



**LABOUR FORCE PATTERNS AND
SELF-PERCEIVED HEALTH STATUS
AMONG OLDER AUSTRALIANS:
IMPLICATIONS FOR HEALTHY AGEING**

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Abstract

Using the data from the first wave of the Household Income and Labour Dynamics in Australia (HILDA) Survey conducted in 2001, this study examines differences in self-perceived health status among the employed and non-employed older adults. The results confirm what has been found in other developed countries that people in paid employment, including those in older age groups, have better health than those who are unemployed or are no longer in the labour force. A preliminary descriptive analysis suggests that this association between employment in later life and positive self-assessed health status may have a more complex relationship to health risk behaviours such as smoking and physical inactivity than may have been anticipated. Social relationships and self-rated economic wellbeing are also found to play an important role in the complex relationship between work in later life and health. Policy implications for healthy and successful ageing are discussed.

INTRODUCTION

The relationship between work in later life and health is complex and has not yet been well understood. In most developed countries including Australia, there is a trend of an ageing workforce due to the long-term decline in mortality and fertility and the fact that the 'baby boomers' are approaching mature age. Moreover, the 'normative' age of retirement at 65 years old for male workers in Australia is also changing. An increasing number of older male workers are exiting the labour force earlier than their previous cohorts. In recent decades, the average age of retirement for men in Australia has been declining. Within the context of social, economic and demographic changes, it is not known if employment helps to keep mature age workers healthy or whether chronic illness and disability keep certain older Australians out of the labour force.

In Australia, about three-quarters of older men aged 55 and 59 are still in the labour force, compared with the peak participation rate of 94 per cent for those in prime working ages of 25-44 (ABS, 2002). For women aged 55-59, about half are economically active. Employment status in relation to health measures has not been fully examined in the past. Understanding the links between work conditions, full-time or part-time employment and older workers' psychological and physical health may be useful for planning to reduce health costs and loss of productivity.

For older Australians aged 50 years and over who are not looking for work, it is not clear whether they fare better than those who are employed in terms of health status. Some argue that early retirement does not necessarily lead to negative health consequences (Encel, 1997). With changes in attitude, some older men may voluntarily choose to leave the

labour market early for life style reasons. Because their children have usually left home by this stage, the demand on their finances is reduced.

With regard to unemployed people, while past literature suggests a negative impact of unemployment on both mental and physical health (Graetz, 1993; Mathers and Schofield, 1998; Wilson and Walker, 1993), very few studies focus on this association for older adults in particular. It remains unclear to what extent a lack of opportunities for paid employment in old age has a profound health impact.

RESEARCH QUESTIONS

Focusing on older Australians aged 50 and over living in private households¹, this paper examines differences in self-perceived health status by labour force categories. Specifically, the paper aims to answer the following questions:

- Are there any marked differences in self-perceived health status among older Australians across labour force status categories (e.g., employed either full-time or part-time, unemployed, not in the labour force either marginally attached or not marginally attached)?
- Are the patterns similar for both men and women, after controlling for socio-economic status variables such as education?
- Are there any links between health risk behaviours (e.g., smoking, excess alcohol consumption and physical inactivity), employment and health?
- Are there any links between social determinants such as social support and economic wellbeing, employment and health?

EMPLOYMENT AND HEALTH

The relationship between work and health is complex and it has long been a subject for debate in the literature whether good health status is a cause or effect of employment. The 'social causation' hypothesis argues that employment protects and fosters health (Ross and Mirowski, 1995). Previous cross-sectional and longitudinal data show that people who work for pay report better physical wellbeing than those who are unemployed, retired or keeping house. One explanation of this association is that employment increases status, power and economic independence as well as conferring non-economic rewards such as social support and recognition from others and that those benefits translate directly and indirectly into better health. Moreover, it has been argued that economic wellbeing is a primary link for the relationship between employment and health. Employment increases household income and decreases economic hardship, both of which improve physical and mental wellbeing. Poverty and economic hardship have been shown to erode health (Feinstein, 1993; Ettner, 1996).

The 'social selection' or 'healthy worker' hypothesis, on the other hand, postulates that good health improves the chances of getting or keeping a paid job and there is empirical evidence to support this view (Arrow, 1996; Baillargeon, 2001; Lea et.al., 1999). Some

¹ The majority of older Australians live in private households. In 1996, approximately 6% of people aged 65 years and over live in health establishments and 3% live in other non-private dwellings (AIHW, 1999).

people without jobs cannot work because of a disability and/or illness. Others seem less attractive to employers because of a disease and/or disability. For older workers, health is cited as one of the reasons for ceasing employment². Thus, the observed correlation could represent an effect of health status rather than effect of employment.

