CHAPTER 4

Unemployment: A Case for Medicine and Psychology?

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Work is more than merely an existential necessity in many nations; indeed, it represents an ethical value and serves as an important source of individuals' identity and social status. Due to the importance attached to work, unemployment is considered a major social problem in most societies (Allmendinger & Ludwig-Mayerhofer, 2007). Providing social security for individuals who do not work is regarded as one of the key functions of the traditional welfare state. For instance, Esping-Andersen's (1990, p. 37) typology of welfare regimes is built on the level of decommodification—that is, "the degree to which individuals, or families, can uphold a socially acceptable standard of living independently of market participation"—that different welfare states provide. In order to deal with unemployment, many welfare states provide unemployment- and/or minimum income benefits, but more benefit schemes—including old-age pensions and

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N. Reibling, M. Ariaans (eds.), *Toward a Biopsychosocial Welfare State?*, https://doi.org/10.1007/978-3-031-32793-3_4

parental-leave benefits—also exist that cover individuals who do not work for specific reasons. Notably, two (usually comparatively generous) programs tie benefits to sickness and involve the medical profession in determining eligibility: *sickness benefits* and *incapacity pensions*.[1] These benefit programs constitute a form of the medicalization of unemployment because they rely on medical ideas, practices, and actors to provide income replacement for an individual's inability to work. Since these programs were among the first to be established in welfare states (e.g., in Germany, invalidity pension insurance was introduced in 1891), the medicalization of unemployment in the welfare state has a long history. Thus, the general notion of the medicalization of unemployment can even be found in some early contributions, such as Parson's (1951) work on medical practice and the sick role and Stone's (1984) book *The Disabled State*. Nevertheless, the medicalization of unemployment has never been an important research topic in the medicalization literature or in social policy research.

However, this neglect of the medicalization of unemployment has changed in the last 20 years as both researchers and the policy community have become interested in the issue. This new concern with the medicalization of unemployment is linked to changes in welfare discourses and policies. While sickness benefits and incapacity pensions were viewed as clear achievements during the golden age of the welfare state, their appraisal changed with the rise of economic recessions and mass unemployment in the 1980s and 1990s. At first, these programs were considered solutions to mass unemployment, and individuals were deliberately channeled toward incapacity pension schemes (Lindsay & Houston, 2011). However, with the turn to neoliberalism and social investment discourses, the medicalization of unemployment came to be increasingly identified as a problem. This change resulted to some extent in the demedicalization of unemployment as access to—and the generosity of—these sickness-related programs became substantially reduced (McVicar et al., 2016) and the use of sickness as a justification for inactivity came to be challenged: "Many people with health problems can work and indeed want to work in ways compatible with their health condition, so any policy based on the assumption that they cannot work is fundamentally flawed" (OECD, 2010, p. 3). Within this new discourse and policy context, not

[1] In the US as well as in some of the research on this issue, the term "disability pensions" is used. We rely on the term "incapacity pensions" because it is closer to the term used by German schemes.

only were unemployed individuals with health problems pushed into labor market participation, but their ill health became increasingly considered a key point of intervention for the welfare state (Friedli, 2016). Considering the central role of medicine in these prevention, disease management, and rehabilitation programs, this time period also bore witness to a new form of medicalization along with both the growing role of mental illness in unemployment and the psychologization of unemployment.

In this context, a number of new social science contributions engaged with the medicalization of unemployment from various theoretical and empirical perspectives. Scholars have discussed the role that general practices (Ford et al., 2000; Wilfer et al., 2018), employment agencies (Holmqvist, 2009), the institutional characteristics of the welfare state (Buffel et al., 2017), and neoliberal policy reforms (Pulkingham & Fuller, 2012) have played in the medicalization of unemployment. Moreover, the medicalization of unemployment has developed from a theoretical concept into a measurable phenomenon. Studies have empirically operationalized the medicalization of unemployment through the use of mental healthcare among the unemployed (Buffel et al., 2015, 2017), through employability assessments of applicants for incapacity pensions (Schneider et al., 2016), through discourses in policy documents (Juberg & Skjefstad, 2019), and through changes in recipiency rates of disability- and non-disability-related benefits (Pulkingham & Fuller, 2012; Wong, 2016).

In this chapter, we synthesize this new line of research using our theoretical framework that conceptualizes the medicalization and psychologization of unemployment as a multi-level and multi-dimensional process (see Chap. 3). Moreover, we add new evidence from several types of data that we have collected to (a) illustrate the many forms in which we can investigate and empirically measure the medicalization and psychologization of unemployment and to (b) elaborate how the context of the German welfare state affects the extent and nature of the medicalization and psychologization of unemployment in comparison with liberal and social democratic welfare states, which have been the focus of the existing research in this area. The chapter proceeds as follows: First, we examine in greater detail how the existing literature views the concept the medicalization of unemployment and how we situate the concept within our own theoretical framework. Next, we turn to the German case and investigate how the institutional context of the welfare state affects medicalization processes. In so doing, we outline both medicalization and demedicalization trends and highlight how in the case of Germany, the turn

to activation has created new institutional categories and processes for medicalizing minimum income beneficiaries. In the following section, we reflect on the implications of these medicalization processes and present results regarding how medicalizing unemployed individuals affects labor market reintegration, health status, and public opinion within the context of the German minimum income system.

4.1 Medicalization and Psychologization of Unemployment: A Closer Look at the Phenomena

Applying Conrad's definition of medicalization (i.e., "to make something medical") to unemployment suggests that unemployment is *made* medical; thus, it is *transformed* into a medical problem. But what exactly does that mean? While many examples can be found in this research where medialization research has resulted in a new diagnosis of a social phenomenon (e.g., alcoholism, ADHD), the situation in the case of unemployment is more complex, and the medicalization of unemployment thus needs to be traced by following less apparent—but nevertheless powerful—changes in the way welfare states address unemployment. Using our conceptual framework, these changes can mean that medical *ideas* play a more important role in how we think and talk about unemployment in the welfare state, that medical categories and technologies are critical to the welfare state's *institutional* apparatus for dealing with unemployment, or that medical doctors become increasingly involved as *actors* in policymaking, welfare organizations, or personal interactions. In this chapter, we address all three dimensions by underlining the notion that the welfare state is integral to this process: Indeed, without its programs, organization, and regulations, there would be no medicalization of unemployment. The literature has also discussed and demonstrated the psychologization of unemployment, for instance, in terms of psychological profiling and psychological training programs, which have expanded with activating reforms (Friedli, 2016; International Labour Organization/European Commission, 2017; Peeters, 2019). However, the data sources that we rely on for Germany provide little evidence of the psychologization of unemployment, which is why this chapter is primarily focused on the medicalization of unemployment.

