- 9 Boorse C. On the distinction between disease and illness. *Philosophy and Public Affairs* 1975;5(1):49-68.
- 10 Culver CM, Gert B. *Philosophy in medicine*. New York and Oxford: Oxford University Press, 1982:64-125.
- 11 Feinstein AR. *Clinical judgment*. Baltimore: Williams and Wilkins, 1967:145-8.
- 12 ten Have H, Sporken P. Heroin addiction, ethics and philosophy of medicine. *J Med Ethics* 1985;11:173-7.
- 13 Anonymous. Heroin, health and disease [Editorial]. *J Med Ethics* 1985;11:171-2.

Bibliography

- Sigerist HE. *A history of medicine. I: Primitive and archaic medicine*. New York: Oxford University Press, 1967:125-80, 331-5, 441-64.
- Engelhardt HT, Spicker SF, eds. *Evaluation and explanation in the biomedical sciences*. Dordrecht and Boston: Reidel, 1975. (Especially Toulmin S. Concepts of function and mechanism in medicine and medical science, and Engelhardt HT. The concepts of health and disease, with commentary by Kopelman L.)
- Engelhardt HT, Spicker SF, eds. *Health, disease and causal explanations in medicine*. Dordrecht and Boston: Reidel, 1984.
- Beauchamp TL, Walters L, eds. *Contemporary issues in bioethics*. Encino and Belmont, California: Dickenson, 1978. (Especially Kass LR. Regarding the end of medicine and the pursuit of health: 99-108, Engelhardt HT. The disease of masturbation: values and the concept of disease: 109-13, and Sedgwick P. What is illness? 114-9.)

- Journal of Medicine and Philosophy* 1976;1:201-80. (Monothematic issue on health and disease, especially Margolis J. The concept of disease: 238-55 and Redlich FC. Editorial reflections on the concepts of health and disease: 269-80.)
- Journal of Medicine and Philosophy* 1984;9:231-59. (Especially Hawkins A. Two pathographies: a study in illness and literature: 231-52, with commentary by Hudson-Jones A: 257-9, and Shelp EE. The experience of illness: integrating metaphors and the transcendence of illness: 253-6.)
- Sontag S. *Illness as metaphor*. Harmondsworth: Penguin, 1977.
- Dubos R. *Mirage of health*. London: George Allen and Unwin, 1960.
- Mitchell J. *What is to be done about illness and health? Crisis in the eighties*. Harmondsworth: Penguin, 1984.
- Engelhardt HT, Spicker SF, eds. *Mental health: philosophical perspectives*. Dordrecht and Boston: Reidel, 1978.
- Edwards RB, ed. *Psychiatry and ethics*. Buffalo: Prometheus Books, 1982. (Various relevant papers on the concepts of mental health and disease, especially Szacz TS. The myth of mental illness: 19-28, Edwards RB. Mental health as rational autonomy: 68-78, and Engelhardt HT. Psychotherapy as metaethics: 61-7.)
- Foucault M. *Madness and civilisation—a history of insanity in the age of reason*. London: Tavistock Publications, 1967.
- Szacz T. *Ideology and insanity*. London: Penguin, 1974.
- Journal of Medicine and Philosophy* 1977;2:191-304. (Monothematic issue on mental health.)
- Journal of Medicine and Philosophy* 1980;5. (Monothematic issue on social and cultural perspectives on disease, especially Young A. An anthropological perspective on medical knowledge, and Unschuld PU. Concepts of illness in ancient China: the case of demonological medicine.)
- Hastings Center Studies* 1973;1(3). (Issue on the concept of health.)
- Journal of Medicine and Philosophy* 1985;4. (several articles on diseases and maladies.)

Occupationless Health

Training and "work" for the unemployed

RICHARD SMITH

People look to work for both money and a purpose, a sense of achievement, a time structure to the day, social contact outside the family, regularity, and social status.¹ Traditionally, a good full time job for life has met all these requirements, but for many people it may never do so again. As Handy has explained, not only has unemployment increased but also the nature of employment has changed.² A generation ago people would expect to work for 100 000 hours in a lifetime (47 hours a week for 47 weeks a year for 47 years), but now even those with jobs are down to 50 000 (37 hours a week for 37 weeks a year for 37 years). Some professionals may adopt yet another pattern and work long hours for fewer years, and some others—pop singers or sports stars—may work round the clock for just a few years.