The relationship between employment and health cannot be understood in isolation. It has been argued that individual workers are also involved in social roles that have consequences for their health and wellbeing. A range of social roles occupied by older adults, including paid employment, care-giving and volunteer work may be associated with older workers' health. There is evidence of social support from various sources including workplaces in affecting health (Dean et.al., 1990; Marshall and Barnett, 1992 as cited in Marshall, 2001; Seeman, 2000). Hence, there is a need to know more about the varied roles taken by older workers and non-workers and the association of these roles with health and illness outcomes.

DATA AND METHODS

The analysis is based on the data from the first wave of the Household Income and Labour Dynamics of Australia (HILDA) survey conducted in 2001. The survey contains detailed information on employment history and status as well as self-perceived health status. The sample includes 13,962 individual members of 7,680 households. In this paper, only older adults aged 50 years and over are considered yielding a total sample of 4,894 respondents.

Measures

Self-perceived health status This variable is drawn from the SF-36 instrument in the self-completed questionnaire of the survey. It is measured by using the respondent's global judgement of personal health. Through a self-completed questionnaire, each individual was asked: "In general, would you say your health is: excellent, very good, good, fair, poor." The responses are calculated as per cent self-perceived fair or poor health in subsequent descriptive analyses.

Labour force status This paper adopts the labour force concepts outlined by the ABS (2001) which are in line with the international standards for labour statistics recommended by the International Labour Organisation. According to the ABS, persons in the labour force are defined as those who worked or looked for work for one week or more at the time of survey. *Employed* persons are defined as those aged 15 and over, who during the reference week work for one hour or more for pay, profit, commission or payment in kind, in a job or business or on a farm; or worked for one hour or more without pay in a family business or on a farm. *Unemployed* are defined as persons aged 15 years and over who were not employed during the reference week and had actively looked for full-time or part-time work at any time in the four weeks up to the end of the reference week; and were available for work in the reference week; or were waiting to start a new job within four weeks from the end of the reference week, and could have started in the reference week if the job had been available to them. Hence, people who are in the labour force (economically active) include those who are either employed or unemployed.

² In Australia, about half of men aged 50-54 years old and 40% of men aged 55-59 years old cited own ill health and injury as the reason for ceasing last full-time job. The corresponding figures for women are 23% and 17% respectively (ABS, 1998).

On the contrary, persons aged 15 and over who had neither worked nor looked for work for one week or more at the time of survey are considered as not being in the labour force. They include: persons who were keeping house (unpaid), retired, voluntarily inactive, or permanently unable to work; persons in institutions; members of contemplative religious orders; and persons whose only activity during the reference week was jury service or unpaid voluntary work for a charitable organisation.

Health risk behaviours Three variables are selected to indicate health risk behaviours. First, frequency of moderate/intensive physical activity is based on a question used in the ABS 1995 National Nutrition Survey. Each respondent was asked: “In general, how often do you participate in moderate or intensive physical activity for at least 30 minutes?” The answer of “not at all” is used as an indicator for lack of physical activity. Secondly, smoking status is measured by asking: “Do you smoke cigarettes or any other tobacco products?” The response categories are: (1) no, I have never smoked (2) no, I have given up smoking, (3) yes. In this paper, only currently smoking is considered and the two remaining categories are collapsed together. Thirdly, the question on daily consumption of alcohol comes from the AIHW 1998 National Drug Strategy Household Survey which asks: “On a day that you have an alcoholic drink, how many standard drinks do you usually have? A standard drink is a small glass of wine, a 285 ml glass of regular beer, a nip of spirits, or a mixed drink. Harmful drinking is recoded based on the NHMRC guidelines of alcohol consumption. Harmful drinking refers to more than 4 standard drinks a day for males aged 45 and over and more than 2 standard drinks a day for females of the corresponding ages.

Social isolation This variable is measured by asking how strongly a person disagrees with the statement: “I often feel very lonely.” Frequency is measured on a seven point scale. In this paper, the fourth quartile is used as the level of being socially isolated.

Social support A wide range of measures of social support including among older adults have been used in the literature (Krause and Markides, 1990). In this study, one of the items from Henderson et.al., (1978) is used. A respondent was asked how strongly he/she disagrees with the statement “I have no one to lean on in times of trouble.” The fourth quartile indicates a lack of social support.

