2003). Indeed, over recent years there has been an emergence of literature such as that of Kahneman (2005) and Layard (2005) combining economics and psychology which propose that governments should perhaps focus more on improving the well-being, happiness and self-esteem of their inhabitants via psychosocial interventions rather than solely attempting to increase individual incomes. Health and well-being, it is proposed, are value-adding features and goals of socially just government intervention (Marmot 2003; Sennett 2003).

In light of progressive and modernised policy aims, the evidence void that exists, the policy emphasis on returning the unemployed and economically inactive to work, and the current and ever worsening fiscal crisis, it is academically and politically 'intelligent' to examine how the transition from unemployment to employment via ALMPs can affect the health and well-being of those they intend to help.

### **What type of evidence is needed?**

Conducting the evaluation and health impact assessment of policy interventions such as ALMPs and in particular government training programmes in order to generate rigorous evidence is problematic, due to the complexity involved in the dynamics of social problems themselves such as unemployment and ill health, but also that of policy delivery itself (Curtis

*et al* 2001). This causal complexity, i.e., being able ‘to see the forest *and the trees*’ in order to unpack ‘the web of causation’ is a problem which is generally endemic to social science, in particular to epidemiology and sociology (Berkman 2004; Krieger 1994; Rychetnik *et al* 2004; Winship and Morgan 1999). Also, as highlighted above, whilst there is a large body of research on employment, unemployment and health, only a small part of it relates directly to the health effects of ALMPs. Indeed, much of the past research has focused on what happens when employment status worsens, for example, through redundancy and long-term unemployment. In comparison, there is relatively little empirical evidence on the health effects of improving employment status or the quasi ‘non-employment’ status or changes produced by ALMPs (Coutts 2005).

The strength of the evidence is also variable. As Whitehead *et al* (2004) and Petticrew *et al* (2004) have noted, arguably the most robust evidence needs to come from natural experiments and longitudinal studies of individuals showing whether changes in the determinants of health, such as change in employment status, are followed by changes in the person’s health. The review presented below demonstrates that the evidence concerning the relationship between unemployment, employment, ALMPs and health tends to be limited to cross-sectional studies.

Conventional strategies in epidemiology and evaluation stress the value of data on ‘control’ groups – those that have not been subject to the same change as the ‘intervention’ groups – in order to test whether health change is really an effect of the intervention. Data from cross-sectional studies or studies without control groups can provide useful information, but may be considered to carry less weight than longitudinal case-control studies – also known as natural quasi experiments. Furthermore, studies which provide information on why such changes may take place, and whether intervening factors mediate the health

effects of employment change, are more useful than those which simply demonstrate associations between employment and health change. This is because an understanding of the causal pathways by which change in employment status may relate to change in health can inform the theories on which successful social intervention and policy can be based.

Traditionally in the evaluation of social policy interventions, health outcomes or health change – if are considered at all – are treated as the subjective, unintended effects or soft outcomes and they are generally placed within the frame of ‘quality of life effects’ (for a exception see Lakey and Bonjour (2001)<sup>2</sup>). The evidence presented in research – for instance, that of Casebourne and Britton (2004), John et al (2001), Lewis et al (2000) or Thomson et al (2003) – regarding the health of lone parents for example is normally that of cross-sectional anecdotal qualitative assessments by the participants or target groups of the intervention. Further, there are a number of large-scale comprehensive evaluations concerning the impacts and outcomes of these interventions such as the New Deal for Lone Parents (NDLP) (see, for example, Evans et al 2002, 2003; 2004). However, these studies are limited to the traditional, more tangible, ‘hard’ objective indicators such as numbers of individuals moving off the welfare register, numbers of lone parents participating in the programmes, and the cost-benefit of this to the Treasury and the Department for Work and Pensions (Coutts in preparation and 2005). As Petticrew et al (2004) and this research note, perhaps the main reason amongst others<sup>3</sup> for the use of ‘hard’ measures such as job outcomes is the political preoccupation with the cost effectiveness of policy

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<sup>2</sup> Lakey and Bonjour (2001) is the only work that has been identified in this research to provide an evaluation that incorporates the health impacts of a government social intervention. They do refer to their study of the effects of the New Deal for Young People (NDYP) as a ‘health impact assessment’. However, they do not utilise any form of HIA methodology.

<sup>3</sup> From the evidence presented, one may also add that the focus upon objective ‘hard’ measures of policy success in past evaluations is due to the availability of variables within existing data sets such as the Family and Children’s Survey (FACS), in which health and well-being are rarely measured longitudinally in the relation to those affected by policy interventions. Nevertheless, there does not seem to be any move to include measures of health or health impact of interventions such as the New



As Macintyre (2003) comments, there is a considerable lack of information on the actual health impacts of interventions. Although the longitudinal monitoring of the actual health effects of policy interventions generates the most rigorous empirical evidence, it has rarely been utilised due to the prolonged time scales needed in order to conduct comprehensive monitoring and the inherent lagged exposure-effect rates that are exhibited by physical health in particular<sup>4</sup>. In sum it is the age old problem of short-time scales for policy delivery which are endemic within policy and politics, and which mean that the longitudinal examination of the impact of policy on ‘fuzzy’ concepts such as health often prove too costly in terms of time and money (Cabinet Office 2003; Duncan 2004; Mindell *et al* 2003).

### **Natural experiments**

As noted in the previous section little is known at present about the differential health effects of social interventions. The best evidence on these effects is in the short-term likely to come from longitudinal natural experiments, as randomised studies remain uncommon due to limited funding, lack of political will and their often unethical nature (Cabinet Office 2003; Petticrew *et al* 2004; Thomson *et al* 2004). Evaluations of natural experiments are common within epidemiology and economics but are less so within public health research and non-existent within sociology (Berkman 2004; Winship and Morgan 1999). This represents a “lost opportunity”, and is perhaps as stated earlier one of the main reasons for the evidence ‘void’ currently surrounding the health impacts of social policies and interventions (Thomson *et al* 2004).

