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IN-DEPTH REVIEW

Older women, work and health

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Aims Older women make up an increasingly important sector in the labour market. However, we know little about their health—the various influences on their health and the ways in which paid and unpaid work impact on both physical and mental well being. This paper reviews the available literature on older women's health in the workplace, focussing on work-specific and more general risks for older women, including stress, discrimination, physical hazards and the 'double burden' of paid work and caring responsibilities.

Methods Databases searched included Web of Science, CAS, CINAHL, Medline and ASSIA, together with UK and European statistical sources.

Conclusions We conclude with a three-point research agenda, calling for more empirical work on the risks faced by older women, studies that take a life-course perspective of women's occupational health and work that explores the interactions between unpaid and paid work in later life.

Key words Gender; gender equality; old age; older women.

Introduction

The International Labour Organization's (ILO) international standard on older workers (R162), published in 1980, addressed wages, working time, age, discrimination, the family responsibilities of older workers, and their health and safety [1]. The ILO recommended that jobs and the workplace should be adapted to minimize the adverse effects of work, including those posed by poor ergonomic design, pace of work and stress, while also highlighting the need for more research on the health of older workers, to identify and provide solutions for those activities that might 'hasten the ageing process or in which older workers encounter difficulties in adapting to the demands of their work' [1].

Although standard R162 did not identify gender differences in the relationships between paid employment and health for older workers, more recent statements by the ILO have called for attention to be paid to the specific experiences of older women in employment. This paper explores the relationships between paid work and health for this group of workers and forms a companion paper to the one by Granville and Evandrou on the health of older male workers in this volume.

Methods

This paper is based on a review of national and international literature on the health of older women workers. Databases searched included Web of Science, Conference Abstract Search (CAS), Cumulative Index to Nursing and Allied Health Literature (CINAHL), Medline and Applied Social Sciences Index and Abstracts (ASSIA), together with UK and European statistical sources. As the companion paper notes, keyword searches in this area are particularly difficult due to variations in the terminology used and the focus of the literature.

Gender and the ageing workforce

For the first time ever, there are more people in the UK over the state pensionable age than under the age of 16 [2]. The proportion of the UK population >65 has been steadily increasing, due to reductions in mortality, and it is estimated that by 2030 nearly a fifth of the population will be >65 compared with just 12% in 2000 [3]. At the same time, the average age of the labour force has been rising and will continue to do so in the foreseeable future [4]. This is partly the result of increases in the older population but it also reflects other changes in participation in paid work—particularly among women.

While the proportion of older men in work has remained relatively steady since 1990, the proportion of women aged between 55 and 64 in the labour market has increased from just <40% in 1990 to nearly 50% by 2004 [3]. It is this that largely explains the growth in the older workforce. This reflects earlier changes in employment patterns among cohorts of women now reaching

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later life—women who remained attached to the labour market after having children, for example, and who are now becoming 'older workers.' In the future, the proportion of women in paid work in later life is likely to increase further as more and more women combine paid work, either full-time or part-time, with family responsibilities [4].

Alongside these demographic changes, policy in the UK has placed an increasing emphasis on delayed retirement [5]. From 2020, the state retirement age for women in the UK will be 65, the same as for men, having been phased in from 2010 onwards. Increasing life expectancy among older people and the corresponding extension in the number of years dependent on a pension, combined with the fall in the proportion of population of working age, suggest that more and more men and women will need to work well into their 60s and 70s. Women's better life expectancy in comparison with men also means that while in paid work, they will need to find ways to provide for their financial security in very old age [3].

These changes suggest an urgent need to consider the health implications of the ageing workforce. As a group, older workers are often seen as more vulnerable than younger workers. They can be more at risk of redundancy and experience difficulties re-entering the labour market because progressive pay can mean they are more expensive to employ, because older workers are often seen as less productive and because they are likely to have fewer qualifications than younger workers [3]. However, older workers are also vulnerable in other ways, particularly in relation to their health, and poor working conditions may accelerate a decline in physical and mental health [6].

