Older Men, Work and Health

Reviewing the evidence
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A report for Help the Aged and TAEN – The Age and Employment Network

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Help the Aged and TAEN – The Age and Employment Network share the common belief that the middle years are the key to ‘getting things right’ to prevent disadvantage in older age. Maintaining good health and the ability to work for as long as they want or need to is fundamental to giving people a better life in old age. Yet few studies have examined the interrelationship of work and health in later life and fewer still have taken a gendered approach.

In 2006 we published a research report, Older Women, Work and Health. This built on an earlier work commissioned for the Pennell Initiative for Women’s Health, which has now been absorbed into Help the Aged. We felt it important to complement that research with a similar review of the evidence on the work and health of older men. While many of the health benefits and risks of work are the same for men and women, and for older and younger workers, there are also significant age and gender differences. These need to be understood and taken into account if effective policies are to be established.

Extending working life and improving the health of working-age people have moved up the Government agenda. The review of the health of the working-age population led by Dame Carol Black, the National Director for Health and Work, is one expression of the priority now attached to this issue. We hope that Older Men, Work and Health, along with its companion report on women, will help inform this work and underline the requirement to develop health, work and well-being strategies and programmes that address the needs of older men and women.

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Foreword
Executive summary

The rising number of older people in society together with the increasing policy focus on active ageing, combating ageism in the workforce and reversing the trend towards early retirement have led to a growing interest in the role of older people in work and an expansion in the literature on employment, work and retirement.

Greater attention is also being paid to the health effects of work, worklessness and retirement and their impact on health inequalities and well-being in later life. However, few studies have brought these two bodies of work together to examine the effects of work on health in later life.

One exception to this is a review on older women, work and health (Doyal and Payne 2006) commissioned by Help the Aged and TAEN – The Age and Employment Network. Older Men, Work and Health aims to complement that earlier review by providing an overview of the literature regarding the complex interrelationships between work and health among older men. It highlights the usefulness of a lifecourse approach that acknowledges the importance of experiences earlier in the lifecourse on socio-economic position including occupation, gender, health and well-being. It also reflects the changing patterns over the last decade in the nature of work, the concept of retirement and the impact retirement has on older men.

The review of the evidence is structured in terms of a number of key themes emerging from the literature, overlaid with the cross-cutting issues of gender, ethnicity, age and socio-economic inequalities. It begins with the current policy context of work, health and gender and concludes with a discussion of the implications for future research, for policy formulation and implementation, and for public health practice.

The key themes are:

- older men and the labour market
- the changing nature of work and its impact on older men
- the critical link between gender, health and work, and the cumulative effects of inequalities through the lifecourse
- work, family life and health
- work-caused and work-related ill-health
- promoting health in the workplace.

The policy context

The importance of the health and well-being of working-age people has risen up the political agenda over recent years, and cuts across public health and employment policies. The public health White Paper Choosing Health: making healthier choices easier (Department of Health [DH], 2004) highlights the central part that work plays in health and well-being, and in determining inequalities throughout the lifecourse. One of the commitments in Choosing Health was that the NHS would support a wider occupational health approach, NHS Plus, to increase the occupational health services for small and medium-sized businesses.

In 2005 a strategy for improving health and well-being of working-age people was produced (DWP, 2005a) with the aim of co-ordinating the Government’s approach to improving health and tackling inequalities through the workplace. In the same year, the national strategy on ageing, Opportunity Age (DWP, 2005b), was produced with the aims of ending the perception of older people as dependent; ensuring that longer life is healthy and fulfilling, and that older people are full participants in society. The Government’s aspiration is to achieve an 80 per cent employment rate, including one million more older people in work, and the national strategy on ageing lays out the direction of travel. A key driver to achieving this is the recent publication of the public service agreement (PSA) to tackle poverty and promote greater independence and well-being in later life (HM Treasury, 2007). In 2006 the Government appointed Dame Carol Black as the first National Director for Health and Work, and in March 2007 a comprehensive review of the health of the working-age population was announced.

The other key area of policy relevant to this review is the equality legislation. In October 2007 a single commission was created, the Equality and Human Rights Commission. It is using a human
The changing nature of work

Over the past four decades there has been a transformation of the labour market, with a move away from permanent ‘jobs for life’ towards new forms of work characterised by short-term contracts, self-employment and portfolio careers. There has also been an increase in policies to promote flexible working patterns, as well as evidence of men leaving the labour market before state pension age. The traditional image of retirement as a sudden change from a full-time job on a Friday to doing nothing on a Monday is increasingly out of date (Hirsch, 2003; Vickerstaff, 2004), although retirement is still perceived as one of the key transitions for men in mid-life and consequently has a marked influence on their future health and well-being.

Gender, work and health: exploring the critical link

Work is generally good for health, with employment being found to have a consistent health-protective effect. However, the causal relationships are complex; associations may also reflect selection effects. Poor health was given as the most common reason to retire before state pension age. This was most marked among people with no formal qualifications or an income from a private pension, reflecting inequalities in health between occupational status.

Work plays a central role in the lives and identity of men. Paid work is more salient for men’s well-being, with stronger health effects being reported for men than women (Janzen and Muhajarine, 2003). Both the absence and the presence of work can be a key source of health problems to men. Paid work occupies more of men’s time than women’s, with fewer men in part-time employment. Men cite career, money and redundancy as their main reasons for changing jobs, while women are more likely to make a job change specifically to work more flexibly, particularly to carry out caring and domestic responsibilities (McNair et al, 2004).

Gender differentials also reflect differences in work environments. Men are more likely to be involved in potentially dangerous environments,
with more men than women suffering work-related mortality and disability (White and Cash, 2003). Men are also more likely to work away from home, face inflexible hours, work full-time rather than part-time and face structural barriers in accessing health care (Conrad and White, 2007). The correlation between job stress and health is well documented. Higher job demands are related to higher blood pressure levels in men (Clays et al, 2007). An older person’s previous labour market position continues to have a major influence over their health for many years after leaving the labour market (Arber, 1996; Marmot et al, 2002; Chandola et al, 2007).

Work, family life and health

In addition to the important role of paid worker, men and women undertake a variety of other economic and social roles, including those of parent, spouse and carer. It is essential, therefore, to briefly examine the mediating effect that occupying other roles may have on men’s health. Research using the longitudinal data to investigate the links between multiple economic and social roles and health in mid-life (45–64 years) found a positive association between employment and health (Glaser, Evandrou and Tomassini, 2005), supporting the view that work is generally good for health. However, the same study found that occupying a parental role during mid-life, either alone or in combination with other roles, appeared to have negative health consequences for men. Studies have found that married men tend to live longer than their unmarried counterparts (Lillard and Panis, 1996), indicating that having a partner provides men with a protective factor. The relationship between family roles and health is therefore complex and not clear-cut.

Although more individuals in mid-life now have surviving parents or even grandparents as well as children of their own, recent work has highlighted that being ‘caught in the middle’, in terms of simultaneous care-giving responsibilities to dependent children and frail parents while being in paid work, remains an atypical experience, but there is some evidence that members of younger cohorts are increasingly taking on multiple roles. More research is needed to understand the complex interactions between family responsibilities, work and health.

Work-caused and work-related ill-health

Two examples of major industries in which men have dominated the workforce are coal-mining and the construction industry. These demonstrate that occupational histories are key factors in influencing the health of men in later life and provide important lessons for policy-makers. For example, the recent rise in the numbers of men diagnosed with the more severe form of pneumoconiosis (a lung disease caused by breathing in dust from coal, graphite or man-made carbon over a period of time) is in part a function of the changing age structure of the workforce, reflecting a policy of practically no recruitment into the industry as increasing numbers of older miners remained in the mines, hence being exposed to coal dust over a longer time period. Environmental policy and discussions on alternative sources of energy need to learn from these experiences and focus on the health risks and how to minimise these for future generations.

