

## Health, Employment and Age

If longer working lives are to be rewarding and productive, managing health in work is vital. This briefing puts together some of the key facts from the evidence on the impact of work, worklessness and age on health; of health as a barrier to employment; the trends in sickness absence; disability and incapacity benefit; and health inequalities by socio-economic status, occupational activity, geographical location, education and ethnicity.

### 1. Impact of worklessness on health

***There is a clearly established association between worklessness and poor physical and mental health. While unemployment can cause or contribute to poor health, poor health also leads to unemployment.***

- The epidemiological evidence suggests that the direction of causation from unemployment to illness is greater than the inverse but the relationship is complex.

*(Worklessness and Health, Health Development Agency, March 2005)*

- The rate of long-term illness or disability amongst the long-term unemployed is three times higher and for those who had never worked six times higher than those in managerial and professional occupations.

*(2001 Census, Office for National Statistics)*

- In the 2001 Census, three-quarters of economically active people aged 16-64 reported their health as 'good' compared with only half of the economically inactive group.

*(Focus on Health, Office for National Statistics, 2006)*

- People out of work experience poorer mental health than those in employment. They make increased use of GP and hospital services and use more prescribed medication. Those unemployed more than a year experience eight times the levels of psychological ill-health of those in work.

*(The Health and Work Handbook, 2005, Faculty of Occupational Medicine)*

- A University of California School of Medicine study of 100 unemployed and 100 matched employed healthy men and women showed people's immune function declined with the stress of unemployment. There was a substantial recovery of the function in the 25% of the unemployed group who subsequently found work.

*(Psychosomatic Medicine, March 2007)*

- Those who are employed or self-employed perform best on almost every measure of cognitive function while the permanently sick or disabled perform poorly on most. The unemployed group perform at a comparable level to the employed on some measures although they show a substantial impairment in memory, search speed, literacy and numeracy.

*(English Longitudinal Study on Ageing\*, Wave 2, 2004. \* A survey of people born before March 1952)*

- The relative risk of suicide is 10 times greater among unemployed people than employed.

*(Owen & Watson, 1995. Journal of Psychiatric and Mental Health)*

- There is a positive link between mortality and unemployment for all age groups with cardiovascular mortality accelerating after two to three years of unemployment and continuing for the next 10 to 15 years.

*(Brenner, Employment and Public Health, Report to the EC, 2002)*

***The fear of unemployment can also have an adverse effect on health.***

- Studies show that during the anticipation and termination phase of factory closure, illness and health service use increase, the rate of hospital admission doubles and conditions such as cardiovascular disease and high blood pressure increase.

*(Worklessness and Health, Health Development Agency, March 2005)*

***The effects of unemployment on health continue at older ages.***

- Differential mortality rates can be partially explained by differential unemployment rates, especially among the over-50s.

*(Brenner, Employment and Public Health, Report to the EC, 2002)*

- For older workers, especially those of low socio-economic standing who are near retirement, involuntary exclusion from the workforce may be a contributor to ongoing mental health issues.

*(Age-Related Capacity Decline: A Review of some Workplace Implications, Oxford Institute of Ageing, 2006)*

## **2. The impact of work on health**

***Work can have positive and negative effects on health. Degree of personal choice, control and quality of work all influence the outcomes.***

- The findings of a comprehensive review of the scientific evidence show that work is generally good for physical and mental health and well-being of healthy people, many disabled people and people with common health problems.

*(Is Work Good for Your Health and Well-being? Department for Work and Pensions, September 2006)*

- The conclusions that work is generally good apply equally to people with cardio-respiratory, musculoskeletal and common mental health problems; to people doing manual as well as non-manual work; and to people of all ages.

*(ibid.)*

- For work to have a beneficial impact on health, it needs to be good work, characterised by safety, fairness, job security, personal fulfilment and job satisfaction, good communications, personal autonomy, and a supportive environment.