A number of writers have highlighted the relative lack of research on occupational health among older workers although recent analyses such as the European study on working conditions of an ageing workforce [6] are beginning to redress the gap. There has also been a lack of research on women's health in the workplace at all ages. This is partly because paid work is still often seen as a predominantly 'male' activity but also because much of the research on occupational health is carried out in large workplaces where men still predominate [7,8]. To some extent, this gap in research follows from an assumption that women's employment is less hazardous—that is, that segregation in the labour market is also associated with segregation in terms of the health risks of paid work and that men do 'dangerous' work, whereas women do not [9,10]. Women less often receive compensation for work-related health problems [10] and this reflects traditional stereotyping of men's work as dangerous, while also reinforcing that concept.

The particular gap in our understanding of the health of older women workers reflects not just the absence of data on the direct effects of waged work but also a lack of understanding of the complex interaction between current and previous patterns of work and between paid and unpaid work. As a result, efforts to improve older women's health or to protect women against employment-related risks and stresses are less likely to succeed.

Benefits of paid employment

Before looking at the costs to health of paid work, it is important to consider the various ways in which having a job can be beneficial for older women, particularly as large numbers of women continue to work into old age. Women report mixed feelings about their work—in Doyal's 2000 survey of older women, the majority described paid work as being positive overall, but for a third of the women the benefits were mixed and 5% of the women reported an adverse effect overall. Positive features of paid work for older women include access to an independent source of income, engagement in social support networks, opportunities for satisfaction and enhanced self-esteem and the contribution employment can make to positive mental health [11–15].

In addition, older women workers report that employment helps to keep their mind and body active and generates a feeling of contributing something of value to society [12]. However, it is also important to note the diversity of older women and their employment—not all women benefit equally from the work they do, and the nature of the benefits paid work might offer will depend on the job itself, pay, status, the control a woman has over her work and access to transport to place of work. When work offers little by way of financial and non-financial rewards, for example, when getting to work requires two bus rides and when the job itself is carried out in isolation from others and with little opportunity to determine how it is done, there are fewer opportunities for positive health benefits.

In addition, there is little research evidence of how the benefits of paid work change across the life course for women, in relation to other changes including family responsibilities.

What are the influences on older women's health in paid work?

Recent writing on the health of women and men has stressed the need to consider sex-linked, or biological, influences on health, stemming from physiological and genetic differences between women and men for example, and also those influences which reflect socially constructed or gender differences, including differences in access to resources and expectations of roles and behaviour [16]. When we look at the relationships between paid work and health for older women, both sex and gender play a part. As with all workers, older women's health is the outcome of both current and earlier working patterns as well as other influences, and it is important to recognize the cumulative impact of working conditions and stresses, alongside factors outside the workplace, on their health in later life.

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Biology

In recent years, research has generated increasing understanding of the ways in which biology affects the health of women, reflecting not only reproductive factors but also hormonal and genetic influences [17]. However, the ways in which biological risk factors might affect older women in the workplace form a major gap in our understanding of occupational health. We know that women are more vulnerable than men to some conditions associated with biological difference—arthritis and other autoimmune diseases and osteoporosis [17]. Some forms of paid work, especially those that involve repetitive movement, are likely to affect women differently as a result. Similarly, women and men appear to metabolize chemicals differently, which means that women of all ages working with some substances may experience different risk profile [18].

Despite the fact that increasing numbers of women work throughout later life, little is also known about the ways in which women's occupational health and well being is affected by menopausal status [19]. However, research showing the adverse effects of stress on menopausal health suggests that where paid work increases stress this may have a particularly important impact on older women's health [20]. Stress in postmenopausal women also produces detrimental physical effects—increases in heart rate, blood pressure and blood levels of epinephrine, for example—and again this suggests that particular types of paid work may be especially harmful for women [20]. Experiences of menopausal symptoms such as hot flushes or heart palpitations during working hours or the tiredness that can accompany night sweats may further increases difficulties for women in their paid work.

Gender

Gender refers to socially constructed roles, expectations and opportunities. Gender is a significant factor shaping segregation in the labour market and hence affects the occupation-specific risks women encounter. It is also important in creating expectations of women in relation to caring responsibilities and unpaid work that may further affect women's health. Gender is also important in shaping discrimination in the workplace including, for example, increased risks of redundancy, bullying or harassment [21].

