



Health of older women in employment

Introduction

The age of qualification for state pensions is increasing in both the Republic of Ireland (ROI) and Northern Ireland (NI). The aim of the policy change is to create a sustainable state pension system given the rise in life expectancy. However, it is important that policymakers fully understand and take account of the health impact of introducing longer working lives especially for those in caring roles.

This edition of the CARDI "Focus on" series looks at older women in employment.

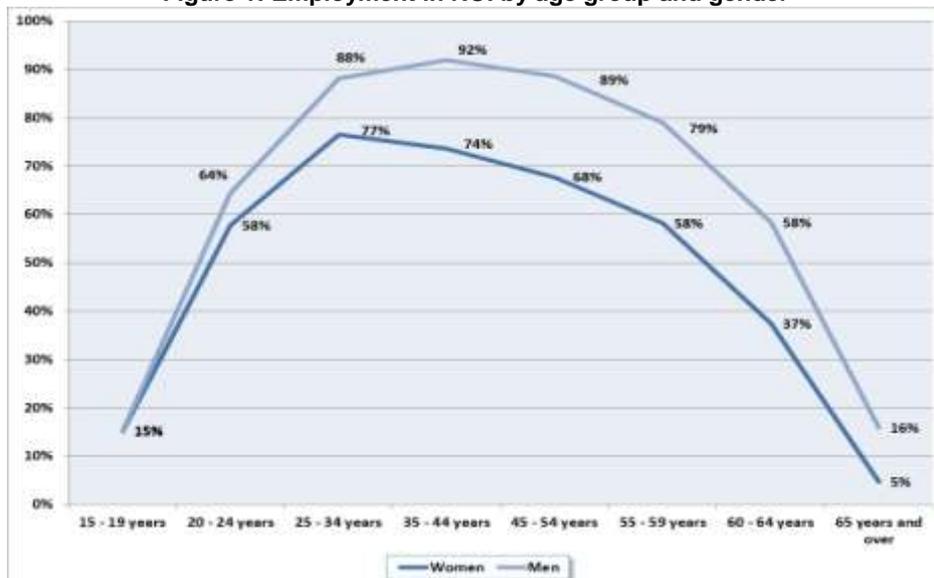
Key findings

- By 2028, the age of qualification for the state pension will be 68 for women in ROI (Department of Social Protection, 2012) and 67 for women in NI (Department for Work and Pensions, 2011).
- Older women are more at risk for work-related health issues than those in younger age groups (Health and Safety Executive, 2008).
- Women are more likely than men to work part-time, are more likely to be in low-status jobs and women earn less than men (Payne & Doyal, 2010)
- The health and well-being of women in employment is affected by factors such as caring responsibilities, income and age (Payne & Doyal, 2010).
- There is a link between hours of unpaid care and employment, with women aged between 16-64 who provide up to 14 hours of care per week having an employment rate of 71% compared to 38% for those who provide more than 43 hours of unpaid care per week (Care Alliance Ireland, 2013).
- Consideration of the impact of longer working lives on health and well-being has been virtually absent in policy discussions (Corna, 2014).

Older women in Employment

In ROI, employment for women peaks at 77% for those aged 25-34. 58% of women aged 55-59 are in employment, reducing to 37% of those aged 60-64 and 5% of those aged 65 and over.