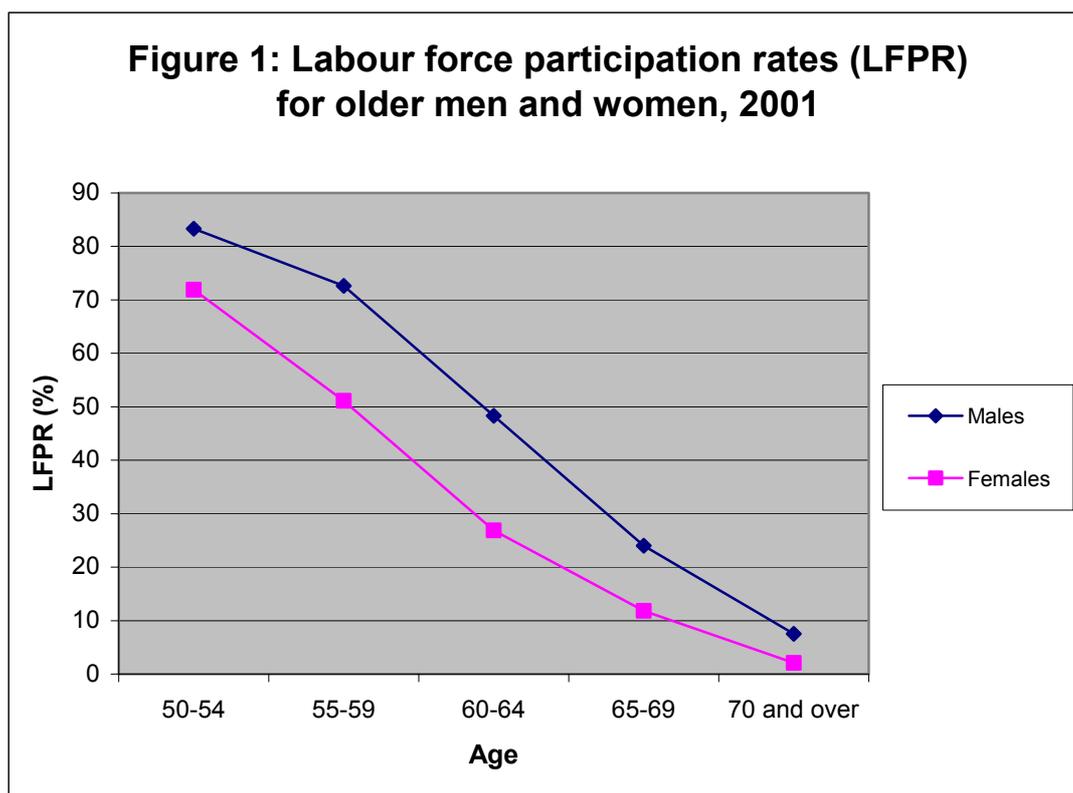
Social interaction The HILDA survey includes a question on social activities which indicates degree of social interaction among individuals. Specifically, respondents were asked: “In general, about how often do you get together with friends or relatives not living with you?” Frequency is measured on a seven point scale (everyday, several times a week, about once a week, 2-3 times a month, about once a month, once or twice every 3 months and less than once every 3 months. The fourth quartile is used to indicate a lack of social interaction.

RESULTS

An analysis of labour force patterns among older Australians based on the HILDA survey data is presented in Figure 1 and Table 1. The data show that the labour force participation rates (LFPR) declined with increasing age for both males and females. In 2001,

approximately 83% of men aged 50-54 were in the labour force, compared with a quarter of those in the 65-69 age group. For women, the LFPR were much lower than those of men in the corresponding age groups.

Part-time employment was significant for older women in their 50s representing 28% for the 50-54 age group and about one-quarter of these older women in the 55-59 age group. Among older men, the proportion of part-time employment in the corresponding age groups were much lower (6% and 12%, respectively).



The unemployment rates among older men ranged from 0 per cent for those who were 70 years and older to 5 per cent for the 55-59 age group. For older women, the unemployment rates were lower than those of their male counterparts for almost every age group.

The relatively low official unemployment rates among older Australians may reflect the fact that a proportion of them are “discouraged job seekers”.³ Hence, a proportion of them are classified as not in the labour force, marginally attached.⁴ In 2001, the proportions of

³ Discouraged job seekers are defined as persons with marginal attachment to the labour force who wanted to work and were available to start work within the next four weeks, but whose main reasons for not actively looking for work was that they believed they would not find a job for any of the following reasons: considered to be too young or too older by employers; lacked necessary schooling, training, skills or experience; difficulties with language or ethnic background; no jobs in their locality or line of work; or no jobs available at all. (ABS, 2001).

⁴ Persons with marginal attachment to the labour force comprise those persons who are not in the labour force, who wanted to work, and had actively looked for work (in the four weeks up to the end of the survey reference week) but did not meet the availability criterion to be classified as unemployed; or were not actively looking for work but were available to start work within four weeks (from the end of the reference week) if child care was available.

older men classified as not in the labour force, marginally attached, ranged from 12 per cent for those aged 50-54 to 25% for the 60-64 age group.