In Great Britain currently 3,500 people die each year from asbestos-related diseases, making asbestos the single foremost cause of work-related fatalities (O’Regan et al, 2007). Those at greatest risk of coming into contact with asbestos are those who worked, or are working, on buildings built or refurbished in 1950 to 1970s in construction-related trades, for example plumbers and carpenters (O’Regan et al, 2007). Recent changes in patterns of working have implications for the future incidence of asbestos-related diseases. Today at least three in ten of the construction workforce are self-employed older men. Many of these will not have participated in training regarding the effects of asbestos; indeed, a study found that those who had never had training were the most confident. The case study highlights the importance of the age and experience profile of workers and their training needs in initiatives to improve workplace health.
Promoting workplace health

The workplace can also be seen as an opportunity to improve the health of the workforce, with growing recognition by government, and among some employers, that looking after the health of their employees improves their productivity. It also presents an opportunity to engage men in particular, because work is so central in their lives, and because of the problems men have in accessing health services (Conrad and White, 2007).

In addition to the statutory duty of employers to conduct risk assessments to identify hazards to health and safety, it is equally important to ensure that health and well-being are promoted in the workplace. In order to be effective, interventions should be part of a corporate wellness programme which combines corporate responsibility with individual behaviour change. Embedding programmes in small and medium-sized enterprises (SMEs) with no occupational health services remains problematic (Bowers et al, 2003; Carroll et al, 2005). Similarly, organisations with self-employed contractors, such as taxi drivers or lorry drivers, who are often older men, present particular challenges of engagement.

Understanding differences in work trajectories and life circumstances is necessary when planning workplace interventions with older men. For example, men in manual jobs may be more readily accepting of a decline in their bodies and an inevitable loss of functioning related to manual work, while professional workers tend to be more anxious about their ageing bodies and more likely to try to combat and control the ageing process. Key characteristics of ‘successful’ workplace interventions (Health Development Agency, 2002) include:

- visible and enthusiastic support and involvement from management
- involvement of employees in all levels of planning and intervention phases
- tailoring interventions to suit the characteristics and needs of employees.

Work Fit, a lifestyle management programme focusing on nutrition and physical activity created by the Men’s Health Forum in association with BT, was particularly successful in engaging older men.

Conclusions and recommendations

Three significant themes emerge from the review:

- the central role that work plays in the lives and identity of men and therefore the impact this has on their health
- the occupational histories of men expose them to work-related and work-caused ill-health, which has consequences for life expectancy and chronic disease in old age
- the successful targeting of men regarding health promotion requires specific action.

These findings have implications for future research, policy formulation and implementation, and for public health practice.

Identifying gaps in the evidence

The reviewers found:

- a lack of research on the effects of work on health among older people within a gender perspective
- little empirical evidence in the literature on the cumulative effect of working lives on the health of men (or women) as they age. Such research is vital for enhancing our understanding of the implications of an ageing workforce
- that further research which adopts a lifecourse approach would be extremely useful, because this provides a better basis for considering the cumulative effect of work in relation to gender and age cohorts. In particular, such research could inform the design of health improvement programmes. This would allow for the creation of programmes based on a deeper understanding of what is effective in particular circumstances among certain groups of people.
given the changing ethnic composition of the older population and the recent increase in migrant workers, more research is needed that investigates the impact of work on health among older workers from different ethnic groups and the implications of this for health services in the future.

given the changing pattern of the lifecourse and the likelihood that more older workers will also occupy roles as carers and parents during mid-life, further research is needed on the impact of family life on health and how social roles may mitigate or reinforce the health impacts of economic roles.

more longitudinal research and pilot projects are required to develop a stronger evidence base for the type of programmes that support behaviour change in the workplace, such as Work Fit.

Supporting policies for improving health in working-age people

The literature reviewed in this report demonstrates the long-term benefits in improving the health of working-age people associated with the cumulative effect of work on health status in later life, and furthers our understanding of the differing needs of older men and women. This evidence can be used to inform the Government’s co-ordination of the strategy for work and health (DWP, 2005a), and the implementation of Extending Working Lives, in the National Strategy for an Ageing Population, Opportunity Age (DWP, 2005b).

Work-caused and work-related ill-health are issues that resonate beyond the UK. The recent influx of migrant workers, all bringing with them their occupational histories and associated occupational health risks from their previous working lives, is a significant new development. Therefore factors relating to workplace health outside the UK may be reflected in any assessment of the health of older men in the UK.

Work-caused and work-related ill-health have a disproportionate effect on contractual and self-employed workers in risky occupations, of which the majority are men. Health and safety policies in industries such as construction need to focus more on management strategies and risk management, rather than on individual behavioural safety.

The evidence of the risks to freelance workers, of which many are older men, suggests that policies need to be developed to offer more protection to this group.

Informing public health practice

The health inequalities agenda has focused largely on socio-economic factors as being central to the health divide. There has been less emphasis on gender as a health inequality that causes differences in health outcomes between men and women. The new Commissioning Framework for Health and Well-being (DH, 2007) provides an ideal mechanism to address these differences, with the central driver being equality of outcomes, not equality of service provision. Commissioning gender-sensitive services would also support public sector organisations in fulfilling their statutory duty under the Equality Act (2006) to promote gender equality policies.

The workplace is a setting that could potentially be used to reach men to encourage them to improve their health and well-being, and men are under-represented in health promotion programmes (Lambert et al, 2007). Workplace health-promoting activities need to be designed with specific consideration to gender. Dissemination and adoption of the learning from successful work-based interventions such as Work Fit need to be encouraged through the scoping and publication of examples from practice.

Occupational health services have a key role to play in embedding workplace wellness into organisational objectives, as well as a role in delivering health-promoting activities in the workplace. Occupational health services should develop different approaches for different generational cohorts, and recognise the importance of the transitions that take place during mid-life.
Recent public health policy (DH, 2004) has put in place initiatives to support individuals to change their behaviour. For example, the workplace would be an ideal setting to recruit and deliver health trainer programmes. Another initiative is the ‘mid-life life check’ (DH, 2006), a self-assessment process for people to assess their health for people of 45–65. This web-based approach may be particularly attractive to IT-literate men with access to the internet, and could usefully form part of a suite of activities to promote workplace health.
The health and work of older men

Introduction

The last 50 years have witnessed a change in the age structure of the population. In 1951 there were 13.8 million people aged 50 and over in the UK; by 2001 this had increased by 45 per cent to 20 million. The number is projected to increase by a further 36 per cent by 2031, when there will be 27.2 million people aged 50 and over (ONS, 2005a).

The rising number of older people has led to an increased focus on the role of older people in work and an expansion in the literature on employment, work and retirement. At the same time, evidence of a health divide has been developing, with some people continuing to live active, healthy lives well into old age while others experience multiple health problems. Concurrently, there has been growing interest in the health effects of work, worklessness and retirement and their impact on health inequalities and well-being in later life. Few studies have examined the effects of work on health in later life using a gender perspective. One exception to this is the review of older women, work and health (Doyal and Payne, 2006) commissioned by Help the Aged and TAEN – The Age and Employment Network. This report aims to complement that earlier review by providing an overview of the literature regarding the complex interrelationships between work and health among older men.

Given that in future more people will be living and working for longer, it is important to map the evidence base on the interrelationship between work and health; it is also crucial to highlight the messages for improving health and well-being among older men through work and employment policies and to identify the gaps in the literature, in order to inform future policy and practice. This report reveals the value of a lifecourse approach that acknowledges the significance of earlier experiences in terms of socio-economic position, including occupation, gender, health and well-being. It also reflects the changing patterns over the last decade in the nature of work and the concept of retirement, and the impact that has on older men.

The review of the evidence is structured in terms of key themes emerging from the literature, into which issues of gender, ethnicity, age and socio-economic inequalities are cross-cut. It begins with the current policy context of work, health and gender, and concludes with a discussion of the implications for future research, for policy formulation and implementation, and for public health practice.

The key themes are:

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- promoting workplace health.

Concepts and definitions

For the purposes of this study working age has been defined as 16–64 years for men, and 16–59 years for women, notwithstanding that from 2020 women’s state pension age (SPA) will be the same as that of men, with the increase being phased in over a ten-year period from 2010 to 2020. ‘Older male workers’ are defined as those aged 50–64 unless otherwise stated.

State pension age is the age at which men and women are eligible to draw the state pension. However, some of the literature interchanges state retirement age (SRA) with state pension age, although there has not been a compulsory state retirement age in the UK.