4.2 Medicalization of Unemployment in the German Welfare State: How Institutions Shape the Form and Dynamics of the (De-)medicalization of Unemployment

As a conservative welfare state, Germany relies heavily on contribution-based social insurance schemes to cover social risks. Much of the interest in and scholarship on the medicalization of unemployment has focused on incapacity pensions since they are costly and usually lead to permanent dependency. Figure 4.1 illustrates public spending on in-cash incapacity benefits as a percent of GDP in OECD countries, which can be taken as an indicator of the prominence of the program in different countries over time. The amount that OECD countries spend on incapacity benefits varies widely. While some countries do not have an established incapacity

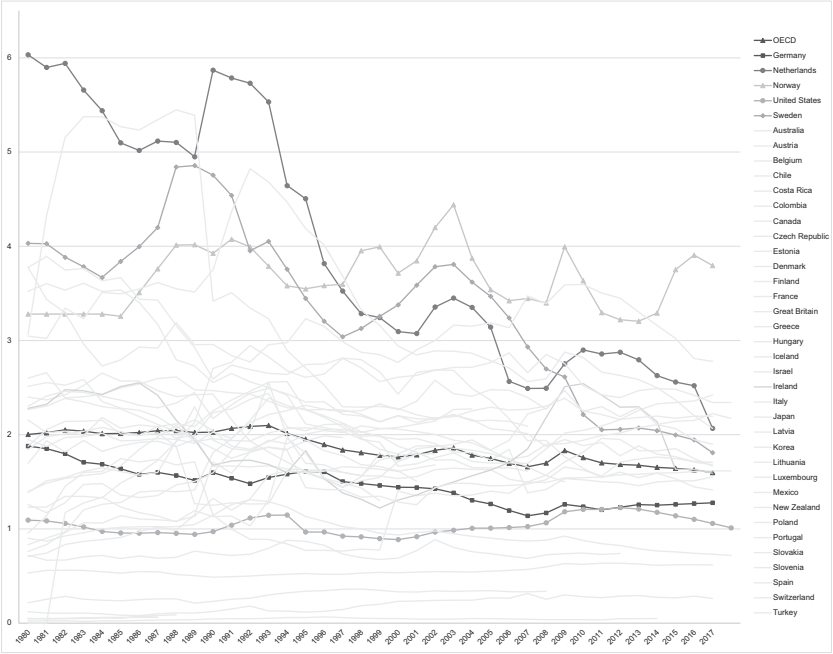

Fig. 4.1 OECD (2022), public spending on incapacity as a % of GDP (indicator); DOI: 10.1787/f35b71ed-en (last accessed 10 June 2022), own graph

pension, other countries sometimes spend up to 6% of their GDP on this scheme. The figure also reveals that between 1980 and 2018, many countries bore witness to a dynamic that looks in part like a convergence on the steadily declining OECD average.

Germany already had a comparatively low spending rate in 1980 that further declined in the following decades. The primary reason for this low spending rate is that in Germany, access to incapacity pensions has been limited due to an early reform that aimed to address the rising recipiency rates over the 1970s (McVicar et al., 2016). Only individuals who have paid social insurance contributions in three of the five years before their application and who have additionally accumulated five years of contributions overall are eligible to receive incapacity pensions. This eligibility criteria excludes young individuals, long-term unemployed individuals, and people—particularly women—who have not worked enough years or who work in so-called mini jobs, for which social insurance contributions are not paid. In 2001, a second reform took place that tightened the eligibility criteria even further. Before the reform, applicants had needed to show that they were unable to work in their trained occupation, whereas now, they need to show that they are unable to work in any job (McVicar et al., 2016). In effect, access to incapacity pensions has been strongly restricted in Germany. However, this restriction has occurred without changing the medical criteria or the underlying assessment process because it has been possible to constrain eligibility based on the payment of contributions that require previous employment. Thus, it seems that the institutional configuration of contribution-based social insurance schemes for incapacity pensions has enabled Germany to achieve a low level of the medicalization of unemployment through incapacity pensions. However, we should not conclude that the conservative welfare state generally limits the medicalization of unemployment. As we demonstrate in the following sections, the complexity of several schemes that cover unemployment has entailed great potential for a different form of temporary sick leave for minimum income beneficiaries—a form of medicalization that has been overlooked in the literature thus far.

4.3 Institutional Complexity and Competing Organizational Actors as Mechanisms of Medicalization

In Germany, benefits for individuals who are unemployed *and* ill do not come from a single welfare scheme; rather, several schemes are involved. This fragmented benefit structure is based on the historical creation of different social insurance schemes and social assistance systems, namely, (1) public *health insurance*, which provides sickness benefits of up to 78 weeks; (2) *unemployment insurance*, which provides unemployment benefits of up to 18 months; (3) means-tested minimum income benefits, which are provided as *social assistance*; and (4) incapacity pensions, which are paid via *pension insurance* to individuals who have limited working capacity. In 2004/5, Germany passed several neoliberal reforms that rearranged the unemployment insurance and social assistance system. In essence, the duration of unemployment insurance benefits was shortened so that now, individuals are transferred to minimum income benefits relatively quickly (after one year) and lose access to benefits if they have savings or a partner who provides sufficient working income. Following other countries, Germany also introduced a new system of unemployment activation measures (Bonoli, 2010) that reinforce work incentives through the increased conditionality of benefits (Clasen & Clegg, 2007; Dwyer, 2008; Watts & Fitzpatrick, 2018). Importantly, the conditionality of benefits is now extended to individuals on minimum income benefits.

