

**Health conditions and
employment among senior
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enablers and barriers to
continued engagement in
the labour force?**

**Ruth Williams, Thoa Menyen
and Tim Adair**

September 2014

National Seniors

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Health conditions and employment among senior Australians: What are the enablers and barriers to continued engagement in the labour force?

Ruth Williams, Thoa Menyen & Tim Adair
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Foreword

Workforce participation of mature age Australians has been increasing over the past 10 years. Although this trend is encouraging, there still remain a significant proportion of people who are not in paid work because of ill health, injury and disability. To assess the role of ill health in inhibiting workforce participation, National Seniors Australia undertook a survey of 2,000 Australians aged 50 years and over. We are pleased to present the findings in this report.

The findings confirm that illness, injury and disability are major reasons for being out of the workforce for people aged 50 years and over. A range of adverse health conditions were found to hinder workforce participation. Musculoskeletal conditions were most likely to prevent people from working or looking for work, while having arthritis was most likely to keep people away from work for the longest period of time. Despite the fact that most people are able to return to work after an absence of at least one month due to adverse health conditions, there is a significant proportion that remain disengaged from the workforce.

A range of factors were identified as assisting people with adverse health conditions to return to work. It was found that flexible work options, management support and co-worker support were important factors in facilitating return to work after having suffered illness related work absence. In addition, return to work can be facilitated by understanding and support managing pre-existing health problems and implementing effective health and wellbeing programs.

The findings of this report underscore the importance of the role of employers in actively facilitating continued workforce engagement for employees suffering from ill health, injury or disability.

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September 2014

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Executive summary

Background

Successive Australian governments have promoted longer working lives to assist with the economic consequences of an ageing population. However, ill health, injury and disability are major barriers to many people being engaged in the labour market. As mature age people are more likely to develop and suffer from ill health, injury and disability, efforts to increase labour force participation of this cohort will need to take into consideration the retention and recruitment of people with adverse health conditions.

There is much literature from Australia and overseas showing how chronic illness such as cardiovascular disease, disability, work-related injuries and mental illness are each related with lower labour force participation. These health conditions also often occur concurrently; research has found that physical-mental co-morbidity significantly increases work-loss and there is strong evidence of the bidirectional relationship between mental illnesses and physical health outcomes.

A strong relationship has also been found between health and the growth of non-standard employment such as part-time, casual, contract, and self-employed work. Research suggests that the voluntary or involuntary nature of such employment contracts is extremely important in determining the effect this has on overall health. Involuntary non-standard employment is often associated with higher levels of job insecurity, while prolonged exposure to job insecurity is often related to adverse psychological stress such as fear and anxiety. However, voluntary part-time or other non-standard work agreements have also been found to play a substantial role in contributing to the improvement of employee mental health. Further, flexible working arrangements can also increase the employment participation of older Australians who face other barriers to working, such as physical illness, or injury and care-giving responsibilities.

Literature also shows that continued engagement of people with health problems in the labour market can be largely facilitated by employers through understanding and support to manage pre-existing health problems (reactive measures), and the implementation of effective health and wellbeing programs which are designed to establish and maintain healthy behaviours (preventive measures).

Overall, the relationship between health and employment is complex. Using data from the 2013 National Seniors Social Survey this report seeks to better understand:

- What was the extent of workforce interruptions of mature age Australians due to ill health?
- What was the prevalence of different types of health conditions among mature age Australians, and to what extent did these effect workforce engagement?
- What were the workforce outcomes for mature age Australians following interruption due to illness, injury or disability, and did they differ by type and number of health conditions, education, occupation and industry?
- What specific factors are enablers or barriers to remaining engaged with the workforce following interruption due to illness, injury or disability?
- What is the extent of access to employer health and wellbeing programs among mature age Australians?

Data and methods

The data in this report was taken from the National Seniors Social Survey Wave 3. The survey was conducted from late September to late October 2013, among 2,018 members of National Seniors Australia who were aged 50 years and over. The National Seniors Social Survey Wave 3 covered a range of topics, and included health, employment, financial and social modules. Both bivariate and multivariate analyses were used to answer the research questions.

Results

Illness-related factors were the fourth most common reason for people having ceased paid work for at least one month in the past five years.

Almost one-half of respondents (46%) reported having an illness, injury or disability for at least one month in the previous five years. The most common conditions were cardiovascular disease (50% of those with an illness, injury or disability), arthritis (35%), musculoskeletal injury (34%), and mental health illnesses (23%). Co-morbidities were common; almost half of people with an illness, injury or disability had three or more conditions in the past five years (49%).

Labour force participation was significantly affected by poor health. Of people who had worked in the last five years and had an illness, injury or disability, 46% reported that the illness had prevented them from working, 37% reported that it prevented them from working as much as they would like, and 13% reported that it prevented them from looking for work. People with a musculoskeletal injury (61%) and mental illness (58%) were most likely to have reported that their illness had prevented them from working or looking for work.

Almost half (49%) of the people with poor health returned to work after an absence of at least one month. However, a further 21% had yet to return to work or had retired. The multivariate analysis revealed that older people and males were significantly less likely to stay in paid work or return to paid work after an illness, compared to their counterparts. Additional multivariate analysis revealed that both age and the number of health conditions were positively and significantly related with whether people retired permanently or were yet to return to paid work versus people who left paid work but had since returned.

The most commonly cited factors which assisted people to return to work or stay in work following a health condition were flexible work options (47%), management or supervisor support (41%) and peer group or co-worker support (38%). The factors that caused difficulties in remaining engaged in the workforce included: having limited support such as being able to alter tasks or having a lack of back-to-work support for the illness (22%), a lack of understanding or discrimination by managers/supervisors (20%), discrimination due to age (18%) and a lack of flexible work options (16%).

Almost three-quarters (73%) of workers stated their employer offered at least one health and wellbeing program in the workplace. The most commonly offered programs were OH&S guidelines (54%), vaccinations (52%) and psychological counselling (34%). Just over half of people who worked in the past five years participated in at least one health and wellbeing program (55%); this was equal to 76% of all people who were offered a program.

Health assessments or checks were in high demand by mature age workers; 46% of people stated they would participate in such a program if it was offered by their employer. Health insurance subsidies (44%), exercise breaks (42%), information for a healthy lifestyle (39%) and diet and nutrition programs (39%) were also in demand among people who were not offered these programs. Over half of the respondents who did participate in health and wellbeing programs found them somewhat useful (58%), and a further 22% found them extremely useful.

Conclusion

Illness, injury and disability were found to be significant factors in affecting the labour force participation of mature age people. However, a range of factors were found to be helpful in enabling the successful return to the workplace following an adverse health condition, such as flexible work options, and support from both management and co-workers and less psychologically demanding roles. Previous research has predicted that a lack of flexibility in the workplace prevents employment participation by a large number of mature age people. However, as the literature review describes, non-standard work arrangements can have either beneficial or detrimental effects on the physical and mental health status and long-term retention of employees depending on the voluntary nature of the arrangement.

The findings of this report underscore the importance of employers having a coordinated and pro-active approach to developing programs to facilitate job retention for employees suffering from pre-existing ill health. For example return-to-work programs can include job adaptations and modifications to the type of work and job tasks.

Additionally, employers have a role in preventive measures through the promotion of healthy behaviours in an attempt to avoid future illness, injury or disability. Encouragingly, there is considerable demand by employees for health and wellbeing programs, especially health assessments, exercise breaks/gym membership and information for a healthy lifestyle.

Future research can build on these findings by understanding employer perspectives on flexible work arrangements and health and wellbeing programs, and develop ways to better understand the short and long term benefits of various health and wellbeing programs, as well as exploring self-management of chronic health problems in the workplace.

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Introduction

Successive Australian governments have promoted longer working lives to assist with the economic consequences of an ageing population. Working longer can help individuals increase retirement savings to fund post-employment lives, while easing reliance on the Age Pension. This policy shift is represented by eligibility for the Age Pension increasing from 65 to 67 years in 2023, with a further increase announced in the 2014/15 Federal Budget to age 70 by 2035. Employment trends among mature age workers in the past decade have increased, with the proportion of people aged 60-64 years in employment rising from 32.1% in 2000 to 53.8% in 2014.¹

Although the trend of increasing employment among mature age people is encouraging, there remains a significant proportion of people who are not in paid work. A major reason for people not being engaged in employment is ill health, injury and disability. Recent Australian Bureau of Statistics (ABS) data shows that illness, injury or disability is the primary reason for people retiring, after being eligible for the Age Pension or drawing down of superannuation.² Since 2004, there has consistently been more people out of work in Australia due to disability than those who are unemployed.³ Research has also revealed that in many other countries, there are more inactive working age people due to disability than due to unemployment.⁴ Therefore, efforts to increase labour force participation of mature age people will also need to take into consideration people with one or more adverse health conditions.

This report firstly examines the effect of poor health on the workforce participation of Australians aged 50 years and over and the extent of workforce interruptions due to ill health. Secondly, it seeks to identify which population sub-groups with an adverse health condition are most likely to successfully remain engaged in the workforce, and thirdly it seeks to identify the enablers and barriers of people with an adverse health condition remaining engaged in the workforce following interruption due to illness, injury or disability. The report reviews literature regarding the relationship between ill health and employment, it identifies how specific types of health conditions effects ability to participate in the workforce, and the enablers and barriers to remaining engaged in the workforce.

Literature review

Ill health and workforce participation

The effects of illness, injury and disability on early retirement, job loss, unemployment, and the ability to re-enter employment has been extensively examined both in Australia^{5,6} and in European countries.^{7,8,9,10} It has been found that poor physical and mental health are major factors leading to early permanent retirement^{11,12}, with findings from a UK study¹³ reporting that 37% of respondents were forced to retire or leave their job due to their poor health. Furthermore, the likelihood of having left their job or retiring rose in accordance with the number of health problems, from 22% for one adverse health condition or disability to 68% for those with five or more health problems.

Unsurprisingly, health related job loss is more common at older ages rather than younger ages.¹⁴ However, a study by Vegeris et al. found that despite many mature age workers having health problems that were both manageable and temporary, these people faced greater difficulties in finding a job following a period of ill health.¹⁵ This indicates that mature age people with health problems have the potential to remain or return to the workforce if their conditions are acknowledged and supported.

¹ Australian Bureau of Statistics. 6291.0.55.001 - *Labour Force, Australia, Detailed - Electronic Delivery, April 2014*. ABS, Canberra: 2014.

² Australian Bureau of Statistics. 6238.0 - *Retirement and Retirement Intentions, Australia, July 2012 to June 2013*. Canberra: ABS, 2013.

³ OECD. *Sickness, disability and work: Breaking the barriers - Australia, 2010*. Accessed on 27/05/14, available at <http://www.oecd.org/australia/46497207.pdf>

⁴ Stattin M. Retirement on grounds of ill health. *Occupational and Environmental Medicine*. 62: 135-140, 2005.

⁵ Cai L & Kalb G. Health status and labour force status of older working-age Australian men. *Australian Journal of Labour Economics* 10: 227-52, 2007.

⁶ NSW MACA. *Work and Older People Roundtable Discussion Report*. Tweed Heads: NSW Ministerial Advisory Committee on Ageing, 2009. Available at http://www.maca.nsw.gov.au/_data/assets/pdf_file/0015/232044/Work_and_Older_People_Report_Low_res.pdf

⁷ Cobb-Clark DA & Stillman S. *The Retirement Expectations of Middle-Aged Individuals*. IZA DP No. 2449, 2006. Available at <http://dspace-prod1.anu.edu.au/bitstream/1885/45260/1/DP540.pdf>

⁸ Kalwij A & Vermeulen F. Health and labour force participation of older people in Europe: What do objective health indicators add to the analysis? *Health Economics*, 2007. DOI: 10.1002/hec.1285.

⁹ Millward C & Brooke L. Should we work for longer? Public expectations about older workers and retirement. In Denmark et. al., eds. *Australian Social Attitudes 2: Citizenship, Work and Aspirations*. Chapter 7, pp.147-73, Sydney: UNSW Press, 2007.

¹⁰ Smeaton D, Vegeris S, Sahin-Dikmen M. *Older Workers: Employment Preferences, Barriers and Solutions*. Equality and Human Rights Commission Research Report Series. London: Policy Studies Institute, 2009. Available at http://equalityhumanrights.com/uploaded_files/research/older_workers_employment_preferences_barriers_and_solutions_v2.pdf

¹¹ Luo M-C & Herzog AR. Individual consequences of volunteer and paid work in old age: Health and mortality. *Journal of Health and Social Behaviour*. 43: 490-509, 2002.

¹² Brown J, Gilmour H, Macdonald EB. Return to work after ill-health retirement in Scottish NHS staff and teachers. *Occupational Medicine*. 56: 480-484, 2006.

¹³ Humphrey A, Costigan P, Pickering K, Stratford N, Barnes M. *Factors Affecting the Labour Market Participation of Older Workers*. Research Report No 200. London: Department for Work and Pensions, 2003. Available at <http://193.129.121.133/asd/asd5/rports2003-2004/mrep200.pdf>

¹⁴ Solomon C, Poole J, Palmer KT, Coggon D. Health-related job loss: findings from a community-based survey. *Occupation and Environmental Medicine*. 64: 144-149, 2007.

¹⁵ Vegeris S, Smeaton D, Sahin-Dikmen M. *50+ back to work evidence review and indicative guide for secondary data analysis*. Research Report No. 615. London:, Department for Work and Pensions, 2010.

When considering ill health and workforce participation by gender, results from the HILDA survey showed that the probability of employment for men in fair health was 30% more likely than males in poor health.¹⁶ However, ABS data found that women's labour force participation is more adversely affected by poor health than men's.¹⁷ Other characteristics of socioeconomic inequalities such as lower education, unskilled labour and low income, have also been strongly correlated with lower employment and poorer health. Overall, a review of literature has found that the relationship between health and employment is bi-directional, that is poor physical and mental health can negatively influence workforce engagement, while poor working conditions can negatively affect one's health.¹⁸

Common ill health conditions and labour force participation

Chronic diseases

The prevalence of chronic illnesses, such as cardiovascular disease, is increasing in Australia as a result of both the ageing population and lifestyle factors such as poor diet, heavy alcohol consumption and physical inactivity.¹⁹ The nature of chronic diseases, which require treatment over long periods of time and are generally correlated with co-morbidity, means there are significant associated social and economic costs. The health burden of chronic illness accounts for 70% of total health expenditures in Australia.²⁰

ABS analysis has found that a range of chronic illnesses, such as arthritis, asthma, cancer, diabetes and heart disease, have negatively affected labour force participation.²¹ This is in line with a report by the Australian Institute of Health and Welfare (AIHW) which found that people with chronic disease were 60% more likely to be unemployed and were less likely to be employed full-time, than those without chronic disease.²² The AIHW also found that older people were more likely to have chronic disease than younger people (54% of 55-64 year olds compared with 21% of 25-34 years olds).