Regarding economic activity, individuals are defined as economically active, or in the labour force, if they are either in work or actively looking for work (International Labour Organization [ILO] definition). Economic activity includes both those who are employed and those who are unemployed. Individuals who are in employment include employees, those who

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1EC directive 79/7/EEC dealing with the principle of equal treatment between men and women, legislation (the Pensions Act 1995).
are self-employed, participants in government employment and training programmes, and people doing unpaid work for a family business.

There are a number of different definitions and measures of an individual’s or family’s socio-economic status. One frequently used measure is a fifth, or quintile, of household income (usually adjusted for differences in household size or composition). Another is the individual’s socio-economic group, which reflects their occupation and the type of employer. Here we present data according to a range of measures as appropriate.

The term ‘health’ is used as a positive concept involving the whole person in the context of their situation, and follows the World Health Organization’s (World Health Organization, 1992) definition of health as a state of physical, mental and social well-being, not simply the absence of disease.

The policy context

The importance of the health and well-being of working-age people has risen up the political agenda over recent years. The public health White Paper Choosing Health: making healthier choices easier (Department of Health [DH], 2004) highlights the central part that work plays in health and well-being, and in determining inequalities in health throughout the lifecourse. The White Paper set out the actions that need to be taken to reduce barriers to work to improve health and reduce inequalities through employment; improve working conditions to reduce the causes of ill-health related to work; and promote the work environment as a source of better health.

Following this, a strategy for improving the health and well-being of working-age people was produced by the Department of Health, Department for Work and Pensions and the Health and Safety Executive (DWP, 2005a). This aimed to co-ordinate the Government’s approach to improving health and tackling inequalities through the workplace, and to identify gaps where further work was needed. An area that was not identified in the strategy was the need for a more detailed understanding of the differing needs of older workers, or those of men and women.

Also in 2005, a landmark document for a national strategy on ageing, Opportunity Age, was produced (DWP, 2005b). This had the ambitious aims of ending the perception of older people as dependent, ensuring that longer life is healthy and fulfilling, and enabling older people to be full participants in society. Work and income form one of the key strands in the strategy in the quest for achieving higher employment rates overall and greater flexibility for over-50s in continuing careers, managing any health conditions and combining work with family (and other) commitments. The Government’s aspiration is to achieve an 80 per cent employment rate, including one million more older people in work, and the national strategy on ageing lays out the steps needed to achieve this.

A key driver for this is the recent publication of the public service agreement (PSA) to tackle poverty and promote greater independence and well-being in later life (HM Treasury, 2007). It is hoped that this report will contribute to the delivery of the Government’s commitment on poverty, employment and health through its presentation of the evidence regarding the particular circumstances and aspirations of older men.

In 2006 the Government’s commitment to improving the health of the working-age population was further strengthened by the appointment of Dame Carol Black as the first National Director for Health and Work. In March 2007 a comprehensive review of the health of the working-age population was announced. This review of the literature on older men, work and health offers essential evidence on which to base further actions, and highlights the necessity of recognising the differing needs of the working-age population in terms of age and gender.

One of the commitments in Choosing Health was to ensure that the NHS supports a wider occupational health approach. NHS Plus (a network of NHS occupational health departments across England supplying services
In terms of age legislation, the Employment Equality (Age) Regulations 2006 came into effect on 1 October 2006 and are overseen by the Equality and Human Rights Commission. The regulations apply only to employment and training, as the Government made the decision, despite strong lobbying to the contrary, that the regulations should not cover ‘goods, facilities and services’ as well. The regulations were further weakened by the introduction of a default retirement age, although the Government gave a commitment in Opportunity Age (DWP, 2005b) to review this in five years. The legislation covers all age groups, although it has been popularly viewed as supporting older workers. However, the effectiveness of the legislation to protect older workers is being queried: a recent survey by the Employers’ Forum on Age,4 carried out one year after its introduction, claimed that ageism is still endemic in UK workplaces, with nearly six out of ten (59 per cent) workers claiming to have witnessed ageist behaviour in the workplace during the last 12 months, almost the same percentage as when the legislation was introduced.

Older men in the labour market

In 1971 there were 4.7 million men aged 50–64 in the UK; by 2001 this number had increased by nearly a fifth to just over 5.5 million and by 2007 there were 5.7 million men aged 50–64 living in the UK. The 1970s and 1980s witnessed a rapid decline in the economic activity rates of older men, with an increasing exodus of older men from the workforce at progressively younger ages in the UK and other industrial countries. This has been described as one of the most remarkable labour market transformations of modern times (Duncan, 2003). Employment rates for men aged 55–65 fell by 21.2 per cent over the two decades (DWP, 2002a). When New Labour came to power in 1997, a key policy objective was to encourage more older workers to stay in the labour market and reverse the trend towards early retirement.

The health and work of older men

to non-NHS employers) aims to increase the occupational health services available for small and medium-sized businesses (SMEs). In 2006 and recently in September 2007 the Government announced capital funding to finance demonstration sites for NHS Plus, to drive further innovation in the way occupational health services are delivered to businesses, which often do not have such services for their own workforces. Another form of support to SMEs run by the Health and Safety Executive is Workplace Health Connect (WHC), which was launched in February 2006. This free, no-obligation service provides SMEs with advice on workplace health and safety. However, an interim evaluation (Tyers et al, 2007) has found that although the main focus of the service is workplace health, employers are not calling for help with health or back-to-work issues in any great numbers. The final evaluation is due in 2008.

The other key area of policy relevant to a review considering gender and age in the working population is the equality legislation. The Equality Act 2006 created a single commission that replaces the Equal Opportunities Commission (EOC), the Commission for Racial Equality (CRE) and the Disability Rights Commission (DRC). The Equality and Human Rights Commission,2 as it is called, became operational on 1 October 2007. The first commission of its type in the world (Trevor Phillips, 2007), it will use a human rights framework, taking issues of respect and dignity and applying them to all areas of diversity. The underpinning rationale is that a human rights framework prevents people being pigeonholed into one diversity area, when in reality everyone covers at least two (age and gender) and often more. However, concern remains among age organisations (Butler, 2006) that age will not be as strong a strand as the others. With regard to gender, the legislation places a duty on public sector organisations to ensure gender equity in outcomes, and thus reduce the health inequalities between men and women. Currently, there is no additional duty to do so with regard to age.

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2 www.equalityhumanrights.com

4 http://www.efa-agediversity.org.uk/index.htm
In late 2007 there were about 4 million older men (50–64) in work in the UK. Older male workers are a diverse and varied group, working in different circumstances, facing different challenges and having a wide range of different characteristics (Yeandle, 2005). For example, when compared to workers aged 25–49, they are less likely to be in full-time employment (42 per cent compared with 68 per cent), more likely to be self-employed (18 per cent compared with 14 per cent), and three times more likely to report ill-health or disability (Yeandle, 2005). They are also more likely to work in education, manufacturing or agriculture than younger men, and more likely to be in elementary, process or machine operative, or skilled trade occupations. Men have been hardest hit by the 11 per cent decline in the demand for low-skilled workers in manufacturing between 1985 and 2005, although a substantial increase in jobs has occurred in the service industry for both men and women (HM Treasury and DWP 2003).

Both the 1998 and 2002 Pensions Green Papers included proposals to tackle ‘distortionary incentives’ in the tax and benefit system that might encourage people to leave work before retirement age, including changes to disability benefits and Inland Revenue tax rules for occupational pension schemes (DSS, 1998; DWP, 2002b). To support older workers remaining in the labour market, the New Deal 50-plus was launched in 1998. However, in the recent Government Green Paper In Work, Better Off (July 2007) a more personalised, flexible and responsive New Deal is proposed which is more tailored to the needs of individuals. The consultation period ended in October 2007.

