Reducing the impact of unemployment on health: revisiting the agenda for primary health care

Elizabeth Harris and Mark F Harris

ABSTRACT

Objective: To identify potentially effective strategies to be used in the primary health care (PHC) setting to prevent, detect and manage the health problems of unemployed people.

Design: A narrative review of articles on PHC-based interventions for unemployed people that were published during the period January 1985 to February 2009.

Results: Seven articles with a focus on improving the health of unemployed people through assessment, management and referral within PHC settings were identified. Four were based in Australia, and the others were from Canada and Europe. Most described interventions that incorporated strategies aimed at increasing general practitioners' awareness of the health problems of unemployed people and providing guidance on the management of these problems. One article included an evaluation of the impact of the intervention on health and social outcomes, but no impact was shown.

Conclusions: There have been few formal scientific investigations into the effectiveness of PHC-based interventions for unemployed people. GPs and other community health workers have a central role in preventing, and providing early management of, the health problems of unemployed people, and supporting return to work. People who are unemployed have poorer physical and mental health than those who are employed. Research should move from describing these health problems to developing interventions that are subject to rigorous evaluation.

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The association between unemployment and poor physical and mental health is well described, and our understanding of the pathways through which these associations occur has increased.[1,2] Unemployment is consistently associated with poor mental health, anxiety, depression, suicide and parasuicide, and less consistently associated with cardiovascular disease, respiratory disease and musculoskeletal problems.[3-9] There are also higher rates of behavioural and physiological risk factors for poor health among people who are unemployed.[1]

Four general mechanisms have been proposed to explain these associations: "selection effect", whereby people who are sick are more likely to become unemployed or be retrenched; higher rates of behavioural risk factors, such as smoking, alcohol misuse and poor diet; the impact of poverty on the ability to meet basic needs and access services; and the loss of purpose, structure and identity that may accompany unemployment.[10] Families of people who are unemployed are also affected directly, through increased levels of interpersonal violence, and indirectly, through the impact of poverty and social exclusion. Recently, there has been increased interest in insecure employment (eg, contract, part-time and casual work) and its negative effects on health.[11]

As the consequences of the current global financial crisis unfold, it is timely to revisit the potential agenda for the health care system in reducing the impact of unemployment on health.[12,13] It has been estimated that 800 000 Australians will be unemployed by the end of 2009.[14] Any intervention to address health problems for unemployed people and their families will need to have large reach, be capable of managing a wide range of physical and mental health problems within diverse populations, and be available close to where people live.

During the recession of the 1990s, a range of programs was undertaken by the Unemployment and Health Project in south-western Sydney.[12] This work showed that an important priority in dealing with unemployment was to ensure access to high-quality primary health care (PHC). The 2004–05 National Health Survey revealed that, compared with people who were employed, unemployed people were more likely to visit emergency departments; consult with a general practitioner, medical specialist or dentist; or attend other health services.[15] However, this does not necessarily reflect the quality of services they receive. Despite higher rates of attendance, unemployed patients are less likely to receive preventive care in general practice.[16] We previously found that GPs who reported treating patients for anxiety or affective disorders were significantly more likely to prescribe medications for unemployed patients compared with employed patients, but were no more likely to refer unemployed patients to other health services and less likely to refer unemployed patients to self-help groups.[8] Also, patients reported that they would like to have more time to discuss their problems and, in particular, more information on the medication they were provided.[8]

We aimed to identify potentially effective strategies to prevent, detect and manage the health problems of unemployed people and their families through PHC.

METHODS

We conducted a narrative review of articles, books and reports on PHC-based interventions for unemployed people that were published during the period January 1985 to February 2009. Publications were identified by searching major electronic databases of health, medical and social science publications — including MEDLINE, EMBASE, the Australasian Medical Index, the Australian Public Affairs Information Service, Health and Society, PsycINFO, Scopus, Web of Science, Global Health, the Academic Research Library and Sociological Abstracts — and by using keywords and database-specific subject headings that represented the research question and were manipulated for each database (by broadening and narrowing keywords and subject headings to reflect database content). Keywords and subject headings included "unemployment", "employment", "not in the labour force", "socioeconomic status", "primary health care", "family medicine", "family practice", "general practice", "health care access", "health checks", "health assessments", "health examinations", "outreach", "prevention", "early detection prevention", "psycho-