As a basis for benefit receipt, individuals on unemployment or minimum income benefits are obligated to sign an integration agreement that specifies the requirements for receiving their benefits. Unemployed individuals must always be available for their Federal Employment Agency officers, attend appointments with them, and participate in suggested training measures. These individuals are additionally required to seek and accept any reasonable job, even if (depending on their personal situation) this requires a change of residence. If they do not comply with these obligations, the Federal Employment Agency can impose sanctions. For instance,

minimum income benefits could be reduced by between 10% and 30% for three months if appointments at the Federal Employment Agency are not met.[2]

The underlying idea of these reforms was to create work incentives not only for those who are formally considered unemployed (i.e., those who receive unemployment insurance benefits and who are actively looking for work), but for all inactive individuals. While medical and psychological ideas played hardly any role in the political discourse that preceded the reforms (see Chap. 5), it is clear from this discourse that the general intention of the reforms was to limit the possibilities of being able to justify the receipt of long-term or permanent benefits for most individuals. Thus, activation policies were explicitly extended to vulnerable populations (including sick individuals). This issue was controversial in the reform discussions, as the following quote demonstrates: "The mobilization of the unemployed and of minimum income beneficiaries is particularly difficult for single mothers and fathers, for the elderly, and for the sick. What, then, should be done with those who—despite the strongest will—can no longer be made fit? Are benefit cuts really all that comes to the government's mind?" (Deutscher Bundestag, 2002, p. 417). Despite this protest, the extension of activation to all minimum income beneficiaries was kept in the legislation.

However, the reform set the capability of working as the central legal basis for activation decisions. In §8 (1) of Social Code Book II, the capability of working is defined as follows:

> Someone is considered able to work if they are not incapable of working at least three hours per day for the foreseeable future due to illness or disability under the usual conditions of the general labor market.

Since this definition highlights the fact that sickness and disability are the only accepted reasons that preclude labor market integration, the reform

[2] A recent ruling by the Federal Constitutional Court in 2019 significantly restricted the sanction regulations and called on the legislature to introduce new regulations. According to this ruling, sanctions above 30% of minimum income benefits are generally unconstitutional and must be abolished. Currently, the so-called sanction moratorium applies until the new regulation—that suspends sanctions for breaches of duty (e.g., the rejection of work)—takes effect. However, sanctions for failure to report (e.g., failure to keep appointments) are still possible.

upgraded the legal status of sickness/disability in the context of unemployment. Thus, although it was not the intention of the reform, its implementation resulted in the medicalization of unemployment within the minimum income system.

Aside from this promotion of medicalization through the abovementioned reform, the historically developed coverage system in Germany—with its high degree of *institutional complexity* and *competing organizational actors*—also fosters the medicalization of unemployment. In order to understand how institutional complexity and organizational competition are associated with medicalization, we next walk step by step through the institutional process through which every unemployed person in Germany who becomes ill must navigate. Figure 4.2 outlines the involved organizations and regulations that structure this process.

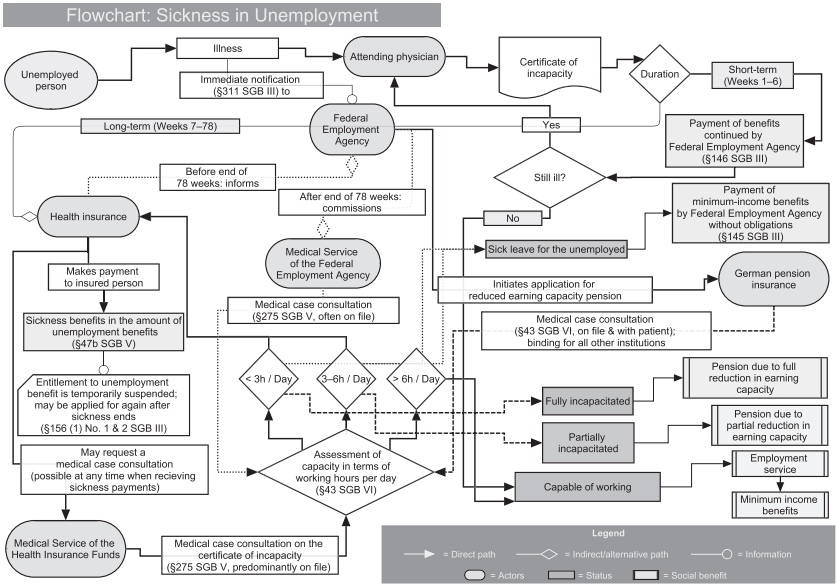

Fig. 4.2 Flowchart of the institutional process through which unemployed individuals who are ill must navigate

4.3.1 Temporarily Incapable of Working: The Transition to Health Insurance Schemes

The process begins with an unemployed person, who—depending on the duration of their unemployment—receives either unemployment insurance or minimum income benefits. If this person becomes ill, they are obligated to promptly report their incapacity to work to the responsible advisor of the Federal Employment Agency. For this purpose, a certificate of the individual's incapacity to work that is issued by a personal physician must be submitted no later than the third day of illness. This certificate must include the expected duration of the illness as noted by the physician. For up to six weeks, the beneficiary receives their usual benefits. The sick-leave certificate is used to justify the individual's incapacity to meet their obligations (e.g., looking for work, participating in training measures) and to safeguard their benefits against sanctions as a result of this incapacity. The status of being incapable of working can be considered a form of the medicalization of unemployment because medical expertise is required and influences the status of the unemployed person. The sick-leave status is assumed to refer to the person's temporary incapability of working. If the person recovers, they return to the status *capable of working* and are then considered to be available to the labor market again.

If an individual's incapability of working is foreseen to last between 7 and 78 weeks and the person receives unemployment insurance benefits, the Federal Employment Agency must inform the health insurance fund with which the person is insured. Having a persisting sickness status of up to 78 weeks makes an unemployed individual eligible for sickness benefits at the level of their unemployment benefits. Thus, in the case of a long-lasting illness, an unemployed individual is effectively transferred from the benefit system of the Federal Employment Agency to the health insurance fund. Since both programs are financed through independent funding schemes that are administered by independent organizational bodies, the institutional configuration constitutes a zero-sum game. For the Federal Employment Agency, an individual who receives sickness benefits means that the agency must no longer pay and provide services for this individual and that the individual is not considered unemployed. In a situation with high levels of unemployment or limited funds, transferring an individual to the health insurance system can constitute temporary relief for an employment agency. The sick unemployed person can receive sickness benefits as long as their personal physician provides a certificate of their incapacity to

work for a maximum of 78 weeks. However, the health insurance fund can commission a medical report at any time during this period that reviews the case and provides an assessment of the likelihood that a given treatment will restore the individual's capability of working. These reports are conducted by a health insurance fund's medical service—an agency that is funded and organized by all regional health insurance funds[3]: "The purpose of the expert opinion is to support the therapeutic efforts of the treating physicians with the aim of achieving reintegration into the work process and preventing permanent exclusion from working life" (Pfeiffer & Pick, 2011).

