Title: Women, work and chronic illness: an exploratory investigation of themes from HILDA

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Abstract

This paper explores HILDA data in order to look at workplace outcomes for women with chronic illness. Literature supports the assertion that women with chronic illness tend to be at a disadvantage when attempting to achieve desirable outcomes at work in order to accommodate their particular life circumstances. This exploratory study on attitudes and outcomes of women with chronic illness shows that there are significant links between their position of disadvantage and their satisfaction with various aspects of their working lives as well as their workforce outcomes.

Introduction

Rights of women in the labour force have expanded throughout the later half of the twentieth century. Increasing female participation in paid work has resulted in a burgeoning body of literature about the roles women undertake in the various aspects of their lives. More recently research on women with chronic illness has emerged as part of this literature

This study examines HILDA data to explore some of the outcomes of working with chronic illness. We are interested in two dimensions of the impact of chronic illness on women's workplace outcomes: first, the impact that chronic illness has on all workers, regardless of gender; and second, the specific, additional impacts that chronic illness has on women that it doesn't have on men. A number of areas will be examined including: casual status, hours of work, employment and career opportunities and job satisfaction.

Literature

Existing research suggests that women with chronic illness are at a disadvantage in the workplace. For example, female employees with chronic illness are faced with a work-life juggle which may have the potential to affect their workforce outcomes. Vickers' (1997) qualitative examination of women with chronic illness focuses on issues of disclosure of women with an invisible chronic illness in the workplace. She examined the literature pertinent to the decision-making process of women who were deciding whether, how or when to disclose a chronic illness to colleagues. This research concluded that concessions made at work for an ill individual significantly influenced their ability to mange work and life. Her research highlighted that this field is under-researched and more research is needed to understand the variables which affect women with illness in the workplace (Vickers, 1997).

This paper aims to address gaps in the existing literature from the fields of management, gender and work, sociology and worker disadvantage and highlighted by common perceptions of what it means to be ill (Bury, 1991; Parsons, 1970) and implications for those working with chronic illness. An abundance of literature on chronic illness is available in the areas of education and

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health but in a society where chronic illness is becoming increasingly prevalent (Dwyer, 2004), the implications for employment merit further investigation. Most studies which address women with chronic illness and their experiences at work have been qualitative and focus on small numbers of participants (Myers, 2004; Vickers, 1998, 2001a, 2001b; 2003a). This paper looks at a much larger number of individuals with chronic illness and therefore provides a broader perspective on the issue.

Support for those with chronic illness in the workplace helps to eliminate the hurdles which confront individuals (Vickers, 1997). Social rules which define situations where the application of stigma is acceptable are framed by the expectations of individuals in the workplace (Stuber, Meyer, & Link, 2008). An employee's revelation of illness to an employer can freeze the resources (Myers, 2004) that may be available to them as a 'useful' worker (Bury, 1988). The perceptions by colleagues and managers of the role women with chronic illness should assume when working can add to the disadvantage these women might encounter (Jung, 2002). They are faced with the challenges associated with undertaking multiple roles including a 'sick role' (Myers & Grasmick, 1990). A socially acceptable sick role involves meeting expectations of others, at home and at work, despite the fact these expectations may not be consistent with those experienced by the individual (Parsons, 1970). Working part-time is a way that women can deal with the conflict of role ambiguity and still maintain some normality in their work life (Robbins, Judge, Millett, & Waters-Marsh, 2008). Part-time workers when compared to full-time workers have low expectations regarding the quality of their job (Jocoy, 2003). The expectations of women with chronic illness for workforce outcomes tend to reflect their position of disadvantage rather than their skills and abilities, result in less desirable pay and conditions than their healthy counterparts.

The literature shows that the achievement of positive labour market outcomes for women affected by chronic illness appears to be more likely where they have access to flexibility, collective power and greater employer understanding (Gordon, Feldman, & Crose, 1998; Peetz, 2007; Vickers, 2001). These issues remain problematic, due in part, to the social circumstances surrounding the employment of women, such as their caring roles and their predominance in part-time and casual work (Todd & Eveline, 2004). Collective power through the influence of unions, in unionised workplaces, has gone a long way towards correcting the existing power imbalance in the workplace women experience, specifically women with chronic illness (Peetz, 2007; Vickers, 2003b). However, the predominantly economic rationalist approach to management in Australian business has devalued the importance of work-life balance to the point where workers are unsure of their rights concerning conditions of employment which allow for the contingencies of illness (Goffman, 1976; Timberlake, 2005).

Contingency for women can take the form of part-time or casual work (Burgess, 2005), inconvenient working hours (Vickers, 2001b), insufficient career and pay opportunities (Dixon, 2002) which lead to dissatisfaction in employment outcomes which are further complicated by circumstances of chronic illness (Vickers, 1997).