Table 1: Labour force status by age and sex, older Australians aged 50 years and over

Labour force status	50-54	55-59	Age		
			60-64	65-69	70 and over
			(per cent)		
MALES					
In labour force					
Employed	79.2	67.2	45.8	23.3	7.5
Full-time	73.0	55.2	30.7	11.5	3.7
Part-time	6.2	12.0	15.1	11.8	3.8
Unemployed	4.1	5.4	2.5	0.7	0.0
Not in labour force					
Marginally attached	12.2	14.9	24.7	21.9	21.4
Marginally unattached	4.5	12.4	27.0	54.2	71.1
Total per cent	100.0	100.0	100.0	100.0	100.0
Number	559	442	397	288	630
FEMALES					
In labour force					
Employed	67.5	49.4	26.6	11.5	2.0
Full-time	39.5	24.2	10.7	1.8	0.6
Part-time	28.0	25.1	15.9	9.8	1.4
Unemployed	4.4	1.7	0.3	0.3	0.1
Not in labour force					
Marginally attached	13.9	19.7	19.1	13.0	20.2
Marginally unattached	14.2	29.2	54.0	75.1	77.7
Total per cent	100.0	100.0	100.0	100.0	100.0
Number	597	466	383	338	794

It is important to understand factors affecting older Australians' decisions to 'exit' the labour force and examine the extent to which these decisions are associated with health and illness. Table 2 provides data on reasons for not working by age and sex for older Australians.

Table 2: Reasons for not working by age and sex, older Australians aged 50 years and over

Reason for not working	Age			
	50-54	55-59	60-64	70 and over
	(per cent)			
MALES				
Involuntary non-employment ^(a)	37.9	36.6	35.5	11.1
Not working due to illness or disability	45.7	44.1	32.1	14.2
Voluntary non-employment ^(b)	16.4	19.3	34.4	74.6
Total per cent	100.0	100.0	100.0	100.0
Number	116	145	215	583
FEMALES				
Involuntary non-employment ^(a)	27.7	23.6	18.2	10.2
Not working due to illness or disability	20.2	23.6	16.4	7.7
Voluntary non-employment ^(b)	52.1	52.8	65.3	82.2
Total per cent	100.0	100.0	100.0	100.0
Number	188	229	274	718

^(a) Includes being laid off/no work available/retrenched/made redundant/employer went out of business, etc, self-employed: business closed down for economic reasons or sold for other reasons, job was temporary or seasonal.

^(b) Includes being in school, retired, or home-making, did not want to work any longer.

It has been argued that involuntary non-employment may diminish health, whereas voluntary non-employment may not (Ross and Mirowsky, 1995). In this paper, illness and disability are treated as a separate category from involuntary non-employment because it is the focus of this investigation. Generally, involuntary non-employment includes being unable to work because of illness and disability as well as being laid off, fired, or unable to find work. Voluntary non-employment includes being in school, retired, or home-making.

The data in Table 2 show that older men were more likely than their older women to report reasons for not working as involuntary (e.g., laid off, retrenched, made redundant, own-business closed down, no work available). With regard to the reason for not working due to illness and/or disability, the proportions were quite substantial particularly for males (46% for 50-54 years old and 44% for 55-59 years old). This finding indicates the extent to which health determines labour force status among older Australians, although it may be possible that some older adults state health reasons as their justification for not working.

It should be pointed out here that it is not possible to examine the relationship between reasons for not working due to illness or disability and self-perceived health status because the two questions refer to different points in time. Respondents were asked to assess their health status at the time of the survey. However, reasons for not working could refer to different points in time for different respondents. Hence, we cannot expect that those who did not work due to illness or disability would assess their health as being fair or poor at the time of this survey.

Labour force patterns and self-perceived health status

An examination of the relationship between labour force patterns and self-perceived health provides evidence of marked differences in self-perceived health status among older Australians across labour force categories (Figure 2). Table 3 shows that being in paid employment decreases the likelihood of reporting poor or fair health. Among older men, 13% of employed people reported fair/poor health, compared with 23% of the unemployed (a difference of 10 percentage points). A similar pattern is observed among older women (10% vs 24% for women). Older Australians who were not in the labour force had the highest proportion of self-perceived fair/poor health and this pattern holds true for both men and women (42% for men and 34% for women). The highest proportion of perceived fair or poor health among older adults who are not in the labour force cannot be due to age (more older people in the category of not in the labour force). As shown in Table 3, after adjusting for the effect of age, those who are not in the labour force reported the highest proportion of self-perceived fair or poor health. Hence, the cross-sectional data confirm that employment is associated with good health in later life and those who are out of the labour force experience the worst health.