The last decade has seen a reversal of the trend towards early retirement among men, with rising levels of labour force participation among those aged 50 and over (figure 1). Since 1997, the employment rate for men aged between 50 and the state pension age has risen from 67 to 72 per cent, although rates for people over 50 years still remain below the rates for people aged 25–49 (DWP, 2002a).
Interpretation of these figures suggests that while some older men hold white-collar jobs, where seniority is likely to have come with age and working conditions do not normally make heavy physical demands, many older men are still working in manual jobs. In such areas, remuneration may have peaked or plateaued some years ago, and the heavy and physical nature of the work will become difficult if muscle power declines or injuries are sustained (Yeandle, 2005). This may contribute to the fact that one in five older male workers leaves the labour market for reasons of sickness or disability (CROW, 2004a), with nearly 10 per cent of older people economically inactive rather than unemployed. Sickness, disability or injury are cited as the main reason for not seeking work (ONS, 2005a), with almost half of all those seeking incapacity benefits being aged between 50 and state pension age. These patterns of ill-health and disability have implications for health and well-being in later life.

It is important to bear in mind that there are significant differences in economic activity rates among older men by ethnicity. Results from the 2001 Census showed 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 of the same age (ONS, 2006a). The experience of disadvantage varies across different ethnic groups, with some doing very well. Interestingly, economic activity rates among Black Caribbean men (76 per cent) and Indian men (80 per cent) were similar to British White men and rates among Chinese men (82 per cent) exceeded them. Among those who were employed, some ethnic minorities were better represented in the managerial and professional occupations than White British people. In particular, a higher proportion of employed Indian men worked in managerial and professional occupations. The proportion employed in managerial and professional occupations was lowest among Pakistanis, Bangladeshis, Black Caribbean and Other Black men (ONS, 2006a).

Pakistani, Bangladeshi and Chinese men are more likely to be working part-time, or in temporary and casual jobs, due in part to the nature of their high representation in the distribution, transport, hotel and restaurant industries. This compounds their disadvantage with respect to not having access to full-time or permanent contracts in the workplace. Qualitative research found that older men in these ethnic groups who were unemployed wanted to return to the unskilled jobs they knew best (Tackey et al, 2006). Age was a barrier to new forms of employment because the unskilled jobs men from these ethnic groups had undertaken in factories in the 1980s meant they possessed skills that were limited, outdated and no longer relevant to current job opportunities. The research also found that welfare-to-work programmes may not be operating as effectively for ethnic minorities as they do for white populations, and Jobcentre Plus staff do not always reflect the communities they serve (Tackey et al, 2006). There also remained strong perceptions of discrimination within the Pakistani, Bangladeshi and Chinese groups (Tackey et al, 2006). It is expected that in future ethnic minority groups will account for increasingly large proportions of the working-age population, of which many will be older men and the issues of skill development will be relevant for this population.

The changing nature of work

Over the past four decades there has been a transformation of the labour market, with a move away from permanent ‘jobs for life’ towards new forms of working characterised by short-term contracts, self-employment and portfolio careers. Not all older workers will, however, be affected by these new working practices, and there is evidence of regional variation.5

Generational differences are also important in terms of the changing nature of work. The current generation of older men born during the first baby boom, 1946–8 (Evandrou, 1997), emerges from an historical context in which it has experienced tough competition for high-quality work, organisational re-structuring of the

5Work by the Dorset Strategic Partnership found that over one-third of Dorset’s workforce is over 50 and that an increasing proportion are self-employed, work part-time and have portfolio careers. http://www.dorsetforyou.gov.uk/index.jsp?articleid=2736
workplace, and corporate downsizing (Theorell et al, 1998; Phillipson, 2002; Wickrama et al, 2005). These men may have begun their working lives when there was full employment and UK prosperity, but as they move towards retirement they have had to adapt to a rapidly changing work environment. It is therefore necessary to look beyond the demographic and economic trends and consider in more detail the underlying social, cultural and attitudinal characteristics that shape this generation (Evandrou, 1997; Huber and Skidmore, 2003).

It was also during this period that the first generation of predominantly male workers came to the UK from Pakistan, attracted to work in the textile industries of the northern towns and in the metalworking and car industries in the Midlands. The decline of manufacturing in the 1980s and 1990s resulted in many of these older Pakistani men suffering long periods of unemployment (Tackey et al, 2006).

Flexible working
The opportunity to have more flexible working patterns in the older workforce is valued by many groups, although those from routine and semi-routine occupations have poorer access to quality flexible employment (Phillipson and Smith, 2005). Most flexible working takes the form of part-time or self-employment, and is most common for managers and professionals and among those with qualifications. This was similar for men and women (Lissenburgh and Smeaton, 2003).

Self-employment
Self-employment is more common among older men compared with women (26 per cent against 11 per cent), and compared with younger men (Yeandle, 2005). Almost a third of self-employed men work in the construction industry (ONS, 2005b). Pakistani, Chinese and White Irish groups are more likely to be self-employed than
Early exit from the labour market

In 2004 a man aged 50 could expect to live, on average, for a further 29 years and a woman could expect to live for a further 32.6 years. This compares with 24.1 years for men and 29.2 years for women in 1981 (ONS, 2007a). Although people are living longer, men are leaving the workforce at an earlier age than 25 years ago, with the result that the length of time spent in retirement is increasing. In particular, men working part-time face an increased risk of leaving the labour market early (McDonough and Amick, 2001). There is concern over the high levels of unemployment among older Pakistani and Bangladeshi men who do not manage to return to employment before retirement. A large number of men from these communities have left the labour market during their 40s and 50s, and are likely to be suffering multiple health problems (Tackey et al, 2006).

The fact that men leaving the workforce before SPA are not always leaving at a time of their own choosing has important implications for retirement incomes and for economic and social participation in later life (Hirsch, 2003). Workers in professional and managerial jobs tend to enjoy greater choice and control over how they leave the workforce than those in less privileged occupations (Yeandle, 2005). However, other research has shown that men who accessed better jobs and had greater opportunities for progression over their lifecourse did not necessarily have this advantage continuing into later working life. Those who had reached some level of security appeared to be the most vulnerable to ‘premature ousting’ and loss of labour market position (Owen-Hussey et al, 2006).

‘Portfolio careers’

There has been some debate on alternative employment situations, which may be more attractive to older men and allow them to return to, or remain in, paid employment. Such alternatives include portfolio careers, freelancing and consultancy (Platman, 2004).

One study (Platman, 2004) examined the extent of choice, freedom and autonomy among a group of older freelances (both men and women) in the UK media industry, and whether, for example, this way of working allowed older workers to circumvent ageist structures in organisations. The conclusions were that portfolio working is an inherently risky form of employment for all members of the freelance workforce, with certain groups – such as those in poorer health or with caring responsibilities – being particularly vulnerable. The study did not show particular risks for older men, but with the more rapid decline of older men from the workforce, this is a potential approach often available to them. While the encouragement of flexible working packages may have attractions, it seems that this can lead to a precarious existence for certain groups of older workers who may be among the most vulnerable in later life (Yeandle, 2005).

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One of the major causes for people in lower socio-economic groups leaving the labour market is that they experience greater health problems at this stage of life, with 45 per cent citing ill-health as against 10 per cent citing compulsory redundancy (McDonough and Amick, 2001; McNair et al, 2004). A study of black men in Canada found them less responsive to ill-health as a reason to leave the labour market early, possibly due to lack of financial resources.

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A ‘portfolio career’ comprises multiple part-time jobs (including part-time employment, temporary jobs, freelancing and other forms of self-employment) with different employers that when combined are the equivalent of a full-time position.
allowing them to leave the labour force early (McDonough and Amick, 2001).

Caring responsibilities are another reason why older men may leave the workforce early, although in other cases leaving before state pension age is not an option because of reduced income. However, there was concern that the demands and stress of work had increased in recent years, with some carers feeling guilty if they needed to have time off for caring responsibilities. In some cases, this led to men moving to less stressful or part-time jobs, so it was easier to combine work and caring and protect their own health (Mooney et al, 2002).