But, Handy argues, in the 50 000 hours that people today have "spare" compared with their parents they will often be doing different sorts of work—unpaid work that will save them spending money (doing up the house), looking after dependants, working in the community, pursuing "hobbies" to "professional" standards. Maybe then these important categories of work that are still not regarded by many people as "proper work" will come to be more valued. Unemployment, meaning not having a paid job, might then come to be less painful and unhealthy if those without jobs found satisfaction in unpaid work and at the same time had an adequate income. Right now, however, this prospect seems rather far away as the unemployed feel unwanted and stigmatised, and their income is almost always much lower than when they had work.

This article will consider what is being done to help the unemployed find the satisfaction in their lives that has traditionally been found in paid employment, and the next will consider how their incomes might be increased.

The Manpower Services Commission

Much is already being done to try to provide work and training for the unemployed, particularly the young unemployed, but the various programmes run by the Manpower Services Commission are not nearly as well known as they should be.³ In their survey of social workers, health visitors, and health education officers in Scotland and the Midlands Popay *et al* found that knowledge of local initiatives funded by the Manpower Services Commission was very limited, especially among health professionals.⁴ Yet the commission is in its second decade and in 1984-5 was operating 4000 youth training schemes for almost 400 000 youngsters as well as running many other programmes.

The aims of the commission are to "promote a more efficient labour market and competitive workforce" and to "help those at disadvantage in the labour market to overcome their employment problems." The youth training scheme is the largest single item in its budget, absorbing almost £800m in grants in 1984-5. The rhetoric of the scheme is that it is not a way of reducing youth unemployment but rather of "providing a permanent bridge between school and work." If this is its aim then it is not doing awfully well because in October 1985 only 48% of those emerging from the scheme were entering full time or part time work; a few were returning to full time education, and 9% were starting another youth training scheme, but 38% were going straight on to the dole.⁵ Generally, as youth unemployment has risen the proportion of those emerging from the scheme and finding jobs has fallen.

The scheme aims at providing not only work experience but also training, and it is intended that some of the entrants to the scheme will already be in employment. In 1984-5 about 60% of 16 and 17 year old school leavers started on the scheme, which was rather less than expected. This was because more school leavers got jobs than had been predicted, more stayed at school, and 20 000 youngsters opted not to join the scheme. (Some young people are hostile to these schemes, labelling them slave labour—the training allowance has been £27·30 but is being raised to £35 a week.) There are three

strands to the scheme and each currently is supposed to last for a year: mode A caters for the unemployed and employed, is led by employers, and offered work experience to 284 000 young people in 1984-5; mode B1 is only for the unemployed and last year offered experience with voluntary organisations, local authorities, and private sector sponsors to 88 900 young people; and mode B2 caters for the unemployed and has put 16 000 young people into schemes run by "linked providers," largely colleges of further education and employers.

The youth opportunities programme got something of a bad name for often failing to supply training or useful experience, and the youth training scheme is an attempt to mend these deficiencies. Evaluation is difficult and the scheme is still only young, but the quality is widely agreed to be patchy. Hearst argues that little serious evaluation is being attempted: "Most training managers think that just to get trainees into jobs is an achievement. No attempt is being made to find out what jobs, how long their ex-trainees stay, and whether they are still being trained by their employer."⁵ Furthermore, most trainees stayed only 35 weeks on average on their year long scheme. Yet the government is making money available to increase the programme to a two year scheme, and costs will rise to £1.1 billion.

The Archbishop of Canterbury's commission on urban priority areas confirmed its strong support both for the Manpower Services Commission in general and for the youth training scheme in particular.⁶ It was long overdue, the commission thought, that the effective age of starting work in Britain became 18, which is what the two year training scheme will mean. But the commission was disappointed that so few of those who emerged from the scheme got jobs, and it received evidence that the proportion was even lower in inner cities. Evidence was also given that young black people had great difficulty in getting on to mode A schemes.

