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Rise up and Work![1]

Workless people with impaired health under Germany's new activation regime

Abstract

'Unemployment benefit II' is the newly created benefit in Germany for workless and needy people of working age who lack or have exhausted entitlements in the contribution-based unemployment insurance system. Re-analysing data from a recent customer panel survey of this population of recipients, the paper explores the effects of an 'activating' benefit regime on respondents with inferior health-related capacities. For one, the overall level of activation produced by the new system is differentiated with regard to the health status of the target population. Secondly, the effects of activation on two employment-related outcomes are estimated taking health into account.

1 Introduction

'Activation' has become a policy paradigm extending far beyond labour market or 'welfare to work' policies. Where not only people but entire systems of social protection are being 'activated' (Barbier 2004, S. 236), activation may cast its spell on health care systems (Sundmacher 2006), on pensioners (Casey 2004) and, in particular, on people hitherto considered as 'incapacitated' or 'disabled' (Carcillo, Grubb 2006). A main goal of Jobcentre Plus in the UK was to get people on incapacity benefits back to work through work-focused interviews (Finn et al. 2005; Konle-Seidl, Lang 2006; Stafford, et al. 2007; Adam et al.). In Norway, the ongoing merger of the National Employment Directorate and the National Social Insurance Directorate – plus compulsory cooperation and co-location of this new NAV bureaucracy with municipal social assistance offices – is aiming primarily at persuading recipients of disability benefits back to work (Overbye 2007). Switzerland is reinforcing both preventive and rehabilitation schemes for (potential) recipients of disability insurance (Bonvin, Rosenstein 2008). In Sweden, where people may remain – still formally employed – on sick leave for long periods, re-activation of this category of 'inactive' people has become an issue (Hetzler 2008).

With regard to the ascription of a social and benefit status to 'inactive' people, the German situation is unique. Gatekeeping before disability pensions is very strict both in terms of medical definition and of the assessment process, the latter being entirely in the hands of institutional doctors, social courts and medical experts commissioned by those courts. Consequently, percentages of the German population of working age receiving

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[1] "Then Peter said, Silver and gold have I none; but such as I have give I thee: In the name of Jesus Christ of Nazareth **rise up and walk**." (Passage Acts 3: 6)

incapacity, disability or sickness related benefits is low in international comparison (Grubb, Miyamoto 2003). By contrast, it almost goes without saying that unemployment – and long-term unemployment, in particular – is high in Germany. There is ample evidence of a trade-off between the status ascriptions of 'unemployed' and 'incapacitated / long-term ill'. The role of disability insurance benefits as an absorber of labour market shocks has for long been described by many authors and for several countries (Parsons 1980; Gruber, Kubik 1997; Autor, Duggan 2003; Campolieti 2004; Beatty, Fothergill 2005; Becker 2000). 'Activation' in one status category may actually lead to the crowding out of recipients into another category (Clasen et al. 2004). Conversely, an analysis of European Social Survey data has demonstrated that individuals who are comparable in terms of a number of demographic characteristics and in their subjective health reporting have a much higher propensity to describe their status as 'incapacitated' in a number of countries compared to Germany (Erlinghagen, Knuth 2008).

Thus we have good reason to assume that the kind of persons targeted for 're-activation' from a sickness or disability related scheme in a number of other European countries tend to be in an unemployment-related regime of social protection in Germany. This particular allocation of social risks may give rise to ambivalent appraisals: If one believes that relevant proportions of people with problems that at least once were severe enough to justify a health or disability related benefit, can be reactivated for employment in other countries, then this should be all the easier to accomplish in a setting like the German one where most such people were never released from 'adult worker' obligations. If, however, one tends to believe that poor physical or mental health will increasingly lead to exclusion from an employment environment that is becoming ever more demanding and stressful, then the inclusion of high proportions of customers with impaired health in an activation oriented regime of labour market and welfare policy would appear a heavy deadweight which might finally shipwreck the of the whole activation mission.

The recently created German benefit and activation regime of 'Basic income support for jobseekers' (vulgo: *'Hartz IV',* with a benefit called 'unemployment benefit II') provides an ideal test case for these alternative hypotheses. Concentrating the workless population of working age not covered by contribution-based unemployment benefits, that is the long-term unemployed, those only marginally and intermittently employed and thus unable to earn an entitlement, and spouses considered 'inactive' before the reform, the new regime should be replete with 'bad risks' with regard to health. The recent evaluation of the reform, though focused on dissimilar issues, has provided customer survey data suitable to explore the questions denoted above.

The remainder of the paper is organised as follows:

Chapter 2 very briefly explains the policy context of the new German regime (2.1) and the research context from which the data used in this paper were derived (2.2). Chapter 3 describes and summarises the health condition of the relevant population (3.1), the activation received by 'customers' in different health conditions (3.2), and their professed satisfaction broken down by health condition and degree of activation. In

chapter 4, the effects of both activation and health condition on two different employment outcomes are explored. Chapter 5 summarises the findings and discusses their policy and research implications.