This assessment focuses on evaluating a person's ability to work and their overall health. However, assessing work capability cannot be done with illness symptoms or medical diagnoses alone (Meershoek, 2012); thus, even though medical doctors are responsible for these reports, the decision is considered to be socio-medical and additionally takes into consideration, for example, the individual's work requirements. Health insurance funds commission these assessments in order to review the individual's sick-leave status because these funds have an incentive to terminate the payment of sickness benefits. If the assessment concludes that the person is capable of working, the case is re-transferred to the Federal Employment Agency and the minimum income-benefit system. If the assessment indicates that the person could be partially or fully incapacitated for a longer period, the health insurance fund can inform the pension fund of a potential case for incapacity pensions. Nevertheless, the health insurance fund is still required to exhaust the 78 weeks of sickness benefits before a referral to the pension system may be made.

4.3.2 Sickness Benefits Exhausted: The Transition Back to the Federal Employment Agency

Before sickness benefits expire after 78 weeks, an individual's health insurance fund informs the Federal Employment Agency of the individual's status. If the individual is still sick, the Federal Employment Agency usually commissions its own medical service agency to make an assessment. The medical service agency consists of approximately 350 nationally

[3] The legal structure of the medical service has recently been changed, thereby making this service independent from sickness funds and created a nationwide organization with coherent assessment regulations.

operating full-time physicians as well as contracted physicians (about 20–40%, depending on the social security institution). In the case of a mental illness, employed and contracted psychologists are also consulted (Allert, 2021). The medical service agency provides consultancy services that include support and medical/psychological advice for Federal Employment Agency officers regarding both how to proceed as well as arranging meetings with individuals who have health restrictions. Before an individual's health insurance scheme terminates their sickness benefits, employment officers may initiate an assessment by the medical service of the Federal Employment Agency in order to clarify the further course of action. The unemployed person is then required to fill out a health questionnaire and must release any previous treating medical doctors from confidentiality. At this point, the sick-leave status is exclusively assessed and granted by the medical service of the Federal Employment Agency and no longer by the individual's treating medical doctors.

The requested assessment is mostly carried out based on the information ascertained from the health questionnaire and the existing medical documentation (in about 70–80% of cases) and rarely includes a personal examination (in about 20–30% of cases). Personal appearances are especially indicated for addictive disorders, mental illness, or an evaluation for educational or retraining eligibility (Hotz, 2022). Based on this documentation, the medical service provides an assessment of how many hours per day the person is capable of working (in any job). If this assessment establishes that the person is still unable to work more than six hours per day for more than six months, the individual's ability to work is assumed to be incapable of being restored in the foreseeable future. In this case, the employment officer can suggest that the unemployed person apply for an incapacity pension. However, this is only possible for individuals who fulfill the eligibility criteria (i.e., contributions must have been paid to the pension insurance fund for five years in total and in three of the preceding five years). Both during the pension insurance scheme's decision-making process and in the event that the individual does not meet the eligibility criteria, they receive the status of "sick leave for unemployment," which means that they continue to receive minimum income benefits but do not have to meet any work obligations. Moreover, they do not have to fear sanctions for non-compliance, such as a cancelation of their benefits.

4.3.3 (Temporary/Partial) Incapacity Pensions: The Transition to Pension Insurance

Before a final decision has been made as to whether an individual is to receive an incapacity pension, benefit recipients have the option (just like employed individuals who are ill) to apply for occupational rehabilitation in order to restore (partial) work capacity. For this purpose, a transitional rehabilitation allowance for the duration of the medical rehabilitation service is paid. The application is filed with the pension insurance scheme, and the applicant must have paid at least six months of compulsory contributions in the two preceding years. The amount of the benefit is then equal to the amount of the unemployment benefit or the minimum income benefit. Moreover, during occupational rehabilitation, the individual receives an additional benefit of 35% of the general standard benefit on top of their minimum income benefits.

If all other options (including rehabilitation) have been exhausted, an unemployed individual who is ill can apply for an incapacity pension. This application must also be submitted to the pension insurance fund, which itself may use the existing reports by the medical service of the health insurance fund or the medical service of the Federal Employment Agency but can—and often does—prepare its own socio-medical assessment of the individual's capability of working. Similar to the assessment by the medical service of the Federal Employment Agency, these socio-medical case assessments are often carried out on the basis of records as well as—albeit to a lesser extent—via direct interactions with the person concerned. Depending on the number of hours that this assessment determines that the individual is capable of working, this individual may be eligible for a partial or full incapacity pension. The incapacity pension is earnings-related and thus depends on previous earnings and the age of the applicant. In 2020, the average pension was 415 euros for a partial incapacity benefit and 830 euros for a full incapacity pension. This means that the average partial incapacity benefit levels are roughly the same as those of minimum income benefits (which were 432 euros in 2020). The pension insurance fund alone decides on the individual's respective entitlement to incapacity pension benefits. This decision is binding for all other social benefit providers. If an application is rejected by the pension insurance fund, the person remains within the jurisdiction of the Federal Employment Agency and receives minimum income benefits.

4.3.4 *Summary: Medicalization Within the Institutional Process*

The flow chart in Fig. 4.2 illustrates the complexity of the process that we outlined in detail above. This complexity derives from the parallel existence of multiple schemes that provide benefits based on different logics and eligibility criteria. The focus of this institutional process is not on the individual or on the question of how best to support an individual who is unemployed and apparently also has poor health; instead, the process is oriented toward institutions and actors as well as toward the question of who is responsible for this person and who must pay the benefits.

The current system fosters medicalization via several processes. First, organizational actors—particularly the Federal Employment Agency—use medical definitions of employability and accredited illnesses in order to transfer an individual to another benefit system. Thus, the current legal rules incentivize to some extent the provision of sickness-related benefits and thus also medicalization in the *institutional* dimension (see theoretical framework in Chap. 3). Moreover, several medical doctors assess the case throughout the entire process, which is itself indicative of medicalization in the *actor* dimension. These medical assessments are based on medical diagnostic criteria as well as on instructions and regulations from the specific benefit system. Thus, in his comparison of assessments made by the medical service of the Federal Employment Agency and the pension insurance scheme, Brussig (2018) notes that it is not uncommon for performance assessments to differ significantly.

