

## **The Older Learner, Health, Education and Work**

### **Introduction**

In this paper I aim to examine the links between work, education and health in the older person. For purposes of this paper the term older person refers to persons of working age usually between the ages of 50 and 65. Although the links are at times tenuous at other times they prove to be very strong. Much has been researched about the correlation of these life streams and I will explore the literature to try to understand some of the inter-relationships between our working lives, our educational achievements and how these impact upon an individual's health, wellbeing and longevity.

Over the past 50 years there has been a drastic change in the demographics of the United Kingdom. In 1951 there were 13.8 million people aged 50 and over by 2001 there had been a significant increase in this number to 20 million and it is predicted that these numbers will increase to 27.2 million by the year 2031 (ONS, 2005a). With the increase of seniors within the population in most countries in the world, a 'greying' of the workforce has been seen with the average age of employees increasing (Auer and Fortuny 2000). Until recently the United Kingdom's response to this was to encourage older workers to take early retirement. Recently however, the fear of a dependency crisis brought about by increased cost of pensions and healthcare has seen the UK have a reversal of policy on retirement. Older workers are now encouraged to remain in the workplace for much longer (Loretto et al 2005). With this rise in the older workforce their role within workplace is changing rapidly. As people live longer they will inevitably work for longer whether for socio economic reasons or social policy reasons. For example, the increase in the state pension age. A health divide has been developing in the UK with some individuals experiencing multiple health problems whilst others live active healthy lives well into old age. The current Government's aspiration is to achieve an 80 per-cent employment rate which includes an extra one million older people aged over 50 in the workforce and moving another million off incapacity benefit into

work (TAEN 2007b). With a projected decline in a million people in their 20s from the workforce the adaptability of the workforce for workers in their 50s, 60s and 70s is important both for the economic stability of the country and for the workers themselves.

## **Work**

Generally, work is good for the health and wellbeing of a person. The longer one works can have a direct impact on longevity and the nature of the work done impacts greatly on health and wellbeing both in work and post work in retirement. In 2006 the Department for Work and Pensions published the findings of a comprehensive review of scientific evidence to show that work is generally good for both physical and mental health and the well-being of healthy people. It also showed that work was also beneficial to the health of many disabled people and people with common health problems (Waddell & Burton 2006). Over the last 40 years the labour market has dramatically changed with the move away from 'jobs for life' to different ways of working which include more self employment, short term contract working, part-time work and portfolio careers<sup>1</sup>. Policies of flexible working have also impacted on the working environment making the working environment of today much different than it was. This has had a dramatic effect on many of today's older workers. This dramatic change has had a greater affect on older men who started their working lives in full employment and now have to adapt to this rapidly changing work environment (Evandrou, 1997; Huber and Skidmore, 2003). Women who are traditionally more likely to be employed in part-time work have adapted to these changes better although very little is known about the quality of their working lives (Doyal & Payne 2006) and more research is needed into this important area.

## **Worklessness**

Whilst work can generally be good for ones health, worklessness can have quite an opposite affect on health. There are clear links between worklessness and poor mental or physical health and whilst

---

<sup>1</sup> Portfolio career involves employment in a number of part time jobs that can include freelancing, temporary work, short term contracts with a number of different employers.

unemployment can lead to poor health, poor health can also lead to unemployment (TAEN 2007). The rates of long term illness amongst those who have experienced long-term unemployment is three times higher and for those who had never worked six times higher than people who worked in a managerial or professional employment (ONC 2001). In this same census three quarters of the economically active people reported their health to be 'good' which compared to only half reporting good health in the economically inactive group (ONC 2005a). In 2005 The Health and Work Handbook noted that unemployed people experienced poorer mental health than that of their employed counterparts and they also made more use of hospital services and visited their GP more frequently. They were also more likely to use prescribed medication and could experience up to eight times the levels of psychological ill-health than those in employment. The English Longitudinal Study on Ageing (ELSA 2004) found that individuals who were self-employed or employed performed better on almost every measure of cognitive function than an un-employed group who showed a substantial impairment in memory, search speed, literacy and numeracy. The risk of suicide is 10 times greater in unemployed groups than employed groups (Owen and Watson 1995).

### **Education and its impact on health**

As with work, qualifications and years of education seem to have a positive effect on ones health and wellbeing. Positive correlations can be made with good physical and mental health (TAEN 2007a). ELSA (2004) report that the more education people had the longer their physical function was preserved. People with no qualifications are more likely to report poor health than those with qualifications 13% rather than 6% (ONC 2006b). However, 76% of individuals with a degree or a higher level qualification reported their health as 'good' compared with only 56% of those with no qualifications (ONC 2006). Other studies show the causal effect of education on increased life expectancy (Lleras- Muney 2005).