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Deal programmes (see, for example, the establishment of the Employment, Retention and Advancement Demonstration Project for Great Britain (Cabinet Office 2004).

<sup>4</sup> This is being challenged by psychobiological/biomarkers research such as that of Steptoe *et al* (Forthcoming, 2004) and Westerlund *et al* (2001), which demonstrate that physiological health changes can take place within a short-time scale of an intervening stimulus or change of the individual’s psychosocial context.

## **Labour market status and health**

### **Unemployment and health**

For over fifty years much of the past work on labour market status and health has tended to focus on the health damaging effects of unemployment (Feather 1990; Fryer and Fagin 2003; Jahoda 1982; Murphy and Athanasou 1999; Warr 1987). This wealth of evidence has demonstrated unequivocally that the incidence of unemployment has both psychological and physiological health impacts such as depression, anxiety, low self-esteem, low affectivity, i.e., unhappiness and ultimately suicide (see Bartley *et al* 1999; Benach *et al* 2007; Clark 2003; McKee-Ryan *et al* 2005; Murphy and Athanasou 1999; Ozamiz *et al* 2000 for comprehensive reviews). Research has found that the health disadvantages induced by unemployment are primarily related to poverty created by the low-income nature of unemployment (Bartley *et al* 1999; Benzeval 1998; Benzeval and Judge 2001; Brown and Moran 1997; Stronks *et al* 1998; Shaw *et al* 1999; Weich and Lewis 1998). Poverty engenders health disadvantages through direct material and indirect pathways. The material pathways relate to the direct health impacts of poor housing and nutrition, whereas the psychosocial health impacts occur indirectly through the perception of social isolation, loneliness and the consequent individual impression that they are not socially included (Jahoda 1982; Warr 1987).

Longitudinal research on individuals has produced evidence that changes in a number of aspects of health can be detected after redundancy, extended periods of unemployment, or negative changes in job attributes. Examples of the possible health impacts of redundancy or periods of unemployment include increased risk of mortality or morbidity from a range of physical diseases, notably heart disease. Changes in mental health consequent on redundancy or unemployment are also reported (for example, suicide, depression and anxiety, psycho-

social malaise). Physiological changes to blood cholesterol and calcium levels have also been detected, as well as increased claims of disability pensions. This evidence is based on studies which have examined what happens to population health when working conditions deteriorate (including the individual experience of unemployment). In these circumstances, much (but not all) of the evidence shows that health will worsen. However, it is not simply the case that unemployment, in itself, is most likely to have effects causing poor health because negative attributes of work, often associated with high risks of unemployment, are also health damaging.

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 (Baker and North 1999). Indeed, the few studies which exist such as Claussen *et al* (1993), Fineman (1983), Isaksson (1990), Iverson and Sabroe (1988), Kessler *et al* (1989), Lahelma (1989), Thomas *et al* (2005), Vinokur *et al* (1987, 2000) and Warr and Jackson (1985) that examine the impacts of reemployment of the unemployed do in fact demonstrate that reemployment can reverse the negative health effects of unemployment. However, it is dangerous to infer the simple causation that the transition to employment will function as a panacea of the economic and social problems faced by the unemployed and economically inactive – Jahoda’s (1982) notion that “any job is better than no job”. Indeed, the approach adopted in this review considers the caution signaled by a number of authors, in particular Burchell (1994), Dooley *et al* (2000), Fryer (1999) and Halvorsen (1998), who note that when considering the “labour market weak” one must recognise that the simplistic dichotomy between employment and unemployment is rather more complex than viewing unemployment as ‘bad’ and employment as ‘good’. This is particularly pertinent given the evidence that the employment opportunities available to the ‘labour market weak’ may be dominated by conditions of low pay and limited sustainability (Evans *et al* 2004).

## Theories of unemployment and health

The unemployment and health literature, and more specifically the conceptual frameworks of Jahoda (1982), Warr (1987) and Fryer (1986) as described below, have provided the foundations for the study of unemployment, employment and health. Researchers have used these 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. These relate to such features as: security (Burchell 1994; Ferrie *et al* 2001; Halvorsen 1998; Strandh 2000); satisfaction (Creed *et al* 2001; Graetz 1993); demands and control (Karasek and Theorell 1990); effort reward balance (Siegrist and Marmot 2004); supervisor and peer support (Burchell *et al* 1999; Stansfield 1999; Vahtera *et al* 2000); and perceived financial strain (Creed *et al* 2001; Kessler *et al* 1988; Leana and Feldman 1995). These psychological 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.

Jahoda's (1982) latent deprivation theory proposed that employment provides access to five important categories of experience, including time structure, activity, social contact, collective purpose, and status. In other words, being employed imposes a structure for time use, enforces some level of activity, provides opportunities for contact with others outside of one's family, provides a sense of social status, and opportunities to work within unison towards collective goals (Jahoda 1982).

“Employment provides the imposition of a time structure, the enlargement of the scope of social activities into areas less emotionally charged than family life, participation in a collective purpose and effort, the assignment by virtue of employment of status and identity, and required regular activity” (Jahoda 1982: 59).

According to Jahoda (1982), deprivation of these latent functions of employment accounts for the psychological distress experienced by the unemployed. The theory maintains that, whilst employment is not the only social institution that can fulfill latent needs, it is primary because it is associated with earning an income. Although Jahoda's theory of deprivation has not been widely used outside of work psychology, Julius Wilson (1996), in his ground breaking study of deprived urban neighbourhoods in Chicago, utilised Jahoda's theory to suggest that due to the absence of work within the inner city populations – particularly amongst single mothers, this had given rise to social isolation and lack of 'ties' to everyday life which, it was proposed, could be provided through employment.