There is some indication that this system may have increased the degree of the medicalization of unemployment in Germany over time. First, between 2009 and 2017, the number of assessments made by the medical service of the Federal Employment Agency varied between 500,000 and 550,000 cases. However, the number of unemployed people steadily decreased from 3.4 million to 2.5 million in the same period (Fig. 4.3). Thus, the share of unemployed individuals who were reviewed by medical services increased over this period from 16% to 22%.

Second, data from a representative survey of minimum income recipients (Linden & Reibling, 2023) indicate that the share of respondents in the survey who were receiving sick leave for unemployment—that is, minimum income benefits without work obligations—had tripled over time.

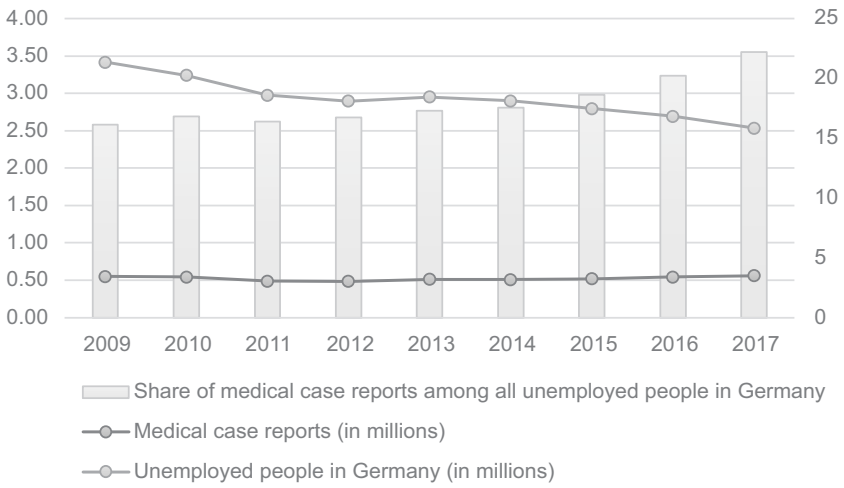

Fig. 4.3 Share (bars) of medical case reports completed by the medical service agency of the Federal Employment Agency among all unemployed people in Germany (lines). Sources: data on medical assessment services from the Federal Employment Agency, and annual reports on unemployment and minimum income benefits for jobseekers in Germany (2006–2018)

While this may also be the result of the poorer health status of the remaining unemployed individuals in the sample (and in the system), the fact that on average 18% of unemployed individuals in the study reported receiving sick leave indicates the importance of this sickness-related category for unemployed individuals in Germany (Linden & Reibling, 2023). Thus, the neoliberal labor market reforms that aimed to include all inactive individuals in the activation regime has led to the inclusion of many individuals with health problems in the minimum income scheme. Despite the ambitious aims and expectations of the reforms, the challenge of integrating this vulnerable group into the labor market has often failed. While this failure likely has many reasons (e.g., locally difficult labor markets, missing instruments for health promotion, and rehabilitation), one result has been a new form of medicalization of unemployment through the category of sick leave for the unemployed.

4.4 What Are the Consequences of the Medicalization of Unemployment?

Identifying processes of medicalization or psychologization does not indicate whether—or for whom—these developments are beneficial or problematic. Nevertheless, the consequences of the medicalization of unemployment motivate most research on this issue and make it socially relevant. Existing research has outlined potential consequences of the medicalization of unemployment, which can be grouped in the categories listed below. Notably, in most categories, medicalization can be both beneficial and detrimental, which highlights the contradictory consequences it can have.

- *Economic consequences*: For society, the medicalization of unemployment is expensive (e.g., medical expertise, permanent sickness-related benefits) and reduces the available human capital for the labor market (Lindsay & Houston, 2011). For individuals, the medicalization of unemployment can mean income security but also increased poverty risk if re-employment opportunities are lower in the long term (Hansen et al., 2014; Holmqvist, 2009).
- *Health consequences*: Tying benefits to sickness and requiring the repeated demonstration of an individual's sickness/incapacity leads to the development of a chronic-illness identity, the acceptance of (potentially harmful) medical/psychological treatment, and an impeded recovery (Hansen et al., 2014; Schneider, 2013). In contrast, the medicalization of unemployment has brought attention to the health consequences of unemployment, has created access to specialized programs, and—in the case of long-term incapacity—may improve health compared with being employed in harmful working conditions (Burgard & Lin, 2013) or living in poverty without access to benefits (Hansen et al., 2014).
- *Individualization and stigmatization*: A central claim of medicalization theory is the inherent risk of individualizing social problems (Conrad, 1992; Zola, 1972). Medicalizing unemployment means that the reason for unemployment—and consequently, also its solution—is attributed to the individual (Holmqvist, 2009). This means that the medicalization of unemployment runs the risk of leading to the further social exclusion of individuals who are not only unemployed, but also sick (Lindsay & Houston, 2011). While being sick

used to be an accepted justification for unemployment and potentially reduced the stigma surrounding illness, the current welfare discourse on activation may induce additional stigma for individuals because it often characterizes these individuals as failing to manage their health or considers them potential "benefit scroungers" (Garthwaite, 2014; Hansen et al., 2014).

While existing studies have used these consequences as a source of motivation or have pointed to the consequences of medicalization in their conclusions, there is limited evidence on the actual consequences of this medicalization of unemployment. Existing evidence comes mostly from qualitative studies, which indicate the difficulties that individuals experience and the strategies that they use to navigate their given situations (Garthwaite, 2014; Hansen et al., 2014; Kupka et al., 2017). In the following two sections, we present the evidence that we have gathered on the consequences of medicalization in Germany. The first of these two sections examines the implications of being on sick leave for the unemployed who do not (yet) have access to incapacity benefits in the minimum income system. The second of the two sections presents data on how the medicalization of unemployment has influenced public attitudes toward the unemployed based on a nationwide vignette survey that we launched in 2020.

4.4.1 Being on Sick Leave: Consequences Regarding Re-employment Opportunities and Health

In order to better understand the consequences of the status of "sick leave for the unemployed" in the German minimum income system, we examined data from a representative survey on minimum income beneficiaries: namely, the German Panel Study Labour Market and Social Security (PASS).[4] In this study, 3910 individuals—or 21% of the sample—reported being on sick leave for the unemployed. Of these cases, a transition from unemployment to sick leave can be seen in 1585 cases or 8% of the sample. As outlined above, the number of individuals with this status in the survey tripled over time (observation period: 2008–2019). Moreover, we detect that certain groups who have less favorable labor market outlooks—that is, older people and people with lower levels of education—are more likely to be on sick leave, which serves as a strong indication that this category is

[4] For a description of the study, please refer to Bethmann et al. (2013).