The positive benefits of education on health are more beneficial for women, who are more prone to depression than men (Chevalier and Feinstein 2006). They argue that individuals having 'O' level qualifications, or their modern equivalent, are much less at risk from

depression and having these qualifications shows a positive effect on the individuals mental health.

With the impact of qualifications on health it would be prudent to examine some of these causal relationships. A number of reasons why health is improved with education could be argued. For example better educated people may have the ability to better understand information which may help with making informed choices on a healthier lifestyle, seeking medical advice or preventative care earlier or just being able to manage a health condition more effectively (Chevalier and Feinstein 2006). There are other benefits to an improved education which can lead to a better job or working conditions, more affluence, superior diet, and improved housing all which can have a positive influence health and well being. Education reduces the likelihood that an individual will work in the most hazardous jobs (Feinstein et al 2006).

If education is good for us then I think that we should examine the current educational policies which influence how effective an individual may be at gaining a job and being successful in the ever changing environment of work. Whilst Government policy on education works some of the time, the frontloading of education for the young must now be supplemented by the availability of and encouragement to participate in continual professional development (CPD) through out the life course. The new government legislation of withdrawing funding for students who enroll on an equal level qualification (ELQ) or lower level qualifications than they already have qualified in must surely hinder the development of a portfolio career and be a major barrier to lifelong learning and life chances for all the individuals affected. This particular fact was highlighted by the recent review by the House of Commons committee, Innovation, Universities, Science and Skills Committee 2008. One of its recommendations was a review by the Commission for Employment and Skills of the effects on the Leitch/ skills agenda of the withdrawal of funding on ELQ students (Innovation, Universities, Science and Skills Committee 2008). Perhaps a rethink by the Government on this policy may be in order.

## **Retirement**

The notion of working on Friday and retiring on the Monday now seems as dated as a 'job for life' and in reality retirement is a very complex and multifaceted issue. With the implementation of the age discrimination legislation 2006 many individuals are now choosing to work past the statutory state pension age (SPA). In 2020 women's SPA will be increased to 65 years old in line with that of men's. This increase is being phased in over a ten year period from 2010.<sup>2</sup>

Leaving the workforce before the SPA has important implications for retirement incomes and for economic and social participation in later life (Hirsch, 2003). Different socio-economic groups generally leave the labour market citing different reasons. A major cause for people in the lower socio-economic group was ill-health (45%) as against 10% citing compulsory redundancy (McDonough and Amick 2001; McNair et al, 2004). In a US study of 3500 ex-employees of the oil company Shell, mortality was shown to be twice as high in the first 10 years of retirement at 55 than those who stopped working at 60 or 65 (Tsai, et al 2005). Surely, a strong case for working for longer and later in life?

### **Good job/bad job**

Earlier, the notion that work in general, is good for ones health was explored however, some jobs are more beneficial to health than others and some are positively bad for an individual's health. For work to have a beneficial impact on health it needs to be good work. This is characterised by being fair, safe, offering good job security, good job satisfaction and personal fulfillment. Good communication is also important as is a supportive environment where the worker can gain personal autonomy (Waddell & Burton 2006). An older employee who can choose the hours worked and works in a low stress job experiences better health than an individual who does not (Merman, Johnson and Murphy 2006).

Some occupational groups are exposed to particular health risks because of their jobs. These include people working in the police, fire services, prisons, skilled construction, building and agricultural trades, teaching and research professionals and skilled metal and

---

<sup>2</sup> EC directive 79/7/EEC dealing with the principle of equal treatment between men and women, legislation (The Pensions Act 1995)

electrical trades. These groups were particularly at high risks from work related illnesses (Waddell & Burton 2006). The Health and Safety Executive report that workers with the highest risk of muscular skeletal disorders include typists, metal plate workers, shipwrights, riveters and road construction workers with rates 15 times the average for all occupations (Health and Safety Executive 2004/2005). Non Commissioned Officers (NCOs) and other ranks in the British armed forces and medical practitioners were occupations with high rates of mental ill health, hairdressers and beauty therapists have the highest rates for contacting Dermatitis whilst care assistants and home carers have an average of 25 times the average for occupational infections (Waddell & Burton 2006).