Methodology

This paper will examine weighted cross-sectional data from the HILDA (Household Income and Labour Dynamics in Australia) survey wave 7, to examine a broader cross section of women in the community who are affected by chronic illness. Examination of the literature on chronic illness in the areas of health, education and sociology show that chronic illness influences all

aspects of life. Industrial relations literature supports the premise that vulnerable workers are more likely to be at risk of lesser workforce outcomes. We would hypothesise from this literature that women with chronic illness would have workforce outcomes compared to those without chronic illness, and that possibly these differences in outcomes might be greater for women than for men.

HILDA data, has been collected since 2001 by the University of Melbourne. Each wave has surveyed individuals and individuals within households to find information related to income and economic wellbeing, households and family life, labour market outcomes and life satisfaction health and wellbeing. Wave 7 (2008) received 12 789 responses.

Chronic illness is defined as a long term condition or ailment which is still restrictive even though it is being treated or medication being taken for it and/or any long term condition such as arthritis, asthma, heart disease, Alzheimer's disease, dementia etc. Information on whether an individual fits any of these criteria is collected in a multiple response question which also collects data on other types of physical disabilities and symptoms.

Bivariate analysis has been undertaken to assess the significance of the variables of age, indicators of casual status, hours of work preferences, satisfaction with employment opportunities, level of job, pay, satisfaction with work itself and overall job satisfaction.

Age and chronic illness: implications for the study's population

We have limited the population to those in the labour force and under the age of 40. The reason for this is that age is closely related to chronic illness. Many labour force outcomes are related to age (for example, older workers are less likely to be employed as casuals and more likely to be in more highly paid jobs). We need to be able to control for the effects of age so it is not conflated with effects of chronic illness.

Figure 1 illustrates the strong, statistically significant relationship between age and chronic illness. The correlation coefficient for all ages is highly significant at .135. As our exploratory analysis is essentially bivariate, we examined the data to see whether age was correlated with chronic illness across all age groups. When the population was limited to those in the labour force over the age of 40 it was also significant at .126. The population for this study was reduced to those in the labour force with chronic illness under the age of 40 as the correlation coefficient amongst this group ($r = .011$) was not statistically significant. This allowed chronic illness to be examined without the polluting influence of age. As Figure 1 shows, the occurrence of chronic illness really only begins to increase with age after respondents pass the age of 40.

The population of those with chronic illness who fall within these definitions means that there are about 90 men and 80 women with chronic illness examined. While this is a relatively small number, this weakness is more than offset by the importance of removing the confounding effect of age.

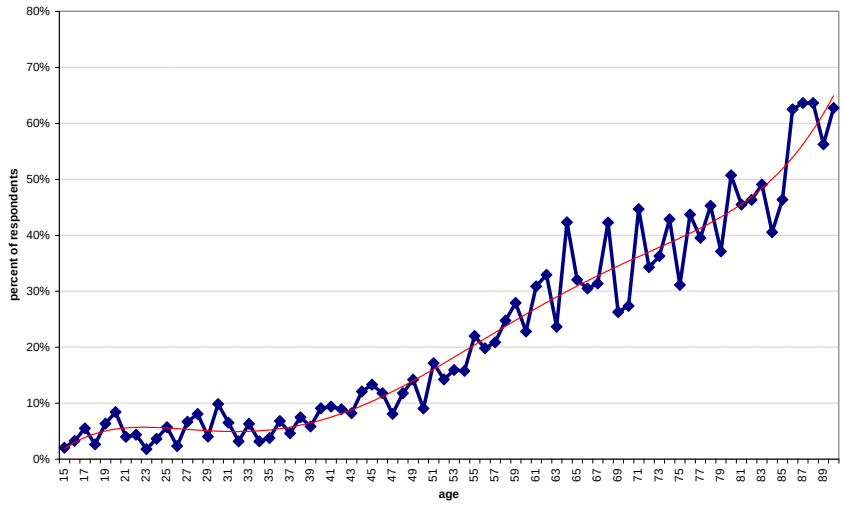

Figure 1: Incidence of chronic illness by age
Population: all persons. Cross-sectional weights applied using variable ghhwtrps

Indicators of casual status and hours of work

We begin by examining the relationships between chronic illness, hours of work and indicators of casual status. These include access to paid holiday leave (Table 1) and preference for hours of work (Table 2).

The predominance of both men and women with chronic illness who do not have access to paid holiday leave is highlighted in Table 1. Nearly half of females with chronic illness work in positions where they do not have access to paid holiday leave compared with 36 per cent of females who do not have chronic illness. For men, too, there is a reduced access to paid leave associated with chronic illness but they start from a superior base. The difficulties in balancing circumstances of illness and work are compounded by the lack of access to conditions which make this more achievable (Vickers, 2003a).