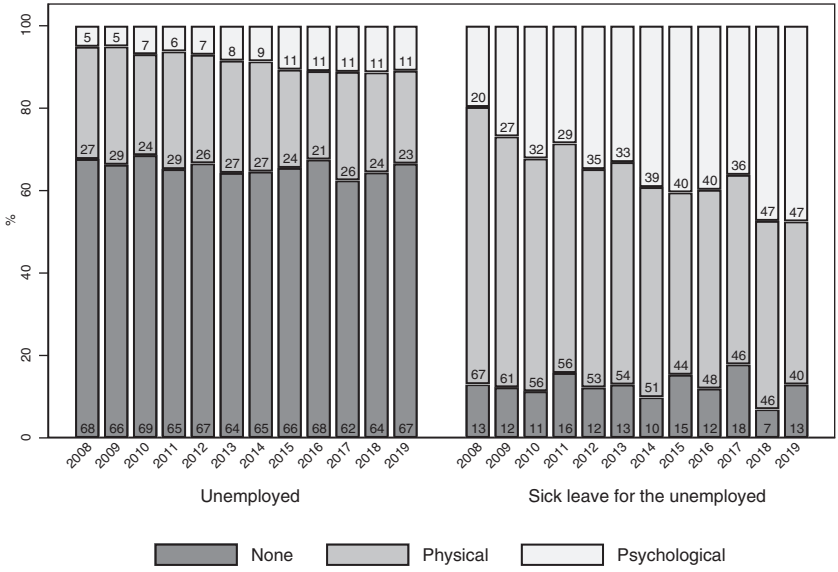

Fig. 4.4 Type of sickness over time for the unemployed/sick leave for the unemployed. Source: PASS Waves 2–13, DOI: 10.5164/IAB.PASS-SUF0619.de.en.v3, weighted Federal Employment Agency sample, $N = 20{,}196$

also used to dealing with the problems of labor market integration (Linden & Reibling, 2023). In line with the literature, there is little indication that this category is abused to cover individuals who are actually in good health (Lindsay & Houston, 2011). Indeed, as can be seen in Fig. 4.4, around 85% of individuals on sick leave report having a long-standing, limiting illness, while only around 35% of the minimum income recipients who are not on sick leave report the same.

Moreover, we see a striking trend in the increasing number of individuals who reported a psychological condition (Fig. 4.4). This trend toward the psychologization of unemployment that we find here for sick-leave status has also been found for sickness benefits and incapacity pensions in many countries. This finding indicates that although this chapter has thus far told the story of the medicalization of unemployment (which is also what we primarily see in the benefit systems), a psychologization of unemployment is also taking place. While our data cannot reveal much more

Fig. 4.5 Transitions within the German minimum income system. Source: PASS Waves 2–13, DOI: 10.5164/IAB.PASS-SUF0619.de.en.v3, weighted Federal Employment Agency sample, $N = 20{,}196$

about the latter process, it seems that it is has become a topical issue in both scientific and public debates (Buffel et al., 2017; Friedli, 2016).

Now that we have characterized both the category of sick leave and the individuals who receive these benefits, we can next turn to the consequences of being in this medicalized category in terms of employment/income opportunities and further health development. As outlined above, the medicalization of unemployment has been hypothesized to have ambiguous consequences: On the one hand, medicalization may provide economic stability, lower the pressure caused by being exempt from activation, and provide time for health recovery. On the other hand, this category could cause people to become stuck in the benefit system and increase their levels of social exclusion. Figure 4.5 reveals what happened to individuals who at some point during their participation in the survey were granted the status of sick leave for the unemployed ($N = 1585$). On average, these individuals kept this status for 2.25 years, which indicates that the status often has a long duration.

Forty-two percent of those on sick leave transitioned from this status to old-age pensions, which indicates that sick leave for the unemployed is quite often used for older minimum income beneficiaries in the years before their retirement. Another 41% of those in our sample remained in

the sick-leave category for as long as we could observe them. Eleven percent transitioned back to unemployment, which suggests that their health status had improved so much that they were considered capable of working again. Only 4% of those on sick leave transitioned to incapacity pensions, which indicates that sick leave for the unemployed is not primarily a transitory status on the way to receiving incapacity benefits and that it instead compensates for the problem that occurs when individuals who are unemployed and sick but who are not considered incapacitated (or who are not eligible for this benefit) do not transition back to the labor market. This finding is also supported by the fact that only 2% of those who were on sick leave transitioned directly to employment. These analyses do not constitute causal evidence of the re-employment opportunities of medicalizing unemployment through sick leave[5]; however, we can clearly see that sick leave for the vast majority of people means remaining in the benefit system and either staying on sick leave or transitioning to other benefit schemes.

Being on sick leave could also impact the development of an individual's health status, as is illustrated in Fig. 4.6. On the left-hand side, we see that respondents who were on sick leave had a poorer health status on average than did regular minimum income beneficiaries. The health status of both groups remained constant over time. However, if we look at individual transitions, such as how individual health developed before and after the transition to sickness, we see the following pattern: In the three years prior to moving to sick leave, the health status of individuals deteriorated, but after being on sick leave, their health status stabilized at the level of the transition.

In sum, our analyses of the impact of the medicalization of unemployment on re-employment and health suggest that being on sick leave in Germany might simultaneously foster better health and social exclusion. While these results are only first attempts at shedding light on the consequences of the medicalization of unemployment, they illustrate that medicalization often goes hand in hand with ambiguity for the welfare state as well as for the life chances of affected individuals.

[5] Due to endogeneity, this would be difficult to establish with observational data.