Work-related injuries

In addition to chronic ill health conditions, work-related injuries have a significant negative effect on workforce participation. ABS data reveals that male dominated industries, such as agriculture, forestry and fishing; manufacturing; and construction (all of which involve high levels of physical demand), generally have higher rates of work-related injury.²³ The prevalence of injury in these industries is generally manifested in musculoskeletal disorders such as sprains and strains. Research has shown that musculoskeletal disorders have traditionally been amongst the most common causes of sickness absence from paid work, long-term work incapacity and early retirement. Despite musculoskeletal disorders being common in male dominated industries, there is a rising prevalence in occupations such as nursing where there is significant manual handling and heavy physical demands involving actions of lifting, pushing or pulling heavy objects.^{24, 25, 26, 27}

Poor health may be a problem for older workers in particular as their physical capabilities begin to decline. However, the ABS found that workers aged 55 years and over have the lowest rates of work-related injury.²⁸ This possibly indicates that poor health at older ages is less likely to be caused by work-related injuries and more likely as a result of pre-existing health conditions.

¹⁶ Cai L & Kalb G 2007, op. cit.

¹⁷ Australian Bureau of Statistics. 1351.0.55.049 - *Research Paper: Examining Association Between Self-Assessed Health Status and Labour Force Participation Using Pooled NHS Data, Feb 2014*. ABS, Canberra: 2013.

¹⁸ e.g., De Lange AH, Taris T, Kompier M, Houtman I, Bongers P. The relationships between work characteristics and mental health: examining normal, reversed and reciprocal relationships in a 4-wave study. *Work and Stress: An International Journal of Work, Health & Organisations*. 18: 149-166, 2004.

¹⁹ PricewaterhouseCoopers. *Workplace wellness in Australia, Aligning action with aims: Optimising the benefits of workplace wellness*. PricewaterhouseCoopers, 2010.

²⁰ Australian Institute of Health and Welfare. *Chronic diseases and associated risk factors in Australia*. Cat. No. PHE 81. Canberra: AIHW, 2006

²¹ Australian Bureau of Statistics, 2014, op. cit.

²² Australian Institute of Health and Welfare. *Chronic disease and participation in work*. Cat. No. PHE 109. Canberra: AIHW, 2009.

²³ Australian Bureau of Statistics. 4102.0 - *Australian Social Trends, 2007: Work-related injuries*. Canberra: ABS, 2007.

²⁴ Brown J et al. 2006, op. cit.

²⁵ Waddell G. Preventing incapacity in people with musculoskeletal disorders. *British Medical Bulletin*. 77 & 78: 55-69, 2006.

²⁶ Solomon C et al. 2007, op. cit.

²⁷ Karpansalo M, Mannine P, Kauhanen J, Lakka TA, Salonen JT. Perceived health as a predictor of early retirement. *Scandinavian Journal of Work and Environmental Health*. 30: 287-292, 2004.

²⁸ Australian Bureau of Statistics, 2007, op. cit.

Disability

Disability encompasses a wide range of conditions which effect people in a variety of ways. The ABS defines disability as 'any limitation, restriction or impairment which restricts everyday activities and has lasted or is likely to last for at least six months'. According to the ABS Survey of Disability, Ageing and Carers (SDAC), 2.2 million working-age Australians had a disability in 2009, which represented around 15% of the working age population.²⁹

As shown by the ABS, people with disabilities are significantly underrepresented in Australia's workforce, and are also more likely to be working part-time (38%) than people without a disability (31%).³⁰ The average time spent on income support for people receiving the Disability Support Pension is around 10 years. During this time, individuals are at significant risk of poverty and social exclusion.³¹ The incidence of physical decline and disability increases with age, resulting in a greater number of older people with disability compared to the general population. However, employment is vital for social inclusion, physical and mental health, overall wellbeing, and a sense of identity and self-worth.³² These statistics indicate there is significant room for policy and program development to ensure the accessibility to equal employment opportunity through facilitating and supporting people with a disability to enter and remain in the labour market.

Mental health

The World Health Organisation defines mental health as 'a state of wellbeing in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community'.³³ Mental ill health can manifest in a number of ways and to varying degrees. Examples of mental illness include anxiety and psychotic disorders, and mood disorders such as clinical depression and psychological stress. The prevalence of mental ill health in Australia appears to be increasing significantly and is having a substantial negative effect on workforce engagement. In 2007-08 the ABS showed there were 1.8 million people of working-age living with mental illness in Australia.³⁴ Similarly, in 2003 around half of Australians aged 45-64 years who were not in the labour force were reported as having a long-term mental or behavioural disorder.

The relationships between mental illness and early retirement, job loss, unemployment, and difficulties re-entering employment have been well documented in several Australian studies.^{35, 36, 37} In particular, mental ill health in the workplace has the potential to negatively affect rates of absenteeism, long-term sickness absence, organisational productivity, employee performance, accidents and rates of staff turn-over.^{38, 39} A study based on the Australian National Health Survey found that among three types of diseases (heart disease, diabetes, and mental illness), it was mental illness that had the largest effect on labour force participation.⁴⁰ It is estimated that depression in the Australian workforce costs the community \$12.6 billion over one year, with the majority of these costs related to lost productivity and job turnover.⁴¹ Mental illness was also the cause of the longest absences from work.

Mental illness appears to be particularly prevalent in occupations held by teachers and police officers where stress, depression and anxiety is often high.⁴³ Generally speaking, much of the effect of poor workplace mental health can be traced to low job satisfaction, stemming from long work hours, work overload and pressure, and the effect these factors have on personal lives (poor work/life balance); lack of control over work; lack of participation in decision making; poor social support; and unclear management and work roles.⁴⁴

²⁹ Australian Bureau of Statistics. *4102.0 - Australian Social Trends, June 2011: Work and Health*. Canberra: ABS, 2011.

³⁰ Australian Bureau of Statistics. *4102.0 - Australian Social Trends, March Quarter 2012*. Canberra: ABS, 2012.

³¹ Deloitte Access Economics. *The economic benefits of increasing employment for people with disability*. Canberra: Deloitte Access Economics, 2011.

³² Council of Australian Governments (COAG). *National Disability Strategy 2010-2020*. Canberra: COAG, 2011.

³³ World Health Organisation. *Mental health: A state of wellbeing*. 2013. Accessed 31/05/14, available at http://www.who.int/features/factfiles/mental_health/en/

³⁴ Australian Bureau of Statistics, 2012, op. cit.

³⁵ Cobb-Clark, DA & Stillman S, 2006, op. cit.

³⁶ Millward & Brooke, 2007, op. cit.

³⁷ NSW MACA, 2009, op. cit.

³⁸ Glozier N. *Mental ill health and fitness for work*. *Occupational and Environmental Medicine*. 59: 714-720, 2002.

³⁹ World Health Organisation and International Labour Organisation. *Mental health and work: impact, issues and good practices*. Geneva: WHO & ILO, 2000.

⁴⁰ Cai L & Kalb G, 2007, op. cit.

⁴¹ LaMontagne AD, Sanderson K, Cocker F. *Estimating the economic benefits of eliminating job strain as a risk factor for depression: summary report*. Melbourne: Victorian Health Promotion Foundation (VicHealth), 2010.

⁴² Australian Bureau of Statistics, 2011, op. cit.

⁴³ Solomon C et al. 2007, op. cit.

⁴⁴ Schnall PL, Dobson M, Roskam E. *Unhealthy work: Causes, consequences, cures*. Amityville: Baywood Publishing, 2009.

Although the role that mental health plays in the incidence and presentation of physical injury is more complex, it has been found that physical-mental co-morbidity significantly increases work-loss⁴⁵ and there is strong evidence of the bi-directional relationship between mental illnesses, specifically depression and anxiety, and physical health outcomes.⁴⁶ In addition, it has been speculated that an individual's mental state may affect their physical capacity to act in a safe way as their perceptions of risk may be altered (e.g. inattentiveness and impaired cognitive ability). The increased incidence of poor mental health may also be as a result of changes in perception and attitudes toward health related job loss. For example, these changes in community attitudes over time may explain an increased acceptance and willingness to admit to workplace stress and mental illness which in the past may have been susceptible to social ridicule and negative stereotyping.

Non-standard employment and health

One of the most significant changes in the current work environment has been the decline in 'standard' full-time permanent jobs.⁴⁷ These traditional types of employment have been replaced with a growth in non-standard employment or non-permanent employment such as work that is: part-time; temporary; fixed-term; contract and sub-contract; self-employment; freelance; casual; seasonal; project work; and on-call work.^{48, 49}

In order to determine the effect of non-standard employment on health, it is extremely important to consider the voluntary or involuntary nature in the employment contract. Involuntary part-time or other non-standard work agreements constitute a component of underemployment.⁵⁰ Underemployment can include adverse effects on income adequacy, underutilisation of skills or qualifications, employment stability, and desired hours of work, all of which can potentially have harmful effects on employee mental health status. However, voluntary part-time or other non-standard work agreements have also been found to play a substantial role in contributing to the improvement of employee mental health. Working in non-standard employment arrangements by choice will be discussed further in the next section.

In addition, it has been found that workers in non-standard employment can have an increased exposure to 'bad' job characteristics and potentially face a number of disadvantages including: an erosion of income; job insecurity; deficient benefits; lower levels of career planning and participation in education and training including on-the-job-training; lack of prospects for promotion; exposure to hazardous work conditions (e.g. vibrations, loud noise, or hazardous products); work involving painful, repetitive or tiring positions; lack of induction and safety training (e.g. as Occupational Health and Safety regulation training); little or no superannuation; low levels of unionisation as workers are transient between jobs; work involving greater physical and psychological demands; lower control over processes; low rewards; and involuntary part-time or seasonal work.^{51, 52, 53, 54} All of these disadvantages have the potential to erode both physical and mental health outcomes. In acknowledgement of the 'bad' characteristics often associated with non-standard employment and in order to protect those in non-standard work, the European Union's Framework Directive outlining the equal treatment of part-time and fixed-term workers now ensures that employees in non-standard work have access to the same sick pay and pensions schemes as full-time workers.⁵⁵

⁴⁵ Buist-Bouwman MA, de Graaf R, Vollebergh AM, Ormel J. Co-morbidity of physical and mental disorders and the effect on work-loss days. *Acta Psychiatrica Scandinavica*. 11: 436-443, 2005.

⁴⁶ Churchill R. No health without mental health: A role for the *Cochrane Collaboration*, Editorial. *Cochrane Database Syst RevLibrary*. 2011:ED000012, 2010.

⁴⁷ Benach J, Gimeno D, Benavides FG. *Types of employment and health in the European Union*. Dublin: European Foundation for the Improvement of Living and Working Conditions, 2002.

⁴⁸ Menendez M, Benach J, Muntaner C, Amable M, O'Campo P. Is precarious employment more damaging to women's health than men's? *Social Science and Medicine*. 64: 776-781, 2007.

⁴⁹ Benach J et al. 2002, op. cit.

⁵⁰ OECD. Involuntary part-time work as a component of underemployment, Chapter 7 in *Employment outlook 1990*, Accessed on 30/05/14, available at <http://www.oecd.org/els/emp/4343175.pdf>

⁵¹ Virtanen M, Kivimaki M, Joensuu M, Virtanen P, Elovainio M, Vahtera J. Temporary employment and health: a review. *International Journal of Epidemiology*. 34: 610-622, 2005.

⁵² Virtanen M, Kivimaki M, Joensuu M, Virtanen P, Elovainio M, Vahtera J. Disparity in occupational training and career planning between contingent and permanent employees. *European Journal of Work and Organizational Psychology*. 12: 19-36, 2003.

⁵³ Quinlan, Michael, Mayhew, Claire, Bohle, Philip, The global expansion of precarious employment, work disorganisation and occupational health: a review of recent research, *International Journal of Health Services*, Vol. 31, No. 2, 2001, pp. 335-414.

⁵⁴ Benach J et al. 2002, op. cit.

⁵⁵ McGovern P, Smeaton D, Hill S. Bad jobs in Britain: Nonstandard employment and job quality. *Work and Occupations*. 31: 225-249, 2004.

A number of studies have examined how lack of attachment to the labour force, through involuntary non-standard employment, affects mental health status.⁵⁶ It was largely found that involuntary non-standard employment is often associated with higher levels of job insecurity, while prolonged exposure to job insecurity is often related with adverse psychological stress such as fear and anxiety. For example, studies show that workers in seasonal/casual jobs experience more job insecurity⁵⁷, job dissatisfaction^{58, 59}, and psychological morbidity⁶⁰ than workers on permanent contracts. Fortin also found that poor mental health, attributed to the job insecurity associated with involuntary non-standard employment, was affected in part through social isolation, lack of social support and self-esteem.⁶¹ A study by PricewaterhouseCoopers suggests that job insecurity could be equally as detrimental to mental health as unemployment.⁶²

Regarding non-standard employment and mature age workers, McGovern et. al. found that once mature workers reach their 50s and 60s and approach pension eligibility age, they increasingly move to non-standard jobs.⁶³ This transition to non-standard jobs may be either involuntary, having being made redundant and facing limited alternatives, or voluntary in order to achieve greater flexibility during the remainder of their working lives. This highlights the importance of choice as some people prefer stable permanent jobs, which guarantee a certain flow of income but require a full-time attachment to the labour market, while others prefer more flexible work arrangements, even if these pay less or are relatively less secure.

Flexible work arrangements

Work-life balance is becoming an essential factor in determining job satisfaction and in assisting the planning of lives and careers of workers. Work-life balance can be addressed through introducing flexible work options, which include structures that differ from the traditional work norms. Flexible work arrangements may take the form of a re-scheduling of hours (e.g. flexible start and finish times and compressed work weeks) and shifts and break schedules; alteration to the number of hours such as part-time and job sharing; or offering an alternative place of work such as working from home or at a different office. Flexible work arrangements are therefore likely to benefit people who have conflicting external commitments such as care-giving responsibilities.