Figure 1: Employment in ROI by age group and gender

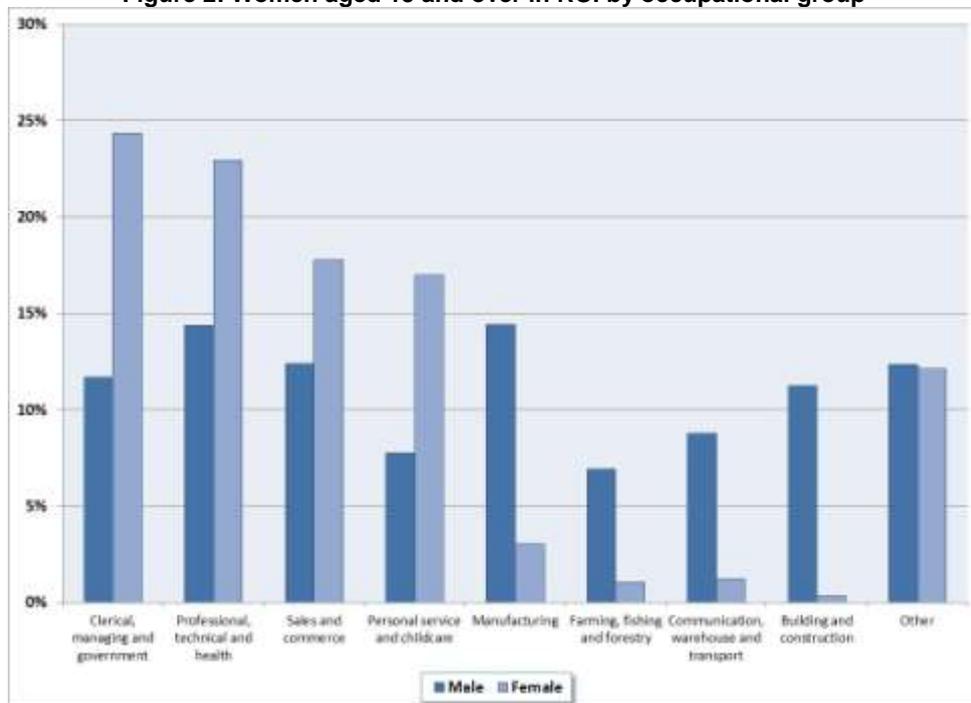


(Central Statistics Office, 2014)

The workforce of women over the age of 45 in ROI has more than doubled since 1998 – standing at 325,000 in the first quarter of 2015 compared to 134,000 in the first quarter of 1998 (Central Statistics Office, 2015).

Most women employed in ROI are in four occupations – “clerical, managing and government”, “professional, technical and health”, “sales and commerce” and “personal service and childcare” (Central Statistics Office, 2012).

Figure 2: Women aged 15 and over in ROI by occupational group

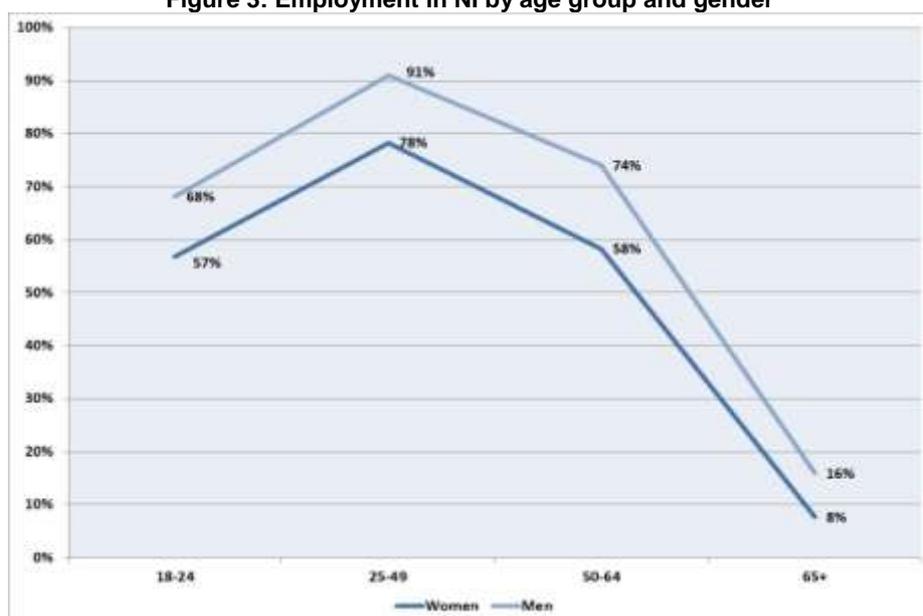


Source: (Central Statistics Office, 2012)

Among women aged 55 and over in ROI, 14% are clerical or office workers, 13% are personal service or childcare workers and 11% work in sales occupations (Central Statistics Office, 2012).

In NI, 57% of women aged 50-64 are in employment compared to 6% over the age of 65. The pattern of employment for men by age group is similar with 74% of men aged 50-64 in employment and 16% of men aged over 65 in employment (Department of Enterprise, Trade and Investment, 2015).