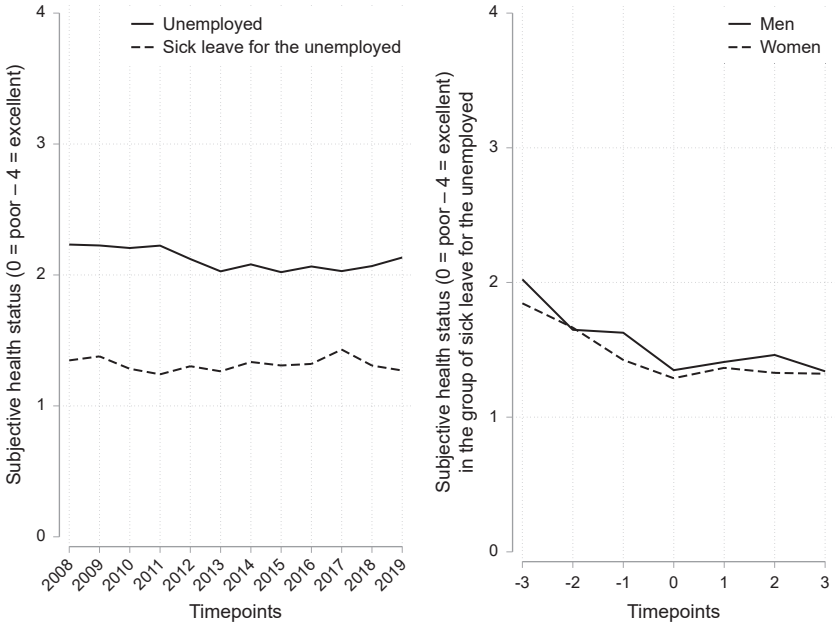

Fig. 4.6 Comparison of subjective health status over time between the unemployed and those on sick leave for the unemployed (left), and a comparison of subjective health status before and after a transition to sick leave for the unemployed ($T = 0$) between gender groups (right). Source: PASS Waves 2–13, DOI: 10.5164/IAB.PASS-SUF0619.de.en.v3, weighted Federal Employment Agency sample, $N = 20{,}196$

4.4.2 Medicalization and Public Attitudes Toward Unemployed Individuals

Evaluating the implications of medicalization for an individual's life chances is important, but there is another key aspect that should be considered: namely, how the perception of unemployment and unemployed individuals changes through medicalization and psychologization. This aspect has been central to the theoretical literature on medicalization and psychologization and has been shrouded in controversy. On the one hand, some scholars have argued that medicalization and psychologization go hand in hand with the benefit of being relieved from blame and stigma, particularly in comparison with a moral or penal interpretation of a social problem (Conrad & Schneider, 1992; Parsons, 1951). This *relief hypothesis* could also apply in the case of unemployment, where sickness can work as

a justification for being inactive. On the other hand, the contrary argument has also been put forward. Nevertheless, the medicalization and psychologization of social problems tie these problems to the individual (Zola, 1972). Psychological explanations in particular always focus on attributing the solution to problems in an individual's cognitions or behavior (Rose, 1998). However, in the current neoliberal and social investment interpretation of sickness, the view that the individual is self-responsible also applies to medical conditions (Holmqvist et al., 2013). Thus, in the current discourse, we could additionally formulate a *responsibility hypothesis* in which medicalization and psychologization attribute the responsibility for being unemployed to the individual.

We studied the consequences of the public perception of both unemployment and the unemployed using a self-designed factorial survey that was fielded in an online access panel of YouGov Germany in December 2020/January 2021 with a quota-based sample of the general German adult population. Respondents were given descriptions of hypothetical individuals who had become unemployed for various reasons: (1) personal misconduct—individual; moral reason; (2) employer bankruptcy—external; social reason; (3) chronic back pain—individual; medical reason; (4) depression—individual; psychological reason; and (5) risk group for COVID-19—individual; medical reason. Respondents were asked different questions about this hypothetical vignette person. By comparing answers between groups that had received different vignettes as part of the experimental variation, we can assess how the medicalization or psychologization of unemployment compares with a moral or social explanation of unemployment.

We asked respondents about the extent to which they agreed with the statement that the described person was to blame for (1) losing their job and (2) not having found a new job after 12 months. Respondents provided answers on a 7-point Likert scale ranging from 0 = "not at all" to 6 = "entirely." Figure 4.7 reveals the effects of the multivariate regression model. We can see that compared with individuals who had become unemployed due to the bankruptcy of their employer, individuals who had become unemployed due to chronic back pain or depression were blamed significantly more for their unemployment. At the same time, these individuals were blamed substantially less than if a moral explanation (e.g., personal misconduct) had been given. In terms of blame for not finding a new job, there was no difference between the psychologization of unemployment and employer bankruptcy, whereas the medicalization of

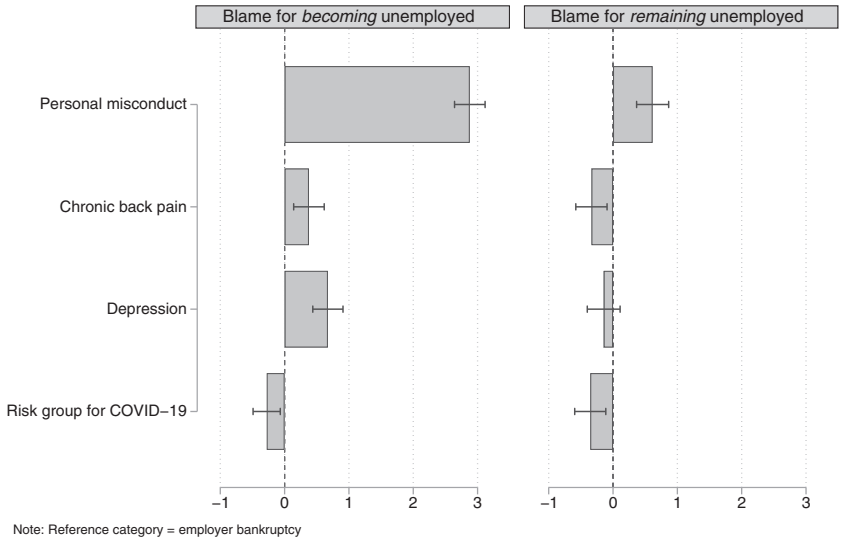

Fig. 4.7 Multivariate OLS coefficients and 95% confidence intervals of approval ratings for the question of whether the described unemployed individuals were themselves to blame for (1) their unemployment and (2) not finding a new job based on different reasons for unemployment. Widths of bars indicate the difference in approval ratings on a 7-point Likert scale compared with the reference category (employer bankruptcy). Source: vignette study, Wave 2 (in 2020) (N = 1843), own weighted sample calculations

unemployment went hand in hand with slightly less blame. Individuals who had lost their job due to personal misconduct were again blamed significantly more, whereas individuals who had lost their job because they belonged to a risk group for COVID-19 were blamed significantly less for both becoming and remaining unemployed. This latter finding could point on the one hand to the respondents' high sensitivity to this issue at the time of data collection (i.e., during the second wave of COVID-19 in Germany). On the other hand, respondents might have attributed less control to the reasoning risk group for COVID-19 than they would have if unemployment had been justified by chronic back pain or depression. In sum, while our results suggest that the medicalization or psychologization of unemployment indeed results in some *relief* compared with the moralization of unemployment (personal misconduct), they also suggest a

stronger attribution of *responsibility* when compared with a social explanation (employer bankruptcy).