There have been many national and international studies that demonstrate flexible work arrangements contribute to good employee mental health. For example, research has shown that workers on flexible arrangements report higher levels of job satisfaction and have lower turnover intentions than those on standard work arrangements.⁶⁴ Similarly, while surveying workers in High Performance Workplace Organisations (HPWOs), Bauer found higher rates of job satisfaction among employees which was attributed to the positive effect of flexible work systems.⁶⁵ Bauer also found that workers particularly valued the opportunities associated with flexibility, such as an increased autonomy over how to perform work tasks and increased communication with co-workers. Richman et al. also revealed that perceived workplace flexibility and supportive work-life policies were related to greater employee engagement and longer than expected retention. These findings are particularly important for the long-term engagement and retention of the mature age workforce.⁶⁶

⁵⁶ e.g., Fortin M. The connection between low income, weak labour force attachment and poor health. *Canadian Studies in Population*. 37: 25-52, 2010.

⁵⁷ Klein Hesselink DJ & van Vauuren T. Job flexibility and job insecurity: The Dutch case. *European Journal of Work and Organisational Psychology*; 8: 273-293, 1999.

⁵⁸ Bardasi E & Francesconi M. The impact of atypical employment on individual wellbeing: evidence from a panel of British workers. *Working Papers of the Institute for Social and Economic Research*. Paper 2003-2. Colchester: University of Essex, 2003.

⁵⁹ Benach J, Gimeno D, Benavides FG, Martinez JM, Del Mar Torne M, Types of employment and health in the European Union: Changes from 1995 to 2000. *European Journal of Public Health*. 14: 314-321, 2004.

⁶⁰ Virtanen M et al. 2005, op. cit.

⁶¹ Fortin M, 2010, op. cit.

⁶² PricewaterhouseCoopers, 2010, op. cit.

⁶³ McGovern P et al. 2004, op. cit.

⁶⁴ Dreike Almer E & Kaplan SE. The effects of flexible work arrangements on stressors, burnout, and behavioral job outcomes in public accounting. *Behavioral Research in Accounting*. 14: 1-34, 2002.

⁶⁵ Bauer TK. *High performance workplace practices and job satisfaction: Evidence from Europe*. IZA DP No. 1265, 2004.

⁶⁶ Richman AL, Civian, JT, Shannon LL, Hill J, Brennan RT. The relationship of perceived flexibility, supportive work-life policies, and use of formal flexible arrangements and occasional flexibility to employee engagement and expected retention. *Community, Work & Family*. 11: 183-197, 2008.

Similarly, the ability to work part-time or flexible hours has been found to be the most important facilitator, after good health, for older people to work beyond retirement age.^{67, 68, 69} This finding is consistent in both Australian and international studies which demonstrate that flexible work arrangements can facilitate a phased transition to retirement among mature workers through a reduction in hours.^{70, 71} Flexible working arrangements can also increase the employment participation of older Australians who face other barriers to working, such as physical illness, or injury and care-giving responsibilities. For example, a UK Equality and Human Rights Commission study concluded that flexible work arrangements were a primary facilitator to the employment of older people with poor health.⁷²

Thus, it has been demonstrated that non-standard work arrangements can have either a beneficial or detrimental effect on the mental health status and long-term retention of employees. It appears the vital determining factor regarding the positive or negative health outcomes of non-standard work arrangements is the ability to exercise personal preference in the work contract.

Other enablers and barriers to engaging in work

Enablers and barriers to people with poor health remaining engaged in the labour market can often be facilitated by employers through understanding and support to manage pre-existing health problems (reactive measures), and the implementation of effective health and wellbeing programs which are designed to establish and maintain healthy behaviours (preventive measures).

Reactive barriers

Reactive workplace health initiatives for employees take place after illness, injury or disability has occurred and aims to reduce long-term disability. A major barrier to promoting the workforce engagement of employees with pre-existing health conditions includes a lack of management support. Research in the UK reported that nearly one-third of older workers with poor health did not feel able to approach their managers to discuss their health difficulties and request alternative arrangements such as changes in work hours, shifts or workload, or redeployment to other jobs (compared with around 15 per cent of those in good health).⁷³

For older workers, lack of supervisor support in managing pre-existing health problems may also be further compounded by age discrimination. Research has found that for mature age workers and job-seekers, having been directly told they are too old for a job, more subtle forms of age discrimination such as being given lesser responsibilities, and general negative perceptions of age discrimination, were more common among people with an illness, injury or disability than those in relatively good health.⁷⁴

Despite the importance of workplace health and wellbeing programs, evidence suggests that few organisations have comprehensive policies designed to support health-related workplace adjustments. As a result workers may be deterred from carrying out the self-management of their pre-existing health problems at work for fear of drawing attention to themselves and their illness, leading to negative stereotyping or risk of being targeted in redundancies.⁷⁵

⁶⁷ NSW MACA, 2009, op. cit.

⁶⁸ NSW MACA, 2009, op. cit. Haukka S, Robb W, Alam K. 'Chart of Accounts': A Framework for Measuring the Economic and Social Contributions by Older Australians. Canberra: National Seniors Productive Ageing Centre, 2009.

⁶⁹ National Seniors Productive Ageing Centre. *AdvantAGE Australia: Maximising the Potential of an Ageing Population*. Canberra: National Seniors Australia, 2008.

⁷⁰ OECD. *Ageing and Employment Policies: Live Longer, Work Longer*. Paris: Organisation for Economic Co-operation and Development, 2006a.

⁷¹ OECD. *Ageing and Employment Policies: Australia*. Paris: Organisation for Economic Co-operation and Development, 2006b.

⁷² Smeaton et al. 2009, op. cit.

⁷³ Smeaton et al. 2009, op. cit.

⁷⁴ National Seniors Productive Ageing Centre. *Age Discrimination in the Labour Market: Experiences and Perceptions of Mature Age Australians*. Canberra: National Seniors Australia, 2013.

⁷⁵ Munir F, Khan HTA, Yarker J, Haslam C, Bains M, Kalawsky K. *Health behaviours among older and younger workers with chronic illness*. Working Paper 109. Oxford: Oxford Institute of Ageing Working Papers, 2009.

Reactive enablers

Researchers argue that improving job retention among chronically ill workers requires a coordinated and pro-active approach within the workplace by health professionals, line managers and human resource managers.⁷⁶ Cooperation, organisational policy and workplace culture are seen as key components in developing job retention programs for chronically ill employees. Return-to-work plans can be devised regarding one or a combination of initiatives including job adaptations, modifications to the type of work and job tasks, number of hours, or requirement for additional leave, special equipment and individualised assistance.

In addition, workplace health promotion for employees with a pre-existing chronic illness may include the encouragement and enabling of self-managing behaviours such as taking prescribed medications, symptom management, following an appropriate diet plan and exercising, as well as providing the space and privacy for the safe completion of these behaviours. Although mature age workers are more likely to have a higher incidence of chronic illness, a study by Munir et al. showed older workers (aged 50-69 years) were more likely to self-manage health behaviours related to their chronic illness, compared to their younger colleagues (aged 20-49 years).⁷⁷

For people with a disability, it has been suggested that initiatives by both government and private organisations will be necessary to improve workforce outcomes. Alleviating employer concerns and the provision of relevant and effective programs will help people with disability to successfully integrate into the labour market.⁷⁸ Meanwhile, identification of vulnerable workers and the provision of rehabilitative support may assist employees to remain and return to the workforce.⁷⁹ The emphasis on the crucial role played by line managers in managing employees' absence and resumption of work should be a focus in policy implementation and communication.⁸⁰ In line with, Dame Carol Black's review of the health of Britain's working age population, *Working for a healthier tomorrow* suggests that employers have significant scope to facilitate an employee's early return from sickness absence through early, regular and sensitive contact with ill employees.⁸¹ The report also suggests replacing the paper-based sick note with an electronic fit note as this would alter the current mindset of focusing on what employees cannot do to what they can do. It is also envisaged that this type of initiative could potentially improve communication between employers and GPs.

Preventive measures

Preventive workplace health and wellbeing initiatives are interventions put in place by employers that aim to prevent future risk of injury, illness or disability.⁸² Programs may include a variety of employee initiatives such as controlling hazards, modifying the workplace environment, and the promotion of healthy behaviours through initiatives such as smoking cessation and physical activity programs which are usually tailored to the identified needs of staff within an organisation. Workplace flexibility may also contribute to positive lifestyle behaviours, and may play an important role in effective worksite health promotion programs.⁸³

Since increasing age is a risk factor in developing many chronic illnesses, the health and wellbeing of older employees is of vital importance. Increased public awareness efforts are gaining momentum and assisting people to engage in health-sustaining activities so they can remain working for longer.⁸⁴

Despite the increasing cost of chronic illness to the Australian community, there appears to be an unsustainable imbalance in resources spent on the treatment of chronic diseases compared to their prevention. Reactive and preventive workplace health initiatives could facilitate healthy and productive workforce engagement resulting in mass savings for the individual, organisations and the economy at large.

Finally, the nature and characteristics of the jobs that employees do is vitally important in terms of satisfaction and control. Good managers have a role in identifying and supporting people with health conditions in order to facilitate good workplace health and wellbeing.

⁷⁶ Haafkens JA, Kopnina H, Meerman MGM, van Dijk FJH. Facilitating job retention for chronically ill employees: perspectives of line managers and human resource managers. *BMC Health Services Research*. 11: 104-115, 2011.

⁷⁷ Munir F et al. 2009, op. cit.

⁷⁸ Deloitte Access Economics, 2011, op. cit.

⁷⁹ Haafkens et al. 2011, op. cit.

⁸⁰ CBI, Healthy returns? Absence and workplace health survey 2011, London.

⁸¹ Secretary of State for Work and Pensions. *Dame Carol Black's Review of the health of Britain's working age population: Working for a healthier tomorrow*. London: Secretary of State for Work and Pensions, 2008.

⁸² Haafkens J et al. 2011, op. cit.

⁸³ Grzywacz J, Casey P, Jones F. The effects of workplace flexibility on health behaviours: A cross-sectional and longitudinal analysis. *Journal of Occupational and Environmental Medicine*. 49: 1302-1309, 2007.

⁸⁴ PricewaterhouseCoopers, 2010, op. cit.

Research questions

The literature review has shown that the relationship between health and disability and employment is complex, covering a range of health issues and causal pathways. To understand these issues more clearly, this report uses a recent survey of mature age Australians to seek to answer the following research questions:

- What was the extent of workforce interruptions of mature age Australians due to ill health?
- What was the prevalence of different types of health conditions among mature age Australians, and to what extent did these affect workforce engagement?
- What were the workforce outcomes for mature age Australians following interruption due to illness, injury or disability, and did they differ by type and number of health conditions, education, occupation and industry?
- What specific factors are enablers or barriers to remaining engaged with the workforce following interruption due to illness, injury or disability?
- What is the extent of access to employer health and wellbeing programs among mature age Australians?

Data and methods

The data in this report was taken from the National Seniors Social Survey Wave 3. The survey was conducted from late September to late October 2013, among members of National Seniors Australia who were aged 50 years and over. A total of 10,000 members were invited to complete the survey. Of these, 1,358 respondents who answered the National Seniors Social Survey Wave 2 in August 2012, who indicated in that survey they would like to participate in future waves of the survey, and whose membership number was in the National Seniors membership database, were invited to complete the survey. The remaining 8,642 respondents who were invited were selected from the National Seniors Australia database of approximately 200,000 members. The number of respondents allocated to each of the 48 strata (3 age groups x 2 genders x 8 states/territories) was calculated proportionally to reflect the Estimated Resident Population in Australia aged 50 years and over in June 2012.⁸⁵ The respondents within each stratum were selected randomly from the database. Selection was undertaken to ensure two members from the same family were not chosen.

A paper survey was mailed to each of the selected members. Respondents had the option to complete the paper survey and return by mail, or to complete the survey online. Results from a total of 2,062 surveys were received and entered. Survey weights were applied to each combination of age, gender and State/Territory, to adjust for differences in response rates by these population groups and to make the results representative of the Australian population aged 50 years and over. There were 44 cases with no information on at least one of these characteristics, reducing the sample to 2,018 cases that could be used in the analysis.

The National Seniors Social Survey Wave 3 covered a range of topics, and included health, employment, financial and social modules. This report presents results from the health and employment modules. These modules included questions addressing employment history, self-reported health conditions, the impact of health conditions on labour force engagement, enablers and barriers to remaining engaged in the labour force following a health condition, and access to employee health and wellbeing programs. As a worker's relationship with management is deemed a significant aspect to facilitating the retention and return of staff, items were included in this study which had been adapted from the Australian Work Ability Survey (WAS). The WAS included perceptions of management support for career through future promotion opportunities and skill needs; and social support through willingness to listen to personal problems and degree of reliance on immediate supervisor.

A range of questions elicited information from respondents about their demographic and socio-economic characteristics. The survey was approved by the Bellberry Human Research Ethics Committee.

This report presents summary statistics of the health and employment variables and various cross tabulation results with other variables, related to type and number of health conditions, employment, education and demographic characteristics.⁸⁶ Both binary and multinomial logistic regression analysis was conducted to understand the relative strength of factors predicting whether a person returned to work, stayed in work or retired/has yet to return to work following an illness, injury or disability. The statistical software package, STATA 11.2 was used to conduct the analyses.

Additional tables are presented in the Appendix.

⁸⁵ Australian Bureau of Statistics. *3101.0 - Australian Demographic Statistics, Dec 2012*. Canberra: Australian Bureau of Statistics, 2012.