In contrast, Fryer (1986) has argued that the latent deprivation theory represents individuals as passive agents at the mercy of social institutions and external forces. Fryer (1986) saw individuals as proactive, able to influence their environment, and striving to have some control over their lives. He argued that it was the loss of the manifest benefit (income), and thus the experience of poverty, that accounted for the deterioration in well-being of the unemployed. Fryer's agency restriction model proposed that economic deprivation places restrictions on the unemployed individual's ability to exercise personal agency, making it impossible to plan and organise a meaningful future and, thus, negatively impacting upon an individual's well-being. Whilst Fryer acknowledged the role that the latent benefits played in mental health, he argued that they could not fully account for the reduced well-being experienced by the unemployed individual (Fryer and Payne, 1986).

Until recently, research has largely examined the two theories independently and has found supporting evidence for the impact of both economic and latent deprivation on the

well-being of the unemployed. For example, researchers have shown that unemployed individuals report more financial strain than their employed counterparts (Jackson 1999) and strong links have been found between financial strain and psychological distress (Kessler *et al* 1989; Schaufeli and Van Yperen 1992; Vinokur and Schul 2002; Vinokur et al 2000; Winefield 2002). Given that the theories have merit, researchers such as Creed and Machin (2002) and Creed *et al* (2001) urge the consideration of both the latent and manifest benefits of employment in studies of well-being in the unemployed.

From studies that have included both domains, it appears that the manifest benefit, typically operationalised as financial strain or economic deprivation, is a better predictor than latent deprivation of well-being in unemployed samples. For example, Brief *et al* (1995) found that economic deprivation was a more accurate predictor of subjective well-being than experiential deprivation. Similarly, measuring both the latent and manifest benefits, Creed and Macintyre (2001) found financial strain to be the most important predictor of well-being amongst the unemployed.

Further, it is also argued that the latent functions may not contribute equally to psychological distress (Creed and Macintyre 2001). Whilst Jahoda (1982) maintained that time structure was the most important of the latent functions, the few studies carried out to date on the relative contribution of each of the latent functions have suggested otherwise. Using the Access to Categories of Experience scale (ACE), Creed and Macintyre (2001) found Status to be the most important predictor of well-being in an unemployed sample, followed by time structure, and collective purpose. In a study comparing the unemployed with underemployed individuals, Creed and Machin (1999) found that, together, the five latent functions significantly predicted psychological distress, but status emerged as the only significant unique contributor.

There is a significant and multi-disciplinary evidence base<sup>5</sup> that demonstrates that social contacts may serve as a stress buffering coping resource; there is, however, less agreement over the issue of whether and in what way unemployment may involve deprivation in terms of social contacts. Results of studies by Evans and Haworth (1991) provided empirical support for Jahoda's theory by demonstrating that employment provides greater social contact and access to social ties. In addition, research shows that, although the unemployed and economically inactive possess more free time, they tend to become more socially isolated, with a home-centred leisure patterns (McKee-Ryan *et al* 2005).

With regard to the importance of the social status associated with employment, Warr (1987) states that "on becoming unemployed a person loses a socially approved role and the positive self-evaluations which go with it. The new position is widely felt to be one of lower prestige, deviant, second-rate, or not providing full membership of society" (1987: 224). Further, studies have also examined the issue of social position, perceived hierarchy and the "shaming" aspects of unemployment. Eales (1989) found that one in four adult unemployed men had experienced feelings of shame that could be related to unemployment. Half of them had changed social activities to avoid shame. As a consequence, feelings of shame were strongly related to depression, anxiety and minor affective disorders.

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<sup>5</sup> Social support networks may provide instrumental and material benefits and opportunities as well as close social contacts and emotional support, which generate opportunities for participation and social integration, consequently reducing feelings of social isolation. The research evidence shows that social exclusion and the ensuing isolation and lack of social support are linked to various health outcomes such as poor psychological health, depression, cardiovascular disease and coronary heart disease (For authoritative reviews see: Berkman and Glass 2000; Cacioppo and Hawkey 2003; Cacioppo *et al* 2002, 2000; Cohen *et al* 2000)

A Swedish study of unemployed young people, Rantakeisu *et al* (1997), explored the shaming elements experienced by the unemployed and the effects of these on various health outcomes. The concept of shame was operationalised by six questions on respondents' experiences of other people's attitudes towards them because of their unemployment. They were questioned as to whether other people had been annoyed with them, spoken about them in negative terms, avoided them, regarded them as less competent and lazy, or taken no notice of what they had said or done. The researchers found that experience of a more shaming environment was significantly associated with headaches, sleeping disorders, powerlessness, depression, restlessness, nervousness and anxiety, tiredness, lack of strength, as well as difficulties in relaxing, increased alcohol consumption, increased smoking, less exercise, fewer recreational activities, less contact with friends, anxiety, and less self-confidence.

Despite the prevalence of research highlighted above examining Jahoda's and Fryer's theories, there is a lack of consistency in the scales used to measure the latent and manifest benefits, making comparative studies difficult. Further, those that have been used more frequently, such as the ACE scale (Evans and Banks 1992) and the Significance of Work Scale (SWS) of Williams *et al* (1975) have been criticised for their questionable psychometric properties (Muller *et al* 2003). In response to this, Muller *et al* (2003) developed the Latent and Manifest Benefits (LAMB) scale see Appendix 1 The LAMB scale includes six subscales: financial strain (measures the manifest benefit), collective purpose, social contact, status, time structure, and activity (measure the five latent benefits). Compared to the ACE scale, the LAMB subscales have strong internal reliability, ranging from .74 (time structure) to .93 (financial strain) (Muller *et al.*, 2003). Validity tests performed by Muller *et al* (2003) on the LAMB scale indicated that it also



has sound construct and criterion validity. As a result, more rigorous investigations of Jahoda's theory can now be undertaken.

Using the LAMB scale in a study of 250 unemployed participants, Muller *et al* (2003) found significant correlations between each of the latent and manifest benefits and scores on the 12-item version of the General Health Questionnaire (Goldberg 1972). The highest correlation ( $r = .38, p < .001$ ) was between financial strain and the GHQ. The results support the contention that higher levels of psychological distress are associated with less access to the latent and manifest benefits of employment.