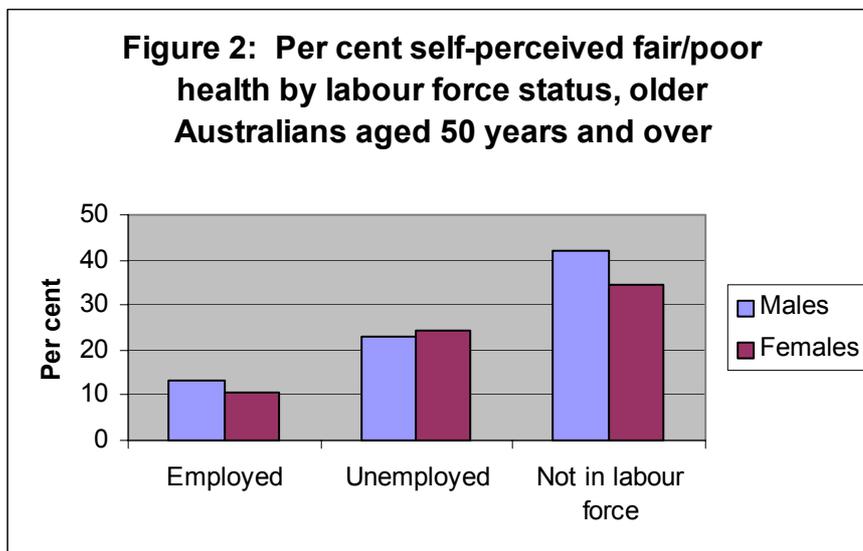


Table 3: Per cent self-perceived fair or poor health by labour force status, age and sex, older Australians aged 50 years and over

Age and sex	Labour force status		Not in labour force
	In labour force Employed	Unemployed	
	(per cent)		
MALES			
50-54	11.5	23.8	63.1
55-59	14.2	29.1	55.7
60-64	11.6	11.1	42.7
65 and over	18.3	--	37.6
<i>50 and over</i>	<i>13.1</i>	<i>23.2</i>	<i>42.2</i>
Number	1,036	59	1,221
FEMALES			
50-54	7.8	29.2	38.5
55-59	11.3	14.3	34.7
60-64	14.1	--	30.8
65 and over	18.6	--	34.5
<i>50 and over</i>	<i>10.5</i>	<i>24.2</i>	<i>34.3</i>
Number	790	37	1,751

-- Number of cases less than 3.

One of the common characteristics of old age employment is that it is increasingly based on part-time work⁵ (ABS, 1999:76). It is of interest to examine if there are differences in self-perceived health between the part-time and full-time employment categories as evidence from past studies does not show consistent results. The findings of this study are shown in Table 4. Among older men, those who worked full-time were less likely than their counterparts in part-time employment to perceive themselves as having fair or poor health, but the difference is small (9% versus 11%). Part-time employment did not appear to be related to health among women as no difference in per cent self-perceived fair or poor health was observed.

For older Australians who are not in the labour force, discrepancies in per cent perceived fair or poor health exist for those classified as marginally attached and marginally unattached. The marginally attached older Australians, comprising a large proportion of discouraged job seekers, reported worse health than their marginally unattached counterparts. The differences are especially pronounced among older men (43% versus 32%). This finding reflects the negative health consequences for those who wanted to work but were discouraged to find work.

⁵ The proportions employed part-time for both men and women rise sharply for the older age groups (55-64 and 65 years and over) to a level even higher than that of the very young (15-24 years old). Part-time employment is more common among women as compared with men across all age groups. For details, see ABS, 1999:76.

Table 4: Per cent self-perceived fair or poor health by labour force status, older Australians aged 50 years and over

Labour force status	Males	Females
	(per cent)	
In labour force		
Employed	13.1	10.5
Full-time	9.1	8.2
Part-time	11.1	7.9
Unemployed	23.2	24.2
Not in labour force		
Marginally attached	43.2	29.1
Marginally unattached	32.0	24.9
Number	2,316	2,578

As education has previously been found to be an important factor affecting health status (Kunst and Mackenbach, 1994; Mathers, 1994), it is important to control for the effect of this variable. The results in Table 5 show that pronounced differences in per cent perceiving fair or poor health among older Australians exist across labour force categories even when education is taken into consideration. For older men, it is clear that the group who are no longer in the labour force report the highest proportion of perceived fair or poor health and this is true for all educational levels. A similar pattern is observed for older women with an exception for those who completed year 12 or obtained certificates.

Table 5: Per cent self-perceived fair or poor health by labour force status, and sex, education, older Australians aged 50 years and over

Educational attainment	Labour force status		
	In labour force		Not in labour force
	Employed	Unemployed	
	(per cent)		
MALES			
Bachelor degree and above	6.9	--	23.6
Year 12 and certificates	14.3	22.6	37.6
Less than year 12	15.6	29.4	50.5
Number	954	56	1,097
FEMALES			
Bachelor degree and above	8.7	--	28.0
Year 12 and certificates	9.9	33.3	28.8
Less than year 12	12.0	23.5	37.5
Number	728	33	1,553

-- Number of cases less than 3.