Studies reveal the complexity of modern pathways out of work and the factors that influence them: simple financial sticks and carrots are unlikely on their own to change retirement behaviour greatly. Many difficulties that people encounter stem not from an inability to face up to the trade-off between income and leisure in later life, but from a lack of choice and control (Hirsch, 2003). Research at the Joseph Rowntree Foundation’s ‘Transitions after 50’ Programme concluded that, because of the diversity of the working-age population, public policy promoting opportunities to extend working lives would only succeed if a set of options was produced, rather than trying to find a single solution appropriate for everyone. Government and society were presented with six key challenges that need to be faced if older workers are to be encouraged to extend their working lives. These were:

1. improve choice and control for the ‘have nots’ in later working life
2. fit jobs to older workers as well as older workers to jobs
3. create a new balance of priorities between working, living, health and well-being
4. make financial choices after 50 more transparent
5. improve opportunities to build retirement income among people other than males in stable careers
6. develop new modes of paid and unpaid work that are accessible later in life.

Retirement decisions

The traditional image of retirement as being a sudden change from doing a full-time career job on a Friday to doing nothing on a Monday is increasingly out of date (Hirsch, 2003; Vickerstaff, 2004). However, retirement is perceived as one of the key transitions in mid-life, particularly for men, and is significant event that has a marked influence on their future health and well-being.

Leaving the labour market before official retirement has become more socially acceptable in some Western countries (Henkens, 1999), but this acceptability of early retirement can depend on social networks. People with negative experiences on leaving work, and those with financial difficulties, are less likely to engage in fulfilling activities in retirement, such as involvement in their communities (Hirsch, 2003). Retirement can be associated with better mental health but only for those in higher positions (Chandola et al, 2007). Looking at gender differences, the importance of having a role as ‘worker’ to retain their self-esteem is more marked in men (Henkens, 1999), and may affect their retirement decisions. This reflects the key findings of this review in that work plays a central part in the lives of men.

Decisions by men to retire early are influenced by a number of factors including organisational context – in particular, physical/environmental demands, job challenge and job pressure (Mutran et al, 1997). A review into factors influencing work and retirement (Phillipson and Smith, 2005) reinforced that decision-making in the work/retirement transition is influenced by the degree of control which individuals have over key events affecting their lives. Those who leave work for reasons beyond their control through redundancy, ill-health or dismissal have a less positive experience of retirement, poorer health and higher mortality rates (Higgs et al, 2003). When men and women experience functional limitations, they see their time at work as less meaningful and poor health makes them feel less competent and active. This leads to them finding the job less satisfying and pushes them into early retirement (Mutran et al 1997).
Income in retirement clearly has a major influence on decisions to retire and a significant impact on health. Pension provision is higher for professional men, and ethnic minority groups have been identified as an under-pensioned group who are significantly less likely than the white population to access private pensions (Barnes and Taylor, 2006).

Men’s and women’s different attitudes to retirement partly reflect their different experiences in and out of paid work, with men’s retirement decisions less influenced by their partner’s decisions. The most successful retirements are those where both partners chose independently when to retire (Henkens, 1999; Pienta and Hayward, 2002). A difference has been noted in the retirement goals of men and women, which are also influenced by socio-economic status. Women are more likely to list contact with others and self-orientated goals (such as relaxing, enjoying life), while men are more likely to mention leisure goals which are specific and task-orientated, e.g. playing golf, gardening. It appears that in relation to health and well-being, men tend to focus on the means to achieve well-being, whereas women focus on the end state (Hershey et al, 2002).

It is important to bear in mind that improvements in survivorship have not been shared equally across the population. Data on life expectancy by social class produced by the Office for National Statistics (ONS) shows that during the period 1997–2001 at age 65 a man from social class I could expect to live for a further 18.3 years while a man from social class V could expect to live just 13.3 years, i.e. five years fewer than his higher-social-class counterpart.

The differences for women are less marked, a 65-year-old woman from social class I being likely to live for a further 20.6 years compared with 16.5 years for a woman from social class V (ONS, 2007b). This highlights the link between occupation and health among men. Regional variations also exist with a ten-year difference between the local authority with the lowest male life expectancy (Glasgow City, 69 years) and that with the highest level (North Dorset, 79 years) (2001 Census). In London, Kensington and Chelsea is cited as having the highest level of life expectancy at 65 (83.1 years), which markedly contrasts with 79.4 years in Newham.

There is evidence that a uniform rise in conventional retirement age would reinforce health inequalities in developed countries, and runs counter to the UK government policy to reduce inequalities. Increasing effective retirement to a uniform age such as 70 years (and presumably when the State Pension is drawn), would disadvantage men, manual workers and people in areas where unemployment is relatively high, deepening inequalities still further (Bellaby 2006). This view is supported by other research, which claimed that for those who are now over 50 paid employment is neither a feasible nor an attractive option among these groups (Phillipson, 2002).

Gender, work and health: exploring the critical link

The connection between work and good health is strong. A comprehensive review of the link between health, well-being and work (Waddell and Burton, 2006), commissioned to underpin the Government’s Health, Work and Well-being Strategy (DWP, 2005a), concluded that work is generally good for health and well-being. However, it recognised a number of causal links between these elements, with complex interactions and sometimes contradictory effects, and although gender and ethnic differences were not particularly highlighted, ageing was a factor. Studies showed that there is mixed evidence that older workers experience any decline in perceived or reported health despite increasing disease prevalence (Tuomi et al, 1997; Wegman, 1999; Scales and Scase, 2000). An earlier study in the US (Rushing et al, 1992), which looked at the effects of social roles such as marriage and employment on health among older men, found that employment had the most consistent health-protective effect on men; this was more pronounced for the black than for the white populations.
Further studies have shown that economically inactive men are more likely to have consulted an NHS general practitioner in the last fortnight: 19 per cent compared to 8 per cent of working men (Marmot et al, 2002; Blane et al, 2004). Poor health was given as the most common reason to retire before state pension age, and most notably these people were more likely to have no formal qualifications and much less likely to have an income from a private pension (Marmot et al, 2002 and Marmot and Brunner, 2005; Lissenburgh and Smeaton, 2003).

Voluntary retirement before state pension age is more likely among those with an occupational pension, and the majority of these are men. Women were just as likely as men to leave the labour market early if they had health problems, but, in contrast to men, years with a current employer had no effect on their likelihood of leaving. This difference may reflect women’s less substantial occupational pension entitlement (Lissenburgh and Smeaton, 2003). This might change in the future as more women build up better pension entitlements, reflecting recent changes in career patterns and family structure.

The effect of occupational status on widening inequalities in later life is now documented. Relative social inequalities in physical and mental health increase between middle age and early old age, occupational class continues to affect the self-reported health of older people well into their retirement, and people from lower occupational grades age faster in terms of a quicker decline in physical health than people from higher grades. An older person’s previous labour market position continues to have a major influence over their health for many years after leaving the labour market (Arber, 1996; Marmot et al, 2002; Chandola et al, 2007).

**The centrality of work in men’s lives**

Work occupies more of men’s time than women’s (ONS 2007c) and it plays a central role in the lives and identity of men, which has strong implications for their health and well-being throughout the lifecourse and into later life. Paid work is more salient for men’s well-being, with stronger health effects being reported for men than women (Janzen and Muhajarine, 2003). But both the absence and the presence of work can be a key source of health problems in men.

The importance of work in men’s lives is borne out in studies of the changes men make at work. Men cite career, money and redundancy as their main reasons for changing jobs, showing a significant difference to women. Women are more likely to make a job change specifically to work more flexibly, reflecting women’s greater involvement in caring and domestic responsibilities (McNair et al, 2004). While men are also more likely to have been made redundant in the last five years of the working lives, they are more likely to go back into work, with many more men of 60+ seeking work than women of that age. Similarly, while men and women are equally likely to seek work in retirement, men are more likely to seek paid work, while women consider voluntary work (McNair et al, 2004).

This centrality of work in men’s lives has implications for their health as they age. Economically active men report higher rates of good health than economically active women (77 per cent), but among the economically inactive, a third of men rate their health as ‘not good’ compared with just a fifth of women (ONS, 2006b). As men over 60 grow older they report a higher prevalence of limiting long-term illness, while below the age of 60 there are similarities between men and women. The reporting of limiting long-term illness varied with socio-economic status: people aged 50 to 59 from routine and manual working classes are more likely to suffer ill-health than for those from professional and managerial social classes (Marmot et al, 2002; Hyman, 2003). Seventy per cent of men in managerial and professional jobs said they had no long-standing illness compared with 64.5 per cent of those in lower supervisory and routine jobs. Levels of limiting long-term illness and self-reported poor health are particularly high in UK South Asian older workers (Szczepura et al, 2004). Unemployed men and those who have ‘never worked’

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*Chronic or long-term illnesses that limit activities that people can perform in their daily life.*
experience particularly poor health – only 49 per cent reported having no long-standing illness (ONS, 2006b). Unemployed men in mid-life report greater functional limitations in their daily activities (Melchoir et al, 2006).