2 Policy and research context

2.1 Basic income support for jobseekers: the new German benefit regime

As of 2005, Germany merged two benefits for workless people devoid of unemployment insurance entitlements into a new flat-rate benefit financed mainly from the federal budget. Unemployment assistance (roughly 2 million recipients at the end of 2004) and social assistance for people of working age and considered 'able to work' (roughly 1.6 million) were replaced by a new benefit called 'unemployment benefit II' (UB II). The justification for this far-reaching and – for many concerned – 'retrenching' benefit reform was that only by merging the benefits, employment and social services previously delivered by Agencies for Work and municipalities, respectively, could be merged, too. The aim was to form unified 'Job-Centers' which would be better prepared than their forerunners to activate jobseekers and to address their manifold restraints against re-employment in a holistic manner (see Knuth 2007 for details).

'Ability to work' defines the watershed between the new benefit on the one side and disability pensions or – in the absence of an entitlement – of residual social assistance on the other. It is defined as "being able to work for at least three hours per day under normal conditions of the general labour market" or "being expected to become able to do so in the foreseeable future". Both the temporarily ill and those currently not available for work because of caring responsibilities are considered 'able to work'. It is obvious that under such a broad definition, many people with poor health conditions will be included in the new benefit regime called 'for jobseekers' even though individuals may be exempt from job search requirements for the time being.[2] Therefore, the question arises what 'activation' means for them and what effect it may have.

2.2 Evaluation and data

For reasons that are beyond the scope of this paper, the new benefit and services are being delivered in competing organisational models, i.e. either by municipal social service departments alone or by so-called consortia formed between such a department and the local Agency for Work (see Knuth 2008 for details). The official evaluation of the reform has therefore focused on comparing the performance and effects of these two models of service delivery in order to inform policy makers on future choices to make. Since the allocation of the two organisational models to the roughly 440 regional units was based on self-selection and therefore was far from random, the evaluation followed a regional matching approach for which 154 regional units were selected. One element

[2] The majority of the recipients of the new benefit are not counted as unemployed – either because they are not currently available for work or because they are actually working but still depending on the benefit, which is also granted as an in-work benefit for those not earning a living wage.

of the evaluation was a computer aided telephone survey of 25,000 respondents in two waves, part of which was organised as a panel. Sampling was restricted to the 154 regional units under consideration, and it was stratified in several dimensions in order to capture sufficient numbers of individuals in defined target groups. In order to monitor expected achievements in 'early activation', a smaller part of the samples were drawn from recent entries before the two sample points. These samples will be excluded from the analysis presented here, which is therefore based on those 11,108 respondents who had been sampled from the caseload as it existed between September 19 and October 18, 2006 and who were actually interviewed twice ('real panel')[3]. The first wave of interviews was conducted between January and April 2007, the second wave between November 2007 and March 2008. As far as possible, individual interviews were sequenced in such a way as to have roughly equal time spans between the first and the second wave. Percentages calculated in this paper have been adjusted for sample stratification and for differing response rates in different strata of the sample. It should be noted, however, that – strictly speaking – these findings are representative only for the 154 regional units on which the evaluation was based and not representative for the Federal Republic as a whole. Descriptive values must therefore be taken 'with a pinch of salt', while the multivariate models should not be effected by this regional bias in the sample design.

The survey contains several indicators of self-reported work ability and health, descriptions of the kind of activation respondents experienced by jobcentres, and subsequent employment outcomes between the two waves of the panel which were conducted roughly 12 months apart. Since a proportion of the benefit is also available for 'working poor' unable to support their families, taking up work while continuing to draw benefits provides an additional indicator of integration into employment not yielding a living wage.[4]

3 Health and activation

3.1 Health condition of the target population

The customer survey confirms the expectation that health would be a relevant problem among the target population. 11.4 per cent of the male and 6.8 per cent of the female respondents report an officially recognised handicap, more than half of these (6.5 per cent of male and 3.9 per cent of female respondents) saying that they fulfil the legal requirement of 'severely handicapped'. Around one third of those with a handicap are saying that they would be very strongly restricted with regard to work.

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[3] In order to compensate for panel mortality, there was also a proxy panel in which information with regard to the period of the first wave was gathered in retrospect. These proxy interviews were excluded from the analysis presented here because subjective health information was not collected in retrospect, assuming that such information would be less valid and not comparable with responses in the real panel.

[4] Since this situation can result from low hours, low hourly wages, large families, or any combination of the three, we will not go into depth exploring the reasons for continued benefit recipience in this paper.