Labour force patterns and health risk behaviours

Why do employed people have better health than those who are unemployed or not in the labour force? Is this observed association due to the fact that employed people are less likely than those who are non-employed to engage in health risk behaviours such as smoking, harmful drinking and physical inactivity? Past studies, for example, found the proportion of current smokers and ever smokers to be considerably higher among the unemployed (Lee et.al., 1991; Morris et.al., 1992).

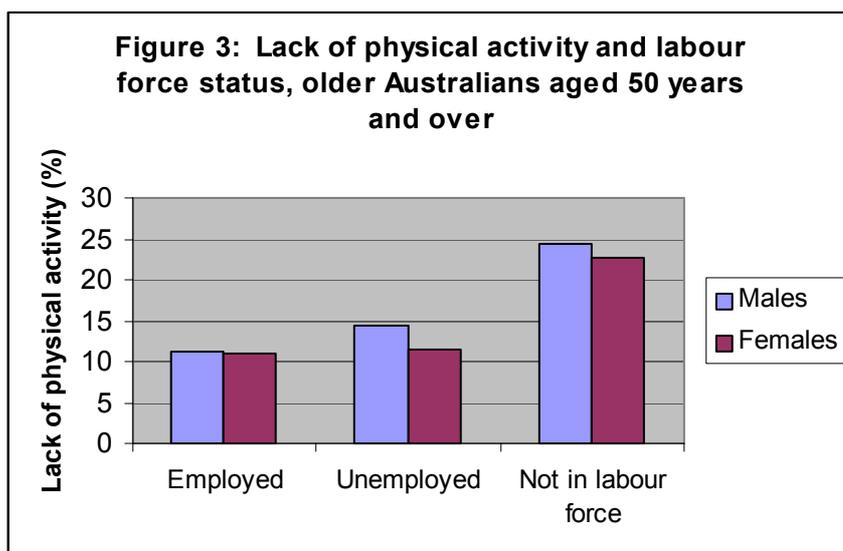
The data in Table 6 show per cent health risk behaviours by labour force status categories for men and women aged 50 years and over. With regard to smoking and harmful drinking, unemployed people have the highest proportions of those reporting these risk behaviours and this is true for both men and women. The data also show that physical inactivity is associated with not working. Older persons who are not in the labour force are twice as likely as those who are in the labour force (regardless of whether employed or unemployed) to report not having any physical activity at all (Figure 3). This result contradicts the notion that people who are out of the labour force are more likely to engage in physical exercise because they have more leisure time than those who work.

Table 6: Per cent health risk behaviours (smoking, harmful drinking and lack of physical exercise) by labour force status, older Australians aged 50 years and over

Health risk behaviours	Labour force status		
	Employed	Unemployed	Not in labour force
	(per cent)		
MALES			
Currently smoking	17.2	25.0	15.0
Harmful drinking ^(a)	16.3	19.6	15.0
Lack of physical activity	11.3	14.3	24.3
Number	982	56	1,019
FEMALES			
Currently smoking	13.2	34.3	10.2
Harmful drinking ^(b)	19.0	31.3	14.8
Lack of physical activity	10.9	11.4	22.7
Number	758	35	1,606

^(a) Older men (aged 45 and over) drinking more than 4 standard drinks a day (NHMRC, 2001).

^(b) Older women (aged 45 and over) drinking more than 2 standard drinks a day (NHMRC, 2001).



Employment and social support

In addition to health risk behaviours, increasing attention is being given to the social roles of older people and the social support they receive and/or give and the relationship with their health and wellbeing. The availability of information on social isolation as measured by degree of loneliness enables an examination of this variable by labour force categories. The data in Table 7 show that employed men and women are least likely to report feeling lonely, which reflects their lack of social isolation. For the non-employed categories, a different pattern is observed between men and women. Older men who are not in the labour force reported the highest proportion of social isolation (15%). This is not the case for older women; of whom the unemployed are most likely to report as being socially isolated (39%).

Table 7: Per cent social support by labour force status, older Australians aged 50 years and over

Social indicators	Labour force status		
	Employed	Unemployed (per cent)	Not in labour force
MALES			
High degree of social isolation	11.2	10.9	14.7
Lack of social support	12.6	13.0	16.3
Lack of social interaction	16.7	16.1	14.7
Number	982	56	1,133
FEMALES			
High degree of social isolation	12.0	39.4	17.4
Lack of social support	10.1	27.3	18.2
Lack of social interaction	10.4	13.9	9.9
Number	760	36	1,611

The lack of social support, as measured by degree to which a person has someone to rely on in times of trouble, was also examined. As expected, non-employed persons were more likely to report lacking social support as compared with those who were employed. For older women, the extent of lacking social support is particularly striking for those who were unemployed (27%).