In order to understand the ways in which paid employment might affect older women's health, we first need to consider the work women do. Women's working lives are often very different from those of men, and the effects of their employment on their health will reflect these differences. Labour market segregation—both vertical and horizontal—shapes many of the differences between women and men in their paid work. Female workers are concentrated in specific sectors of the labour market and in specific occupations within different sectors. In 2005, for example, women made up 79% of those working in health care and social work, 73% of those in education and 56% of people working in hotels and restaurants, compared with only 10% of the construction industry workforce [22]. This vertical segregation is found across all age groups, with older women as likely as younger women to be concentrated in traditionally female sectors of employment.

Within different sectors, 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. And women are more often located in lower levels of occupational hierarchies and career paths.

Women's work is also more likely to be transient rather than permanent and is more often part-time [6,22]. In 2005 in Britain, for example, 45% of employed women aged 45–64 were in part-time work compared with only 10% of men in this age group. Part-time work is more common among those aged $\geq$65, although the gap between women and men remains with 82% of women $>$65 working part-time compared with 63% of men [22]. Women also work more often in the informal economy, where there is no protection in terms of health and safety or job security [23].

Women are also paid less than men, despite $>$30 years of equal opportunities legislation. However, the widest pay gap is found among older workers [22] and especially among those working part-time, leaving older women most likely to be poorly paid.

Finally, we need to consider the implications for older women's health of the 'double burden': gender differences in the distribution of unpaid work leave women carrying out more hours in caring work and domestic labour [11,16].

These differences in the labour market and unpaid work are significant in understanding the health risks women experience. While women's work is more likely to be chronically stressful, rather than exposing them to traumatic events or the risk of accidental injury, there are specific physical risks for some women that remain under-researched. In addition, the lack of opportunity, poorer pay and type of work women do, together with the ways in which women are treated by others in the labour market, combine to create specific costs for their health [24].

Hazards on the job: work-specific risks

While many of the risks of paid work are experienced by both men and women and while many of the traditionally 'male' jobs carry particular health risks, there are also occupational specific risks in some areas of traditionally

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female work. For example the European Union Survey on Working Conditions found that women's occupational risks reflected vertical segregation in the labour market, with women more likely than men to be exposed to infectious materials and risks associated with lifting or moving people, due to the number of women working in health and social care [25].

Musculo-skeletal disorders are a key health risk for older women, particularly those engaged in repetitive work such as manufacturing and assembly work [26,27]. Figures from the Health and Safety Executive (HSE) for the UK, for example, show a prevalence rate of 3590 per 100 000 for women aged 55–59 for musculoskeletal disorders caused by or made worse by work, while the rate for women aged 60–74 was 3660—three times the prevalence rate among women aged 16–24 [28]. However, women are less likely than men to be moved to less strenuous or 'lighter' work as they get older [29,30].

In addition, the risk of injury in the workplace increases with age and for women, those aged 45–54 have the greatest risk of being injured at work [31]. Risks of accidental injury due to falling, tripping or slipping at work also increase with age for women [32]. Many of the problems women experience in the workplace relate to poor ergonomic design, where workstations, work cycles and equipment are designed for male employees [33].

Older women working in health and social care experience a particular set of risks including physical injuries from lifting people, needle injuries and toxic chemicals, and older nurses are also at greater risk of developing asthma [34].

Although in the UK the risks of violent death are lower than other countries (in the US for example the leading cause of death among female shop workers is gunshot wounds [16]), violence is an occupational risk for those working with the public, especially women employed in health and social care and in service industries [18]. In 2005–06, incidence figures for workplace violence showed that among those aged 55–59, women were more at risk of violent injury than men [28].

There is also evidence that shift work increases women's risk of cardiovascular events more than it does for men [35], and although women as a group are less likely to work in shifts, it is common in some traditionally female jobs, especially in health care.