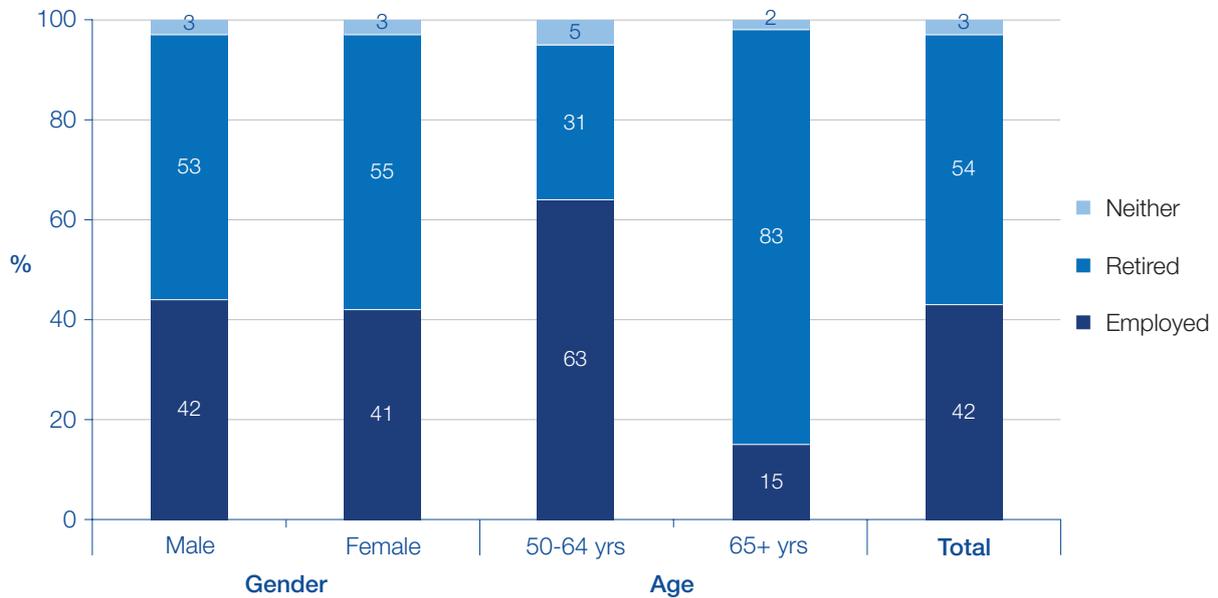
⁸⁶ Table footnotes present the number of cases for the major denominator groups (e.g. number of people who have worked in the past five years). Percentages based on a denominator of less than 50 cases are presented in italics, because such results may be unreliable because of the small sample size.

Results

Labour force engagement of senior Australians

Over half of respondents had already retired (54%), with 42% still employed, and a further 3% who were neither employed nor retired. As expected, the majority of those in the 65+ age group had retired (83%), while the majority of those in the younger age group were still employed (63%) (Figure 1).

Figure 1: Employment status (% of all respondents), by age and gender

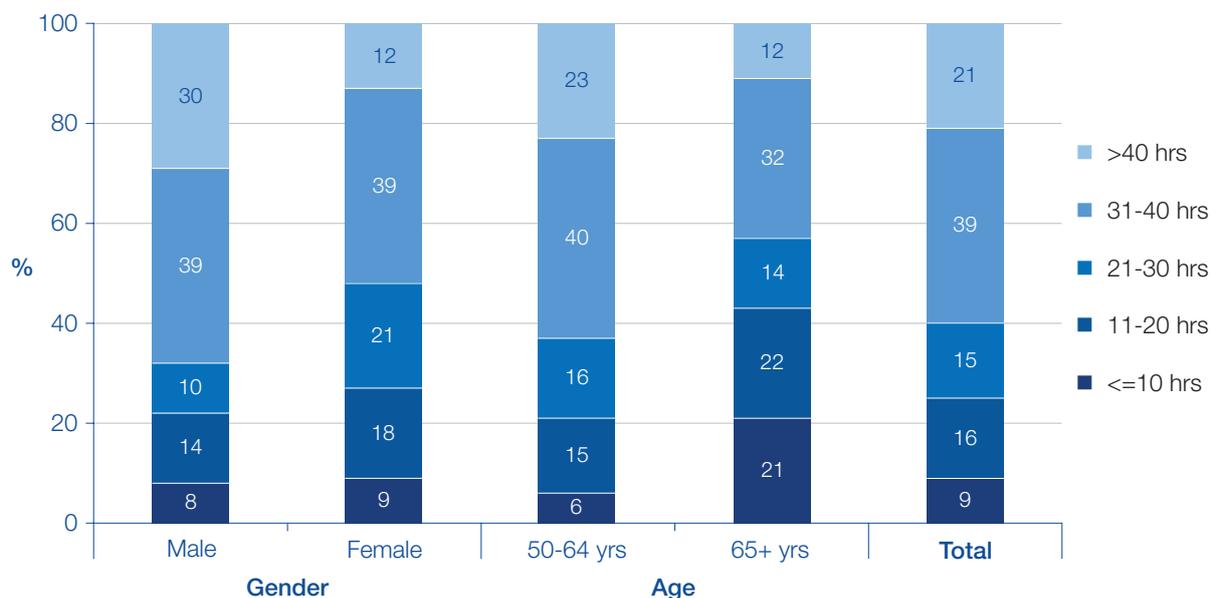


N=2062

Note: 0.6% of eligible respondents did not answer the question. Total of 100% includes "can't say" responses.

Of those currently working, 39% reported that they worked between 31 and 40 hours in an average week. One in five respondents worked more than 40 hours in an average week (21%) and 40% worked less than 31 hours in an average week. Twice as many females compared to males worked between 21 to 30 hours (21% versus 10%). However, the older age group (65+ years) were three times more likely to work 10 hours or less in an average week compared to the younger age group (50-64 years). On the other hand, working more than 40 hours in an average week was twice as likely for males and the younger age group (50-64 years) compared to females and the older age group (65+ years) (Figure 2).

Figure 2: Number of hours worked in an average week (% of those currently employed), by age and gender



N=722

Note: 3.0% of respondents did not answer the question

The most common occupation types of those who had worked in the past five years were managerial or professional roles (44%), followed by community related roles and clerical roles (24% and 20%) (Table 1). Not surprisingly, males were over-represented in manual related occupations (20% versus 2%).

Table 1: Occupation type (% of those who have worked in the last five years), by gender

Occupation type ⁸⁷	Gender		Total
	Male	Female	
Type A – Professional etc.	44.6	43.9	44.2
Type B – Technician/trade etc.	20.2	2.0	11.1
Type C – Community etc.	23.6	25.0	24.3
Type D – Clerical etc.	11.6	29.1	20.4
Total	100.0	100.0	100.0

N=1231

Note: 9.4% of eligible respondents did not answer the question.

Of those currently employed in paid work, one-third of respondents either work in the government, education, communication, finance or insurance industries. Twenty-two per cent of people currently employed work in health related industries such as recreational, personal, and health/community services. Not surprisingly, males were over-represented in construction and agriculture related industries whereas females were over-represented in health related industries (Table 2).

Table 2: Industry type (% of those who have worked in the last five years), by gender

Industry type ⁸⁸	Gender		Total
	Male	Female	
Type A – Construction etc.	18.0	4.6	11.3
Type B – Agriculture etc.	18.2	4.2	11.2
Type C – Government etc.	31.8	35.9	33.8
Type D – Retail etc.	10.3	10.0	10.2
Type E – Health etc.	9.7	34.6	22.1
Type F – Other	10.7	9.5	10.1
Total	100.0	100.0	100.0

N=1231

Note: 9.1% of eligible respondents did not answer the question. Total of 100% includes "can't say" responses.

Those who had finished high school tended to work in the government, education, communication or financial services (43%) as well as health and community related services (23%). Apart from health related industries, there were no major differences in the types of industries worked amongst those who had not finished high school (Table 3).

Table 3: Industry type (% of all who worked in last five years), by educational attainment

Industry type	Education			Total
	Finished HS	Not finished HS & other qualification	Not finished HS & no other qualification	
Type A – Construction etc.	9.7	13.1	13.6	11.4
Type B – Agriculture etc.	6.6	14.8	18.4	11.2
Type C – Government etc.	43.2	22.7	29.0	34.2
Type D – Retail etc.	7.9	11.9	13.5	10.1
Type E – Health etc.	23.7	24.2	12.4	22.0
Type F – Other	8.1	11.8	12.4	10.0
Total	100.0	100.0	100.0	100.0

N=1231

Note: 9.1% of respondents did not answer the question on industry type; and 1.4% eligible respondents did not answer the question on education.

Total of 100% includes "can't say" responses.

HS = high school.

⁸⁷ Occupation categories used throughout this report are:

Type A: Manager/professionals (e.g. engineer, doctor, etc.); Type B: Technician/trade/machinery operator/driver/labourer; Type C: Community/personal service worker/business owner/ other; Type D: Clerical/administrative/sales

⁸⁸ Industry categories used throughout this report are:

Type A: Construction/Manufacturing/Mining; Type B: Agriculture, Forestry and Fishing/Transport and Storage/Electricity/Gas/Water; Type C: Government/Education/Communication/Finance/Insurance; Type D: Wholesale/Retail/Hospitality/Tourism/Property & Business services; Type E: Culture/Recreation/Personal/Health & Community services; Type F: Other

Employment disruption – what is the role of illness, injury and disability?

The most frequently reported reason for having decided to retire was the ability to access super funds (60% rated as somewhat or very important) (Table 4). The next most frequently reported reasons included the stress of the job (38%), access to private income support (36%), having access to other government pensions/benefits (31%), and the psychological demands of the job (32%). The two least likely reasons for deciding to retire included discrimination based on gender and discrimination based on ethnicity (less than 5%).

Table 4: Reasons people had retired (% of retired people)

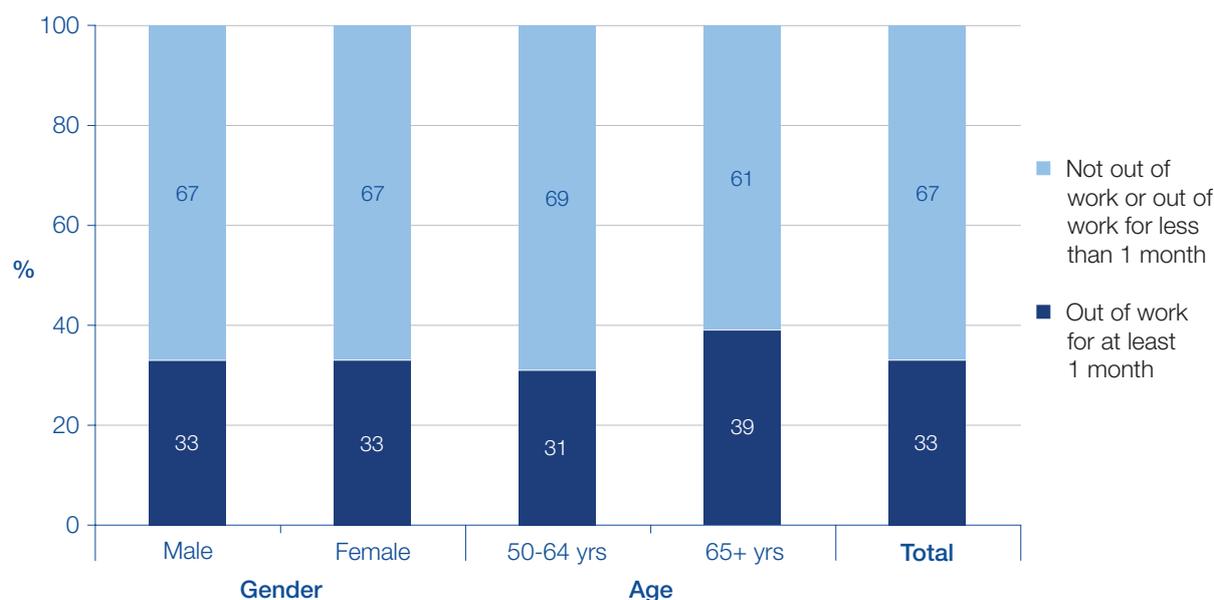
Reasons people had retired	Not at all important	Somewhat important	Very important	Can't say or N/A
Ability to access super funds	26.0	18.9	41.0	14.2
Private income support	34.5	14.9	21.5	29.1
My own illness, injury or disability	37.3	7.5	20.3	34.8
Access to other government pensions/benefits	45.6	13.1	18.1	23.2
The stress of my job	34.1	20.8	17.3	27.9
The psychological demands of the job	38.3	18.4	14.1	29.2
Being retrenched/made redundant	44.6	3.0	13.4	39.0
Pressure from my employer to retire	57.7	8.7	11.9	21.7
The physical demands of my job	43.8	15.9	11.7	28.6
Eligible for the Age Pension	53.4	12.0	10.4	24.3
My spouse/partner's retirement	41.1	10.1	9.1	39.6
Discrimination based on my age	43.0	8.7	8.3	40.1
Commenced caring responsibilities	41.7	4.8	8.2	45.3
Discrimination based on my illness	45.9	2.9	5.8	45.3
No flexible employment arrangements	46.8	5.3	5.6	42.3
Pressure from my spouse/partner to retire	57.6	9.9	5.5	27.1
End of contract/tenure	45.5	2.8	5.0	46.7
My skills became out-dated	46.8	14.3	5.0	34.0
Unable to find a job offering sufficient hours	49.8	2.2	4.4	43.6
Inability to find a job at all	47.2	3.2	4.3	45.3
Inability to find the right kind of job	47.4	3.5	3.9	45.3
Ceasing of caring responsibilities	46.4	2.2	3.0	48.4
Relocation to another part of Australia/overseas	48.2	2.8	2.7	46.3
Discrimination based on my gender	52.5	1.6	2.4	43.5
Discrimination based on my ethnicity	52.8	0.8	1.0	45.4

N = 1250

Note: 11% to 15% of eligible respondents did not answer the questions.

N/A: Not applicable

Respondents were asked to report on absences from work that were over at least one month in the previous five years (Figure 3). One-third of respondents had been out of work for at least one month in the last five years. Males and females were equally likely to have been out of work for at least one month. However, the older age group (65+ years) were slightly more likely to have been out of work for one month or more compared to the younger age group (50-64 years).

Figure 3: How long out of work in past five years (% of people who have worked in the past five years), by gender

N=1231

Note: 3.5% of eligible respondents did not answer the question.

The most frequently reported reasons for having ceased paid work for at least one month in the past five years were having retired (33%), job-related factors such as being retrenched or the business closed down (30%) and being on extended leave/holiday (14%). Illness-related factors were the fourth most common reason cited (12%) (Table 5).

Table 5: Reason(s) ceased paid work for at least one month in the past five years (%)

Reasons ceased paid work	%
Retired	33.3
Job-related	30.1
On extended leave/holiday	13.9
Illness-related	12.1
Care-giving responsibilities	10.2
Eligible for super/pension	9.2
Changed where I lived	6.7
Had household responsibilities	2.0
Undertook study/training	1.8
Undertook voluntary work	1.3

N=336

Note: Total does not sum to 100% because multiple responses were allowed.