However, not all unemployed individuals suffer psychological distress. One of the more recent criticisms of deprivation models is that they fail to take into account individual differences, such as temperament, values or experiences (Creed and Machin 2002). A consistent finding in the literature is that people who are high in negative affect also score highly, i.e., poor self-rated health on measures such as the General Health Questionnaire (GHQ). This has prompted a debate as to whether negative affect is a confounding or "nuisance" variable because of its potential to influence self-report data or whether high negative affect individuals do actually experience poorer mental health (Diener *et al* 1999). Creed *et al* (2001) provided evidence that negative affect can exert its influence in the stress-strain relationship, having a direct influence on symptom reports, acting as confounding variable, and also operating as a moderating vulnerability factor. Thus, it seems important to include negative affect in any studies that use self-reports of health.

When individual differences and personality variables are taken into consideration, access to the latent and manifest benefits still seem to add to the prediction of psychological well-being. For example, after controlling for the effects of age, gender,

labour market satisfaction and trait neuroticism, Creed, Muller, and Machin (2001) found that financial strain and access to the latent benefits added significantly to the prediction of well-being. The contribution of access to the latent functions of employment, however, was quite small and less influential than the other variables in the model (Creed *et al* 2001). Similarly, Brief *et al* (1995) controlled for negative affect and found significant paths between economic deprivation and subjective well-being, but not for latent deprivation. Less evidence is available for the influence of Positive Affect on the well-being of the unemployed. It is likely, however, that the tendency to view life events more positively, i.e., high positive affect, will act as a buffer to psychological distress. Similarly, happiness or satisfaction with one's occupational situation is also likely to influence levels of distress. Hesketh *et al* (1987) found that individuals who were happy being unemployed or economically inactive were engaged in purposive unpaid work, had good social contacts and high self-esteem, whereas those who were unhappy had low self-esteem, financial strain, no social contacts and high employment commitment.

It follows that paid employment may be a valued experience because it provides an avenue for people to fulfill certain psychological and financial needs. The value of employment is often measured by employment commitment or work involvement (Warr *et al* 1985), which is defined by Hesketh *et al* (1987: 175) as "the perceived excess of positive over negative features available in an employed state relative to those available in an unemployed state". Employment commitment has been found to be a moderator of unemployment and psychological well-being, such that unemployed people with high levels of employment commitment experience greater distress than those who are more ambivalent about employment (Feather 1990; Mean Patterson 1997; Rantakeisu and Jonsson 2003). Vinokur *et al* (2000) and Wiener *et al* (1999) found that high employment

commitment, along with lower levels of general self-efficacy and a strong intention to seek work were significant predictors of psychological distress.

## **ACTIVE LABOUR MARKET PROGRAMMES AND HEALTH<sup>6</sup>**

ALMPs and more specifically the training programmes which are used to deliver them are an intermediate stage within the process of labour market reattachment that aim to provide the unemployed and economically inactive with the human capital ‘steps’ towards employment. Coutts (2005) highlights the quasi / temporary alternative nature of such schemes in that people are neither employed nor unemployed but occupy a state of ‘labour market limbo’. In terms of the potential health impacts of this intermediate labour market status, participants may, therefore, be subject to both the negative and positive social and psychological impacts of employment and unemployment as well as the mechanisms used by the ALMPs to ‘reinsert’ and attach them into the labour market. The following section considers the evidence that links participation *within* ALMPs to various health outcomes.

Using the models of unemployment and health embodied in the theories of Jahoda (1982), Warr (1987), Fryer (1986) and Bandura’s (1977, 1997) self-efficacy<sup>7</sup> model, it is suggested that training programmes have the potential to improve health, in particular that of psychological health and psychosocial functioning, through the provision of the

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<sup>6</sup> See Table 1 for an overview of the evidence on active labour market programmes and health  
<sup>7</sup> Self-efficacy is defined as the degree of confidence an individual has in their ability to perform specific behaviours such as job search. Individuals with a high level of self-efficacy, Bandura (1997) comments, are more likely to persist at tasks even under conditions of high stress or repeated failure. As Berkman and Glass (2000) note, there is a considerable evidence base to suggest that self-efficacy is one of the main psychosocial mechanisms by which social support operates. Participation and being socially integrated is essential for the maintenance and continued development of self-efficacy (McAvay et al 1996). In addition, there is evidence that demonstrates that self-efficacy and social support are reciprocally related.

latent functions/vitamins and various psychosocial experiences which are assumed to be absent during unemployment (Creed *et al* 2001). Indeed, a small body of research originating primarily from vocational rehabilitation research in Scandinavia (Työhön job search training Programme, Finland<sup>8</sup>) and the Institute of Social Research (Michigan)<sup>9</sup> has identified positive health impacts of training programmes using these theoretical frameworks such as: reductions in psychological distress and depression (Coutts in preparation, 2005; Juvonen-Posti *et al* 2002; Melin and Fugl-Meyer 2003; Vuori *et al* 2002; Vuori and Silvonen, 2005; Vuori and Versalainen 1999, Vinokur *et al* 2000; Westerlund *et al* 2001); increased subjective well-being (Andersen 2008); higher levels of control/mastery (Creed *et al* 1999); improvements in motivation and self-esteem through feeling needed (Coutts in preparation, 2005; Donovan *et al* 1986; Hagquist and Starrin 1996; Harry and Tiggemann 1992); having something meaningful to do, somewhere to go and meet people, less stigma of being unemployed and improved support (Stafford 1982; Winefield 1985). This evidence is equivocal, however, in the extent and duration to which these health gains may persist after the individual has left the intervention. Psychological health benefits have been found to be maintained up to four months (Harry and Tiggemann 1992; Vinokur *et al* 2000) and disappear or decline after participation (Andersen 2008; Creed *et al* 1998; Vuori and Versalainen 1999).

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 (Vinokur *et al* 1995). 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

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<sup>8</sup> Työhön Job Search Program has been implemented country-wide in Finland.