The community programme for the long term unemployed

As well as increasing funding of the youth training scheme the government is also to make more money available for the community programme, which is the main scheme operated by the Manpower Services Commission for helping the long term unemployed. Temporary employment is offered on "projects of community benefit that would not otherwise be done," and participants are paid "a going rate" for the job. But as the commission is allowed to pay £63 only a week for an ordinary worker this means that 72% of the jobs are part time. It also means that single young people are more likely than people with families to join the scheme, and the Archbishop of Canterbury's commission wanted the pay limits relaxed for those with families.⁶ The scheme is open to those who have been unemployed for the past two months

and—for those aged 18-24—six of the past nine months, and—for those aged over 25—12 of the past 15 months. Since October 1984 applicants must also be in receipt directly or indirectly of a state benefit, which reduces the range of those eligible—and in particular makes it difficult for women to join. Both the Manpower Services Commission itself and the Archbishop of Canterbury's commission wanted the eligibility rules changed.

In 1984-5 about 161 000 people participated in the programme, about 12% of those who have been unemployed for more than a year. The plan is to expand places on the programme to 230 000 by June 1986, although the latest predictions are that it will fall short by about 10 000 places.⁷ A follow up, which not surprisingly was uncontrolled, showed that eight months after leaving the programme about a third were employed and 5% were in training.³ The commission hopes to improve the quality of the programme and in particular increase the amount of training that participants receive.

The Archbishop of Canterbury's commission favoured the community programme but wanted it expanded.⁶ It also heard many criticisms, particularly of how shattering it is to be thrown back on to the dole after a year on the programme. Many people also complained to the commission that the training component of the programme was inadequate. Finally, the commission thought that the programme should give priority to social services and improving inner city housing. The commission also pointed out that although the programme might help with the non-financial miseries of unemployment it does nothing for the overwhelmingly important financial aspect.

The Manpower Services Commission runs three other schemes specifically for the unemployed, and all four schemes together helped 278 000 people in 1984-5, about 9% of the unemployed. The enterprise allowance scheme helps unemployed people start their own businesses (by providing an allowance of £40 a week for up to 52 weeks), and demand has been high—about 46 000 people, a fifth of whom were women, were helped in 1984-5. The scheme is now being expanded to help 80 000 people. Research by the commission has shown that for every 100 businesses set up 50 extra jobs are created, and of the first 500 people who took advantage of the full 12 month allowance 60% were still trading three years later.⁸

The voluntary projects programme allows unemployed people to undertake voluntary work without their state benefits being affected, and the community industry scheme helps young people who are "personally or socially disadvantaged" by providing up to a year of work of benefit to the community.

Job centres can thus offer the unemployed a range of possibilities: a full or part time job (and the number of people working part time is increasing); a place on a full time or temporary work programme; a place on a training scheme or an assessment course; or support in becoming self employed.⁹ Some job centres also now offer job clubs where long term unemployed people can meet and help each other

Characteristics of selected Manpower Services Commission programmes

Programme	Youth training scheme	Community programme	Enterprise allowance scheme	Voluntary projects programme
Places in 1984-5	389 400	132 800	46 000	280 projects (63 000 volunteers)
Cost 1984-5 (£m)	849.5	534.3	80.1	9.9
Available to	All 16 year old school leavers Unemployed 17 year old leavers All disabled under 21	Unemployed for previous two months plus (if between 18 and 24) at least six of last nine months or (if 25 or over) 12 of the last 15 months; must be in receipt of state benefit	Unemployed for 13 weeks or under notice of redundancy for 13 weeks; must have £1000 (usually easily borrowed)	Unemployed people
Duration	One year	One year	One year	One year
Work and training provided	Work and training with private employers, voluntary organisations, local authorities, colleges of further education. Includes 13 weeks "off the job" training	Work on "projects of community benefit that would otherwise not be done"	Allowance of up to £40 a week to start own business	Work on voluntary projects that bring new skills and develop old ones
Payment	£27.30	Up to £60.00 per week		No payment, but state benefits not affected
"Results"	48% get full or part time work; 9% start another scheme; 38% back into unemployment	40% find a job in the next 12 months	100 businesses create 50 extra jobs; 60% of businesses still trading after three years	
Planned expansion	Scheme being increased to two years; cost up to £1.1 billion	To 230 000 places by June 1986; cost £711	Places being increased to 80 000; period of qualification reduced to 8 weeks	Budget being increased to £12m; greater emphasis to be placed on education, training, and community work