Only around 60 per cent (59.4 per cent males, 61.2 per cent females) describe their current health condition as 'very good' or 'good'. Comparable values for the population at large (69.8 per cent for males, 68.6 per cent for females) can be derived from the EU SILC database (Statistisches Bundesamt 2006). This confirms our expectation that people with weaker health would concentrate among the recipients of UB II. It must be admitted, however, that this numerical difference is smaller than expected.[5]

Asked how many hours of daily work they would be able to sustain in the longer run, 3.8 per cent of male and 4.1 per cent of female respondents estimated their daily ability to work at less than three hours. If these self-assessments were to be confirmed by medical examination, these respondents would have to be considered as wrongly allocated to the benefit in question, given that the ability to work at least three hours per day is a constituent definition of the benefit. Another 8.1 per cent of male respondents but 19.3 per cent of female respondents said that they would be able to perform daily work of between three and under 6 hours. These recipients, too, are far from normal working ability. However, since gender differences on the other indicators are much smaller, the high share of female respondents reporting restricted working ability should in part be attributed to a mingling of ability with availability and preparedness. This must be seen against the background of an institutionally still strong German 'male breadwinner model' (Gustafsson et al. 1996), lack of childcare facilities for children under three in West Germany (Statistische Ämter des Bundes und der Länder 2007), the concentration of migrants in recipience of the benefit, and the importance of Islamic backgrounds among the migrant population in Germany. – More descriptive indicators of health condition not discussed in the body of this paper are to be found in the annex.

For the purposes of multivariate analyses, the two indicators – subjective health condition and daily workableness – will be combined into one index of health-related capacity (see Table 1). The combination of full temporal working ability (8 hrs. or more per day) and at least 'good' health is recoded as (1) *very good* health-related capacity (47.1 per cent of respondents), whereas a health condition of only 'satisfactory' or a slightly restricted workableness from 6 to under 8 hours makes up index (2) *good* health-related capacity (28.8 per cent of respondents). A health condition less than satisfactory combined with a daily workableness from 3 to under 6 hours makes up for (4) *poor* health-related capacity (5.7 per cent), and the same categories of health condition combined with a daily workableness of less than 3 hours is defined as (5) *very poor* (3.1 per cent). The 15.1 per cent diagonally situated 'in-betweens' are lumped together as (3) *fair* health-related capacity.

[5] A possible explanation and question for further research would be differences in response style among different strata of the population, namely, lower levels of aspiration with regard to health among people threatened by poverty and with a disproportionately high share of low educational and vocational levels. – For comparison, *national* differences in response styles with regard to health have been demonstrated with the SHARE dataset (cf. Jürges 2006.

Table 1 Index of health-related capacity (percentages of responses)

		daily workableness								
		8h or more		6 … < 8 h		3 … < 6 h		< 3 h		total
health condition	very good	18.9	*(1) 47.1*	3.1		1.0		0.0		23.2
	good	28.2		7.0	*(2) 28.8*	2.7		0.2	*(3) 15.1*	38.2
	satisfactory	12.8		5.9		4.4		0.5		23.7
	not so good	2.4		2.2		3.7	*(4) 5.7*	1.0	*(5) 3.1*	9.3
	bad	0.9		0.7		2.0		2.1		5.7
	total	63.3		19.0		13.8		3.9		100.0

Source: UB II customer panel (stock sample only), own calculations

The index of health-related capacity is consistent with other response items related to health: On average, handicapped respondents score significantly poorer on this index than respondents not reporting a handicap. Among the handicapped, restrictions with regard to work are described as stronger as the index of health-related capacity increases in value. The same holds true for the incidence of certain medical diagnoses as well as for the number of diagnoses mentioned. It appears, then, that the index of health-related capacity adequately summarises the various health aspects covered in the customer survey.

Within the population of respondents, those aged 50 and over score less favourable on the index of health-related capacity than the average. Worth noting is the poor value of this index for women with migrant backgrounds. This is the case for the index described as well as for most singular aspects of the health condition.

Table 2 Average index of health-related capacity for selected groups of respondents

			aged 50 and older		migrant background	
	male	female	male	female	male	female
mean	1,757	2,014	2,205	2,695	1,666	2,206
standard error	0,028	0,028	0,049	0,066	0,053	0,065
N	4773	5877	1775	1535	1291	1581

Source: UB II customer panel (stock sample only), own calculations

3.2 Activation and health

Generally speaking, more than two years after their creation, the newly establisehd jobcentres – almost regardless of the model of their governance – still fell far short of their official mission of comprehensive activation. Only slightly more than two thirds (69.8 per cent) of the respondents had had at least one interview with their personal adviser during the six months prior to the survey. Only less than half (47.7 per cent) had a currently valid personal action plan *(Eingliederungsvereinbarung)*, and only slightly

more than one quarter (27.9 per cent) had ever received an offer for a job or (in the case of young people) of an apprenticeship since entering the system or since being referred to it from the two preceding benefit systems as of January 1, 2005.