<sup>9</sup> For downloadable publications from the Michigan Prevention Research Centre and JOBS programme see: <http://www.isr.umich.edu/src/seh/mprc/public.html>

and employment (Caplan *et al* 1989; Vinokur *et al* 1995, 2000). The programme has been found to, via a combination of self-efficacy training in job-search skills, return unemployed workers to new jobs more quickly, in jobs that pay more and reduce mental health problems associated with prolonged unemployment, as well as preventing depression in those most vulnerable to mental health problems (Vinokur *et al* 1991; Vinokur and Caplan 1987; Van Ryn and Vinokur 1992; Vinokur *et al* 1991, 1995, 2000).

In the only recent study of training programmes offered under the New Deal for Lone Parents in the UK, Coutts (2005) found a number of positive health impacts. The study examined the health impacts of two training programmes on lone parents and whether the change in their psychosocial environment as measured by the scale of the latent and manifest benefits of employment (LAMB, Appendix 1) could explain these health impacts. The data for the study were obtained from sixty-two lone parents participating in the programmes who were followed longitudinally for five months. Structured questionnaires comprising scales of psychological health, self-esteem, mastery, positive and negative affect, self-efficacy, perceived psychosocial environment (LAMB) were administered to the programme participants at three time intervals - at the beginning (0 months), during (2.5 months) and end of the training programmes (5 months). In-depth qualitative interviews were also conducted at each time interval with programme participants. The results indicated that entry into the training programmes improved the psychological health and well-being of the training participants. A clear relationship was found between psychosocial environment variables such as social contact, collective purpose and social identity and psychological health. In contrast, material economic variables were shown not to contribute significantly to health measures.

The numerous studies such as Coutts (in preparation, 2005), Creed *et al* (2001) invoke Jahoda's (1982) model of latent functions – LAMB scale, Fryer's (1986) agency

restriction model, as well as theories concerning the health benefits of social support and reducing social isolation and loneliness. They suggest that mechanisms that may produce positive health change include: enhancement of skills and competences; imposition of a structure to the working day; social contact and status; helping participants to set goals for themselves; empowering them to take greater control of their lives; and the provision of a supportive rapport between participant and trainer. Such components of training programmes are thought to explain psychological health improvements reported over the period of participation. These include:

- improved general psychological health and reduced distress – Coutts (in preparation, 2005), Creed *et al* (1999); Creed *et al* (2001); Drury *et al* (1997); Hagquist and Starrin (1996); Harry and Tiggemann (1992); Lakey and Bonjour (2001); Oddy *et al* (1984); Strandh (2001); Stafford (1982); Vuori and Vesalainen (1999), Vesalainen and Vuori (1999); Vuori *et al* (2002)
- reduced depression – Coutts (in preparation, 2005), Creed *et al* (1996); Harry and Tiggemann (1992); Oddy *et al* (1984); Vinokur *et al* (2000); Vinokur and Schul (2002); Vuori *et al* (2001)
- reduced anxiety – Oddy *et al* (1984)
- improved social adjustment – Oddy *et al* (1984)
- reduced sense of helplessness – Creed *et al* (1998)
- improved self-esteem – Coutts (in preparation, 2005), Creed *et al* (2001); Harry and Tiggemann (1992); Oddy *et al* (1984); Westerlund *et al* (2001); Vinokur *et al* (2000)
- improved self-efficacy and mastery<sup>10</sup> – Creed *et al* (2001); Creed *et al* (1998); Eden and Aviram (1993); Harry and Tiggemann (1992); Lakey and Bonjour (2001); Vinokur *et al* (2001)
- improved life satisfaction – Creed *et al* (1998); Oddy *et al* (1984)
- improved role and emotional functioning – Vinokur *et al* (2000)
- improved attitudes to work – Creed *et al* (1996).

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<sup>10</sup> Mastery relates both to an internal locus of control and a positive expectancy about one's ability to engage in behaviours needed to cope with a stressful event or situation (Pearlin *et al* 1981). Evidence shows that mastery is related to the ability to garner needed support as well as the ability to determine when support-seeking behaviour is appropriate (Berkman and Glass 2000).

Some researchers report that certain benefits persist for some time up to two years beyond the period of participation in a training programme (Vinokur *et al* 2000; Vuori and Vesalainen 1999), although studies such as those of Creed *et al* (1998) show that positive effects disappear soon after participation. However, health improvements may not be realised where the programme fails to produce these intended benefits, or where they have unintended outcomes, which have also been reported in evaluations. These negative effects include the possibility that the programme will be perceived as inadequate alternatives to work (Branthwaite and Garcia 1985) or that low financial rewards will exacerbate financial strain (Oddy *et al* 1984).

The nature of the health impacts will also depend partly on mediating effects. For example, gender variations may be apparent (Hagquist and Starin 1996; Vuori and Vesalainen 1999), the duration of unemployment and the severity of financial strain (Eden and Avarim 1993; Vuori and Vesalainen 1999; Hagquist *et al* 1996), as well as the type of programme in terms of whether it consists of advice and support or is more focused upon vocational work-based training which have been found to influence health impacts (Strandh 2001). In addition, from the evidence presented it could also be suggested that any health impacts may also be mediated by the social networks in which individuals are embedded, aiding individual coping abilities (Clark 2003; Cohen *et al* 2000; Warr and Jackson 1985). A common finding amongst the available evidence is that the initial baseline psychological state affects the potential for health improvement. For example, those with initially low baseline well-being in terms of depression and low sense of mastery, self-efficacy and motivation may benefit most, whilst those closer to labour market entry in terms of occupational skills and experience as well as health may exhibit fewer health improvements. This differential

response to the training environment is referred to as a 'behavioural plasticity effect' (Creed *et al* 1999; Creed *et al* 2001; Westerlund *et al* 2001).