*(ibid.)*

***British workers complain least about work-related health issues.***

- A survey of working conditions in 31 European countries showed British workers were the least likely to complain about the effect of work on their health and less likely than workers in 25 other countries to take leave as a result of a work-related illness, falling well below the EU average.

*(4<sup>th</sup> European Working Conditions Survey, European Foundation for the Improvement of Living and Working Conditions, February 2007)*

**Nevertheless, there are still many people in the UK who believe their work has damaged their health.**

- Two million people believed they were suffering from an illness that was caused or made worse by their current or past work.  
(*Self-reported work-related illness and workplace injuries in 2005/06, Health and Safety Executive, 2007*)
- Musculoskeletal disorders were by far the most commonly cited illnesses followed by stress, anxiety or depression. Together they accounted for around three-quarters of the cases of self-reported work-related ill health and for a large proportion of new cases.  
(*ibid.*)
- Work-related stress has been found to be a major cause of diabetes and heart disease in a study of 10,000 civil servants over 14 years. Metabolic syndrome symptoms, including obesity and high blood pressure, are more likely.  
(*University College London study, 2005-06*)
- 24% of GP consultations with working age people are work-related.  
(*Department for Work and Pensions, 2004*)

**Older groups report more work-related health conditions**

- The highest rates for men (ever employed) who reported they suffered from a work-related illness were in the 55-64 and 65-74 year age groups. For women, the 55-59 and 45-54 year age groups carried the highest rates.  
(*Self-reported work-related illness and workplace injuries in 2005/06, Health and Safety Executive, 2007*)

**but fewer new cases of injury.**

- The 25-34 year age group carried the highest rate of non-fatal reportable workplace injuries for males but the lowest for females. The oldest (55+) age group for males carried the lowest rate. However, the differing rates between younger and older

workers is largely explained by industry or occupational profiles of the working population in those groups.

(*ibid.*)

**Certain occupational groups are exposed to particular health risks because of their work.**

- Occupational groups with high rates of work-related illness were health and social welfare professionals, protective services occupations – the police and those working in the fire and prison services; skilled construction and building trades; skilled agricultural trades, teaching and research professionals; and skilled metal and electrical trades.  
(*ibid.*)
- According to reports from rheumatologists, those with the highest risks of musculoskeletal disorders are typists, metal plate workers, shipwrights and riveters, and road construction workers, with rates 15 times the average for all occupations.  
(*The Health and Occupational Reporting Network, Occupational Health Statistics Bulletin 2004/05, Health & Safety Executive*)
- NCOs and other ranks in the UK armed forces and medical practitioners are the occupations with the highest incidence of work-related mental ill health, both with rates of over 15 times the average.  
(*ibid.*)
- Vehicle spray painters and flour confectioners have the highest incidence rates for occupational asthma, at nearly 90 times the average for all occupations.  
(*ibid.*)
- Hairdressers, barbers and beauticians have the highest rate for contact dermatitis, 16 times the average.  
(*ibid.*)
- Care assistants/home carers have 25 times the average for occupational infections.  
(*ibid.*)

### 3. Working at older ages

***The evidence indicates positive physical and psychological effects of working longer but the health selection effect where those in good health work longer and those in poor health give up work at younger ages needs to be taken into account.***

- A study of 3,500 former employees of Shell Oil in the US showed that mortality was twice as high in the first 10 years of retirement at 55 than those who stopped working at 60 or 65.

*(British Medical Journal, 2005)*

- Nearly three-quarters of people who retire early cite ill health as the main cause, well ahead of redundancy. Up to half are subsequently keen to return to work.

*(Department for Work and Pensions Research Report 200, 2003)*

- Performing more than 100 hours a year of volunteer or paid work beyond retirement age has a beneficial effect on older adults' self-rated health and survival but conditions of work are more influential on physical and mental health than the quantity of work.

*(Centre for Retirement Research, USA, 2006)*

- Older employees who work in low-stress jobs with the hours they want, experience better health.