Many women work in employment that requires repetitive movements that are carried out thousands of times a day this can have a damaging impact on particular parts of the body (Sjogaard et al 2006). Women and older women in particular are shown to be at an enhanced risk from chronic muscular skeletal problems like repetitive strain injury, back pain, upper limb disorders and carpal tunnel syndrome from the repetitive nature of the work that they are engaged in (Sjogaard et al 2006). These types of problems can be intensified when women have to work in an environment where desks chairs and factory benches have been designed to meet the ergonomic needs of the average male employee (Misner et al 1997). However, physically demanding jobs have a positive effect on the physical health of individuals aged 65 and over (Merman, Johnson and Murphy 2006).

From the above information it seems that the occupational histories influence the health of the individual in later life. This life course approach to occupation can provide valuable lessons for policy makers about the health of future generations. As the United Kingdom sees an increase in migrant workers and the occupational histories of these workers is examined the results will have implications for the health of future generations (Granville and Evandrou 2008). An example cited to illustrate this potential problem is the issue of Asbestos use. In Great Britain 3,500 people die from health hazards created by Asbestos, which makes it the single greatest cause of work related fatalities (O'Regan et al 2007). Whilst the UK upholds the international agreement on health hazards created by Asbestos many other countries including China, India, Vietnam and Zimbabwe lack regulation on its use and an effective

ban on its use appears unlikely at the this point in time (Watterson 2007, Brophy et al 2007).

### **Gender differences**

The lifespan of men and women varies immensely with women living for approximately 10 per-cent longer than men 81.3 years compared with 76.23 years for men (World Factbook 2007 estimates). Although many theories have been put forward to explain this the real answer has yet to be found. However, as women's lifestyle compares more with that of men's for example driving fast cars, smoking and drinking heavily etc. there has been a harmonisation of lifespan in recent years.

When work patterns of the differing sexes are examined Granville and Evandrou (2008) found that paid work is more salient for men's health and wellbeing with better health effects being reported for men than women and it occupies more of men's time than that of women's (ONS 2007a). Men are likely to be working in more potentially dangerous environments than women and suffer more work-related mortality and disability due to this (White and Cash 2003). Men may also suffer less access to flexible working patterns when employed in a male dominated workforce.

When changing jobs men cite money, redundancy and career as being the main factors whereas women cite working more flexibly. This could reflect women's greater involvement with caring or domestic duties (McNair et al 2004). Women's employment is more likely than men's to be part-time (Equal Opportunities Commission 2006). It is also found that women work in certain areas that include health and social care, education, clerical and secretarial work, personnel and sales work. Meanwhile men tend to work in areas such as engineering, agriculture or manufacturing (Granville & Evandrou 2008).

Women are much more likely than men to be in the lowest position in each occupational setting (Doyal and Payne 2006). This gender difference in occupational status is also reflected in earnings and despite the Equal Pay Act women's pay for working full time in 2005 was 17 per-cent lower than men's while part time earnings were 38

per-cent below (EOC 2005). When we examine pension entitlements less than 20 per-cent of women qualify for a full state pension compared with 98 per-cent of men and few women build up occupational pensions (Doyal and Payne 2006).

Men and Women engage in various economic and social roles which can include paid worker, partner or spouse, parent or grand-parent and sometimes carer. All these roles impact on the health and well-being of both men and women. There are two differing theories we can look at when we examine the impact of these multifaceted roles. The role enhancement theory suggests that involvement in multiple roles will enhance the health of the individual (Sieber 1974; Marks 1977). However, the role strain theory (Goode 1960) associates multiple roles with poor health. Glaser, Evandrou and Tomassini (2005) found that parental roles in mid-life either alone or with other roles appeared to have negative health consequences for men. Another study shows that men in a parental role show greater strains in psychological function than that for women (Simon 1992). However, being partnered has a beneficial effect on men's health and many studies have found that married men out live their single counterparts (Lillard and Panis 1996).

In 2006 cancers were the main cause of death amongst both men and women. When these figures are broken down by gender and age then people aged 50 – 64 we find that four per-cent women compared with two per-cent for men die from cancer although these rates increase with age and for the 60-65 year olds the rates were 8 per-cent for women and five per-cent for men (ELSA Wave 1 2002). Although, in the same year (ONC 2007b) report that in the age group 45-65 years the male death rate was more than double that of the females for circulatory diseases. This presents a strong case for the inclusion of exercise and fitness into the school curriculum and access to regular inclusive exercise and fitness formats for the working population.