As previously noted, in a unique study by Westerlund and colleagues (2001), examined the psychological and physiological health of effects of participation in a labour market programme. Thirty-two female participants in a labour market programme offering temporary, alternative employment in Sweden (Use for All) were followed longitudinally for one year, including a six-month post participation follow-up period. The study found a discrepancy between self-reported health and actual physiological health of participants. The researchers found worsening physiological changes as measured using objective health indicators such as serum prolactin – associated with powerlessness and high blood pressure. The effect of this hormone is considered to be protective in that it shields off adverse stimuli and narrows the emotional field of vision, which may explain the improved subjective ratings of self-control. For the labour market 'weak', this 'protective adaptation' and improvement in coping capacities may outweigh the possible further health disadvantages of entering the labour market, given the negative health impacts that may arise from entering poorly paid insecure employment.

In a follow up study of these results Westerlund *et al* (2004) found that that the effect of participating in what were perceived by the programme participants as 'better' programme activities was a temporary increase in anabolism, possibly indicating lower stress levels. The effect of 'worse' activities led to a temporary decrease in the catabolic index, probably reflecting repressed alcohol consumption, and impaired anabolism. There was also a general but transient decrease in depressiveness measured by the Hospital Anxiety and Depression Scale. The results seem to imply that it is difficult to achieve lasting effects through a relatively short participation in a mobilising programme.



A major conclusion from these studies was that six months participation in an active labour market programme was not enough to achieve lasting health effects.

A further number of negative mental health impacts have also been identified for ALMP participants such as reports of less control over their lives (Donovan et al 1986; Oddy et al 1984; Hagquist and Starrin 1996), feelings of exploitation and generally poor health, particularly amongst women (Branthwaite and Garcia 1985; Hammarstrom and Janlert 2000; Novo et al 2001). In qualitative research by Coutts (2000) on the prospective health impact assessment of employment regeneration schemes in East London, it was demonstrated that due to the temporary nature of the programmes, participants can experience feelings of insecurity, financial strain, role conflicts and concerns about non maternal childcare, as highlighted in the quote below.

“I come here [a training scheme] thinking ‘Yeah I am improving myself getting some skills and education’. But then these other thoughts come into ma head - that I am still poor and my kids have got a stranger looking after them. It’s like being put on a rack with your kids pulling on one end and the government on the other!” (Lone mother respondent – local training scheme – East London, Coutts 2000).

This dilemma between ‘improving yourself’ and ‘being there for the children’ was viewed by many of the respondents to be the hardest ‘hurdle’ to overcome in the entry into a training programme and paid work. This was of course not helped by the fact that participants still receive incomes equivalent to or lower to that received on benefit. In financial terms, they are still unemployed but are subject to ‘spill over’ in terms of extra demands such as travel, trying to arrange childcare and psychosocial work characteristics which create perceptions of stress and ill health. These factors were found to reduce their satisfaction and commitment to completing any education or training, let alone entering paid work (Coutts 2000).

Numerous research, most notably Vuori and Versalainen (1999), Wanberg et al (1996), and Wanberg (1997) has demonstrated that job search is a significant predictor of entry into paid work. Therefore, many ALMPs, and particularly the NDLP, consider it a fundamental aspect of their training delivery. However, the way in which it is conducted and the kinds of support given by such people as job-search advisers can have potentially positive or negative health impacts (Lakey et al 2001). The expectancy valence approach of Feather (1990) suggests that job seekers could be helped by the provision of counselling to enhance 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, the self-efficacy and the learned helplessness models demonstrate that repeated personal experiences of failure may undermine personal efficacy and lead to reduced psychological well-being (Bandura 1997; Frese 1987; Leana and Feldman 1992; Wanberg 1997; Warr and Jackson 1987). Consequently, one could argue that in terms of health it would not be wise to motivate people to look for employment given the evidence that employment demand may be quantitatively and qualitatively 'bad' in terms of the pay and sustainability they provide. It may be considered, as Westerlund et al (2001) and Creed et al (1999) 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 stresses and strains of unemployment.

In light of this, a number of researchers such as Creed et al (1999) and Salipante and Goodman (1976) have pointed to the fact that ALMPs need to be based upon enhancing personal development rather than entirely occupational skills and 'supply-side' factors. Academics at the Institute of Social Research (Michigan) have pursued this idea by developing ALMPs based upon the self-efficacy model – the JOBS programme (Caplan et al 1989; Vinokur et al 2000). They aim to 'immunise' and help the unemployed cope with the

debilitating effects of unemployment by developing their self-efficacy (Bandura 1997; Caplan et al 1989). This is achieved through role-play on how to carry out effective job search, by anticipating potential barriers and setbacks in job search and developing strategies to enhance their resilience in coping with these setbacks. Evaluations of the programmes have highlighted how participants have developed higher levels of self-efficacy and mental health combined with employment in good quality jobs (Vinokur et al 2000).

## **SUMMARY**

The evidence considered in the above sections has demonstrated how the labour market training programmes delivered via the ALMPs may have potentially positive and negative impacts upon health. The evidence suggests that it is the features within the programme, such as role played by job search advisers, and the psychosocial attributes or categories of experience such as increased social contact, support and reduced feelings of loneliness which have an important influence upon health in particular the psychological health of participants. It is also necessary to consider, as Vinokur and colleagues at the Institute of Social Research (2000) note, that health, particularly psychological health, can have a major influence upon job-search motivation and subsequent chances and quality of reemployment.

## **Causation or selection?**

One of the predominant issues within the social determinants of health and the unemployment and health literature is whether unemployment leads to a deterioration in well-being – the social causation hypothesis – or whether individuals are predisposed to becoming or remaining unemployed because of existing mental health problems – the selection ‘drift’ hypothesis (Dooley and Prause 2003). Most studies have examined the

impact of joblessness on psychological well-being, and thus have been interested in well-being as an outcome variable.