PHC-based interventions targeting people who are unemployed, and evaluation of their effects

	Reference						
	18	19	20	21	22	23	24*
Country	Australia	Australia	Australia	Australia	Canada	Norway	France
Year of publication	1988	1996	2002	2004	1986	1999	1999
Type of evaluation	Process evaluation	Randomised controlled study	Randomised controlled study	Before-and-after study	Process evaluation	Descriptive study	—
Strategies							
Raising GPs' awareness about health problems of unemployed people	✓	✓	✓	✓	✓		
Providing GPs with local information on levels and characteristics of unemployment	✓	✓	✓	✓	✓		
Supporting GPs to act as referrers to employment and welfare services	✓	✓	✓		✓	✓	
Providing GPs with clinical practice guidelines and standards on health problems of unemployed people	✓	✓	✓	✓			
Training GPs in specific skills (eg, CBT)			✓	✓			
Audit of practice and audit-based feedback		✓	✓	✓			
Health checks targeting unemployed people						✓	✓
Findings†							
Roles reported to be acceptable by GPs	✓	✓	✓	✓	✓		
Increase in GP knowledge		✓	✓				
Increase in GP confidence		✓	✓				
Change in GP attitude		No change	No change				
Self-reported change in GP practice		✓	✓		✓		
Increase in number of referrals to non-health agencies	✓		✓		✓		
Changes to GP practice as evidenced by follow-up audits		✓‡	✓‡				

PHC = primary health care. GP = general practitioner. CBT = cognitive behaviour therapy. * Intervention proposed but not implemented. † Blank cells indicate that there was no mention of the listed item being evaluated. ‡ Increases in both intervention and control groups. ◆

social care" and "medical certification". Manual searches of reference lists and book chapters to identify PHC-based interventions were also conducted.

Articles were included in the review if they described PHC-based interventions targeting unemployed people, were available in English, and — with one exception — described a quantitative or qualitative evaluation of the impact of the intervention.

A total of 181 publications were selected for screening. Abstracts were screened independently by both of us, and seven publications were identified as relevant. The others were excluded as they did not deal with the subject or did not meet the inclusion criteria. A notable exclusion was a report on an intervention that was not specifically directed at unemployed people, but included unemployment status as a subgroup of an analysis of an intervention to manage patients with anxiety in general practice.[17]

RESULTS

We identified seven publications about intervention studies that focused on improving the health of unemployed people through assessment, management and referral within PHC settings. Four described programs that were based in general practice in Australia,[18-21] one described a family practice program in Canada,[22] and one described a family practice program in Norway.[23] The other publication was a proposal for a program in France for people when they become unemployed, which involved a health assessment by an occupational physician and referral to a GP.[24]

Many common strategies and findings were identified (Box). The most commonly used strategies were raising GPs' awareness about the health problems of unemployed people, providing GPs with local information on levels and characteristics of unemployment, and supporting GPs to act as referrers to employment and welfare services. Three of the Australian interventions were accredited continuing professional development activities, which involved GPs in a cycle of: auditing 10 patients, receiving feedback on individual and group performance, attending two 2-hour skills development training sessions with a range of other health care providers, auditing another 10 patients, and receiving a second round of feedback.[19-21] Two of these programs provided brief cognitive behaviour therapy (CBT) training as part of the skills develop-

ment training for GPs.[20,21] The other training sessions for GPs included an overview of the health problems that commonly affect unemployed people and how these problems could be managed. In addition, the training included presentations by other government and non-government agencies that could assist with job placement or provide specialist support (eg, for drug- and alcohol-related problems, and mental health problems).