Large groups are practically exempt from activation, which explains the above findings to some degree. Mothers with children under three do not have to be available for work since, as said before, childcare facilities for children of this age are almost not existent in the Western and politically dominating part of Germany. Recipients aged 58 or more could still opt out of job search obligations at the time of the survey. Young people of working age but still attending school are no suitable targets for activation. Although the 'working poor' drawing in-work benefits (see p. 2 and footnote 4 for details) are in theory called to reduce their dependency by trying to earn more, it can be assumed that they are often left alone since they are regarded as 'integrated' in the labour market. These caveats notwithstanding, even among those recipients of the benefit officially registered as unemployed (which includes those working no more than 15 hours per week but not those working more), only 70.4 per cent had had a jobcentre interview during the last six months, and only 50.5 per cent had a valid personal action plan. In other words, even among those whose need for activation is beyond doubt considerable proportions are being neglected.

Against this background, it seems relevant how activation is related to the index of health related capacity introduced above. Are those with health problems activated more since they need more support? Or are they activated less due to 'creaming' decisions in an environment with still too high caseloads of personal advisers?

Table 3: Activation and health related capacity

	index of health related capacity				
	(1) very good	(2) good	(3) fair	(4) poor	(5) very poor
interview with personal advisor during the last 6 months					
mean	0,698	0,702	0,708	0,692	0,676
standard error	0,012	0,016	0,019	0,043	0,038
N	4690	3044	1688	589	369
valid personal action plan					
mean	0,506	0,492	0,446	0,354	0,398
standard error	0,014	0,019	0,023	0,045	0,046
N	4104	2708	1531	537	337
offer of job or apprenticeship					
mean	0,306	0,285	0,244	0,221	0,245
standard error	0,012	0,015	0,020	0,030	0,049
N	4540	2996	1689	596	367
average number of activation items (max. 3, min. 0)					
mean	1,473	1,454	1,365	1,263	1,262
standard error	0,027	0,034	0,044	0,081	0,088
N	4025	2634	1484	526	330

Source: UB II customer panel (stock sample only), own calculations

Whereas the incidence of interviews varies little with health, personal action plans as well as job offers decrease as health deteriorates (see Table 3). On the one hand, this seems logical and reflects the emphasis on work in the new regime of Basic Income

Support for Jobseekers. On the other hand, the fundamental justification for the reform that led to the merger of benefits and services from the two preceding benefit systems was to create more comprehensive services including psycho-social and other concomitant services. Even where work is not an immediate option, a personal action plan might include steps towards improving a person's health status, or there could be job offers adjusted to the individual's health condition. However, the evaluation found low intervention rates with regard to social or psychological problems (ZEW; IAQ; TNS Emnid 2007). Furthermore, health has not been explicitly addressed in the reform discourse. Medical rehabilitation in cases of officially recognised handicaps has suffered from the institutional split between unemployment insurance and basic income support for jobseekers (Dornette et al. 2008). Concepts and measures suited to address the often multi-morbid or unspecific syndromes of psychosomatic ill-being among long-term unemployed are evolving but slowly and sporadically (Büttner et al. 2007). This explains why the health score is numerically negatively correlated with the activation score. It is worth noting, though, that those with reduced health-related capacity are not simply left alone, which is reflected in the almost even distribution of jobcentre interviews.

3.3 Customer satisfaction and health

Customer satisfaction was measured for seven specific items (e.g. time available for interviews, accessibility by telephone, time needed to process applications, etc.) and as a global indicator. Of these, the latter will be used here, plus 'understanding of your specific personal situation', since this item might reflect the acknowledgement of a person's individual health situation by her or his personal adviser.

Table 4: Customer satisfaction by degree of activation and health related capacity

	activation				health related capacity				
	0	1	2	3	(1) very good	(2) good	(3) fair	(4) poor	(5) very poor
global satisfaction with jobcentre services									
mean	2,847	2,717	2,536	2,281	2,636	2,575	2,504	2,440	2,430
standard error	0,044	0,038	0,030	0,048	0,026	0,035	0,045	0,099	0,118
N	1684	2983	3102	1303	4437	2903	1629	574	350
Anova	99,72 (0.000)				10,65 (0.000)				
satisfaction with understanding of personal situation					.	.	.	.	.
mean	2,720	2,557	2,431	2,193	2,426	2,454	2,495	2,571	2,518
standard error	0,045	0,038	0,029	0,043	0,024	0,036	0,051	0,111	0,113
N	1662	2979	3101	1293	4418	2886	1625	579	355
Anova	76,15 (0.000)				3,78 (0.0045)				

Source: UB II customer panel (stock sample only), own calculations

Both global satisfaction and satisfaction with the understanding of one's personal situation *increase*[6] quite markedly with the number of applicable activation items from Table 3. In other words, as respondents experience *more* activation, they profess *more* satisfaction. Even though 'activating' interaction with the jobcentre puts additional demands on them, respondents are not generally happy to be left alone.