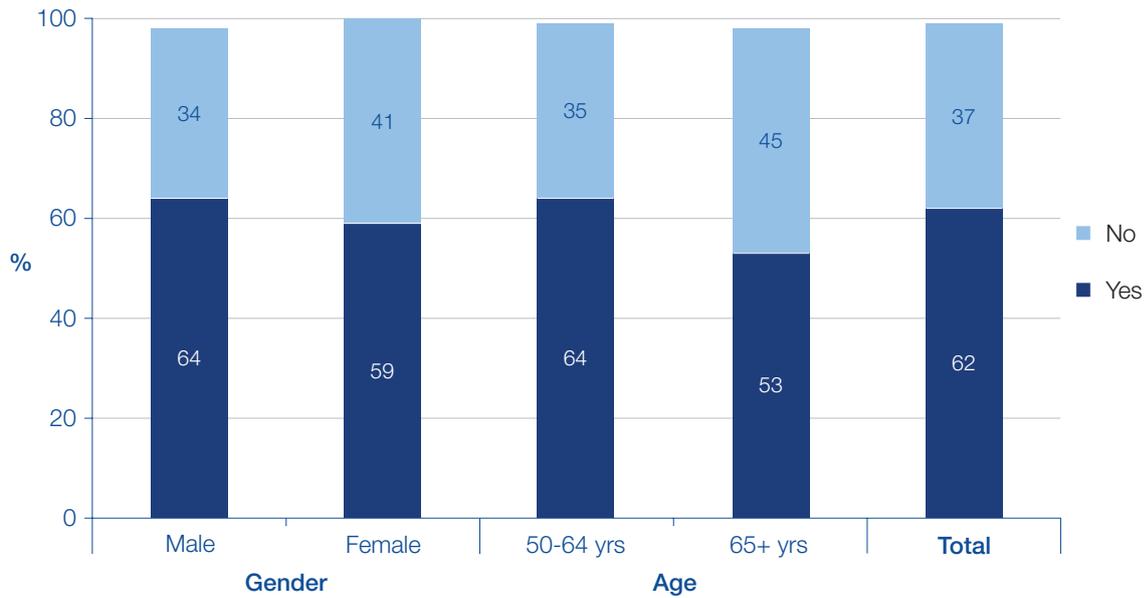
Illness-related includes a pre-existing illness/injury/disability or an illness/injury/disability sustained on the job.

Caring responsibilities includes caring for spouse, partner, parents, elderly relatives, grandchildren or own child(ren).

Job-related includes job was seasonal or temporary, retrenched or business closed down, and dissatisfied with work arrangements/pay/hours.

Most (62%) of the people who had been out of work for at least one month in the previous five years had eventually returned to paid work, while 37% had not (Figure 4). A slightly higher proportion of males and those from the younger age group (50-64 years) than females and those from the older age group (65+ years) had returned to work.

Figure 4: Whether returned to paid work after being out of work for at least one month (%), by gender and age



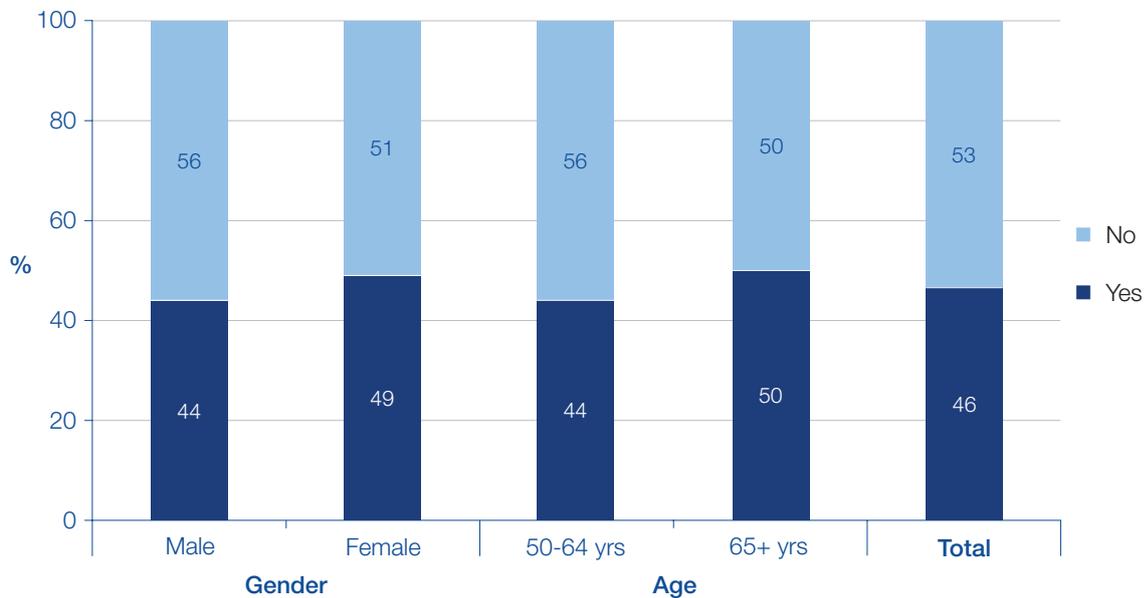
N=336

Note: 0.6% of eligible respondents did not answer the question. Total of 100% includes "can't say" responses.

Health conditions and work

Almost half of respondents (46%) reported having an illness, injury or disability for at least one month in the previous five years (Figure 5). Slightly more females than males, and people aged 65+ years compared to 50-64 years, reported having an illness.

Figure 5: Whether had an illness, injury or disability for at least 1 month in the last five years (% of all respondents), by age and gender



N=2062

Note: 1.0% of eligible respondents did not answer the question. Total of 100% includes "can't say" responses.

Of those with an illness, injury or disability for at least one month in the last five years, 50% had cardiovascular disease, 35% had arthritis, 34% had a musculoskeletal injury, and 23% had a mental illness (Table 6). Those in the older age group were more likely to report having cardiovascular disease (56%), arthritis (44%), cancer of any kind (18%), and respiratory diseases (14%) than the younger age group (44%, 27%, 10%, and 8% respectively). On the other hand, people in the younger age group were more likely to report having a musculoskeletal injury, mental illness, and to be overweight or obese than the older age group. The proportion of people with arthritis was almost twice for females compared to males (44% versus 24%). A slightly higher proportion of males than females reported having diabetes and cancer of any kind.

Table 6: Major health conditions experienced for at least 1 month in the past five years (% of all respondents with an illness, injury or disability for at least 1 month in the last five years), by age and gender

Health conditions ⁸⁹	Age		Gender		Total
	50-64 years	65+ years	Male	Female	
Cardiovascular disease	43.7	56.2	50.9	48.3	49.5
Arthritis	27.4	43.7	24.5	43.9	35.0
Musculoskeletal injury	36.2	31.8	33.7	34.5	34.1
Mental illness	28.1	16.7	23.8	21.9	22.8
Diabetes	16.0	14.9	19.5	12.1	15.5
Overweight or obese	19.4	8.4	13.1	15.3	14.3
Cancer of any kind	9.6	17.8	17.1	10.3	13.4
Respiratory disease	7.6	14.1	8.9	12.0	10.6
Other illnesses	12.6	22.6	18.1	16.6	17.3

N=966

Note: % is based on column percentages. Column figures do not sum to 100% because respondents could report more than one health condition.

There was little difference in the prevalence of each type of health condition across different occupation types (Table 7). Cardiovascular disease was the most common condition among each occupation type, ranging from 17% of professional occupations to 21% of clerical and related occupations.

Table 7: Health conditions experienced for at least 1 month (% of all who have worked in the past five years), by occupation type

Health conditions	Occupation type				Total
	Type A – Professional etc.	Type B – Technician/ trade etc.	Type C – Community etc.	Type D – Clerical etc.	
Cardiovascular disease	16.9	17.0	17.4	21.2	17.9
Musculoskeletal injury	15.4	14.5	14.3	12.1	14.4
Arthritis	9.2	10.8	12.9	13.8	11.2
Mental illness	8.3	9.0	10.2	12.7	9.7
Overweight or obese	6.9	6.2	6.2	7.8	6.8
Diabetes	5.2	7.6	6.5	5.8	5.9
Cancer of any kind	6.3	4.4	4.8	3.1	5.0
Respiratory disease*	2.4	4.7	2.6	3.0	2.9
Other illnesses	6.1	5.4	6.3	4.9	5.8

N=1231

Note: Total % does not sum to 100 because respondents can have more than one health condition.

*Italic percentages indicate that the denominator has less than 50 cases.

Almost half of people with an illness, injury or disability had three or more conditions in the past five years (49%), while a further 22% had two conditions (Figure 6). People in the older age group (55%) and females (52%) were most likely to have had three or more adverse health conditions.

⁸⁹ Throughout the report, the health conditions presented comprise the following specific conditions:

Cardiovascular disease: high blood pressure, high cholesterol in need of treatment, problems with heart, stroke or TIA, hardening of the arteries

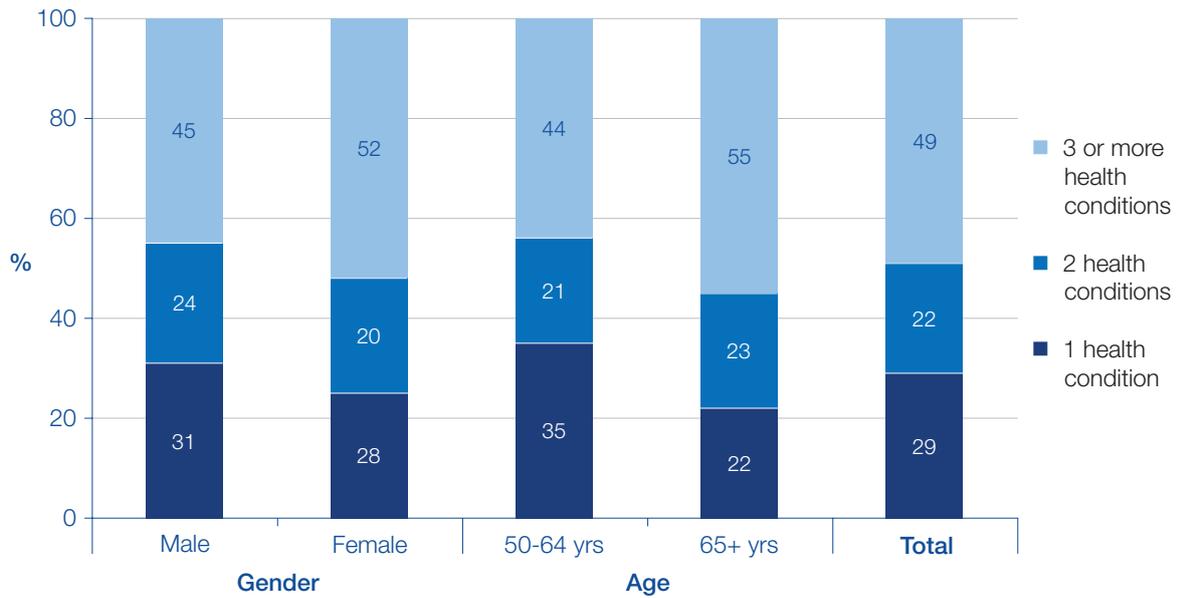
Respiratory disease: lung or breathing problems

Arthritis: arthritis, osteoporosis or a fracture due to weak bones

Mental illness: depression or anxiety

Other illnesses: bowel or colon problems, kidney problems, liver problems or Parkinson's.

Figure 6: Number of adverse health conditions (% of those with illness, injury or disability), by age and gender

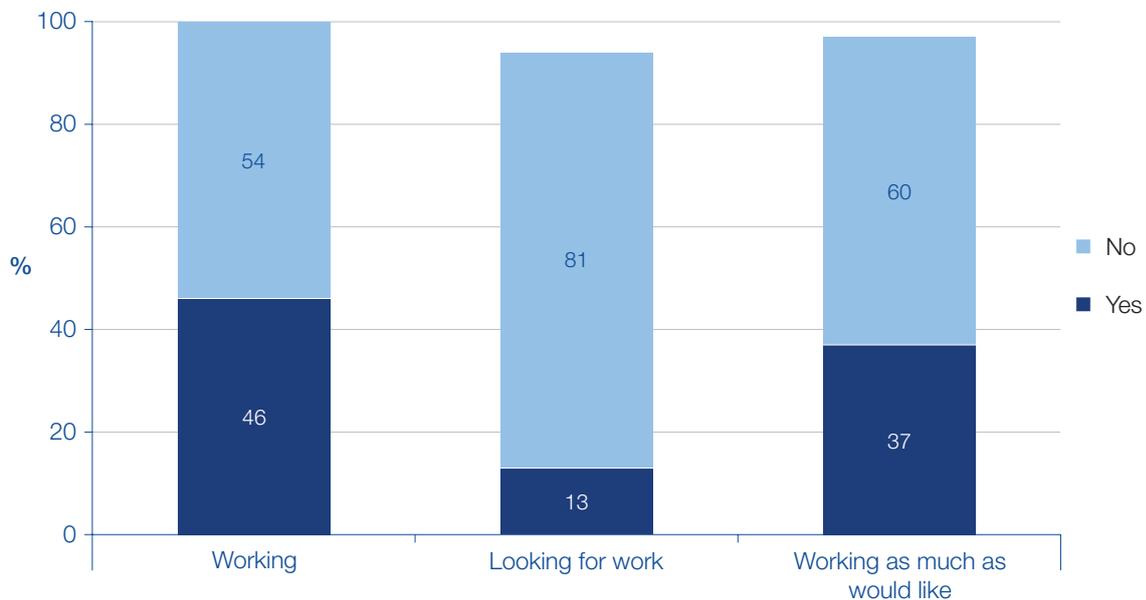


N=966
 Note: 11.4% of eligible respondents did not answer the question.

Effect of illness on work

Of those who have worked in the last five years and have an illness, injury or disability, 46% reported that the illness prevented them from working, 37% reported that it prevented them from working as much as they would like, and 13% reported that it prevented them from looking for work (Figure 7).

Figure 7: Illness, injury or disability has prevented from working, looking for work or working as much as would like within the last five years (% of people with illness, injury or disability for at least 1 month)



N=531
 Note: Total of 100% also includes 'can't say' responses.
 Note: 17.7% of eligible respondents did not answer the question on whether illness has prevented them from working; 32.3% of eligible respondents did not answer the question on whether illness prevented them from looking for work; and 27.7% of eligible respondents did not answer the question on whether illness prevented them from working as much as they would like.