Men are more likely to be employed in potentially dangerous workplace environments, with more men than women suffering work-related mortality and disability (White and Cash, 2003). This also disproportionately affects men in lower occupational groups, who are more likely to be exposed to the most adverse working conditions (Hyde and Rees Jones, 2007). Between 1986 and 1999 partly skilled and unskilled workers were more likely than professional workers to die from respiratory illnesses (Marmot et al, 2002).

However, there are possible variations through ethnicity; a study commissioned by the HSE (Szczepura et al, 2004) found that UK South Asian workers are under-represented within the most hazardous occupational groups.

There are also problems that occur as a result of risk-taking within male cultures, and often, because of work patterns such as working away from home, inflexible working hours and full-time as against part-time work (of the 15.2 million jobs occupied by men in 2007, just 1.6 million were part-time, i.e. 11 per cent, compared with about 42 per cent for women [ONS, 2007c]), there are structural barriers for men in being able to access appropriate health care (Conrad and White, 2007).
Shift patterns have been shown to have a possible link to an increased risk of heart disease, metabolic syndrome and infections (van Mark et al., 2006). These points are developed further in the section on work-caused and work-related ill-health.

Work-related stress, health and ageing

The correlation between job stress and health is well documented, with stress at work now recognised as one of the most common forms of mental distress (Shigemi et al., 2000; Robertson, 2005). Other links to physical health include, for example, low decision latitude, which plays the most significant role in raising blood pressure across gender and socio-economic groups. There are also associations with the onset of diabetes, and people’s ability to give up smoking (Leynen et al., 2003). In terms of workplace stress, several US studies have indicated that ethnic minority workers experience a more negative work environment, in which criticism and bias can often be the triggers (Szczepura et al., 2004).

Other studies have shown the correlation between job stress and heart disease. Results from a large cohort study in Belgium (the Belgian Stress Project – Belstress) looking at the association between perceived job stress on health in men and women, concluded that it raises heart disease risk (Pelfrene et al., 2002). Importantly, a further study (Clays et al., 2007) found evidence that links job strain and cardiovascular disease: this was strongest and most consistent in men aged 40–64; higher job demands were related to higher blood pressure levels, but only in men. The results were ambiguous for women. The association between job strain and diastolic blood pressure was greater in participants over 50 years of age (Pelfrene et al., 2002; De Backer et al., 2005).

The critical role that work plays in the male lifecourse is born out in studies linking mental health and work, which show a greater impact on men (Rolfe et al., 2006). Men appear able to separate the domain of work from other life events, reporting deterioration in their health status and an increase in depression levels when their work control is decreased. In women, although work control may have an influence on their health, they were far more likely to be influenced by non-work negative events (Wickrama et al., 2005). There are implications also for mental health, with a link between the high self-esteem of middle-aged workers and implications for good mental health in retirement (Mutran et al., 1997).

When we look at the impact of ageing on these factors, it appears that levels of and changes in work control during mid-life have a greater influence on middle-aged men than middle-aged women, with long-term direct and indirect health consequences. Individuals in mid-life, if they do not acquire new skills, are more susceptible to adverse changes in work control with direct mental and physical health consequences (Wickrama et al., 2005). When we look at the significance of work to men, they are likely to be disproportionately affected by these changes. Added to this, the influence of stressful conditions may be intensified by a natural increase in biological vulnerability in the middle years because of hormonal changes such as decreases in testosterone (Merluzzi and Nairn, 1999).

Work, family life and health

The previous section highlighted the role that work plays in men’s lives and the important link between work and health. However, men and women undertake a variety of economic and social roles, including those of parent, spouse/partner and carer as well as that of a paid worker. It is essential therefore to briefly examine the mediating effect that occupying other roles may have on men’s health.

There are two opposing theoretical models concerning the impact of occupying multiple (or simultaneous) roles on physical and psychological health. Role enhancement theory suggests that those involved in multiple roles (e.g. spouse, parent and employee) will be in better health than those with fewer work and family responsibilities (Sieber, 1974; Marks, 1977).
In contrast, role strain theory postulates that multiple roles will be associated with poor health outcomes (Goode, 1960).

Research using the longitudinal Retirement Survey (1988/9 and 1994) to investigate the links between multiple economic and social roles and health in mid-life (45–64 years) found a positive association between employment and health (Glaser, Evandrou and Tomassini, 2005), supporting the view that work is generally good for health. However, the same study found that occupying a parental role during mid-life, either alone or in combination with other roles, appeared to have negative health consequences for men. Men who were living with a dependent child (aged under 16 or under 18 and in full-time education) between the survey waves were twice as likely to report poor health (measured by difficulties with activities of daily living and/or instrumental activities of daily living) than those who did not. Given this, it appears that continued parental demands in mid-life may have negative health consequences for men.

Other studies have shown that the parental role imposes greater strains on psychological functioning for men than for women (Simon, 1992). However, not all family roles have deleterious impacts on health. Numerous studies have found that married men tend to live longer than their unmarried counterparts (Lillard and Panis, 1996), indicating that having a partner provides men with a protective factor. Therefore, the impact of family life on the health of older men is not clear-cut.

Although more people in mid-life now have surviving parents or even grandparents as well as children of their own, recent work has highlighted that being ‘caught in the middle’, in terms of simultaneous care-giving responsibilities to dependent children and frail parents while being in paid work, remains an atypical experience. Among those born in 1941–5, only one in nine women and one in ten men occupied all three roles of carer, parent and worker concurrently at ages 45–49 (Evandrou and Glaser, 2002). However, while multiple role commitments in mid-life appear to be uncommon, there is some evidence that the extent of multiple roles is increasing among younger cohorts. It is not clear what the impact of this will be on health in the future. However, it is clear that more research is needed to understand the complex interactions between family responsibilities, work and health.

A review of recent research in the area of work and family life by Dex (2003) highlighted that policies in the workplace need to give more attention to the needs of working carers of older adults and disabled children than is currently the case. Workplaces with mainly male workforces are also often the areas where flexible working is not on offer, with the result that men are less able to combine work and family life.

**Work-caused and work-related ill-health**

The importance of occupational histories for the health of men in later life is already borne out by the empirical evidence. This section looks in more depth at work-caused and work-related ill-health in older men. We know for example that musculoskeletal disorders (MSDs) are the most common occupational illness in Great Britain, affecting 1 million people a year. They include problems such as low back pain, joint injuries and repetitive strain injuries of various sorts. Although studies indicate that women, and in particular older women, are more likely to experience musculoskeletal problems through work (Doyal and Payne, 2006), men, by nature of their work, are also vulnerable to musculoskeletal problems (NIOSH, 1997; Watterson, 1997). The other major problem of work-related disease is mental health (Health Development Agency, 2004).

Two examples of key industries are cited where, by the nature of the work, men have dominated the workforce: coal-mining and the construction industry. A case study is then presented that focuses particularly on the health effects of asbestos use across the lifecourse and the future implications on changing patterns of work for the incidence of asbestos-related diseases.
Coal-mining industry

Coal-mining is an example of how occupational history impacts on men’s health in later life. Although the UK coal-mining industry has been in decline since the 1980s, there are still many men alive today whose health is affected by having worked in the industry. The most serious of these is coal worker’s pneumoconiosis, a lung disease caused by breathing in dust from coal, graphite or man-made carbon over a period of time. Whilst pneumoconiosis is the most serious disease, chronic bronchitis and emphysema are also attributable to dust exposure, and all lead to chronic ill-health and disability.