Two of the Australian programs were evaluated using a randomised controlled study design that assessed changes in management and referral via patient audit, which showed that both were acceptable to the GPs, and both increased GPs' knowledge and confidence.[19,20] Follow-up audits in both studies revealed changes to GP practice. For example, there was increased focus on mental health and lifestyle and higher rates of referral to non-health agencies. One Australian program was evaluated using a before-and-after CBT training audit, and showed that CBT was useful in managing the health problems of unemployed people.[21] The Canadian program involved a mail-out to GPs that included information on health problems in unemployed people, local information on patterns of unemployment, and local agencies that could help with job placement and welfare problems,[22] and one of the Australian programs delivered similar content via a 4-hour training session.[18] Both these programs were assessed by process evaluations, which showed that GP training was associated with GPs' acceptance of their role and increased referrals. The study based in Norway described the findings of GP-conducted health assessments of unemployed people, including patterns of illness and risk factors that were worse for unemployed patients than population norms.[23] Finally, one publication described a proposal that was not implemented or evaluated[24] (see Box). Only one study evaluated the impact of the intervention on health and social outcomes, but found no impact.[19]

DISCUSSION

A plethora of articles have been published over the past 50 years on the impact of unemployment on health. Despite this, we identified only seven that described interventions within PHC settings (of which six described implemented and evaluated interventions). Of these, several were in grey literature. This is consistent with the finding that there are few published intervention studies on unemployment and health, regardless of their setting.[25]

In Australia, the limited analysis of health service use related to employment status that has been conducted suggests that access for unemployed people may be similar to that for the population as a whole but, given their higher rate of morbidity, access may not reflect the health needs of unemployed people. Unemployed patients may not receive preventive care or have access to complex interventions. They would like to spend more time discussing their health problems, rather than relying on medications, suggesting that it is important to evaluate the access, quality and appropriateness of care provided.[6,8]

The interventions that we reviewed were small and of variable quality. It is not possible to determine the effectiveness of the strategies used because of the limited scope of the evaluation studies. Also, there was only one evaluation of the impact of the intervention on health and social outcomes (such as future employment). In the interventions, training per se did not appear to influence management of health problems. However, in two of the evaluation studies clinical audit was shown to promote change in the pattern of care over time.

Since the last major recession, there are more structures and processes that can be used to improve the quality of care for people who are unemployed. These include health checks for 45–49-year-olds, access to allied health services and professionals (including psychologists), and more practice nurses. Most practices are computerised (making practice auditing easier) and the Divisions of General Practice have a clear role in working with practices to improve care provided to specific population groups. There are also closer links between GPs and other community health service providers, which may expand access to multidisciplinary and social care services. This implies that several initiatives could form a basis for intervention and related research:

- health checks offered by GPs for people who are or become unemployed, with a focus on common health problems (eg, poor mental health and behavioural and biological risk factors for cardiovascular disease) and preventive care and management of conditions that could act as barriers to return to work (eg, drug and alcohol misuse);
- a consultant or referral model, as used in shared mental health care initiatives, whereby local community health services provide support to GPs and act as referral pathways to employment and welfare services; and
- a designated broker based in the local Division of General Practice, who can be contacted by GPs and can link patients to the full range of employment and welfare services available in their area (including support groups for people who are unemployed).

All of these approaches assume a high level of understanding of the specific health problems of unemployed people, who are more likely to experience cardiovascular and respiratory disease, intentional and unintentional injury, and anxiety and depression than employed people.[1,2,4-6] There is growing evidence regarding effective interventions in PHC (including CBT) to deal with these common problems, and early assessment and management of risk factors for cardiovascular disease. However, these need to be adapted to meet the specific needs of unemployed people in their social and cultural contexts. A recent review of the evidence for behavioural interventions in low-income groups suggested that providing information and facilitating goal setting may be most helpful.[26]

GPs and other community health workers have a central role in the prevention and early management of the health problems of people who are unemployed and supporting their return to work. However, there is a lack of high-quality evidence of what may be effective for this group. The large number of people who have recently become unemployed should act as a catalyst for action to minimise the health problems associated with unemployment. Research should move from describing health problems to developing interventions that are subject to rigorous evaluation.

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AUTHOR DETAILS

Elizabeth Harris, BA, MPH, Director, Centre for Health Equity Training Research and Evaluation
Mark F Harris, MD, FRACGP, Professor of General Practice
Faculty of Medicine, University of New South Wales, Sydney, NSW.
Correspondence: e.harris@unsw.edu.au

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