As far as health related capacity is concerned (as it was developed in Table 1), we find global satisfaction with the jobcentre to increase slightly inversely to the variation of the health condition. In other words, even though – as demonstrated in Table 3 – those with poorer health-related capacity experience less activation, they seem to accept and appreciate this. In contrast, specific satisfaction with the understanding of one's personal situation *decreases* slightly as health-related capacity deteriorates. If we assume respondents with poor health to focus on health when speaking about their personal situation, then this response pattern may reflect the fact that case managers have neither many opportunities nor much experience for health-related activation strategies.

4 Health, activation, and employment outcome

4.1 Does activation matter?

The impact of different aspects of activation (three single items and one composite indicator) has been estimated for two different outcomes, (1) employment take-up and (2) quitting the benefit in conjunction with employment take-up. As explained before, employment take-up does not necessarily imply quitting the benefit since in-work benefits are available if earned income does not meet the threshold of legally defined needs of the individual and, where applicable, his or her dependents. Obviously, then, the outcomes labelled 'quitting the benefit in conjunction with employment take-up' are a subset of the total of employment take-ups. Since changes occurring simultaneously with re-employment may contribute to the ending of recipience, we refer to this type of outcome as 'in conjunction with', not as 'due to' re-employment. Quitting the benefit for reasons other than taking up work (e.g. receiving a pension, partner takes up work, failing to renew application) are left out of consideration.

In all the eight resulting probit models (Table 5), health-related capacity, gender, and the condition of the regional labour market[7] are used as control variables. Activation indicators do show effects on both types of employment outcome at least on a 5 per cent level of statistical significance (with the exception of quitting the benefit after only one item of activation, which is still significant at the 10 per cent level). Effects increase with the number of activation items that apply. Effects on simple employment take-up are mostly larger than on quitting the benefit in conjunction with employment take-up,

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[6] It should be noted here that following German habits resulting from school grade systems, lower numerical values on a four-point-scale signify higher satisfaction.

[7] The indicator relates to regional jobcentre units ranked into three even terciles according to the probability of employment take-up by unemployed persons before the reform. Cf. IAW, ZEW 2006, p. 157f.

which is a more demanding criterion of success than just finding any, possibly low-paid, job.

Table 5: Efffects of activation on employment outcomes

	employment take-up				quitting the benefit in conjunction with employment take-up			
interview with personal advisor during the last 6 months	0.131 (0.033) 0.000	-	-	-	0.114 (0.035) 0.001	-	-	-
valid personal action plan	-	0.149 (0.032) 0.000	-	-	-	0.106 (0.034) 0.002	-	-
job or apprenticeship offer	-	-	0.121 (0.032) 0.000	-	-	-	0.160 (0.034) 0.000	-
number of applicable items of activation (Reference category: none)	-	-	-		-	-	-	
1	-	-	-	0.127 (0.040) 0.001	-	-	-	0.076 (0.042) 0.073
2	-	-	-	0.271 (0.039) 0.000	-	-	-	0.213 (0.041) 0.00
3	-	-	-	0.377 (0.048) 0.000	-	-	-	0.295 (0.050) 0.000
index of health-related capacity (reference category: fair)								
1 very good	0.227 (0.046) 0.000	0.205 (0.048) 0.000	0.216 (0.046) 0.000	0.219 (0.046) 0.000	0.455 (0.053) 0.000	0.453 (0.056) 0.000	0.435 (0.053) 0.000	0.444 (0.053) 0.000
2 good	0.155 (0.048) 0.001	0.150 (0.050) 0.003	0.153 (0.048) 0.001	0.147 (0.047) 0.002	0.355 (0.055) 0.000	0.344 (0.058) 0.000	0.334 (0.055) 0.000	0.343 (0.054) 0.000
4 poor	-0.173 (0.084) 0.038	-0.208 (0.088) 0.018	-0.181 (0.083) 0.030	-0.181 (0.083) 0.029	-0.165 (0.104) 0.110	-0.143 (0.108) 0.186	-0.164 (0.102) 0.108	-0.164 (0.102) 0.110
5 very poor	-0.464 (0.120) 0.000	-0.484 (0.127) 0.000	-0.492 (0.122) 0.000	-0.456 (0.119) 0.000	-0.449 (0.153) 0.003	-0.571 (0.177) 0.001	-0.554 (0.165) 0.001	-0.436 (0.152) 0.004
gender: female (reference category: male)	-0.210 (0.033) 0.000	-0.215 (0.035) 0.000	-0.216 (0.033) 0.000	-0.198 (0.033) 0.000	-0.162 (0.034) 0.000	-0.193 (0.037) 0.000	-0.165 (0.035) 0.000	-0.155 (0.034) 0.000
regional labour market (reference category: average)								
below average	-0.113 (0.037) 0.002	-0.106 (0.039) 0.006	-0.100 (0.037) 0.007	-0.115 (0.037) 0.002	-0.124 (0.039) 0.001	-0.111 (0.041) 0.007	-0.121 (0.039) 0.002	-0.116 (0.038) 0.002
above average	0.131 (0.036) 0.000	0.133 (0.038) 0.000	0.130 (0.036) 0.000	0.123 (0.036) 0.001	0.060 (0.038) 0.116	0.062 (0.041) 0.133	0.057 (0.039) 0.145	0.065 (0.038) 0.086