The proportion reporting that illness, injury or disability had prevented them from working or looking for work was slightly higher for those who had not finished high school but had other qualifications compared with those who had finished high school (Table 8). People who had finished high school were least likely to have had an illness prevent them from working as much as they would like (30%).

Table 8: Illness, injury or disability has prevented from working, looking for work or working as much as you would like within the last five years (% of people with illness, injury or disability for at least 1 month), by education

Illness has prevented from		Education		
		Finished HS	Not finish HS & other qualification	Not finish HS & no other qualification
Working or looking for work ^a	Yes	43.3	52.3	43.4
	No	56.5	47.2	53.2
	Total	100.0	100.0	100.0
Working as much as would like	Yes	30.4	44.6	42.2
	No	66.1	52.7	55.7
	Total	100.0	100.0	100.0

N=531

Note: 19% did not answer the question on illness preventing them from working or looking for work; and 27.7% did not answer the question on illness preventing them from working as much as they would like, and 1.9% did not answer the question on education attainment. Total of 100% includes "can't say" responses.

HS: High school

^a Working and "Looking for work" were combined to ensure sufficient numbers to produce reliable results.

People in manual work such as technician or trade roles most frequently reported that illness had prevented them from working or looking for work (51%). However, this proportion was based on less than fifty cases and so should be interpreted with caution. People in community and related roles were most likely to report that illness had prevented them from working as much as they would like (51%) (Table 9).

Table 9: Illness, injury or disability has prevented from working, looking for work or working as much as you would like within the last five years (% of people with illness, injury or disability for at least 1 month), by occupation

Illness, injury or disability has prevented from		Occupation type (%)			
		Type A – Professional etc.	Type B – Technician/ trade etc.*	Type C – Community etc.	Type D – Clerical etc.
Working or looking for work	Yes	48.3	50.7	42.0	46.2
	No	51.7	49.3	57.2	51.1
	Total	100.0	100.0	100.0	100.0
Working as much as would like	Yes	27.2	40.2	51.2	36.3
	No	68.0	59.8	47.2	60.9
	Total	100.0	100.0	100.0	100.0

N=531

Note: Total of 100% includes "can't say" responses.

*Italics indicate that the denominator has less than 50 cases.

Those working in wholesale, retail, hospitality, tourism or business related industries had higher proportions of respondents indicating that illness prevented them from working or looking for work (50%) or working as much as they would like (46%) (Table 10). However, these proportions were based on less than fifty cases and so should be interpreted with caution.

Table 10: Illness, injury or disability has prevented from working, looking for work or working as much as you would like within the last five years (% of people with illness, injury or disability for at least 1 month), by industry

Illness has prevented from		Industry					
		Type A – Construction etc.*	Type B – Agriculture etc.*	Type C – Gov't etc.	Type D – Retail etc.*	Type E – Health etc.	Type F – Other*
Working or looking for work	Yes	41.2	44.5	49.0	50.1	48.5	39.8
	No	58.8	55.5	50.4	49.9	50.3	57.2
	Total	100.0	100.0	100.0	100.0	100.0	100.0
Working as much as would like	Yes	30.6	36.2	39.3	46.2	33.0	33.3
	No	69.4	63.8	56.7	50.8	66.1	55.0
	Total	100.0	100.0	100.0	100.0	100.0	100.0

N=531

Note: Total of 100% includes "can't say" responses.

**Italic percentages indicate that the denominator has less than 50 cases.*

Sixty one per cent of respondents with a musculoskeletal injury and 58% of those with a mental illness reported that their illness had prevented them from working or looking for work (Table 11). Cardiovascular disease (43%) was least likely to prevent people from working or looking for work. Respiratory disease (52%) and mental illness (50%) were most likely to prevent people from working as much as they would like.

Table 11: Major health conditions by whether illness, injury or disability prevented from working or looking for work, or working as much as would like (%)

Type of health condition	Illness, injury or disability prevented from:	
	Working or looking for work	Working as much as you would like
Cardiovascular disease	43.2	35.2
Respiratory disease*	54.7	52.4
Musculoskeletal injury	60.9	49.0
Arthritis	44.2	43.4
Mental illness	57.9	49.8
Diabetes	46.4	40.4
Cancer of any kind	50.7	33.3
Overweight or obese	48.0	38.6
Other illnesses	45.9	42.5

N=531

**Italic percentages indicate that the denominator has less than 50 cases.*

Sixty-four per cent of people who had diabetes and 60% who had arthritis were prevented from engaging in the workforce or working as much as they would like for a period of at least six months in the last five years (Table 12). People with a musculoskeletal injury (44%) or being overweight (42%) were least likely to have had their work interrupted for six months or more.

Table 12: Major health conditions, by amount of time illness prevented from working, looking for work, or working as much as would like (%)

Type of health condition	Amount of time illness prevented working, looking for work, or working as much as would like		Total
	Less than 6 months	6 months or more	
Cardiovascular disease	49.6	50.4	100.0
Respiratory disease*	46.5	53.5	100.0
Musculoskeletal injury	55.6	44.4	100.0
Arthritis	39.9	60.1	100.0
Mental illness	44.4	55.6	100.0
Diabetes*	36.3	63.7	100.0
Cancer of any kind*	47.7	52.3	100.0
Overweight or obese*	57.7	42.3	100.0
Other illnesses*	39.8	60.2	100.0

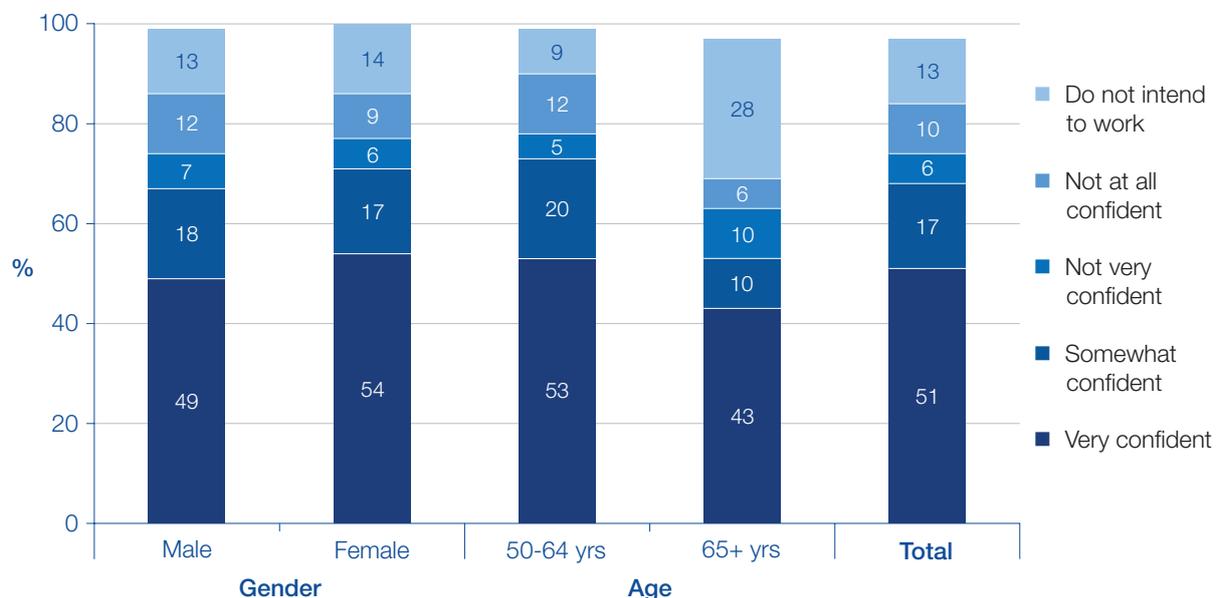
N=223

Note: 8.5% of eligible respondents did not answer the question on the amount of time illness prevented them from working, looking for work or working as much as would like.

*Italics indicate that the denominator has less than 50 cases.

Of those who had an illness, injury or disability for at least one month, 68% indicated that they were *somewhat* or *very confident* in their ability to continue working in the next 12 months. However, 13% had no intention of working (Figure 8). The older age group (65+ years) were less likely to feel *very* or *somewhat confident* in their ability to continue working.

Figure 8: Proportion of people who are confident in their ability to continue working in the next 12 months (% of people who have had an injury, illness or disability for at least 1 month), by gender and age



N=531

Note: 15.5% of eligible respondents did not answer the question.

Note: Total of 100% also includes 'can't say' responses.

Confidence in the ability to continue working over the next 12 months was much lower among people whose illnesses had prevented them from working, looking for work or working as much as they would like for at least six months (29% felt very confident) compared to those whose illnesses prevented them for less than six months (67% felt very confident) (Table 13).

Table 13: Confidence in the ability to continue working in the next 12 months (%), by amount of time illness prevented from working/looking for work/working as much as would like

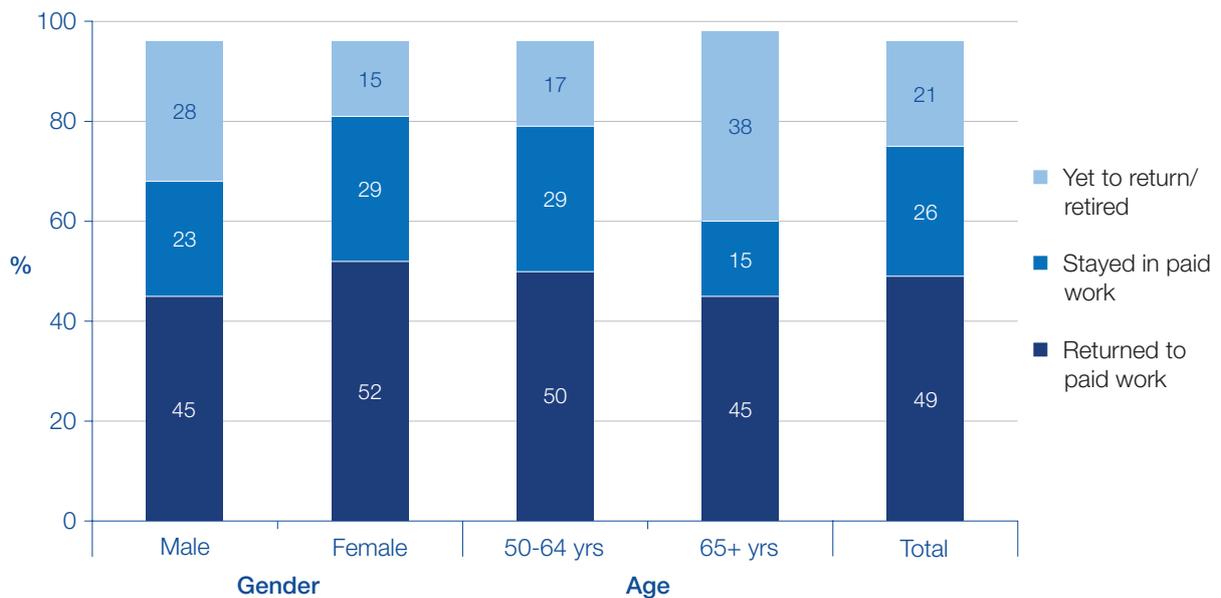
Confidence in the ability to continue working	Amount of time	
	Less than 6 months	6 months or more
Not at all confident	1.8	28.5
Not very confident	2.5	12.9
Somewhat confident	15.4	21.2
Very confident	67.4	28.7
Do not intend to work	11.8	7.3
Total	100.0	100.0

N=249

Returning to work after an illness

Almost half (49%) of people whose illness, injury or disability had affected their ability to work, look for work or work as much as they would like returned to work after an absence of at least one month. A further 21% had yet to return to work or had retired (Figure 9). Males were almost twice as likely as females to have yet to return to work or to have retired (28% v 15%). People aged 50-64 years were more likely to stay in paid work despite their illness while those aged 65 years and over were more likely to have retired or have yet to return to paid work.

Figure 9: Effect of illness on employment situation (% of people whose illness, injury or disability prevented them from working or looking for work, or working as much they as would like), by gender and age



N=236

Note: 16.5% of eligible respondents did not answer the question.

Note: Total of 100% also includes "can't say" responses.

More than half of those who had finished high school or those who did not finish high school but had other qualifications had returned to paid work after illness, which was higher than those who did not finish high school and had no other qualifications (51% and 52% versus 38%) (Table 14). Having finished high school was also associated with a lower likelihood of having not returned to work or having retired (18%).

Table 14: Effect of illness on employment situation (% of people whose illness, injury or disability prevented them from working or looking for work, or working as much they as would like), by education

Effect of illness on employment situation	Education		
	Finished HS	Not finish HS & other qualification	Not finish HS & no other qualification
Returned to paid work	51.0	52.3	37.7
Stayed in paid work	26.8	22.3	31.1
Yet to return or retired	17.9	24.8	23.6
Total	100.0	100.0	100.0

N=236

HS: High school

Note: Total of 100% includes "can't say" responses.

People with diabetes were most likely to have yet to return to work or have retired compared with other health conditions (47%). However, there were less than fifty respondents with diabetes answering this question so results should be interpreted cautiously (Table 15). Returning to paid work was most common among people with cardiovascular disease (47%) and musculoskeletal injury (47%).

Table 15: Effect of illness, injury or disability on employment situation (% of people whose illness, injury or disability prevented them from working or looking for work, or working as much they as would like), by health condition

Health conditions	Effect of illness, injury or disability on employment situation				Total
	Returned to paid work	Stayed in paid work	Yet to return or retired	Can't say	
Cardiovascular disease	47.2	27.1	24.1	1.6	100.0
Respiratory disease*	40.2	29.1	30.6	0.0	100.0
Musculoskeletal injury	46.5	28.1	21.2	4.1	100.0
Arthritis	41.9	28.6	21.8	7.7	100.0
Mental illness	42.4	26.5	27.5	3.6	100.0
Diabetes*	34.7	18.8	46.5	0.0	100.0
Cancer of any kind*	42.3	23.8	26.4	7.5	100.0
Overweight or obese*	28.1	40.6	28.0	3.3	100.0
Other illnesses*	35.3	39.0	17.7	8.0	100.0

N=236

*Italic percentages indicate that the denominator has less than 50 cases.

The more adverse health conditions a person had the more likely that it affected their employment situation. For example, 26% of people with three or more health conditions had yet to return to paid work or had retired compared to 18% of those with one or two health conditions (Table 16). Similarly, a higher proportion of those who had one or two adverse health conditions had returned to paid work compared to those with three or more adverse health conditions (55% vs. 40%).