We also asked respondents about their opinion of the existing activation regime. In the current minimum income system, individuals are required to fulfill certain obligations (e.g., actively looking for work) in order to receive full benefits (see Sect. 4.3). While certain programs offer specific health and rehabilitative services to minimum income beneficiaries, these services are thus far not obligatory for receiving benefits. Nevertheless, we asked respondents whether they thought that individuals should be *obligated* to participate in such health-related measures in order to receive full minimum income benefits. Overall, two out of ten respondents stated that the described hypothetical person should receive benefits without fulfilling any conditions, whereas the remaining respondents were willing to tie the receipt of benefits to one or more obligations.

As Fig. 4.8 illustrates, the reason for unemployment is associated with the obligations that respondents consider appropriate. When the

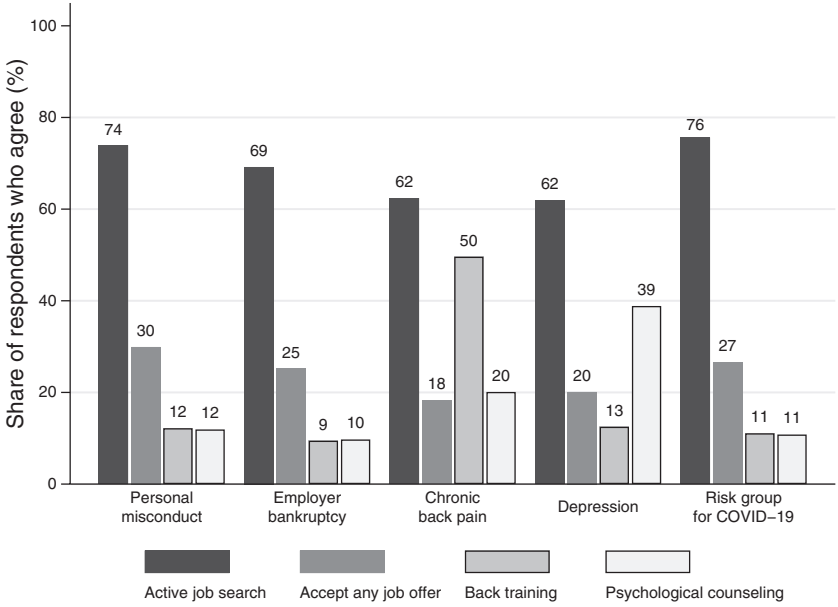

Fig. 4.8 Behavior deemed necessary in order to receive the full amount of minimum income benefits for different causes of unemployment. Source: vignette study, Wave 2 (in 2020) ($N = 1843$), own weighted sample calculations

hypothetical person was described as being ill (i.e., with chronic back pain or depression), fewer respondents supported normal work obligations—such as an active job search or accepting any job offer—compared with all other options. However, most respondents still supported an active job search for this group. Moreover, 50% of respondents supported the notion that the benefits for an individual with chronic back pain could be tied to participating in back therapy, and 39% of respondents supported the notion that psychological counseling could be an obligatory condition for receiving full benefits in the case of depression. Unlike for the question of blame, attitudes regarding obligations for the three health-related groups (i.e., chronic back pain, depression, risk group for COVID-19) were relatively similar and indicated that in this case, actually being sick mattered. Thus, while the medicalization and psychologization of unemployment partially increased respondents' leniency toward this group, which can be seen as an indication of the *relief hypothesis*, the respondents supported obligating these individuals to work on their health in order to restore their employability. All previously described effects remain stable when single obligations are included in a multivariate logistic regression model that controls for respondents' age, gender, and education.

The medicalization and psychologization of unemployment have measurable implications for public opinion. Again, our findings are mixed: There are some signs that medicalization and psychologization are still accepted as a justification both for being inactive and for being treated with greater leniency (*relief hypothesis*); however, we also find that sick unemployed individuals are blamed more if their unemployment is attributed to their sickness and that a segment of the population supports forcing these individuals to improve their health (*responsibility hypothesis*).

4.5 Conclusion

In this chapter, we have taken a tour through the medicalization—and to some extent, also the psychologization—of unemployment. While there is no such thing as "unemployment syndrome," medicine and psychology do have a significant influence on how the welfare state deals with unemployment. On the *institutional* level, we have shown how the definition of

sickness- and disability-related benefit schemes and categories as well as the use of medical concepts and assessment tools shapes social rights in the case of unemployment in Germany. Analyzing the pathway through the system also reveals medicalization on the *actor* level because medical doctors are crucial gatekeepers at multiple points in the system. However, medical doctors and psychologists provide their expertise in the unemployment-related benefits systems based on medical, psychological, and even social criteria. This is an example of how different accounts are integrated in a biopsychosocial approach to dealing with unemployment. We have paid less attention to medicalization and psychologization on the *idea* level; indeed, for once, our analyses of parliamentary debates indicated that there has been little influence from high-level political discourses (see Chap. 5 for more details). However, we found that medicalization and psychologization do impact attitudes in terms of the ideas that individuals hold about unemployment.

The medicalization of unemployment is not a new phenomenon, but it has garnered a new level of interest over the past two decades. Similarly, some of the mechanisms that promote medicalization that we have outlined have been used for a long time and are based on the historically developed setup of the German welfare system. Nevertheless, current neoliberal reforms are also important. Ironically, attempts to activate and push individuals toward participating in the labor market have led to an increase in—and the development of—new forms of medicalizing unemployment. This development has also been discussed for other welfare states, including Sweden (Holmqvist et al., 2013), the US (Hansen et al., 2014; Wong, 2016), and Canada (Pulkingham & Fuller, 2012).

Finally, the controversy surrounding the consequences of unemployment in medicalization and psychologization theory points to the ambiguity that these processes entail in real life. Our analyses—which assessed some consequences empirically—revealed that there are in fact contradictory effects caused by the medicalization and psychologization of unemployment. Medicine and psychology are neither a form of salvation nor nemesis (Illich, 1976); nevertheless, they fundamentally shape how the welfare state engages with unemployment—an insight that should receive greater attention in welfare state research.

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