Hazards of the job: generic risks for older women workers

In addition to work-specific risks, older women workers are also exposed to other factors adversely affecting their health, the result of a mixture of ageism and sexism operating in paid work.

The workplace health hazard most commonly cited by women is stress [36,37]. Data from the HSE show that, for women, over half of all cases of work-related anxiety and depression in 2004–06, and 43% of cases of work-related stress, were experienced by those aged ≥45 [28].

Workplace stress is caused by a number of factors, including lack of autonomy and control. Older men are more likely than women to have jobs which are demanding, but which also offer a high degree of autonomy [6]. Older women are more often found in occupations and in sectors where workers lack control over employment in relation to speed or conditions of work, have fewer opportunities for flexibility—in their hours for example—and take fewer decisions [6,35]. Older women workers also report fewer opportunities for on-the-job learning than men [6].

Caring for others also increases exposure to stress [37]. Caring is often an explicit aspect of women's paid work, as in nursing or service industries for example, but older women, in particular, are also often expected to take on an informal caring role, providing practical or emotional support to other workers [24].

A number of writers have observed that the interaction between gender and age discrimination creates particular disadvantages for older women workers [6]. Differences in the social construction of ageing for men and women mean that women are seen as less attractive and less competent earlier than men are [38]. Women in traditional female occupations such as secretarial, clerical and reception work, where appearance is seen as a significant part of employment, experience discrimination as a result of a combination of ageism and sexism [38]. Employers, for example, describe 25 as the ideal age for reception and clerical staff, typically posts held by women [39]. This negativity towards older women leads to pressure to maintain youthful appearance [21,40]. In the European survey of working conditions for older workers, slightly more women than men reported experiencing age discrimination and of those who had experienced age discrimination, 23% of women had also experienced gender discrimination, compared with 7% of the men [6].

Older women experience other forms of workplace stress. Research in the European Union (EU), for example, shows that older women report more experiences of bullying and harassment than men [6,25]. Older women workers also described discriminatory remarks or attitudes when new technology is introduced in the workplace, and it is expected that older female workers will be unable to cope [21]. The more transient nature of women's work also increases the risk of stress for older women due to ageism and sexism in the labour market and concerns over finding replacement work when one job ends [21,40].

The health hazards of these various sources of stress are well documented. In addition to psychological problems, including anxiety, depression, sleeping difficulties

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and irritability, stress has also been associated with an increased risk of physical disorders such as coronary heart disease, gastric disorders and irritable bowel syndrome [25,35,41,42].

Alongside their paid employment, many women carry responsibilities for unpaid work. For younger women, this usually means parenting and domestic labour, but in later life, older women also have a heavy burden of unpaid work, providing care for grandchildren and older dependants. Across the EU, for example, women over the age of 55 carry out on average an additional 18 h per week of unpaid work compared with 5 h for men [25]. However, the family responsibilities of younger women are more often recognized in the workplace than those of older women, despite ILO recommendations [3,35].

This unpaid work can have an impact on both physical and mental well being. The physical risks of caring for older dependants are similar to those experienced in paid work by nurses and care workers and include the risk of back strain from lifting someone, for example [14,43]. However, the risks experienced by older women providing care for young children, including grandchildren, are less often recognized. The lifting, carrying and bending work which is part of child care can impact on the physical health of older women leading to back pain and potential musculo-skeletal damage [44]. And with all unpaid work, there is an increased risk of poor mental health where such work is stressful, isolated and unacknowledged.

Conclusion

Overall, while many older women report that paid work contributes to their well being, research tends to suggest that paid work also carries risks for their health. For a large number of older women, paid work is essential rather than a luxury, and the proportion of women remaining in the labour market in later life is likely to continue to grow. However, a gap remains in terms of our understanding of the impact of paid work on women's health in later life. The evidence reviewed in this paper suggests a three-point research agenda to redress this knowledge gap. Firstly, there is a need for research on the physical health risks experienced by older women in the workplace; secondly, we need more research on the ways in which the effects of paid work may change across the life course. And finally, we need a better understanding of the links between waged work and domestic responsibilities for older women, in terms of how these interactions impact on the well being of women in later life.

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