Table 1 Access to paid holiday leave

	Male		Female	
	No chronic illness	Chronic illness	No chronic illness	Chronic illness
No access to paid leave	24%	37%	36%	47%
Access to paid holiday leave	76%	63%	64%	53%
Total	100%	100%	100%	100%
Chi-square significance (log likelihood ratio)	.016		.047	

N = 3901
Cross-sectional weights applied using variable ghhwtrps
Population: persons in labour force aged under 40 years
Source: HILDA Wave 7, 2008

Possible reasons for the higher proportion of individuals with chronic illness in casual positions include the need for these people to access flexibility at work (Myers, 2004) which is otherwise difficult to achieve. Table 2 shows that a number of females with chronic illness would prefer to work an increased number of hours of work, indicating that they are in working circumstances not of their own choosing. Almost one third of women with chronic illness would prefer to work

more hours while 18 per cent of women without chronic illness would prefer to work more hours. This indicates that there is a tendency for these women to experience a lack of flexibility at work which would allow them to work the longer hours they desire while still coping with the circumstances of their illness (Vickers, 1997). Importantly, this phenomenon of higher underemployment amongst women with chronic illness is not seen in men with chronic illness. Men with chronic illness appear able to find jobs that match their hours preferences as easily as men without chronic illness, and are only half as likely as women with chronic illness to be underemployed.

Table 2 Hours of work preferences

	Male		Female	
	No chronic illness	Chronic illness	No chronic illness	Chronic illness
Prefer to work fewer hours	24%	19%	23%	15%
Prefer to work the same hours	59%	66%	59%	54%
Prefer to work more hours	17%	15%	18%	31%
Total	100%	100%	100%	100%
Chi-square significance (log likelihood ratio)	.447		.009	

N = 4251
Cross-sectional weights applied using variable ghhwtrps
Population: persons in labour force aged under 40 years
Source: HILDA Wave 7, 2008

These women have their hours of work influenced by factors outside of their personal control (Vickers, 2001a). Expectations of others, in the form of the opinions of family, friends, colleagues and supervisors (Bury, 1991), have been shown in the literature to affect the lives of those with chronic illness. These expectations often take the form of a socially acceptable sick role, which may translate into a reduced workload requirement from the perspective of an employer determined to do the 'right thing' by an employee or pressure from concerned family and friends to undertake a workload considered to be appropriate for a 'sick person' (Myers & Grasmick, 1990). Contingency experienced by women generally and which is brought about by lack of power in the workplace would appear to be compounded by circumstances of chronic illness.

Employment and career opportunities

The following analyses relate to career advancement. Table 3 looks at the satisfaction that individuals with chronic illness experience with their employment opportunities. Table 4 assesses whether there is any link between level of job and chronic illness.

Table 3 Satisfaction with employment opportunities

	Male		Female	
	No chronic illness	Chronic illness	No chronic illness	Chronic illness
Dissatisfied/neutral with employment opportunities	10%	18%	13%	20%
Satisfied with employment opportunities	90%	82%	87%	80%
Total	100%	100%	100%	100%
Chi-square significance (log likelihood ratio)	.037		.085	

N = 4363
Cross-sectional weights applied using variable ghhwtrps
Population: persons in labour force aged under 40 years
Source: HILDA Wave 7, 2008

Table 3 shows a negative effect of chronic illness on dissatisfaction with employment opportunities for both men and women. Although the significance levels differ (for women the effect is only significant at the 10 per cent level) the magnitude of the effect is similar for both groups.

Women with chronic illness may feel that they are not considered seriously for promotion or career advancement opportunities. The findings here could also reflect their concern about accessing new jobs which allow sufficient flexibility to manage their symptoms, as a new job exposes them to different sets of expectations regarding their work and the management of their illness. They may prefer the 'devil they know' and this may result in a feeling that they have limited options for successfully changing employment in the future (Vickers, 2003a).

Table 4 Level of job

	Male		Female	
	No chronic illness	Chronic illness	No chronic illness	Chronic illness
Managers & professionals	30%	21%	33%	20%
Non-managerial, non-professional employees	70%	79%	67%	80%
Total	100%	100%	100%	100%
Chi-square significance (log likelihood ratio)	.076		.014	

N = 4257
Cross-sectional weights applied using variable ghhwtrps
Population: persons in labour force aged under 40 years
Source: HILDA Wave 7, 2008

Table 4 considers the relationship between chronic illness and employment in high level occupations. With the small number of observations for women (~80) and men (~90) with chronic illness, it is not statistically viable to analyse occupation using the 9 category ANZSCO codes. Therefore it is necessary to merge occupational groups into managers/professionals and non-managerial, non-professional employees. This division of the levels of jobs is based on the strength of labour market position of these groups (Peetz, 2004). Notably, women with chronic illness are significantly less likely to hold managerial or professional positions than women without chronic illness.