Left: Schoolchildren watch a puppet show used in the South Sefton dental health education programme created by unemployed people on the community programme (copyright Sefton Newspapers Ltd). Right: An unemployed man on the community programme works with handicapped children at a Scottish adventure playground (MSC crown copyright).

to find work. Thirty people meet for three hours four days a week and must apply for at least 10 jobs each day. Pilot schemes have shown that 70% of the members of the clubs find work, and the commission is now aiming at increasing the number of clubs to 200.

Health authorities and the Manpower Services Commission

Many of these schemes are not nearly as well known as they should be, and certainly health authorities and doctors do not seem to know much about them, although there have been isolated examples of health authorities,^{10,11} general practitioners,¹² and family practitioner committees¹³ taking on people through the schemes. The National Health Service is the biggest employer in Western Europe and is still far from meeting all health needs; yet only 0.5% of places on the community programme are taken up by health authorities compared with 45% by local authorities—and 60% of the NHS take up is by four Merseyside authorities. Victor Paige, the chairman of the NHS management board (and previously a Manpower Services commissioner), has written to all regional health authority chairmen drawing attention to the low take up.

The health services management unit at Manchester University is conducting some research into why the uptake has been so low. Professor Gordon Forsyth, its director, says that the data have not yet been analysed sufficiently to come up with an answer, but he suspects that some authorities may have met resistance from trade unions, although, as he points out, these are often the same unions as have cooperated with local authorities. Another difficulty may be that authorities do not think that they have the managers spare to supervise the schemes, while a general preoccupation with the implementation of the Griffiths plan for reorganisation may have kept administrators' minds on other matters. Perhaps, Professor Forsyth suspects, the main reason is that few individual managers have had any commitment to such schemes.

But, by taking on more people under the many schemes operated by the Manpower Services Commission, health authorities and individual doctors could not only get more done but they could help raise the health and morale of those they take on—and their families.

South Sefton shows the way

An excellent example of what can be done comes from South Sefton Health Authority, where more than 250 long term unemployed people are being used to staff a large health promotion programme, give dental education,^{10,11} undertake a community

survey of health behaviour, provide a day and night sitting service, and maintain security in the authority's hospitals. This considerable scheme (almost certainly the largest in the NHS) has grown up over five years and has needed careful and intensive management. It is now serving as an inspiration to start other such schemes, and Dr Hilary Hodge, the dentist who started it all, believes that the main impediment to there being more such schemes is a professional attitude that does not accept that long term unemployed people can manage such work. Dr Hodge has, however, produced controlled evaluations of her original dental health education schemes which show that they have worked.¹⁴

Dr Hodge began the scheme in a small way five years ago when she arrived in South Sefton with the responsibility for developing dental health and found that she had few staff and resources. As she says, "You need people to educate other people." So she looked round and came across the Manpower Services Commission's youth opportunities programme. She took on 10 young people, many of whom were alienated, low achievers, and depressed, and had low self esteem. With careful and gentle supervision these young people were turned into health workers. Their first exposure was to children in a preschool playgroup, and with them they gained confidence.

Next Dr Hodge took on 11 long term unemployed adults, many of whom were teachers and other professionals, and with them she produced dental health education packages. These were developed, implemented, and tested and are now used by other health authorities. About 40% of those who worked on the scheme subsequently got jobs, and eight have gone on to train as health education officers. It was a year ago, still under the supervision of Dr Hodge, that the range of services provided by these unemployed people expanded, and in the past few months many other health authorities have become interested. Dr Hodge emphasises the importance of starting small and working hard with the participants and their supervisors because things can go wrong. The participants' motivation must be maintained, or they begin to think that they are being fobbed off with jobs "that are not proper jobs."

