RESEARCH PROBLEM & DATA
To what extent is the relationship between unemployment and mental healthcare use driven by the level of unemployment generosity and healthcare generosity in various European countries?

While it is widely known that the unemployed have an elevated risk of mental health problems, scholars have only recently started paying attention to their mental healthcare use. Research shows that mental healthcare use among the unemployed is often higher than expected based on their need for care. The European context—with high between-country variation in unemployment, labor market policies, and healthcare expenditures—is ideal for studying how generosity in unemployment policies and healthcare system characteristics shape the relationship between unemployment and mental healthcare seeking.

We consider unemployment to be medicalized when the unemployed report a level of mental healthcare use that exceeds the level predicted by their self-reported mental health status. This empirical approach provides a straightforward estimation of the level of medicalization of unemployment and its amount of cross-national variation. We analyzed a subsample of 36,306 working-age women and men in over 20 European Union member states from two rounds (2005–2006 and 2010) of the Eurobarometer survey to disentangle individual- and country-level effects. Country-specific logistic regression and multilevel analyses, controlling for public disability spending, changes in government spending, economic capacity, and unemployment rate, were performed.

KEY FINDINGS
• In several European countries, the unemployed use more mental healthcare than the employed—even after adjusting for their mental health status—thereby indicating the medicalization of unemployment.
• The medicalization of unemployment varies across countries and is partly patterned by the country’s level of unemployment generosity and healthcare generosity. A low level of unemployment generosity combined with a high level of healthcare generosity seems to trigger such medicalization.
• In countries where there were governmental expenditure cutbacks between 2005 and 2009, the likelihood of the unemployed contacting a general practitioner for emotional or psychosocial problems decreased.

POLICY IMPLICATIONS
Contrary to what is often thought, our findings suggest that unemployment does not always create a barrier to the use of professional healthcare because of psychosocial problems. Under certain conditions it can coincide with the overconsumption of healthcare. Healthcare policies and unemployment policies may contribute to the medicalization of unemployment, which is a societal problem. Medicalization can hinder the unemployed from returning to work. It is also associated with the overconsumption of healthcare and, thus, contributes to a less efficient use of the healthcare system and increases private and public healthcare expenditures. Investments in effective measures to support the unemployed to find appropriate work, to prevent the devastating psychosocial problems related to unemployment, and to avert the surge of medicalized solutions for these problems may be rational alternatives to over-medicalizing care.

Note: Unemployment generosity scores (including the replacement rate, qualifying period, duration of benefits payments, waiting period, and level of coverage) are based on the Comparative Welfare Entitlements Dataset 2 (Scruggs, Jahn, and Kuitto 2014) and calculations using Scruggs’ (2014) formula. Healthcare generosity scores (including level of coverage, private health expenditures, private hospital beds, and household out-of-pocket payments) are based on data from Eurostat (2015), the Organisation for Economic Co-operation and Development (2012), and the World Health Organization (2005, 2011), and calculations using Scruggs’ (2014) formula.

Figure 1. Countries Positioned in a Two-dimensional Graph of Unemployment Generosity by Healthcare Generosity.

Figure 2. Country-specific Differences in the Predicted Probabilities for Mental Healthcare Use for the Unemployed and the Employed, Adjusted for Individuals’ Mental Health and Other Control Variables.

Note: The predicted probabilities are based on the results of the country-specific logistic regression analysis. A subsample of 36,306 working-age respondents from rounds 64.4 (2005–2006) and 73.2 (2010) of the Eurobarometer cross-national survey was used. \( p < .10, \* p < .05, \* * p < .01, \* * * p < .001 \) (two tailed).