Also controlled for age and for belonging to one or more defined 'problem groups' (parents with small children, lone parents, handicapped persons, and migrant background)
Source: UB II customer panel (stock sample only), own calculations

This finding is contrasted by the item 'job or apprenticeship offer' which seems to impact more on employment yielding a living wage than just on any employment. This may be taken as an indicator that even under the 'activation' paradigm with a considerably broadened definition of acceptability of job offers, the bulk of job offers administered by the jobcentres still tends to conform to certain quality standards – whereas 'activating' pressures to find a job on one's own not accompanied by a job offer are more likely to lead into jobs below a living wage, whatever this may be with regard to the individual family situation and size. However, this hypothesis would need further exploration beyond the scope of this paper.

In all the eight models, the index of health-related capacity works in the expected direction and in a consistent pattern. 'Poor' and 'very poor' health results in negative coefficients where 'fair' health is taken as the reference category. Except for 'poor' health which does not seem to discriminate clear enough from 'fair', all health-related coefficients are highly significant. The effects of 'very good' and 'good' health are stronger with regard to the more demanding outcome of quitting the benefit than with regard to simply taking up any employment.

Gender (female, with male as the reference category) has a slightly negative but highly significant effect in these models in which health is being controlled for. The effect of regional labour market conditions is weak compared to many of the other variables, and notably 'above average' labour market conditions are not significant for three out of four models for the more demanding outcome of quitting the benefit. This conforms to repeated evaluation experience that 'objective' labour market indicators explain little when individual and treatment characteristics are taken into account (Büttner et al. 2001; Büttner et al. 2007).

4.2 How much does health matter?

So far it has been explored whether activation impacts on employment and benefit recipience outcomes when health is controlled for. While both variables showed the expected effects, these models do not sufficiently take into consideration that people with a weaker health-related capacity are activated less intensively (see Table 3) and perhaps in different ways. How do health and activation interact with regard to employment outcomes? Does activation work differently for groups with different health-related capacity?

In order to explore this question, another four probit models were estimated for the two employment outcomes known from Table 5, separated for two health categories: superior (= 'very good' + 'good') and inferior (= 'fair' + 'poor' + 'very poor').[8] Activation is represented here only by the number of applicable items, and the control variables are the same as in Table 5 – except, of course, for health which has become constitutive of the models.

[8] As a test for robustness of the models, the procedure was repeated with different groupings of the original five health categories. The resulting patterns were either the same, or they turned out to be unstable because the number of cases became too small in certain cells.

Table 6: Health-differentiated efffects of activation on employment outcomes

	employment take-up		quitting the benefit in conjunction with employment take-up	
	superior	inferior	superior	inferior
	health-related capacity			
number of applicable items of activation (Reference category: none)				
1	0.144	0.043	0.102	0.047
	(0.046)	(0.088)	(0.047)	(0.110)
	0.002	0.0625	0.030	0.670
2	0.259	0.307	0.213	0.308
	(0.044)	(0.087)	(0.045)	(0.105)
	0.000	0.000	0.000	0.003
3	0.382	0.344	0.300	0.338
	(0.054)	(0.116)	(0.055)	(0.139)
	0.000	0.003	0.000	0.015
gender: female (reference category: male)	-0.235	-0.087	-0.162	-0.189
	(0.037)	(0.076)	(0.037)	(0.090)
	0.000	0.256	0.000	0.035
regional labour market (reference category: average)				
below average	-0.115	-0.099	-0.115	-0.067
	(0.041)	(0.087)	(0.042)	(0.105)
	0.005	0.254	0.006	0.524
above average	0.134	0.118	0.089	0.084
	(0.041)	(0.077)	(0.042)	(0.094)
	0.001	0.125	0.034	0.375

Also controlled for age and for belonging to one or more defined 'problem groups' (parents with small children, lone parents, handicapped persons, and migrant background)
Source: UB II customer panel (stock sample only), own calculations

As Table 6 shows, activation does work for both sub-populations in the expected direction and in a consistent pattern. Those with inferior health, however, need more activation (at least two applicable items) in order to experience a statistically significant improvement of the more demanding employment outcome indicator, i.e. quitting the benefit. Only where all three items of activation are applicable, differences between the coefficients for the two subpopulations become negligible. Significance of gender becomes weaker than in the previous models and is lacking for persons of inferior health with regard to taking up 'just any' employment. In general, the significance of regional labour market conditions becomes even weaker than in the previous models and is lacking for half of the coefficients.