An association between employment and social interaction is also of interest as it may explain how work exerts influence on health. The results show that among older men, there were not marked differences in degree of social interaction as measured by frequency of socially getting together with friends or relatives among the employed, unemployed and those not in the labour force. Among older women, the unemployed reported the least social interaction, while no difference was found between the employed and those not in the labour force.

Employment and Economic wellbeing

The relationship between employment and health could be mediated through economic wellbeing. Employment increases household income and decreases economic hardship, both of which improve physical and mental health (Ettner, 1996; Feinstein, 1993).

The HILDA survey collects a wide range of indicators on economic wellbeing such as self-rated poverty, difficulty in raising money, and a wide range of actions due to shortage of money. Table 7 presents results of selected economic wellbeing indicators by labour force categories for older men and women. It is clear that unemployed people reported the highest level of economic disadvantage for all indicators.

Table 8: Selected economic wellbeing indicators by labour force categories, older Australians aged 50 years and over

Economic wellbeing indicators	Labour force status		
	Employed	In labour force Unemployed	Not in labour force
	(per cent)		
MALES			
Self rated poverty	1.6	21.4	5.4
Could not raise \$2,000 for an emergency	5.5	35.7	15.1
Could not pay electricity, gas or telephone on time	8.9	23.2	11.2
Pawned or sold something	2.4	5.5	3.6
Went without meals	1.7	16.1	2.9
Asked for financial help from friends/family	4.8	12.7	6.1
Asked for help from welfare/community organisations	1.3	10.7	3.5
Number	982	56	1,135
FEMALES			
Self rated poverty	2.4	20.0	4.2
Could not raise \$2,000 for an emergency	8.0	38.2	17.0
Could not pay electricity, gas or telephone on time	10.2	33.3	10.9
Pawned or sold something	2.8	14.7	2.5
Went without meals	1.5	14.7	2.3
Asked for financial help from friends/family	6.0	31.4	6.9
Asked for help from welfare/community organisations	1.1	8.8	3.0
Number	760	35	2,411

The data in Table 8 show that about one-fifth of unemployed older men and women rated themselves as being poor or very poor (self-rated poverty). This is compared with only 2 per cent for employed men and women. Older men and women who were not in the labour force, although appeared worse than the employed in terms of financial wellbeing, were in a much better position than the unemployed. It is worth noting that about 36% of unemployed older men and 38% of unemployed older women stated that they could not raise \$2,000 for an emergency, reflecting their worst economic circumstances among the labour force status categories.

Other indicators of economic hardship such as “went without meals” and “asked for financial help from friends and family” were also examined. Again, the unemployed older

adults were in the worst economic position among the labour force status categories examined.

Social support and health

Although the concepts and measures of social support are continuing to be developed and have not yet been widely agreed upon in the literature, past studies have demonstrated a positive impact of this variable upon health of individuals, including the elderly. Social support can come from various sources such as spouse, friends, adult children or the community at large and the differences in their significance may vary. For example, it has been found that spouse, friends and adult children ranked in descending order of importance in terms of their effects on both physical and mental wellbeing (Dean et.al., 1990). In this paper, sources of social support are not specified due to unavailability of information in the HILDA survey.

Social isolation, social support and social interaction were examined in relation to self-assessed health status. The data in Table 9 show that older adults who were more socially isolated were more likely to report fair or poor health (45% versus 24% for males and 36% versus 24% for females). A similar pattern was found for those lacking social support (35% versus 23%). However, the association between social interaction and self-perceived health status was not as strong and this is perhaps due to accuracy of the measurement used.

Table 9: Per cent self-perceived fair or poor health by selected social support indicators, older Australians aged 50 years and over

Social indicators	Degree of each selected indicator		
	Low	Moderate (per cent)	High
MALES			
Social isolation	23.9	34.0	44.5
Lack of social support	23.5	35.2	35.4
Lack of social interaction	28.4	25.3	36.2
FEMALES			
Social isolation	24.2	37.1	36.4
Lack of social support	23.0	32.9	34.6
Lack of social interaction	25.5	25.2	34.6

Economic wellbeing and health

The negative effect of economic hardship on self-assessed health status is obvious in this study. The data in Table 10 indicate that for all indicators of economic wellbeing, older adults who were economically disadvantaged, were more likely to report perceived fair or poor health. This is true for both males and females. For example, about half of older males who went without meals because of shortage of money perceived themselves as having poor or fair health, compared with approximately 28% of those who did not have this same experience. The difference in percentage points was even more striking for older women (55% versus 25%). It was also observed that older adults who were unable to heat their home due to shortage of money had a tendency to report fair or poor health (54% as compared with 27% for males).