The real beauty of these projects is that they have helped not only the unemployed but also the employed of South Sefton. Other health authorities have developed schemes—for instance, Haringey Health Authority has used unemployed people as interpreters—and so have some family practitioner committees and even some individual general practitioners. Redbridge and Waltham Forest Family Practitioner Committee took people on the youth training scheme and trained them as receptionists¹³ and some individual general practitioners have also trained unemployed young people as receptionists.¹²

Together with the Health Education Council Dr Hodge

and others from South Sefton are producing a guide on how health authorities and individuals can use the Manpower Services Commission community programme. *Medeconomics* has already published a brief guide for doctors on how to use the commission,¹² but any doctor interested should be able to get help from his or her local job centre.

Leisure and work sharing

Working days, weeks, years, and lives are becoming progressively shorter, but these changes have not been associated with any widespread increase in sharing out the paid employment available. Too often reduced working weeks, rotating periods of worklessness, and early retirement have occurred in industries that are hard pressed, and, as the Unemployment and Health Study Group says, have been a means for sharing out miseries rather than benefits.¹⁵

Work can be shared in a variety of ways. One possibility is for two people to do one job between them, and this is happening in many sectors—including health. Often it is married women with children who share, but GEC, concerned by high unemployment among young people around its plants, offered split starter jobs.¹⁶ The new recruits worked half time and received half wages, and spent the rest of their time in voluntary training or further education. If one partner was ill or on holiday then the other would work full time, meaning that the employers could always be sure of somebody to do the job. When, as happened, the industry picked up the half timers became full timers, which again was advantageous to the employers because they had trained people available immediately.

Sabbaticals are a second way of sharing work, and although familiar to some academics are almost unknown in the rest of Britain. They, too, might benefit both employee and employer if intelligently used because often those on sabbaticals will use the time to learn new skills at a time when many are finding their traditional skills inadequate for their changing jobs. Shorter working weeks and working days are likely to benefit the health of the employed and their families as well as that of the unemployed and their families if the work goes to the unemployed. The same applies to longer holidays. Early retirement is a phrase that strikes terror into some because it has too often been a way of concentrating unemployment among psychologically and financially unprepared older workers. But it need not be like that.

All of these trends could be encouraged by governments making grants to support job sharing, legislating to limit working hours and guarantee longer holidays and a right to part time work, and adjusting pension rules so that it could be easier to take sabbaticals and retire early in financial security.¹⁷ Such measures would need to be accompanied, Watkins argues, with measures to increase leisure possibilities—for example, support for sports facilities, education programmes, and increased rights of access to the countryside.

Conclusion

I hope that it comes through clearly from this article that organisations and individuals can do a great deal to reduce the misery of unemployment by pointing unemployed people towards these many schemes and by using them on projects of their own. Doctors may not think that it is any part of their job to help find work for the unemployed, but when the evidence is so strong that unemployment harms health it seems to me that it should be. And the most exciting thing of all is that the unemployed can be used on projects to help raise health standards in the doctor's community. A glance through two issues of *Community Programme News* shows all sorts of imaginative projects related to health^{18 19}: unemployed people are being used in health education, to help mentally handicapped children and other disabled people, to improve communications for the deaf, to man a helpline, and in campaigns against hypothermia.

But it must be remembered that the programmes of the Manpower Services Commission are not offering proper full time jobs

and neither are they offering a living wage. The next article will consider benefits for the unemployed.