To sum up, activation does work even for people with reduced health-related capacities, but a higher dosage is needed before effects become visible. Given the sufficient dosage, the differential effect of activation as compared to no activation becomes equivalent for the two subgroups with 'superior' and 'inferior' health-related capacity. This does not alter the fact, of course, that those of inferior health are less likely to take up employment, be it with or without activation. Since activation of people with impaired health requires higher intensity to be effective at all while still producing

lower rates of desired outcomes, it is more costly but these expenses are not wasted. It would, however, be beyond the scope of this paper and the relevant content of the available data to assess whether there is a positive return in budgetary terms (treatment costs vs. savings in benefits) or in a broader fiscal perspective (including tax and contribution payments resulting from employment).

5 Summary and discussion

Using a very recent two-point panel database of roughly 11,000 recipients of the new German 'Unemployment Benefit II', the expectation inferred from institutional considerations, namely to find high proportions of people with an impaired health condition, could be confirmed. However, comparison with a population survey using comparable indicators shows only modest differences in the expected direction. A more conclusive test of the original expectation would need a database with sufficient numbers of both recipients and non-recipients of the benefit. Such a database already exists (Trappmann et al. 2007), and its questionnaire contains the relevant items; however, it will still be some time until these data become available to the general scientific public.

Self reported daily work ability of around 4 per cent of the benefit population runs below the legal threshold that defines the benefit. Even allowing for gender role related misreporting by part of the female respondents, there is another group of at least 10 per cent of the population whose daily work ability is critical (at least three but under 6 hours), adding up to something like 15 per cent who would not be able to sustain normal working days due to their health condition.

The level of activation produced by the new German benefit regime still falls short of its pretence with regard to all its so-called customers. Most notably, more than two thirds of the respondents said they never received a job or apprenticeship offer. Two of three activation indicators used are positively correlated with health – activation is directed more at those whose health condition seems to promise positive results.

Contrary to some critics' assumptions, activation is not generally perceived as an inadequate imposition by the population concerned. Quite the contrary, 'customer' satisfaction increases with the intensity of the activation they have experienced. The relationship between health, activation and satisfaction seems somewhat perplexing and would need further investigation before drawing any conclusions.

Controlling for health, gender, and regional labour market conditions as well as age and belonging to defined policy target groups, positive effects of activation on taking up employment can be demonstrated. These effects are weaker, however, for the more ambitiously defined outcome of quitting the benefit in conjunction with taking up employment than for taking up just any job. As would be expected, health-related capacity has significant and consistent effects on employment outcomes in the expected direction. It can be shown that activation has a positive employment effect even on the slight majority of the respondents who do not enjoy a 'good' or 'very good' health

condition. However, in order to have this effect on people with inferior health, a higher intensity of activation is needed.

These findings to some degree refute the ironic connotation of this paper's title which was made up before the data analysis was completed. Referring to the two policy alternatives hinted in the introduction, it can be said that, generally speaking, it actually does make sense to keep workless and needy people of superior as well as inferior health within one uniform regime of employment-oriented activation rather than defining them as 'out of the labour market' and assigning them to a benefit without work requirement. Having said this, it still remains to be questioned whether smaller parts of the recipients are perhaps hopelessly misallocated in this benefit regime – namely those reporting daily working abilities below or only slightly above the legal definition of eligibility for UB II. More differentiated analyses focussing on activation and employment outcomes for this particular group would have to assess the degree to which these respondents are simply misjudging or misreporting their general health condition compared to the extent of institutional misallocation.

A policy implication of our findings would be that jobcentres need more adequate possibilities for intervention and support with regard to their 'customers'' health condition. As far as manifest diagnoses and chronic conditions are concerned, co-operation with the health insurance funds and among all the institutions responsible for rehabilitation – a very complex institutional mix in Germany – is urgently needed. With regard to more unspecific conditions of ill-being, integrating health aspects and health-related behaviour into approaches of employment-related coaching and empowerment seems promising. Such projects now only occasionally commissioned by the job-centres to providers should be expanded.

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Appendix: Health indicators for recipients of unemployment benefit II