The combination of information in tables 3 and 4 suggests that women and men with chronic illness are less likely to progress to more senior levels of employment (Vickers, 2001a). Women and men with chronic illness appear to be encountering barriers that prevent them moving into managerial/professional positions.

Table 5 shows that women with chronic illness are significantly more likely than those without chronic illness to earn a weekly wage of under $650. For men, however, the effect is small and non-significant. The negative impact for women reflects both the greater likelihood of casual and underemployed workers in this group and their underrepresentation in managerial and professional positions. This supports the data in table 3 which shows that women with chronic illness experience reduced satisfaction with employment opportunities which indicates that women with chronic illness are caught in lower-level, low-paid positions which could be partly attributed the increased casualisation of women in this group.

Table 5 Pay (gross weekly wages)

	Male		Female	
	No chronic illness	Chronic illness	No chronic illness	Chronic illness
Pay < $649 per week	40%	44%	57%	68%
Pay > $650 per week	60%	56%	43%	32%
Total	100%	100%	100%	100%
Chi-square significance (log likelihood ratio)	.507		.044	

N = 4506
Cross-sectional weights applied using variable ghhwtrps
Population: persons in labour force aged under 40 years
Source: HILDA Wave 7, 2008

Job satisfaction

Table 6 looks at the satisfaction workers derive from the work itself. Women with chronic illness are significantly more likely to be dissatisfied with the work they perform. This may reflect a belief that the work they perform is at a lower level than they are capable of undertaking (Vickers, 1997). Thus not only are women underemployed, as shown in Table 2, they are also under*deployed*. Women with chronic illness may feel they need to forego a more senior position in order to preserve flexibility to best manage their illness. These women may also feel it is not worth working towards developing a career because they may encounter bosses who have the perception that chronic illness reduces their capability at work and suitability for promotion (Vickers, 1997). Aspects of this are supported by the data on level of job in table 4.

Table 6 Satisfaction in the work itself

	Male		Female	
	No chronic illness	Chronic illness	No chronic illness	Chronic illness
Dissatisfied with work	7%	9%	7%	16%
Neutral or satisfied with work	93%	91%	93%	84%
Total	100%	100%	100%	100%
Chi-square significance (log likelihood ratio)	.498		.006	

N = 4255
Cross-sectional weights applied using variable ghhwtrps
Population: persons in labour force aged under 40 years
Source: HILDA Wave 7, 2008

Conclusions

This exploratory study has a number of implications. Chronic illness has an impact on several workforce outcomes of both male and female employees. Any employer wishing to value diversity within their workforce should be willing to provide the flexibility for employees to accommodate such circumstances. However the data suggest that such flexibility is inadequately allowed for at work. Women with chronic illness are particularly at risk of higher rates of casual work. They are more likely to be underemployed and also more likely to be underdeployed. That is, they appear to face poorer career opportunities and end up in lower level, poorer paid, less satisfying jobs than women without chronic illness.

The lower level of power in the employment relationship of women with chronic illness is likely to cause reduced outcomes in negotiation for conditions at work. Disadvantage indeed appears to be two pronged: there are some disadvantages that apply to all people with chronic illness (in relation to casual employment and satisfaction with employment opportunities), but there are other disadvantages that apply particularly or exclusively to women (in relation to underemployment, access to managerial/professional positions, weekly pay, and satisfaction with the work itself). This implies that women with chronic illness experience a double disadvantage in the workplace. This is an area warranting further investigation.

Women with chronic illness may experience difficulty achieving flexibility at work while negotiating from a position of disadvantage. This disadvantage may translate into a reluctance to change jobs due to an unwillingness to negotiate with a new employer for conditions which allow for their illness. Not having confidence to apply for positions which would allow greater job satisfaction and career advancement could be an influencing factor for significantly reduced job satisfaction for women with chronic illness. The influence of possible future employers is only one aspect of attitudes of others which impact on the working lives of those with chronic illness. The expectation of colleagues that women with chronic illness will assume a socially acceptable 'sick role' adds to an already intricate set of roles that women may undertake in their lives. This paper has set out to explore the HILDA data in relation to workforce outcomes of women with chronic illness and while some interesting information has been uncovered there is a need to further examine these variables in greater depth and work towards a more detailed investigation of these patterns in a qualitative study.

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