References

- 1 Jahoda M. *Employment and unemployment*. Cambridge: Cambridge University Press, 1982.
- 2 Handy C. The intense job life, working very hard and retiring very early, is the thinking behind the "shamrock organisation." *The Times* 1986 January 9:29.
- 3 Manpower Services Commission. *Annual report 1984-1985*. Sheffield: MSC, 1985.
- 4 Popay J, Dhooze Y, Shipman C. *Unemployment and health: what role for health and social services?* London: Department of Social Sciences, Polytechnic of the Southbank, 1985.
- 5 Hearst D. A teenage revolution that failed at work. *Guardian* 1985 July 3:11.
- 6 Archbishop of Canterbury's Commission on Urban Priority Areas. *Faith in the city: a call for action by church and nation*. London: Church House Publishing, 1985.
- 7 Felton D. Expansion of aid for young. *The Times* 1986 Jan 16:5.
- 8 Felton D. The politics of unemployment: 2. "Let enterprise flourish" is ministerial aim. *The Times* 1986 Dec 31:2.
- 9 Felton D. The politics of unemployment: 3. Scheme to tackle long term jobs crisis. *The Times* 1986 Jan 2:4.
- 10 Hodge H. Manpower for dental health. *Health and Social Services Journal* 1985 May 30:676-7.
- 11 Hodge H, Griffiths BB. Dental health education and the Manpower Services Commission youth training scheme. *Health Education Journal* 1985;44:124-7.
- 12 Law J. Take on staff at no cost. *Medeconomics* 1982; December: 47-51.
- 13 Kirby J. GPs help train young jobless. *Medeconomics* 1983; December: 49-51.
- 14 Hodge H, Buchanan M, Jones J, O'Donnell P. The evaluation of the infant dental health education programme developed in Sefton. *Community Dental Health* 1985;2:175-85.
- 15 Unemployment and Health Study Group. *Unemployment, health and social policy*. Leeds: Nuffield Centre for Health Service Studies, 1984.
- 16 Williams S. *A job to live: the impact of tomorrow's technology on work and society*. Harmondsworth: Penguin, 1985.
- 17 Watkins SJ. Recession and health—the policy implications. In: Westcott G, Svensson PG, Zollner HFK, eds. *Health policy implications of unemployment*. Copenhagen: World Health Organisation Regional Office for Europe, 1985.
- 18 *Community Programme News* 1985 November.
- 19 *Community Programme News* 1986 January.

Are there any known hazards associated with repeated exposure to domestic oil based paints?

Oil based domestic paints are complex mixtures of chemicals that usually include binders (resins, linseed oil, rubber derivatives), pigments (metallic oxides, salts of cadmium, chromium, or iron), solvents (a wide range of hydrocarbons including alcohols, esters, ketones, and glycolic ethers), and, sometimes, additives such as fungicides, drying agents, and plasticisers. Reports on the hazards of chronic domestic exposure to paints is sparse. Although most constituents theoretically may be harmful, in practice the common hazards arise from solvent inhalation, eye splashes, and skin contact. In addition, most solvents are flammable. Although the question does not specify "manufacturers" or "users," the risks are probably similar for both groups. Solvent intoxication may cause headache, eye and respiratory tract irritation, dizziness, nausea, and, arguably, long term psychological sequelae.¹ Skin contact with paints may cause a primary contact eczema; sensitisation is rare. Solvent inhalation is best prevented by adequate ventilation. In the factory local exhaust ventilation may be used; in the home windows should be opened to provide adequate general ventilation. Skin contact and eye splashes can be minimised by proper training, work practices, and good housekeeping. Eye protection is recommended, especially when working overhead, but vision may rapidly be obscured by paint splashes on glasses. Paints should not be "handled" unless solvent impermeable gloves are worn. Paint should be removed from the skin with a proprietary cleanser, not industrial solvents. The usefulness of barrier creams is questionable.—W R LEE, professor, and A R SCOTT, lecturer, in occupational health, Manchester.

- 1 Rasmussen H, Olsen J, Lauritsen J. Risk of encephalopathy among retired solvent-exposed workers. *J Occup Med* 1985;8:561-6.

In a patient who has to avoid salicylates what fruit is allowed?

There are considerable doubts about the value of a diet that is low in salicylates. The amounts present in food are unlikely to provoke any symptoms, even in individuals who have a clear history of reacting to acetyl salicylic acid or other aspirin like drugs.¹ The traditional "low salicylate diet," for which beneficial effects were claimed, contained several errors. Recent studies have shown that many types of soft fruit (plus pineapple) have a high salicylate content, as have tea, spices, mint, honey, liquorice, and cucumber.² Some fruits, including apples, pears, bananas, peaches, mangos, and lemons are low in salicylates.—M H LESSOF, professor of medicine, London.

- 1 Ormerod AD. Food sensitivity. *Br Med J* 1985;291:1353.
- 2 Swain AR, Dutton SP, Truswell AS. Salicylates in foods. *J Am Diet Assoc* 1985;85:950-60.