Figure 3: Employment in NI by age group and gender

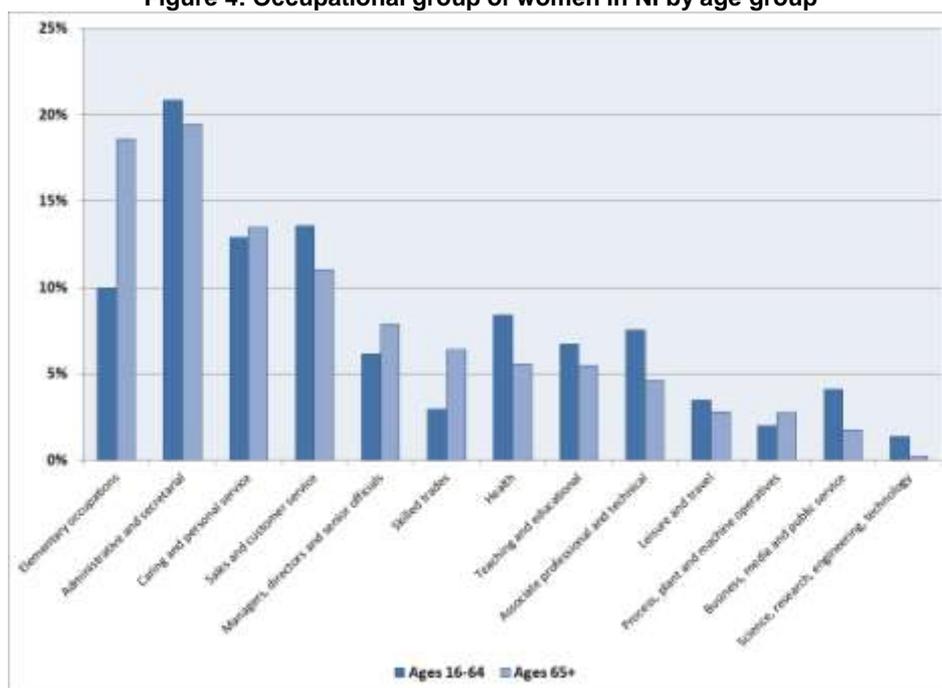


Source: (Department of Enterprise, Trade and Investment, 2015)

As in ROI, there has been a large percentage increase in the number of older women at work in NI. In the first quarter of 1998 there were 51,000 women over the age of 50 in employment compared to 108,000 in the first quarter of 2015 (Department of Enterprise, Trade and Investment, 2015).

Older women in paid employment in NI (those over the age of 65) tend to work in administrative and secretarial roles, caring and personal service, or elementary occupations¹.

Figure 4: Occupational group of women in NI by age group



Source: (NISRA, 2012)

Employment and health

Health has an influence on whether or not people are in paid employment. For example in the TILDA study, 52% of women aged 50+ in excellent, very good or good health were in paid employment but just 30% in fair health and 9% in poor health were employed (TILDA, 2011). In a 2006 study of ill-health and retirement in Britain adverse shocks to individual health predicted retirement behaviour among workers aged from 50 until state pension age (Disney et al., 2006).

However, the actual impact of employment on health and whether or not the impact is positive or negative, is not fully understood. Table 1 summarises some of the potential impacts for older women.

Table 1: Impact of employment on older women

Positive impact	Negative impact
Financial rewards	Occupational health risks (physically demanding jobs)
Self-esteem	Domestic labour
Independence	Care of dependents
Network of social support	Stress / psychological distress

Source: (Doyal & Payne, 2006), (Payne & Doyal, 2010)

¹ Defined by the International Labour Organization as “simple and routine tasks which mainly require the use of hand-held tools and often some physical effort” and include cleaning, washing and packing.

While there can be positive and negative impacts of employment for older women the nature of the benefits will depend on conditions such as pay, job flexibility, status and other issues such as access to transport. If a job was physically difficult, carried out in isolation, came with low pay and was difficult to get to, there would be fewer opportunities for positive health benefits (Payne & Doyal, 2010).

The 2010 Marmot review of health inequalities noted that while work is good and unemployment is bad for health quality of work matters and low-paid and insecure work can be damaging to health (Marmot, 2010).

A 2000 study indicated that older women report that employment helps to keep their mind and body active and generates a feeling of contributing something of value to society (Doyal, 2000).

Women are more vulnerable than men to some conditions associated with biological difference. Examples include arthritis and other autoimmune diseases and osteoporosis. Therefore, some forms of paid work especially those that involve repetitive movement are likely to affect women differently (Payne & Doyal, 2010).