## **Ethnicity**

Just as there are many gender differences in our working patterns, significant differences in working patterns of older men by ethnicity

can also be observed. The 2001 census revealed that 80 per-cent of White British men aged 40-64 were economically active compared to 66 per-cent of Pakistani men and 58 per-cent of Bangladeshi men in the same age group. Although, rates amongst some other ethnic minority men compared with that of White British men for example 80 per-cent of Indian men, 76 per-cent Black Caribbean men and 82 per-cent of Chinese men were found to be economically active. More Bangladeshi, Chinese and Pakistani men were found to be working in casual, temporary or part-time jobs (ONS 2006a)

Ethnicity has an impact on general health and in the ONC Focus on Health 2006b, statistics taken from the 2001 census found that 12 per-cent of Asian and 10 per-cent of Black and mixed race reported that their health was not good, compared with 8 per-cent White and 7 per-cent Chinese and other groups. Generally, in people aged 50 – 64, the reported rate for a long-term illness or disability was 27 per-cent but these rates increased by ethnicity. Mixed groups 30 per-cent, Black 36 per-cent with Asian 40 per-cent. When the Asian group is broken down, 54 per-cent of Bangladeshi and 49 per-cent of Pakistanis report long term illness (ONC 2005).

Whilst these statistics show a picture from the 2001 census further examination of the research is needed to try to better understand some of the causal reasons that these statistics are showing. For example, there is little difference in the economic activity between White, Indian, Black Caribbean or Chinese men. Could it be that these are second and third generation immigrants who have now assimilated well into the workforce? Perhaps many Bangladeshi people may still be first generation immigrants. We must consider that English is not the first language of many of these newer immigrants. We need to question how much of the governments educational policy such as Welfare to Work programmes is failing to impact effectively on certain ethnic minorities (Tackey et al 2006).

## **Conclusion**

Whilst many of the findings in the above report refer to massive quantitative data sets it must not be forgotten that this data refers to real people. Many of whom are experiencing great hardship with regards to their working lives (or lack of) and their health. To better

understand the picture illustrated above further research needs to be done. Human stories need to be considered using qualitative research methods which can supplement the quantitative data. This will enhance our understanding of the impact that work, education and health has on the individuals that participated in this research.

The provision of health care in relation to the older worker has not been examined. Structural barriers can be seen that prevents some older people easily accessing appropriate health care. Herein lies a further issue, as certain sections of the community are prevented from accessing appropriate health care then the access to health provision should be made more flexible. Targeting older people, especially men, perhaps in the working environment where many spend most of their lives would have a beneficial effect on some of the statistics above. The gender divide both in work, education and health must also be addressed if we are to work towards a fairer society which will benefit many disadvantaged older women.

### References

- Auer, P. and Fortuny, M. (2000) *Ageing of the Labour Force in OECD Countries: economic and social consequences*, Geneva: ILO.
- Chevalier, A. and Feinstein, L. (2006) *Sheepskin or Prozac: The Casual Effect of Education on Mental Health*, Centre for Research on the Wider Benefits of Learning, Discussion paper. Centre for Research on the Wider Benefits of Learning: London
- Brophy, J.D., Keith, M.M., Gorey, K.M. (2007) Cancer and Construction: what occupational histories in a Canadian community reveal. *International Journal of Occupational and Environmental Health*. 13 pp32-38.
- Department of Work and Pensions, (2003) *Research Report 200*, London: DWP.
- Doyal, L. and Payne, S. (2006) *Older Women, Work and Health: reviewing the evidence*, London: Help the Aged/TAEN.
- ELSA, English Longitudinal Study on Ageing, Wave 1, (2002). A

survey of people born before March 1952.

ELSA, English Longitudinal Study on Ageing, Wave 2, (2004). A survey of people born before March 1952.

Equal Opportunities Commission (2005) *Facts about Women and Men in Britain 2005*, Manchester: EOC.

Evandrou, M. (1997) *The Baby Boomers: ageing in the 21<sup>st</sup> century*, London: Age Concern.

Feinstein, L., Sabates, R., Anderson, T.M., Sorhaindo, A. and Hammond, C. (2006) *Measuring the Effects of Education on Health and Civic Engagement*. Proceedings of the Copenhagen symposium; OECD.

Glaser, K. Evandrou, M. and Tomassini, C. (2005) The health consequences of multiple roles at older age in Britain, *Health and Social Care in the Community*, 13(5), pp 470-477.

Goode, W. (1960) A theory of role strain. *American Sociological Review*, vol. 25, pp. 483-496.

Granville, G. and Evandrou, M. (2008) *Older Men, Work and Health: reviewing the evidence*, London: Help the Aged/TAEN.

Health and Safety Executive (2004/2005) *The Health and Occupational Reporting Network, Occupational Health Statistics Bulletin*, London: HSE.

Hirsch, D. (2003) *Crossroads After 50: improving choices in work and retirement*, York: Joseph Rowntree Foundation.

Huber and Skidmore (2003) *The New Old: why baby boomers won't be pensioned off*, London: Demos.