Table 10: Per cent self-perceived fair or poor health by selected economic wellbeing indicators, older Australians aged 50 years and over

Economic Indicators	Shortage of money	
	Yes	No
	(per cent)	
MALES		
Could not pay electricity, gas or telephone bills on time	42.2	26.7
Could not pay the mortgage or rent on time	37.9	27.6
Pawned or sold something	41.0	28.1
Went without meals	50.9	27.6
Was unable to heat home	53.6	27.4
Asked for financial help from friends or family	40.7	27.5
Asked for help from welfare/community organisations	47.3	27.7
FEMALES		
Could not pay electricity, gas or telephone bills on time	39.0	24.4
Could not pay the mortgage or rent on time	38.7	25.3
Pawned or sold something	44.6	25.5
Went without meals	55.8	25.3
Was unable to heat home	43.2	25.5
Asked for financial help from friends or family	43.3	24.6
Asked for help from welfare/community organisations	51.8	25.4

DISCUSSION

The outcomes of the analysis confirm the earlier findings regarding the positive association between employment and health and shed new light on the complexity of this relationship for older Australians in particular. As has been previously found, the non-employed have poorer health than those who are employed and this pattern persists after adjusting for the effects of age, sex or socio-economic status. The cross-sectional data used in this paper, however, do not permit a further explanation of whether employment is the cause or effect of good health and this is one limitation of this study. While there is evidence to support either the ‘causation’ hypothesis or the ‘selection’ hypothesis, one study based on longitudinal data argued that both views are correct (Ross and Mirowsky, 1996:241) as “causation and selection are mutually reinforcing, not mutually exclusive” and the authors concluded that “full-time employment keeps healthy workers healthy”. This argument remains to be tested with longitudinal data if this is also the case for older Australians.

The paper focuses on older Australians living in private households and excludes those residing in institutions at the time of the survey such as hospitals, hostels and nursing homes. Those living in non-private dwellings are largely out of the labour force and they are more likely to be in poorer health as compared with those living in private households. If older Australians in non-private households were included, we would expect the association between employment and health to be even stronger.

It should be pointed out that the study relies upon a broad subjective measure of health, rather than specific clinical diagnosis. While this measure of self-assessed health status has been previously found to be a good predictor of morbidity and subsequent mortality, it is not known if the association between employment and health remains if other measures of health are used. It may be that older people in employment tend to assess their health as above average relative to their contemporaries who are not employed, when in fact

objective clinical health measures show no relation. Hence, there is a need to further explore this relationship using a wide range of health instruments such as physical functioning, mental wellbeing, disability, and recent or long-term illness. At this stage, the HILDA survey includes only the SF-36 instrument.

Links between health risk behaviours, employment and health have also been investigated in this paper. While it was found that the unemployed had the highest rates of smoking and harmful drinking, the higher rates of these health risk behaviours among the employed as compared with those not in the labour force do not entirely explain the relationship between non-employment and health. This is not surprising as smoking and drinking are, to some extent, considered as 'social behaviours' normally practised among those who work.

The highest level of physical inactivity among those not in the labour force is of particular interest and this finding has implications for policies and programs aiming at promoting healthy ageing. As already mentioned, one would tend to think that people who are not in the labour force would have more leisure time than those who work to engage in physical exercise. However, the findings did not support this hypothesis and it would be worthwhile to further investigate factors underlying this pattern. There is also a question of whether participation in physical activity among those who work is the result of the workplace influence.

The relationship between employment and health reflects a complex interaction of both financial and social factors. In this paper, a range of economic and social factors were shown to be related to both employment status and health. This descriptive analysis of cross-sectional data provides a basis to further assess the independent effect of employment on health and changes in such effect over time while holding other factors constant. There is also a need to further explore other measures of health such as physical functioning and mental wellbeing using information from the SF-36 questions in this survey.

The results of this study have important policy implications for healthy and successful ageing. If employment does have beneficial effects on health, the move to abolish compulsory retirement age being advocated by OECD and adopted in most jurisdictions in Australia would promote health. Such findings will also support the government incentives (e.g., Pensioner Bonus Scheme workforce) that encourage mature workers to remain in the workforce. By remaining in the workforce, there are associated health benefits. The National Strategy for an Ageing Australia (Commonwealth of Australia, 2001) sets the two following goals in relation to the changing workforce (1) the removal of barriers to the continued participation of mature age workers in the workforce and (2) an employment system that recognises the importance of retaining mature age workers in light of the future predicted decline in new entrants to the workforce. These elements in the Strategy will yield, among other benefits, favourable health outcomes, if one can be sure that employment is the causal factor.

However, the finding on the extent to which older workers withdraw from the labour market due to health reasons should also be taken into consideration. There is a need to further examine if this happens disproportionately across occupational groups so that health promotion interventions could be appropriately targeted. More research with longitudinal data is needed to understand the dynamics of changes in health while in later life employment and following retirement.

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