Although men are more likely to be regularly exposed to physical risks at work than women, women are more likely to be exposed to infectious materials and physical risks associated with lifting or moving people, due to the number of women working in health and social care (Eurofound, 2012).

Older women are more at risk of work-related health issues than those in younger age groups. Figures from the Health and Safety Executive for the UK show a prevalence rate of 3,590 per 100,000 for women aged 55–59 for musculo-skeletal disorders caused by or made worse by work, and the rate for women aged 60–74 was 3,660—three times the prevalence rate among women aged 16–24. The same data show that over half of all cases of work-related anxiety and depression, and 43% of cases of work-related stress, were experienced by employed women aged 45 and over (Health and Safety Executive, 2008).

The impact of longer working lives

The impact of employment on health and well-being is affected by factors such as caring responsibilities, income and age (Doyal & Payne, 2006). This section examines the potential ramifications of longer working lives for older women in each of these three areas.

Caring responsibilities

With the right support, resources and information, caring can be a very rewarding experience with positive impacts on the carer (Care Alliance Ireland, 2013). However, caring responsibilities have an impact on employment particularly where the care recipient requires an intensive amount of care.

Women carry out more hours of unpaid care and domestic labour than men. There is a link between hours of unpaid care and employment with women aged between 16-64 who provide up to 14 hours of care per week having an employment rate of 71% compared to 38% for those who provide more than 43 hours of unpaid care per week (Care Alliance Ireland, 2013).

There is evidence that caring for a relative or loved one can also influence the decision to leave the workforce. An ROI survey of carers providing care to an individual with dementia found that while 63% of respondents were below retirement age half had stopped working in order to care. Of those in full-time employment, 61% had reduced their working hours and 71% of carers in part-time employment had reduced their weekly working hours to below 20 (Care Alliance Ireland, 2013).

A survey of full-time employed family carers in the US showed that higher physical and mental efforts were correlated with the number of hours of care given and the intensity of care required by the recipient. Employed caregivers with a high mental effort and workload in caring were more likely to have poorer self-assessed health and depressive symptoms. The risks were higher for daughters and women who lived with their care recipient. The study also showed that carers who had no family or formal care giving help were under greater mental strain and had higher rates of depression (Juratovac & Zauszniewski, 2014).

Schneider et al. (2013) showed that time conflicts between unpaid care and employment affected job change intentions of female workers but not males. Men who intended to leave their jobs were influenced more by a physical health issue. The same study showed that flexible work arrangements were found to facilitate the attachment of female workers to their jobs and the labour market (Schneider et al., 2013).

Income

Older women are more likely to be in lower-paid jobs which can also have an impact on the health benefits of work. Women are more likely than men to work part-time. They are more likely to be in low-status jobs and women earn less than men (Payne & Doyal, 2010). Having a low-status job with little control over working hours and conditions increases stress and this burden disproportionately affects women (European Agency for Health and Safety at Work, 2015). Women also work more often in the informal economy where there is no protection in terms of health and safety or job security (Payne & Doyal, 2010).

Older women seeking employment often find opportunities limited to low-wage jobs such as those in retail (Frank-Miller, Lambert, & Henly, 2015). The gender division of labour means women are more often in jobs that are lower paid and lower status - in the health services for example they are likely to be cleaners, ward staff, nurses and ancillary workers (Payne & Doyal, 2010). Older women may also be obliged to work longer in the absence of an adequate pension. According to Duvvury et al. (2012) fear of an inadequate income in retirement may lead to many women working longer out of economic necessity.

Income inequalities are linked to health inequalities in that both men and women who have worked in lower grade, manual occupations in their working lives are more likely to be financially disadvantaged in later life and arrive at retirement age in poorer health than their counterparts who have enjoyed careers in professional occupations (Corna, 2014).

Age

In ROI the age of entitlement to a state pension rose to 66 in 2014. It is due to rise again to 67 in 2021 and 68 in 2028 (Department of Social Protection, 2012). The pensionable age is also changing for women in NI. It will rise to 63 in 2016, 65 in 2018, 66 in 2020 and 67 in 2028 (Department for Work and Pensions, 2011).