There is ample evidence from longitudinal studies to support the social causation hypothesis (Murphy and Athanassou 1999). However, there is also evidence that emotional distress influences the risk of unemployment and the chances for reemployment (Schaufeli and Van Yperen 1992; Vinokur and Schul, 2002). Elevated distress levels may represent a lack of, or depletion of, personal coping resources that are important to job-search activity and subsequent job acquisition. Individuals with low self-esteem, low confidence in their ability to perform job-search activities, higher levels of negative affect, and higher levels of psychological distress may lack the necessary resources to effectively engage in such activities, which may prevent them from successfully acquiring a job (Dooley and Prause 2004). This may be the result of unemployment, or it may be that some of these characteristics represent more stable components of personality that make an individual more vulnerable to unemployment.

Research examining the role of psychological distress as a predictor of job-search activities and employment outcomes has been somewhat mixed. Hamilton et al (1993) provided support for the notion that psychological distress is a barrier to reemployment. These researchers found that elevated depressive symptoms predicted continued unemployment 6 and 18 months after a job loss. Interestingly, some researchers have also found what Winefield (1995) has termed the “reverse drift” phenomenon, where unemployed individuals with elevated distress levels at baseline were actually more likely to find a new job within the following year (Kessler et al 1988). However, these individuals may have been inclined to sacrifice job quality for the sake of speedy reemployment. Leana and Feldman (1995), on the other hand, found that unemployed individuals who had greater responsibilities such as more financial dependents, felt more pressure to gain employment no

matter the quality of the job, and these workers were more likely to end up with jobs they did not like. A clearer understanding of the impact of psychological well-being on job-search efforts and employment outcomes is important to the design of interventions and strategies such as training programmes which aim to facilitate labour market attachment.

The evidence presented above is much in line with research such as that of Fryer and Payne (1984), Dooley et al (1988) and Nordenmark and Strandh (1999), which shows that it is the ability to occupy 'other' alternative socially approved roles which may determine the economic and psychosocial need for employment, in turn affecting the likely health impacts. This may of course be termed an 'adaptation' to unemployment (Warr and Jackson 1987; Westerlund et al 2001), something which the political discourses would associate with the underclass debate and consider abhorrent in light of the mantra that work is the best form of welfare.

## **CONCLUSIONS AND RECOMMENDATIONS**

The evidence review has demonstrated that ALMPs and the training programmes and interventions used to deliver them can improve the psychological health and well-being of those they intend to help. These programmes should not as Dorling (2009) recently comments, be merely classed as 'work for the dole' programmes which 'are almost as detrimental to psychological good health as is unemployment itself'<sup>11</sup>. The Youth Opportunity Schemes / Youth Training Schemes set up by the Conservatives in the 1980s

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11 Dorling (2009) cites only one example –Branthwaite and Garcia (1985). This is based on a sample of 14 apprentices, 18 young people on a placement scheme, 8 males on a project scheme, 6 unemployed people.

were not effective<sup>12</sup> at either increasing basic skills, education and therefore labour market attachment (reducing unemployment) nor improving the health and well-being of their participants. However, as more recent evidence from a variety of contexts shows, ALMPs and programmes such as the New Deal have come along way in terms of quality, i.e., that of training provision. These programmes are intended as active labour market mechanisms by which to reduce unemployment. However, again as the evidence suggests their effectiveness and efficacy may lay more in their potential to reduce the incidence and severity of psychological ill health amongst the unemployed and economically inactive than reduce overall rates of unemployment.

The evidence demonstrates that if ALMPs are based upon enhancing personal development (the self-efficacy model) rather than focusing entirely upon increasing occupational skills, ‘supply-side’ factors and ‘getting individuals into any job as quickly as possible’, then positive health impacts may occur. As the JOBS and Työhön job search training programmes show this is achieved through enhancing individual self-efficacy, learning how to carry out effective job search, by anticipating potential barriers and setbacks (inoculation) in job search and developing strategies to enhance resilience in coping with these setbacks. The evaluations of the programmes have demonstrated how participants have developed higher levels of self-efficacy, reduced depression and improved overall psychological health.

An important point is that the impact of ALMPs in terms of their effects on health will depend on their potential to change or reverse the psychosocial aspects of unemployment / economic inactivity. The ability of ALMPs to alter an individuals material circumstances is

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<sup>12</sup> As Richard Smith states “The youth opportunities programme got something of a bad name for often failing to supply training or useful experience, and the youth training scheme is an attempt to mend these deficiencies. Evaluation is difficult and the scheme is still only young, but the quality is widely agreed to be patchy” (1986: 321).

extremely problematic. As the evidence has shown, this is very difficult to achieve within and after participation in the programmes as participants continue to receive income support, and in many instances may be returned to a local labour market that does not offer entry into sustainable and secure employment. In general the evidence would suggest that where labour market programmes can make a difference is in enabling the social inclusion and participation of the socially-isolated via provision of positive psychosocial attributes through, for instance, increased social contact, reducing social isolation and by generating a sense of purpose, worth and control which have been found to lead to positive psychological health impacts (Coutts 2005).

Given the evidence presented in this review, the increasing importance of ALMPs / government training programmes and their absence<sup>13</sup> as an ‘employment condition’ in the Employment Conditions knowledge network report for of the Commission on the Social Determinants of Health (CSDH), this review recommends that they be included. A working definition may run as follows:

A quasi / temporary stage between unemployment and employment in individuals which occupy a state of ‘labour market limbo’. In terms of the potential health impacts of this intermediate labour market status, participants may, therefore, be subject to both the negative and positive social and psychological impacts of employment and unemployment as well as the mechanisms used by the ALMPs to ‘reinsert’ and attach them to the labour market.