The risk of developing pneumoconiosis depends on how long men are exposed to coal dust, and it therefore follows that most men with the disease who have worked in mining all their lives are aged over 50. However, in spite of a decline in the mining industry, there has been a recent rise in the prevalence of pneumoconiosis from 0.2 per cent in the mid-1990s to 0.6 per cent in 2001 (Health and Safety Commission [HSC], 04/03). The Health and Safety Executive (HSE) attributes this to changing work patterns with individuals working long hours, and therefore having high exposure. They suggest that there is a disproportionate effect on contractual workers, as they could be more likely to work longer hours; as has been noted, these are more likely to be men.

Similarly, there has been an increase in numbers diagnosed with the more severe form of pneumoconiosis. The HSC suggests that part of the earlier improvements in the disease occurred because of widespread redundancies among older mineworkers as collieries closed, lessening their long-term exposure to coal dust and risk of developing pneumoconiosis. For those mines that remained in operation, however, the older age structure reflected a policy of practically no recruitment into the industry and increasing numbers of older miners remaining in the mines and being exposed to coal dust for a longer time period. In terms of environmental policy and discussions on alternative sources of energy, there may be much to learn from looking at the health profiles of older men in these industries and how to limit the risk exposure of future generations.
known about work-caused and work-related ill-health, and its consequences for health in later life.

There is also criticism of the industry’s focus on behavioural safety rather than on management strategies and risk management policies, whereby a culture of working earlier and longer days affects safety. This is further exaggerated by the common practice of contracting and subcontracting, which can lead to a lack of central control of health and safety standards and risk management policies. While there are signs of moves being made across the world to raise awareness of the hazards that construction workers face, many older men, as well as future generations of men, will suffer ill-health as a result of their work. To illustrate this further, this report considers in more detail the case of exposure to asbestos.

Construction industry

The construction industry is also dominated by men. In 2007 906,000 out of 914,000 workers were men (i.e. 99 per cent) (ONS, 2007c), and of these three in ten are self-employed older men (O’Regan et al, 2007). White Irish men are over-represented in the construction industry at 20 per cent (ONS, 2004).

The marginalisation of construction workers makes them especially vulnerable to poor health and safety standards, resulting in common injuries and disease. These include musculoskeletal, respiratory and skin hazards, and avoidable deaths, injuries and illnesses (Watterson, 2007). Studies in Canada are showing associations between working in the construction industry and head and neck cancers (Brophy et al, 2007). All this indicates the importance of building up accurate work histories in order that more is
Gender, work and health: the example of asbestos exposure

The example of asbestos exposure and the links to work-caused ill-health is an interesting one because, although there is international agreement about the health hazards created by asbestos for various categories of construction workers, there may not be the same reduction in asbestos-related disease in old age as has been seen in pneumoconiosis. In Great Britain currently 3,500 people die each year from these diseases, making it the single greatest cause of work-related fatalities (O’Regan et al, 2007).

Mesothelioma is the most common of the asbestos-related diseases; occupations carrying the highest risk of mesothelioma are concentrated in metal plate workers (including shipyard workers), vehicle body builders (including rail vehicles), plumbers and gas fitters, carpenters and electricians.

It can take 15 to 20 years from exposure to onset of asbestos-related diseases, and the group of workers most at risk are those who worked, or who are working on, buildings built or refurbished in 1950 to 1970s in construction-related trades: for example, plumbers and carpenters (O’Regan et al, 2007). Asbestos was widely used as a building material until as late as 1999, and it is estimated that many tonnes of it are still present in UK buildings.

The link to work-caused and work-related ill-health comes through the casual nature and age profile of the workforce with, for example, at least three in ten of the construction workforce being self-employed older men. A study by the Institute for Employment (O’Regan et al, 2007) found that although some of the men had been taught about the dangers of asbestos during past training, others based their knowledge on what they picked up from colleagues. Interestingly, older workers in particular were found to have a strong influence over younger workers, which could have a negative effect if they did not take their own health and level of risk seriously.

Older workers also thought they knew as much as they needed to know, and those who had never had training were the most confident.

The issues of asbestos use and its impact on health in old age are continuing to be a problem worldwide. The export of asbestos by Canada to developing countries is, some suggest, setting the stage for another preventable occupational disease epidemic that will manifest itself over the coming decades (Brophy et al, 2007). Similarly, in countries such as China, Vietnam, India and Zimbabwe, there is a lack of regulation on asbestos and effective bans on its use appear unlikely at present (Watterson, 2007; Brophy et al, 2007). The increase in Central and Eastern European migrant workers taking up building work in Northern Europe means that, potentially, there will be an increase of asbestos-related disease. Although migrant workers currently tend to be younger (Zaronaite and Tirzite, 2006), this will have implications for the host countries if migrants settle and grow older. However, relatively little has been published in the mainstream literature on the health and safety of migrant workers moving to poorly regulated urban building sites in Northern Europe (Watterson, 2007). This case study highlights the importance of the age and experience profile of workers and their training needs in initiatives to improve workplace health.

Promoting workplace health

Some commentators recommend that ‘health’ and ‘safety’ at work should be separated out from each other (Hadler, 1997; Waddell and Burton, 2006). Waddell and Burton suggest that as well as the statutory duty of employers to conduct risk assessments to identify hazards to health and safety, it is equally important to ensure that health and well-being are promoted in the workplace. The Scottish Executive (2004) regards a healthy working life as one that continuously provides working-age people with the opportunity, ability, support and encouragement to work in ways and in an environment that allows them to sustain and improve their health and well-being.

10Mesothelioma is a formerly rare form of cancer in which malignant (cancerous) cells are found in the mesothelium, a protective sac that covers most of the body’s internal organs.

11Defined as individuals who arrive in the host country with the intention of finding a job (Zaronaite and Tirzite, 2006).
The workplace itself is seen as a setting in which the health of the workforce can be improved (DH, 2004), with an increasing recognition among some employers that looking after the health of their employees improves productivity. It also presents an opportunity to engage men in particular with health issues, because of the centrality of work in their lives and the problems men experience in accessing traditional health services owing to their work patterns (Conrad and White, 2007).

To be most effective, these interventions should be part of a corporate wellness programme backed by organisational policies which combine corporate responsibility with individual behaviour change. Embedding workplace wellness into overall corporate objectives and a performance management framework is paramount to successful health promotion programmes in terms of achieving healthy active ageing (Bowers et al, 2003). However, embedding programmes in small and medium-sized enterprises (SMEs) with no occupational health services remains problematic (Bowers et al, 2003; Carroll et al, 2005). Similarly, organisations using self-employed contractors, such as taxi drivers or lorry drivers, who are often older men, present particular challenges of engagement.

The pre-retirement pilots were a policy initiative to find ways to improve the health of people in the 50–65 age group (DH, 2000; DH, 2001) with a particular focus on socio-economic inequalities. It looked at various settings and population groups and concluded that the workplace was an appropriate setting for delivering health-promoting services to older men (Bowers et al, 2003; Granville and Bowers, 2002; Granville, 2004). This was particularly true in small and medium-sized enterprises (SMEs), which often have no occupational health services. The research stressed the importance of understanding the context in which interventions take place, including the cultural expectations of the workforce, as well as actively involving the workers in discussion about outcomes (Carroll et al, 2005).
A review by the Health Education Authority (Health Development Agency 2002) into health interventions in the workplace identified that healthy eating interventions had decreased blood cholesterol by up to 10 per cent. Similarly, the workplace proved an effective setting in influencing patterns of alcohol consumption and reducing alcohol-related problems. The reviews identified key characteristics of workplace interventions, which included:

- visible and enthusiastic support and involvement from management
- involvement of employees in all levels of planning and intervention phases
- tailoring interventions to suit the characteristics and needs of employees.

A review by the US Center for Disease Control and Prevention\(^\text{12}\) came to similar conclusions, although age and gender were not specifically identified in either study.