The average age of those exiting the workforce among women in ROI is 62.6 years compared to 64.6 years for men. In the UK, the average retirement age among women is 63.2 years and 63.7 years for men (OECD, 2012).

However, despite the rise in age of entitlement to the state pension the majority of women in both ROI and NI expect to retire before or at 65. According to TILDA data in ROI, 36% of women employees over 50 expect to retire at age 65, 26% plan to retire before 65, 10% plan to work beyond 65 and 16% do not plan to retire (TILDA, 2011). Similarly in NI, 58% of women (of all ages) hope to retire before or at 65, while 25% want to keep on working into later life (Compton, 2014).

Policy implications

Consideration of the gender implications of longer working lives for health and well-being has been virtually absent in policy discussions (Corna, 2014). For example in ROI, the 2007 Green Paper on Pensions published by the Department of Social and Family Affairs discussed the policy, legal and cultural barriers to increasing the state pension age but not the health barriers (Department of Social and Family Affairs, 2007).

In addition, feminist theories of ageing suggest that unpaid care, whether it is of children, parents or other family members, is not valued for pension purposes. Kodar (2012) suggests that women's financial security in retirement is still largely defined by their history as a wage earner or their attachment, by way of the household, with a wage earner. This is important as financial security in older age is the main reason why older women may be forced to stay working even in poor health or in physically demanding jobs (Kodar, 2012).

Republic of Ireland

The National Pensions Framework, published in 2010, outlines the government strategy for the state and private pension systems. It states that a key objective is to maximise the participation of older people in education, employment and other aspects of economic and social life. While the framework states that participation of older people in employment will be encouraged and facilitated it does not address health issues among lower-paid workers (Department of Social Protection, 2010).

In the Positive Ageing Strategy published in 2013, the objective for employment is to remove barriers to continued employment and training while developing a wide range of employment options including options for gradual retirement (Department of Health, 2013).

The National Carers' Strategy for ROI has a central objective of enabling carers to remain in touch with the labour market to the greatest extent possible. This includes access to education and training for re-entering the labour market and home care and community care services to enable the carer to work (Department of Health, 2012).

Northern Ireland

A consultation for the *Active Ageing Strategy 2014-2020* was conducted in 2014 in NI. The full strategy is due to be published in 2015. The consultation draft notes the importance of flexible working conditions for older workers, including the introduction of part-time work. As in ROI, health considerations of older workers particularly those who are also carers are not taken account of in the draft strategy (OFMDFM, 2014).

The *Fit and Well – Changing lives* public health strategy for NI which was published for consultation in 2012 notes that “Good employment is protective of health whilst insecure work or adverse working conditions can impact negatively”. The consultation also notes that caring can have a negative health impact and carers often neglect their own needs. However, the draft strategy does not make provision for older women who are carers or are working in low-paid jobs who must work for longer (DHSSPS, 2012).

Caring for Carers, the NI carers’ strategy, was published in 2006. It recommends a programme of work to promote the adoption of good practice in carer-friendly employment and access to training for carers returning to work (DHSS&PS, 2006).

Policy solutions for older workers

There are a number of policy steps that could be taken to better facilitate employment of older workers. While not gender-specific, full implementation could have a positive impact on the health of older women at work in ROI and NI.

Lifelong learning and building the skills of older people can help older workers to obtain better paid jobs as well as helping older adults seeking employment to find a better quality of job with less exposure to health risks (Breen, 2010). Greengross (2010) suggests that structural employment changes such as job-sharing, flexi-time and reduced hours can facilitate continuing employment among older workers.

Denmark has seen some success in introducing “light jobs” for employees with diminished work capacity. There is a senior scheme which offers reduced working hours to older workers (Andersen & Mailand, 2005).

Ilmarinen (2006) suggests that active ageing in the workplace requires reform in four areas: attitudes toward ageing must be changed; the awareness of managers and supervisors in age-related matters needs to be improved; better age and life course-adjusted and flexible working life is needed; and, healthcare systems must be reformed to meet the needs of older workers.

Conclusion

Older women are more likely than men to be employed in lower paid and part-time jobs and are more likely to be balancing caring duties with employment. Given these circumstances, extending the working age for older women may exacerbate income and health inequalities. While more flexible conditions for older workers and support for carers who are also in employment are essential, it is also important that policymakers fully understand and take account of the health impact of introducing longer working lives for older women.

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