Innovation, Universities, Science and Skills Committee (2008) *Withdrawal of funding for equivalent or lower level qualifications (ELQs) Third report of session 2007-08, Vol 1*, House of Commons. Found at [http://www.bbk.ac.uk/news/news-releases/Embargoed\\_ELQs\\_187-I\\_Final\\_version.pdf](http://www.bbk.ac.uk/news/news-releases/Embargoed_ELQs_187-I_Final_version.pdf)

Lillard, L. and Panis, C. (1996) Marital status and mortality: the role of health, *Demography*, 33(3) pp. 313-327.

Lleras-Muney (2005) The Relationship between Education and Adult Mortality in the United States, *Review of Economic Studies*, Vol. 72, pp.189-221.

Loretto, W. Vickerstaff, S and White, P. (2005) *Older Workers and Options for Flexible Health*, Working Paper Series 31, Manchester:EOC.

Marks, S. (1977) Multiple roles and role strain: some notes on human energy, time and commitment. *American Sociological Review*, vol. 42

pp. 921-936.

McDonough, P. and Amick, B (2001) The social context of health selection: a longitudinal study of health and employment, *Social Science and Medicine*, 53 p135-145.

McNair, S. Flynn, M. Owen, L. Humphries, C. Woodfield, S. (2004) *Changing Work in Later life: a study of job transitions*, Brighton: Centre for Research into the Older Workforce, University of Surrey.

Merman, G.B.T, Johnson, R.W, and Murphy, D. (2006) Why do boomers plan to work so long? *Centre for Retirement Research*. University of Boston, USA.

Misner et al (1997) *Women and Occupational Health*, Canada-USA Women's Health Forum. 1997

ONC (2001) Census

ONC (2005) cited in TAEN (2007a) *Key Facts, Health, Unemployment and Age*, London: Help the Aged/TAEN.

ONC (2006b) Focus on Health

ONS (2005a) Focus on Older People.

ONS (2006a) Social Focus on Ethnicity

ONS (2007a) Labour Force Survey: Employment status by occupation and sex, April – June 2007.

<http://www.statistics.gov.uk/downloads/>

theme\_labour/uk\_all\_inemploy\_soc\_apl\_jun07.xls

ONC (2007b) Health Statistics Quarterly, 34, June 2007 cited in, TAEN (2007a) *Key Facts, Health, Employment and Age*, London: Help the Aged/TAEN

O'Regan, S., Tyers, C., Hill, D., Gordon-Dseagu, V. (2007) *Taking Risks with Asbestos: what influences the behaviour of maintenance workers?* HSE Report RR558.

Owen, K. and Watson, N. (1995) Unemployment and mental health, *Journal of Psychiatric and Mental Health*. Vol. 2, Issue 2, pp 63-71.

Sieber, S. (1974) Towards a theory of role accumulation. *American Sociological Review*, vol. 39 pp. 567-578.

Simon, R. (1992) Parental role strains, salience of parental identity and gender differences in psychological distress, *Journal of Health and Social Behaviour*, vol.33 pp. 25-35.

Sjogaard, et al (2006) Neuromuscular assessment in elderly workers with and without work related shoulder/neck trouble: the NEW study design and physiological findings. *European Journal of Applied Physiology* 96, 2, pp110-121.

Tackey, N.D., Casebourne, J., Aston, J., Ritchie, H., Sinclair, A.,

Tyers, C., Hurstfield, J., Willison, R., Page, R. (2006) *Barriers for Employment for Pakistanis and Bangladeshi in Britain*. DWP Research Report.

TAEN (2007a) Key Facts, Health, Employment and Age, London: Help the Aged/TAEN.

TAEN (2007b) Health and the Working Age Population, briefing paper, London: Help the Aged/TAEN.

*The Health and Work Handbook*, (2005) London: Faculty of Occupational Medicine/DWP

Tsai, S. P., Wendt, J. K., Donnelly, R. P., Jong, G. de, Ahmed, F. S. (2005) Age at retirement and long term survival of an industrial population: prospective cohort study. *Shell Oil: British Medical Journal*, Vol. 331, No. 7523 pp. 995-997.

Waddell, G. and Burton, K. (2006) *Is Work Good for your Health and Wellbeing?* London: DWP.

Watterson, A. (2007) Global construction health and safety: what works? What does not and why? *International Journal of Occupational and Environmental Health*. 13: pp1-4.

White, A. and Cash, K. (2003) *The State of Men's health Across 17 European Countries*, Brussels: European Men's Forum.

*World Facts Book*, (2007) Central Intelligence Agency CIA:USA.