	all respondents		aged 50 or more		migrant background		index of health-related capacity
	male	female	male	female	male	female	
handicapped							
mean	0,114	0,068	0,192	0,178	0,068	0,056	2,896
standard error	0,006	0,007	0,014	0,020	0,009	0,016	0,068
N	4980	6093	1885	1632	1367	1663	1030
severely handicapped							
mean	0,065	0,039	0,108	0,097	0,039	0,035	2,895
standard error	0,005	0,006	0,010	0,018	0,007	0,014	0,099
N	4976	6089	1881	1623	1372	1665	569
restrictions due to handicap: hardly							
mean	0,276	0,222	0,211	0,164	0,259	0,165	1,918
standard error	0,026	0,036	0,032	0,038	0,066	0,080	0,095
N	659	404	388	245	123	68	265
restrictions due to handicap: sensible							
mean	0,391	0,384	0,370	0,319	0,399	0,224	2,720
standard error	0,029	0,052	0,037	0,059	0,069	0,115	0,099
N	659	404	388	245	123	68	378
restrictions due to handicap: strong							
mean	0,245	0,268	0,259	0,372	0,197	0,486	3,703
standard error	0,024	0,059	0,032	0,074	0,048	0,158	0,146
N	659	404	388	245	123	68	229
restrictions due to handicap: very strong							
mean	0,089	0,127	0,161	0,145	0,146	0,125	4,398
standard error	0,014	0,025	0,028	0,033	0,046	0,059	0,105
N	659	404	388	245	123	68	122
well-being: very good							
mean	0,227	0,228	0,113	0,080	0,287	0,217	1,230
standard error	0,011	0,010	0,015	0,011	0,024	0,020	0,018
N	4981	6104	1887	1632	1365	1665	2452
well-being: very good							
mean	0,367	0,384	0,288	0,262	0,369	0,364	1,336
standard error	0,012	0,012	0,020	0,019	0,024	0,026	0,017
N	4981	6104	1887	1632	1365	1665	3961
well-being: fair							
mean	0,249	0,222	0,337	0,291	0,217	0,259	2,207
standard error	0,012	0,011	0,019	0,019	0,024	0,026	0,016
N	4981	6104	1887	1632	1365	1665	2573

	all respondents		aged 50 or more		migrant background		index of health-related capacity
well-being: poor							
mean	0,095	0,103	0,165	0,210	0,066	0,103	3,618
standard error	0,007	0,008	0,014	0,019	0,010	0,020	0,036
N	4981	6104	1887	1632	1365	1665	1029
well-being: very poor							
mean	0,062	0,062	0,096	0,157	0,061	0,058	4,102
standard error	0,007	0,006	0,010	0,019	0,017	0,011	0,059
N	4981	6104	1887	1632	1365	1665	635
daily working abiliy: <3hrs							
mean	0,038	0,041	0,092	0,135	0,028	0,057	4,610
standard error	0,004	0,005	0,011	0,019	0,007	0,011	0,060
N	4786	5880	1780	1536	1300	1583	473
daily working abiliy: 3 … < 6hrs							
mean	0,081	0,193	0,154	0,306	0,082	0,281	3,412
standard error	0,008	0,011	0,014	0,020	0,018	0,027	0,028
N	4786	5880	1780	1536	1300	1583	1573
daily working abiliy: 6 … < 8hrs							
M(X)	0,134	0,243	0,186	0,229	0,140	0,256	2,149
SE	0,008	0,012	0,015	0,019	0,016	0,026	0,014
N_sub	4786	5880	1780	1536	1300	1583	2081
daily working abiliy: 8hrs and more							
mean	0,747	0,524	0,568	0,330	0,750	0,406	1,308
standard error	0,011	0,013	0,020	0,022	0,023	0,027	0,012
N	4786	5880	1780	1536	1300	1583	6523
physical complaints: gastrointestinal system							
mean	0,137	0,153	0,157	0,263	0,157	0,177	2,653
standard error	0,010	0,009	0,013	0,021	0,020	0,021	0,061
N	4997	6111	1893	1636	1377	1670	1578
physical complaints: cardiovascular system							
mean	0,167	0,209	0,325	0,368	0,132	0,204	2,557
standard error	0,010	0,010	0,018	0,021	0,017	0,020	0,043
N	4997	6111	1893	1636	1377	1670	2174
psychic complaints: nervous conditions, anxieties							
mean	0,157	0,226	0,191	0,296	0,163	0,225	2,673
standard error	0,009	0,010	0,016	0,019	0,020	0,022	0,048
N	4997	6111	1893	1636	1377	1670	2026
physical complaints: allergies, dermal problems							
mean	0,170	0,266	0,132	0,244	0,154	0,275	2,137
standard error	0,010	0,012	0,015	0,020	0,020	0,027	0,053
N	4997	6111	1893	1636	1377	1670	2269

	all respondents		aged 50 or more		migrant background		index of health-related capacity
physical complaints: dorsal, neck, spinal disks							
mean	0,407	0,422	0,533	0,626	0,413	0,414	2,333
standard error	0,013	0,013	0,020	0,021	0,027	0,028	0,035
N	4997	6111	1893	1636	1377	1670	4358
physical complaints: other joints							
mean	0,262	0,238	0,411	0,510	0,212	0,224	2,617
standard error	0,011	0,010	0,020	0,022	0,021	0,023	0,043
N	4997	6111	1893	1636	1377	1670	2816
complaint: sleep disorder							
mean	0,214	0,266	0,256	0,440	0,202	0,253	2,628
standard error	0,010	0,012	0,016	0,022	0,022	0,024	0,042
N	4997	6111	1893	1636	1377	1670	2562
number of applicable complaint categories							
mean	1,514	1,780	2,005	2,747	1,434	1,773	
standard error	0,039	0,042	0,067	0,089	0,082	0,092	
N	4997	6111	1893	1636	1377	1670	