Table 16: Effect of illness, injury or disability on employment situation (% of people whose illness, injury or disability prevented them from working or looking for work, or working as much they as would like), by number of health conditions

Effect of illness, injury or disability on employment situation	Number of health conditions	
	1 or 2 conditions	3 or more conditions
Returned to paid work	55.2	39.9
Stayed in paid work	21.4	31.7
Yet to return or retired	17.8	25.6
Total	100.0	100.0

N=236

Note: Due to small number of observations 1 and 2 conditions were grouped together. Total of 100% includes "can't say" responses.

Respondents in manual occupations such as technician or trades roles were far more likely to have yet to return to work or to have retired (43%) compared with other occupations, especially respondents in the professional category (16%) (Table 17). However, the number of respondents in this category is small so interpretation should be done cautiously. Only 32% of people in manual occupations had returned to paid work after illness.

Table 17: Effect of illness, injury or disability on employment situation (% of people whose illness, injury or disability prevented them from working or looking for work, or working as much they as would like), by occupation type

Effect of illness, injury or disability on employment situation	Occupation type			
	Type A – Professional etc.	Type B – Technician/ trade etc. *	Type C – Community etc.	Type D – Clerical etc.*
Returned to paid work	50.7	31.7	46.1	51.9
Stayed in paid work	31.0	16.5	27.4	19.3
Yet to return or retired	16.3	42.5	19.4	26.5
Total	100.0	100.0	100.0	100.0

N=236

*Italics indicate that the denominator has less than 50 cases.

Note: Total of 100% includes "can't say" responses.

People employed in construction related industries (22%) were far less likely to return to paid work after taking time off due to illness than those in other types of industries (Table 18). However, due to the small number of observations in this category interpretation should be done cautiously. Thirty-seven per cent of people in construction and related industries had yet to return to work or had retired, compared with only 6% of workers in health related industries.

Table 18: Effect of illness, injury or disability on employment situation (% of people whose illness, injury or disability prevented them from working or looking for work, or working as much they as would like), by industry type

Effect of illness, injury or disability on employment situation	Industry					
	Type A – Construction etc.*	Type B – Agriculture etc.*	Type C – Government etc.	Type D – Retail etc.*	Type E – Health etc.	Type F – Other*
Returned to paid work	22.4	39.4	52.8	52.5	56.7	36.5
Stayed in paid work	31.2	29.3	22.3	20.3	35.0	20.0
Yet to return or retired	37.0	31.3	20.8	27.2	6.3	30.6
Total	100.0	100.0	100.0	100.0	100.0	100.0

N=236

*Italics indicate that the denominator has less than 50 cases; Total of 100% includes "can't say" responses.

To understand the relative strength of a number of factors in predicting workforce outcomes following illness, injury or disability, both binary and multinomial logistic regressions were conducted. A binary logistic regression analysis was conducted to predict the likelihood of people with an illness staying in paid work or returning to paid work versus having yet to return to paid work or retiring permanently (Table 19). The predictors used were age, gender, high school education, number of health conditions, and occupation type.⁹⁰

The results showed that older people and males were significantly less likely to stay in paid work or return to paid work after an illness, compared to their counterparts. For males, the odds of staying in paid work or leaving work and then returning after the illness were 0.47 times the odds for a female. For a person aged 65 years and over, the odds of staying in paid work or leaving work and then returning after the illness are 0.31 times the odds for a person aged 50-64 years.

Table 19: Odds ratio and confidence interval for predicting stayed/returned to paid work

	Coefficient (SE)	Odds Ratio		
		Lower 95% CI	Odds Ratio	Upper 95% CI
Stayed or returned to paid work vs. yet to return or retired permanently				
Intercept	1.92 (0.44)			
Gender (Ref.= Female)	Ref.		1.00	
Male	-0.75 (0.38) *	0.22	0.47	0.99
Age (Ref.=50-64 years)	Ref.		1.00	
65+ years	-1.16 (0.42)**	0.14	0.31	0.70
Finished high school (Ref. = No)	Ref.		1.00	
Yes	0.50 (0.43)	0.71	1.64	3.83
Number of health conditions	-0.15 (0.09)	0.73	0.86	1.02
Occupation (Ref. = Other)	Ref.		1.00	
Managerial/professional	0.57 (0.41)	0.79	1.77	3.95

* $p < .05$ ** $p < .01$ SE: standard error; 95% CI: 95% confidence interval; Ref. = Reference category

A multinomial logistic regression was also conducted to assess the likelihood of whether a person with an illness would stay in paid work, as well as either the person retiring permanently or yet to return to paid work, versus whether they have left paid work but have since returned to paid work (Table 20). The same set of predictors that were used in the binary model was also used in this model. A test of the full model versus a constant only model was statistically significant (chi square = 27.03, $p < .01$ with $df=10$).

Of the five predictors for having stayed in paid work, only the number of health conditions was found to be near significant (at $p < .065$). Both age and the number of health conditions were positively and significantly related with whether people retired permanently or were yet to return to paid work versus people who left paid work but have since returned (both at $p < .05$). In other words, for those in the older age group (65+ years), the odds of retiring permanently or having yet to return to paid work were 2.71 times larger than the odds of those in the younger age group (50-64 years). Similarly, as the number of health conditions increased the probability of retiring permanently or having yet to return to paid work also increased.

⁹⁰ A test of the full model against a constant only model was statistically significant, indicating that the predictors as a set reliably distinguished between people with an illness staying in paid work or returning to paid work versus having yet to return to paid work or retiring permanently (chi square = 21.98, $p < .001$ with $df=5$).

Table 20: Odds ratios and confidence interval for predicting employment situation

	Coefficient (SE)	Odds Ratio		
		Lower 95% CI	Odds Ratio	Upper 95% CI
Stayed in paid work vs. returned to paid work				
Intercept	-0.97 (0.42)			
Gender (Ref. = Female)	Ref.		1.00	
Male	-0.02 (0.37)	0.47	0.98	2.05
Age (Ref.= 50-64 years)	Ref.		1.00	
65+ years	-0.48 (0.45)	0.25	0.62	1.50
Finished high school (Ref. = No)	Ref.		1.00	
Yes	-0.14 (0.40)	0.40	0.87	1.91
Number of health conditions	0.17 (0.09)	0.99	1.18	1.41
Occupation (Ref. = Other)	Ref.		1.00	
Managerial/professional	0.17 (0.39)	0.56	1.19	2.52
Yet to return/retired vs. returned to paid work				
Intercept	-1.62 (0.47)			
Gender (Ref. = Female)	Ref.		1.00	
Male	0.75 (0.40)	0.96	2.11	4.62
Age (Ref. = 50-64 years)	Ref.		1.00	
65+ years	0.99 (0.44)*	1.15	2.71	6.41
Finished high school (Ref. = No)	Ref.		1.00	
Yes	-0.54 (0.45)	0.24	0.58	1.41
Number of health conditions	0.21 (0.09)*	1.03	1.24	1.49
Occupation (Ref. = Other)	Ref.		1.00	
Managerial/professional	-0.51 (0.43)	0.26	0.60	1.39

* $p < .05$ SE: standard error; 95% CI: 95% confidence interval; Ref. = Reference category

Barriers and enablers for returning to work after an illness

The most commonly cited factors which assisted people to return to work or stay in work were flexible work options (47%), management or supervisor support (41%) and peer group or co-worker support (38%) (Table 21). Flexible work options (57%) and management and supervisor support (49%) were particularly helpful for people who remained in work. Of less importance was a better match between the worker's skills and their job. Less psychologically demanding roles were more important for those who returned to paid work than for those who stayed in paid work.

Table 21: Factors that assisted people to either return to work or remain in work (% of people who returned to paid work after illness or stayed in work), by effect of illness, injury or disability on employment situation

Factors that assisted people to either return to work or remain in work ⁹¹	Effect of illness on employment situation		Total
	Returned to paid work	Stayed in paid work	
Flexible work options	44.1	57.3	47.4
Management/supervisor support	38.0	48.9	40.6
Peer group/co-worker support	41.3	34.4	37.7
Physical adjustments	23.9	28.9	24.7
Reduction in the amount of work	23.6	26.7	23.8
Workplace professional consulted	17.7	21.5	18.1
Other job changes	17.1	20.7	17.5
Less psychological demands	17.9	8.2	13.8
Better match between my skills and job	9.5	7.1	8.2

N=190

Note: % of column. Column figures do not sum to 100% because multiple responses were allowed.

For those currently working, the factors that would assist them to work more hours included having management or supervisor support (16%), flexible work options (15%), and a less psychologically demanding role (13%) (Table 22).

The factors that caused difficulties in remaining engaged in the workforce included: having limited support such as being able to alter tasks or having a lack of back-to-work support for the illness (22%), a lack of understanding or discrimination by managers/supervisors (20%), discrimination due to age (18%) and a lack of flexible work options (16%) (Table 23).

Table 22: Factors that would assist people to work more hours (% of people who returned to paid work after illness or stayed in work), by effect of illness, injury or disability on employment situation

Factors that would assist people to work more hours	Effect of illness on employment situation		Total
	Returned to paid work	Stayed in paid work*	
Management/supervisor support	16.0	16.0	15.9
Flexible work options	17.7	12.2	15.6
Less psychological demands	17.0	8.9	13.3
Peer group/co-worker support	10.1	8.9	9.9
Physical adjustments	9.9	5.5	7.8
Other job changes	7.1	9.8	7.7
Better match between my skills and job	4.1	11.5	6.5
Workplace professional consulted	6.2	4.9	5.4

N=145

*Italics indicate that the denominator has less than 50 cases.

Note: % of column. Column figures do not sum to 100% because multiple responses were allowed.

⁹¹ Reduction in the amount of work: includes adjustments to the pace of work, adjustments to the amount of work, and reduction in responsibilities.
Flexible work options: includes the option of fewer work hours, flexible start & finish times, more breaks during the work day, and the ability to work from home.
Physical adjustments: includes adjustments in access to the office, ergonomic adjustments, and a less physically demanding role.
Less psychological demands: includes a less psychologically demanding role, and a less stressful work situation.
Other job changes: includes change of job, change of job tasks, change of job location, and education & retraining.

Table 23: Factors that caused difficulties in returning to paid work, remaining in paid work, or gaining more work hours (%), by effect of illness, injury or disability on employment situation

Factors that caused difficulties	Effect of illness on employment situation			Total
	Returned to paid work	Stayed in paid work	Yet to return or retired*	
Limited support ⁹²	18.8	23.0	25.0	22.4
Lack of understanding/discrimination by management	19.7	16.5	23.8	20.1
Discrimination due to my age	18.8	15.6	18.3	18.3
Lack of flexible work options	15.7	14.3	19.6	15.5
Government agencies not helpful	13.2	7.5	18.4	13.4
Cannot work at all due to illness	4.9	0.0	42.6	12.1
Overqualified for positions	11.5	3.5	12.6	9.9
Discrimination due to my illness	9.1	8.6	8.7	9.7
No jobs available	7.8	3.1	17.7	9.6
Lack of understanding/discrimination by co-workers	5.5	13.4	8.7	8.7
Difficulty accessing suitable education & re-training	2.3	7.1	4.3	4.4
Discrimination by job recruiters	2.9	3.1	3.1	2.9
Discrimination due to ethnicity/gender	1.9	0.0	0.0	0.9

N=236

Italics indicate that the denominator has less than 50 cases.Note: % of column. Column figures do not sum to 100% because multiple responses were allowed.*

Employer health and wellbeing programs

People who had worked in the past five years were asked what health and wellbeing programs their employers had offered, which programs they participated in, and which programs they would have liked to have participated in but were not offered (Table 24). Overall, 73% of workers said that they had been offered at least one program by their employer. The most commonly offered programs were OH&S guidelines (54%), vaccinations (52%) and psychological counselling (34%).

Just over half of people who worked in the past five years participated in at least one health and wellbeing program (55%); this was equal to 76% of all people who were offered a program. OH&S guidelines (32%) and vaccinations (31%) were the two programs most commonly participated in. These were followed by health assessments/checks (19%), which is a high proportion of employees who were offered the health assessments/ checks (26%); work/life balance arrangements (17%); support with physical aspects of the job (16%) and information for a healthy lifestyle (15%). Psychological counselling (9%) had relatively low participation given it was the third most commonly offered type of program.

The high demand for health assessments or checks was also reflected by 46% of people who had not been offered this program but who wanted to participate. Health insurance subsidies (44%), exercise breaks (42%), information for a healthy lifestyle and diet (39%) and nutrition programs (39%) were also in demand among people who were not offered these programs.

⁹² Limited support included lack of back-to-work support for illness, limited support in ergonomic requirements, limited support to alter the tasks, limited support to alter the rate or pace of work, and limited support to alter the amount of work.

Table 24: Whether employer offered workplace health and wellbeing programs (% of all people who have worked in the last five years)

	Offered	Participated	Would like to participate in
OH&S guidelines	54.0	31.5	22.9
Vaccinations	52.4	30.8	35.8
Psychological counselling (e.g. stress management)	34.1	8.8	30.5
Work/life balance arrangements	31.7	16.8	38.1
Support with handling physical aspects of the job	32.1	16.2	20.8
Ergonomic assessments	27.7	13.7	30.4
Information for a healthy lifestyle	27.0	14.9	38.7
Support with handling the psychological aspects of the job	25.3	9.9	26.8
Health assessments/checks	26.7	18.6	45.7
Smoking cessation programs	17.7	2.5	15.1
Exercise breaks, gym membership	16.1	7.6	42.3
Diet and nutrition	13.1	5.5	38.8
Health insurance subsidies	11.6	5.4	44.0
Other		0.9	0.0
Total % who were offered/participated in at least one program	72.6	55.0	-

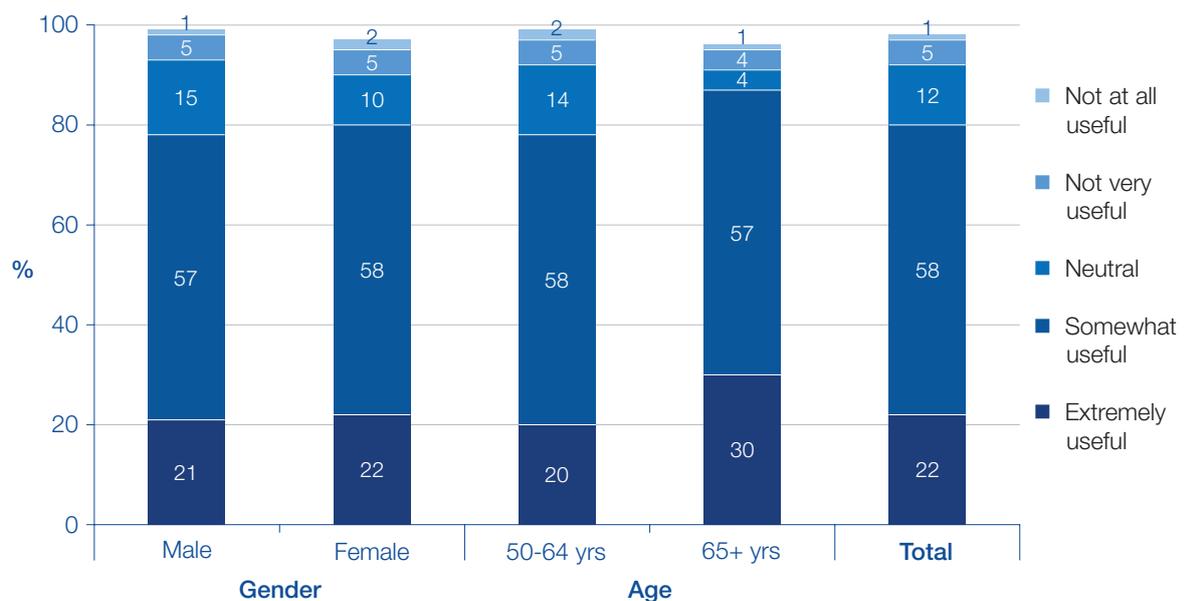
N=1,231

Offered, participated: % of people who have worked in the past five years.