Most policy research and evaluations have focused upon the more ‘hard’ tangible outcomes of policy interventions such as rates of job entry. The evidence presented in this review is an indication that health, particularly psychological health, is also a measurable, tangible as well as a potentially important outcome of training programmes and social

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13 ALMPs are mentioned only once and no link is made to health. Table 12, Page 111 (Benach et al 2007).

interventions more widely. Qualitative studies such as that of Coutts (2005) have show that programme co-ordinators often state they had observed changes in participants' confidence and self-esteem. This is referred to as the 'distance traveled' by the participant and is not considered as an indicator of programme performance or success. In addition to health being an important outcome, ALMP training co-ordinators have noted how psychological health is a necessary part of an individual's portfolio of employability and a 'step' towards labour-market entry. This refers to aspects of psychological health such as self-esteem and self-efficacy which can affect an individual's job search motivation and behaviour and, therefore, influence potential job outcomes. In light of this, the review proposes that psychological health is an influence and measurable tangible outcome upon the success of the labour-market training programmes and therefore should be included within the monitoring and evaluation of government social interventions.

In order to facilitate the inclusion of the 'health' as an outcome and indicator of policy success, the review also proposes that Health Impact Assessment methodologies should form an essential feature of policy decision-making and design. To aide this process, it is recommended that HIA becomes a regulatory legal requirement within policy formulation and implementation.

Within the academic efforts to create rigorous and reliable evidence for policy, it must be recognised that evidence is an essential *but not sufficient* basis for policy action. Several other ingredients besides evidence are involved in the policy-making process, including political will, transferability of evidence into appropriate social strategies, and scalability into different contexts and settings. As Petticrew *et al* (2004) and Whitehead *et al* (2004) note, the policy-making process is often poorly understood by researchers. For instance, the strength of the evidence on any particular topic is not necessarily



proportional to the strength of recommendations that should follow. The latter being dependent upon values, contexts, and judgments about net benefits and harms. In some instances strong recommendations for policy are justified on weak evidence, and vice versa. As a result there is a need to devote further attention to understanding: what are the determinants of policymaking particularly in terms of interventions which promote work as ‘the best route out of welfare’ and hope to enable social inclusion and poverty reduction.

In relation to study design it must be stated that examination of the social determinants of health cannot be feasibly or appropriately manipulated in an experimental manner. For instance Randomised Control Trials of social determinants have generated findings that apparently contradict observational findings. Two recent randomised trials of the provision of social support following major illness (the ENRICHD Trial and FIRST Trial) failed to confirm findings from earlier observational studies of a health-protective effect of social support. It has been argued that these RCT findings do not necessarily disprove the observational evidence. Thus, according to Cohen *et al.* (2000) ‘social support is not a variable; it is a *process* that arises through interaction between people. Nor is social support a commodity that can be ‘delivered’ or abstracted from its relational context’ (Cohen *et al* 2000: 17). In other words, translating observational evidence into testable interventions will continue to be problematic in social determinants of health research.

In relation to the social determinants of health research more broadly, this review shows that there is a good deal of research on health inequalities examining how disadvantage in terms of health determinants like housing and employment and / or the lack of it are associated with negative health outcomes. Much of the past work on health inequalities has focused on the health damaging effects of existing levels of deprivation.

There is considerably less work which directly shows the effects of a change in deprivation, and even less research currently available on what happens to health when there is a supposed amelioration in aspects of material disadvantage such as re-employment or those changes generated by ALMPs. The evidence available on this last point is equivocal about how much positive health gain and reduction in health inequality one can anticipate from the sorts of changes which are likely to flow from government policy and social interventions that promote social inclusion and poverty reduction (Coutts 2005). For instance, a large scale systematic review by the Medical Research Council identified a considerable lack of empirical evidence relating to the health impacts of interventions particularly government-sponsored social interventions which aim to alleviate social and economic disadvantages (Ogilvie et al 2005a and b).

The evidence regarding the ‘reversibility’ of disadvantage on health is extremely limited, with research such as that of Benzeval and Judge (2001) proposing that it is not realistic to expect that the damage to health, especially physical health from poverty, will be quickly reversed when an individual experiences a rise in his / her economic situation and material hardship is reduced. The difficulty of reversing ill health is due to the lagged exposure-outcome relationship of physical health outcomes in particular. To achieve a reduction in ill health and health inequalities, it is suggested that sustained and significant improvement in material and psychosocial health determinants, for the most disadvantaged groups, is likely to be required. This review proposes that further studies be carried out particularly in relation the health impacts of ALMPs but also examining other government social interventions such as housing improvement and re-employment.

The evidence presented does not suggest that labour-market training programmes can improve the health and well-being of the unemployed and economically inactive ‘on the

cheap' and thereby ignore material structural interventions. The evidence demonstrates that it may be more realistic in the first instance to concentrate upon altering and improving the psychosocial aspects of an individual's environment via participation *within* a programme. Given the expected increase in unemployment, ALMPs and similar interventions will become ever more important and could help to protect the health of those who are out of work against the debilitating psychological effects of unemployment. These health gains, yet small, are necessary 'steps' towards improving the quality of life of the disadvantaged and those furthest from the labour market.

## APPENDIX 1

*The Latent and Manifest Benefits Scale (LAMBS)*, Muller *et al* (2003)

This measures Jahoda's five latent benefits of employment and the one manifest benefit as described in section ???. Each of the six subscales consists of six bipolar items measured on a seven-point scale:

- financial strain – e.g. my income usually allows me to socialise as often as I like/my income rarely allows me to socialise as often as I like
- time structure – e.g. I often/rarely have nothing to do
- social contact – e.g. I often/rarely go out and meet with others
- collective purpose – e.g. I contribute greatly/minimally to my community
- status – e.g. I am often/rarely valued by the people around me
- activity – e.g. I usually/rarely do all the things I have to do.

The scales were scored such that a low score on each of the five latent benefits indicates greater perceived deprivation of that benefit, whilst a high score on financial strain indicates greater financial strain. Muller *et al* (2003) reported internal reliability coefficients of .91 (Collective Purpose), .93 (Financial Strain), .92 (Social Contact), .91 (Status), .74 (Time Structure) and .89 (Activity). Similar reliabilities were found in this study with alpha coefficients of .88 (Collective Purpose), .92 (Financial Strain), .92 (Social Contact), .89 (Status), .91 (Time Structure), and .84 (Activity).

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