\(^{12}\)US Center for Disease and Prevention http://www.cdc.gov/Workplace/

Health and men's ageing bodies

Differences in work trajectories and life circumstances are important in structuring the differences in health beliefs and health behaviours between social classes (Cornwell, 1984; Wandel and Roos, 2006). When planning workplace interventions with older men, occupational health and health promotion practitioners may wish to consider how men in different occupational groups view growing older, and how much their work experiences influence the pursuit of activities to improve their health. The connection between living and working conditions can shape people’s health beliefs and expectations of health in later life, with those in manual jobs being more readily accepting of a decline in their bodies and an inevitable loss of functioning related to manual work. Bodies can be seen as used up by work, becoming worthless due to wear and tear, occupational strains and injuries. Feelings of bodily decline through ageing, and uselessness in work life, may be something that unconsciously affects their health seeking behaviours.
Conclusions and recommendations

This review has drawn together a body of literature on older men, work and health, which highlights the cumulative effect of working life on the health of men as they age. It has examined the importance of experiences earlier in the lifecourse and how the combined effect of gender, socio-economic position and ethnic background impact on older men’s health and well-being.

Three key themes emerge from the review which are of particular significance. One is the central role that work plays in the lives and identity of men and hence the impact this has on their health, both in and out of work. Secondly, the occupational histories of men expose them to work-related and work-caused ill-health, which has consequences for life expectancy and chronic disease in old age. Thirdly, the successful targeting of men regarding health promotion requires specific action.

These findings have implications for future research, policy formulation and implementation, and for public health practice.

Identifying gaps in the evidence

This literature review has identified a lack of research focusing on the effects of work on health among older people within a gender perspective. Similarly, there is little empirical evidence in the literature on the cumulative effect of working lives on the health of men (or women) as they age.

More research of this kind is vital in enhancing our understanding of the implications of an ageing workforce.

Further research which adopts a lifecourse approach, and is therefore helpful for considering the cumulative effect of work in relation to gender and age cohorts, would be extremely useful. Specifically, it would serve to inform the design of health improvement programmes, so that they can be based on a deeper understanding of what is effective in particular circumstances with certain groups of people.

In contrast, professional workers tend to be more anxious about their ageing bodies and may try to combat and control the ageing process. They may disguise many of the effects of ageing, seeking out ways to improve their ageing bodies rather than witness their decline (Featherstone, 1987; Shilling, 2003; Wandel and Roos, 2006). This has implications for health promotion, as it raises the question of how attitudes to the ageing body may be reflected in differences in health-related habits of middle-aged men from different social groups.

Work Fit: an example of a workplace intervention that benefits older men

Work Fit is a workplace intervention, designed by the Men’s Health Forum to particularly appeal to men, Work Fit is an online health and lifestyle programme, focusing on nutrition and physical activity. It runs for 16 weeks and comprises weekly goals and challenges, email prompts and online help from health advisers. The initiative was developed in partnership with BT, which wished to improve the lifestyle of its 90,000 (mostly male) staff. BT had a very clear business case for its action because it was losing one employee every two weeks to a heart-related illness.

Some 16,000 men and women registered for the programme, of which nearly three-quarters were men, with middle-aged, overweight men being particularly responsive. Over a period of four months, 4,400 BT employees lost 10 tonnes of weight between them, an average weight loss of 2.3 kg. The findings showed that participants who followed the programme significantly increased their physical activity levels, improved their diet and improved their chances of losing weight, if appropriate.

A follow-up exercise showed that about half of the participants had sustained the lifestyle improvements achieved during the programme itself. The Men’s Health Forum is keen to see this approach rolled out and is currently talking to other companies and trade unions.

13At present no information on Work Fit has been published, although more details can be found on the Men’s Health Forum website: www.mhf.org.uk
Given the changing ethnic composition of the older population and the recent increase in migrant workers, more research is needed to investigate the impact of work on health among older workers from different ethnic groups and the implications of this for health services in the future.

In addition, given the changing pattern of the lifecourse and the likelihood that more older workers will also occupy roles as carers and parents during mid-life, further research is needed on the impact of family life on health and how social roles may mitigate or reinforce the health impacts of economic roles.

More longitudinal research and pilot projects are required to develop a stronger evidence base of the type of programmes that support behaviour change in the workplace, such as Work Fit.

Supporting policies for improving health in working-age people

The literature reviewed in this report demonstrates the long-term benefits in improving the health of working-age people in the light of the cumulative effect of work on health status in later life.

The review of the evidence furthers our understanding of the differing needs of men and women and the importance of age factors, which can be used to inform the Government’s co-ordination of the strategy for work and health (DWP, 2005a), and the implementation of Extending Working Lives, in the National Strategy for an Ageing Population, Opportunity Age (DWP, 2005b). It will also inform the approaches required to reach the Government’s aspiration to increase by one million the number of older workers.

Work-caused and work-related ill-health are issues that resonate beyond the UK. The increase in migrant workers means that these workers will bring with them their occupational histories and associated occupational health risks from their prior working lives. Therefore the state of health of older men in the UK may reflect workplace health both in the UK and outside it.

Work-caused and work-related ill-health have a disproportionate effect on contractual and self-employed workers in risky occupations, of which the majority are men. Health and safety policies in industries such as construction need to focus more on management strategies and risk management than on individual behavioural safety.

The evidence of the risks to freelance workers, of which many are older men, suggests that policies need to be developed to offer more protection to this group if they are not to be disadvantaged in later life.

Informing public health practice

The health inequalities agenda has focused largely on socio-economic factors as being central to the health divide. There has been less emphasis on gender as a health inequality that causes differences in health outcomes between men and women. The new Commissioning Framework for Health and Well-being (DH, 2007) provides an ideal mechanism for addressing these differences, with the central driver being equality of outcomes, not equality of service provision. This will require a shift in the way local health and well-being partnerships commission services for their local populations. Commissioning gender-sensitive services would also support public sector organisations in fulfilling their statutory duty under the 2006 Equality Act to promote gender equality policies. For example, NHS organisations are required to develop and publish a gender equality scheme in consultation with stakeholder groups that is reviewed every three years.

The evidence in this report re-emphasises the potential of the workplace as a setting for improving men’s health and well-being. Men, particularly older men, are under-represented in health promotion programmes (Lambert et al, 2007) and workplace health-promoting activities need to be designed with specific consideration to gender. The growing body of evidence on men’s health and the links to masculinity can inform such programmes: they need to be easy for men to access; health information needs to be specifically marketed to men, and opportunities should be offered for individual, rather than group, involvement such as web-based activities.
Spread and adoption of the learning from successful work-based interventions such as Work Fit needs to be encouraged through the scoping and publication of examples from practice. This could be further enhanced by profiling employers who create a working environment that encourages men to take care of their health, in addition to the existing presentation of ‘healthy workplace’ awards.

Occupational health services have a key role to play in embedding workplace wellness into organisational objectives, as well as a role in delivering health-promoting activities in the workplace. Initiatives such as NHS Plus and Workplace Health Connect should be extended because of the support they offer to small businesses without their own occupational health services. Occupational health services would also be well advised to take account of the evidence (Bowers et al, 2003) that recognises the differences in approaches required by different generational cohorts, and the importance of the transitions that take place during mid-life.

A challenge for all health improvement programmes is to enable people to change their behaviour. The Wanless reports (Wanless, 2004; Wanless et al, 2007) that investigated the future funding of the NHS recommended that people should be ‘fully engaged’ in their own health and well-being if the NHS is to deliver health care services in the future that are free at the point of delivery.

Recent public health policy (DH, 2004) has put in place initiatives such as health trainers to support people to become involved in their health, and the workplace would be an ideal setting for recruiting and delivering health trainer programmes with men. Another initiative is ‘mid-life checks’ (DH, 2006), a self-assessment process for people aged 45–65 to assess their own health. This approach may be particularly attractive to IT-literate men with access to the internet, through a web-based process, and could usefully form part of a suite of activities to promote workplace health.
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TAEN’s aim is to help create an effective labour market which works for people in mid and later life, for employers and for the economy.

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Fighting for disadvantaged older people in the UK and overseas, WE WILL:

**COMBAT POVERTY** wherever older people’s lives are blighted by lack of money, and cut the number of preventable deaths from hunger, cold and disease

**REDUCE ISOLATION** so that older people no longer feel confined to their own home, forgotten or cut off from society

**CHALLENGE NEGLECT** to ensure that older people do not suffer inadequate health and social care, or the threat of abuse

**DEFEAT AGEISM** to ensure that older people are not ignored or denied the dignity and equality that are theirs by right

**PREVENT FUTURE DEPRIVATION** by improving prospects for employment, health and well-being so that dependence in later life is reduced.