Would like to participate in: % of people who were not offered the program by their employer.

Over half of the respondents who did participate in health and wellbeing programs found them *somewhat useful* (58%), and a further 22% found them *extremely useful* (Figure 10). Only 6% of people found the programs *not very* or *not at all* useful. There were no major differences between males and females, however, the older age group (65+ years) were more likely to report that they found the health and wellbeing programs to be *extremely useful*.

Figure 10: How useful found workplace health and wellbeing programs (% of all people who have participated in health and wellbeing programs), by gender and age



N=645

Note: 2.2% of eligible respondents did not answer the question. Total of 100% also includes "can't say" responses.

The most common difficulties faced by people in accessing health and wellbeing programs were lack of time (9%), location (8%), not feeling comfortable accessing programs through work (6%) and concerns regarding confidentiality of personal information (6%) (Table 25).

Table 25: Specific difficulties in accessing workplace health and wellbeing programs (% of all people who have worked in the last five years)

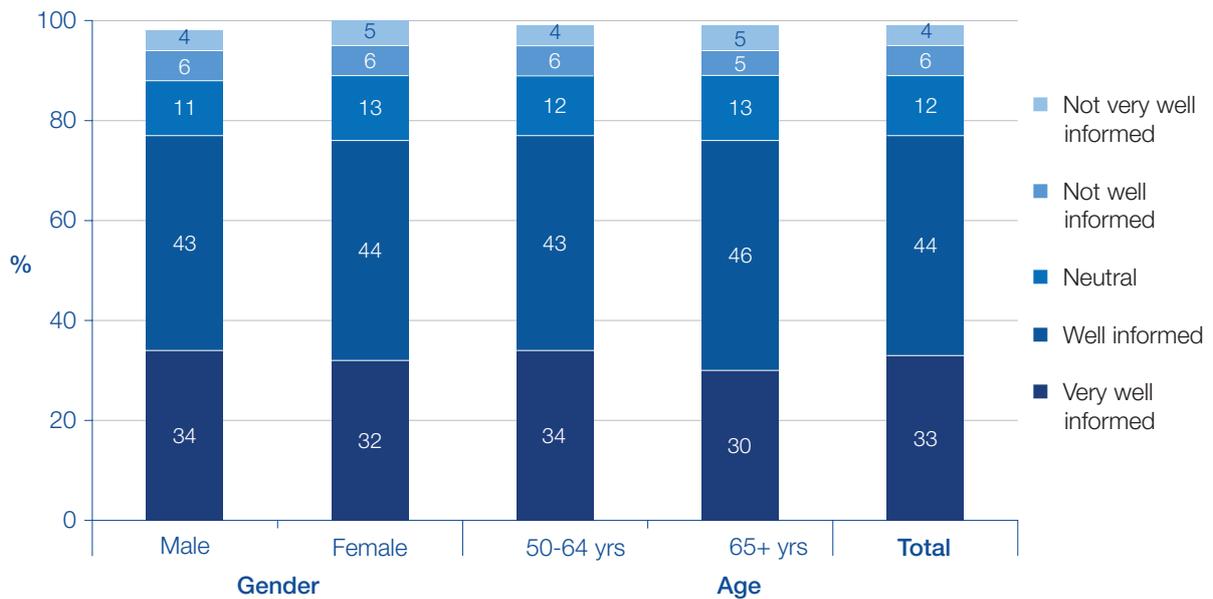
Difficulties in accessing workplace health and wellbeing programs	%
Have no time to access them	8.7
Facilities are not conveniently located	8.0
Don't feel comfortable accessing program through work	5.9
Don't trust personal information will be kept confidential from employer	5.9
Held at inconvenient times	5.0
Too expensive	4.2
Stigma associated with such schemes/programs	3.1
Manager/supervisor opposition	2.9
No problems accessing any programs	29.9

N=1231

Note: Respondents could choose more than one answer.

Most workers (77%) were *well* or *very well* informed about the health and safety risks of their role (Figure 11). Only 10% were *not well* or *not very well* informed of these risks. There were no major differences in feeling either *well informed* or *very well informed* amongst males and females and the two age groups.

Figure 11: How well informed of occupational health and safety risks of the work role (% of all people who have worked in the last five years), by gender and age



N=1231

Note: 12.5% of eligible respondents did not answer the question.

Note: Total of 100% also includes "can't say" responses.

Respondents were also asked about how well their work fits in with their family and social commitments. Almost half (45%) reported that they spend more time than they would like at work and 23% spend more hours working at home than they would like (Table 26). About 30% felt that they have little or no control over their work life and a similar proportion (28%) felt overwhelmed and over-committed by work.

Table 26: How well work had/does fit in with family and social commitments (% of all people who have worked in the last five years)

	Yes	No	Can't say	Total
Spend more hours at work than would like	45.4	53.8	0.8	100.0
Spend more hours than would like working at home	23.1	72.1	4.8	100.0
Feel like you have little/no control over work life	29.0	67.1	3.9	100.0
Regularly enjoy hobbies or interests outside of work	78.8	19.2	1.9	100.0
Have enough time to spend with loved ones	70.3	25.9	3.8	100.0
Have time to do something just for you	72.7	25.0	2.3	100.0
Feel overwhelmed and over-committed	27.5	68.1	4.5	100.0

N=1231

Note: 11.3% of eligible respondents did not answer the question.

Discussion

This study has confirmed that illness, injury and disability is a major reason for being out of the workforce for people aged 50 years and over. Almost half of the respondents who had an adverse health condition for at least one month reported their ability to work had been affected, while 37% reported being unable to work as much as they would like. A range of adverse health conditions were important factors in hindering workforce participation, including cardiovascular diseases, musculoskeletal conditions and mental illness, confirming what was shown in the literature review. Musculoskeletal conditions in particular were significant in preventing people from working, while having arthritis was related with the longest absence from the workforce. As outlined in the literature, the relationship between the prevalence of mental illness and weak labour force attachment was reflected in the results of this study, showing that 58% of those with a mental illness reported their ill health prevented them from working or looking for work. Multiple conditions were quite common, with half of respondents having three or more adverse health conditions.

Where respondents' engagement in work was affected by their adverse health condition, one half had returned to work after an absence of at least one month, while one-fifth had yet to return to work or had retired. This shows that while most mature age people are able to return to work following illness, there is a significant proportion that remain disengaged from the workforce. Notably, males, those aged 65 years and over and people with three or more adverse health conditions were less likely to return to work following illness, injury or disability. While the combination of older age and multiple conditions in relation to returning to work was expected, the finding for males was somewhat surprising. This was particularly the case given that males have higher rates of labour force participation at those ages than females, and given the ABS findings that women's labour force participation is more adversely affected by poor health than men's. Males' greater involvement in more physically demanding occupations and industries may be a reason why they are less likely to return to the workforce. However, the sample size for the regression analysis was too small to identify such reasons in further detail.

A range of factors were identified as assisting the successful return to the workplace following illness, injury or disability, including flexible work options, support from both management and co-workers and less psychologically demanding roles. Barriers to returning to work included lack of support to change working conditions, lack of understanding by management, discrimination on the basis of age and a lack of flexible work options. All these factors demonstrate the importance of employer responses to facilitate prolonged workforce engagement for people with illness, injury and disability and for older workers. Previous research has predicted that a lack of flexibility in the workplace will prevent 450,000 potential employees from working by 2031.⁹³ However, as the literature review described, non-standard work arrangements can have either beneficial or detrimental effects on the mental health status and long-term retention of employees depending on the voluntary nature of the arrangement. The non-standard employment arrangements must also include fair and safe working conditions in order to attract and retain employees.

As indicated in the literature review, there are numerous enablers to remaining engaged in the labour market which can be largely facilitated by employers through understanding and support in managing pre-existing health problems (reactive measures), and the implementation of effective health and wellbeing programs which are designed to establish and maintain healthy behaviours (preventive measures). The findings of this report underscore the importance of employers having a coordinated and pro-active approach to developing programs to facilitate job retention for employees suffering from pre-existing ill health. For example return-to-work programs can include job adaptations, modifications to the type of work and job tasks, number of hours, or requirements for additional leave, special equipment and assistance.

In addition, it was found that management support and co-worker support were important factors in facilitating return to work after having suffered illness related work absence. The items that measured perception of management and co-worker support were adapted from the Australian Work Ability Survey and included perceptions of management support for career through future promotion opportunities and skill needs; and social support through willingness to listen to personal problems and degree of reliance on immediate supervisor. Support from co-workers was determined by perceptions of whether co-workers were easy to talk with, and considered reliable.

⁹³ Adair T & Temple J. *Barriers to mature age labour force engagement in Australia: Report on the 2011-12 National Survey on the Barriers to Employment for Mature Age People*. Canberra: NSPAC, 2012.

It appears that management support is a key component in successful return to work programs. For example, Friesen et al. found that the interdependence of organisational structures and human interactions was evident in successful return to work programs which emphasised teamwork, early intervention, and communication.⁹⁴ This is also recommended in Dame Carol Black's review which suggests that employers have significant scope to facilitate an employee's early return from sickness absence through early and regular communication with ill employees.⁹⁵ The review also makes recommendations around GPs directly supplying employers with an electronic fit note on behalf of the staff member, with the focus being on what the employee can do rather than what they cannot. This change in perception and attitude towards the notion of sickness will assist to dismantle the stigma around ill health and disability which will be key to enabling more people with adverse health conditions find and remain in work.

Additionally, employers also have a role in preventive measures through the promotion of healthy behaviours to prevent illness, injury or disability. This study demonstrates there is considerable demand for health and wellbeing programs, especially health assessments, exercise breaks/gym membership and information for a healthy lifestyle. Future policy efforts could help establish and maintain ongoing workplace health promotion, particularly for mature age employees. Policies directed at improving labour force attachment could prove more beneficial than improving income and may prevent workers from permanently withdrawing from the labour market. In support of the efficacy of workplace health and wellbeing programs, Dame Carol Black's review also "found considerable evidence that health and well-being programmes produced economic benefits across all sectors and all sizes of business: in other words, that good health is good business".⁹⁶

⁹⁴ Friesen MN, Yassi A, Cooper J. Return-to-work: The importance of human interactions and organizational structures. *Work: A Journal of Prevention, Assessment and Rehabilitation*. 17: 11-22, 2001.

⁹⁵ Secretary of State for Work and Pensions, 2008, op. cit.

⁹⁶ Secretary of State for Work and Pensions, 2008, op. cit.

Appendix

Appendix materials can be accessed from nationalseniors.com.au

- Table A1: Employment status by education (% of all respondents)
- Table A2: Number of years since retirement (% of those permanently retired)
- Table A3: Industry type for people who have retired and have worked in last five years (%)
- Table A4: Occupation type for people who have retired permanently and who have worked in the last five years (%)
- Table A5: Proportion who have been out of work for at least 1 month
- Table A6: Factors assisted people to return to paid work or remain in paid work by age (%)
- Table A7: Factors assisted people to return to paid work or remain in paid work by gender (%)
- Table A8: Factors assisted people to return to paid work or remain in paid work by occupation (%)
- Table A9: Factors assisted people to return to paid work or remain in paid work by Industry type (%)
- Table A10: Have participated in health and wellbeing programs (% of those who were offered one or more programs)
- Table A11: Have participated in health and wellbeing programs by the extent of usefulness (% of those who participated in programs)
- Table A12: Able to change the following aspects of job (% of those who worked in last five years)
- Table A13: Have control over working hours by age and sex (% of those who worked in last five years)
- Table A14: Extent in which supervisor did the following (% of those who worked in last five years)
- Table A15: Extent to which agree with the following aspects about relationship with management (% of those who worked in last five years)
- Table A16: Extent in which worry about the following aspects relating to job (% of those who worked in last five years)
- Table A17: Extent in which worry about the following aspects relating to job by age (% of those who worked in last five years)
- Table A18: Extent in which worry about the following aspects relating to job by sex (% of those who worked in last five years)
- Table A19: Have personally experienced the following at work (% of those who worked in last five years)
- Table A20: Have personally experienced the following at work by age (% of those who worked in last five years)
- Table A21: Have personally experienced the following at work by sex (% of those who worked in last five years)
- Table A22: Satisfaction with job as a whole by sex and age (% of those who worked in last five years)
- Table A23: How well informed regarding OH&S by occupation type (% of those who worked in last five years)

ABOUT NATIONAL SENIORS AUSTRALIA

National Seniors Australia is the leading independent voice of over 50s in Australia. As the nation's largest not-for-profit organisation for over 50s, we represent the views of older Australians and their families to governments of all levels, on issues ranging from age discrimination and mature age employment to the age pension and health and aged care. Founded in 1976 and now with more than 200,000 members, we provide unrivalled access to policy makers, innovative and practical research and a raft of commercial benefits to our members. Every day, National Seniors Australia seeks to improve the quality of life for mature age Australians.

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