*(ibid.)*

- Physically demanding jobs have a positive effect on the physical health of those aged 65 and over.

*(ibid.)*

- Longer hours do not appear to have a negative impact on the health of older employees, compared with younger ones, but there are significantly fewer older employees who work more than 40 hours a week.

*(The Ageing Workforce: A health issue? Economic & Labour Market Review, February 2007)*

- Overall, there is no evidence that older workers are more likely to have their health affected by work than younger workers.

*(ibid.)*

### 4. The effect of age on health

***The relationship between age and health is complex. Long-term conditions and disabilities increase with age yet people reporting these may not consider themselves to be in poor health.***

- Between 1981 and 2002, healthy life expectancy (the number of years lived in good or fairly good health) rose for both males and females in Britain. In 2002, healthy life expectancy at birth was 67.2 years for males and 69.9 years for females.

*(Social Trends 37, Office for National Statistics, 2007)*

- Generally people can expect to experience more years living with a disability than they can in poor health but the patterns for the two are very similar. In 2002 males could expect to live for 60.9 years without a disability and females 63.0 years.

*(ibid.)*

- In the 2001 Census, the proportion of people reporting a long-term illness or disability that limited their daily activity or work they could do increased with age. The percentage rose from 21% of 45-59 year olds to 40% of 60-74 year olds.

*(Focus on Health, Office for National Statistics, 2006)*

- The commonest illnesses suffered by people aged 50-64 are high blood pressure, arthritis, asthma, heart disease and diabetes. The prevalence of these conditions varies between the sexes.

*(ELSA, Wave 1, 2002)*

- Arthritis is the main musculoskeletal condition suffered by people aged 50-64 with more women affected than men. At the lower end of the age group (50-54), 16% of men and 24% of women said they had arthritis. The rates rose to 27% of men and 36% of women in the 60-64 age group.

*(ibid.)*

- Asthma is the principal respiratory illness affecting people in their 50s and 60s. 9% of men and 13% of women aged 50-54 said they had asthma with rates increasing to 13% of men and 15% of women in the 60-64 age group.

*(ibid.)*

- Cancers were the leading cause of death in 2006 among men and women aged 45-64 in England and Wales, followed by circulatory diseases, which include heart disease and stroke, diseases of the digestive system and respiratory diseases.

*(Health Statistics Quarterly, 34, Office for National Statistics, June 2007)*

- Within the 45-64 year old age group in England and Wales in 2006, the male death rate from circulatory diseases was more than double the female rate.

*(ibid.)*

- A higher proportion of women than men in the 50-64 age group suffer from cancer. For women aged 50-54 the percentage was 4% compared to 2% for men of the same age. The rates increase with age. For 60-64 year olds, the percentage is 8% for women and 5% for men.

*(ELSA, Wave 1, 2002)*

## 5. The effect of age on capacity

***For the majority of working age people, decline in age-related functional capacity is not significant enough to affect their overall ability to work.***

- It is now widely recognised that very few capacity changes are directly related to decline due to chronological age alone. With the exception of sensory changes, the majority of so-called age-related decline is closely linked to environment and behaviour. Most can thus be modified or reduced.

*(Age-Related Capacity Decline: A Review of some Workplace Implications, Oxford Institute of Ageing, 2006)*

- Although physical strength, stamina and eyesight show decline with age, the average decline is a few percentage points over the last 15 years of working life.

*(Simon Pickvance, University of Sheffield, Hazards Magazine, 2006)*

- Overall tested physical performance declines with age but some of the oldest people maintain high functioning. For example, the top 5% of women aged 80+ have higher grip strengths than the weakest 25% of women aged 52-59.

*(ELSA, Wave 2, 2004)*

- Age-related cognitive decline is gradual in functions such as thinking, memory, learning, attention, focus and use of language. As the decline is gradual, the impact of those of working age – up to 65 or 70 – may be limited.

*(Age-Related Capacity Decline: A Review of some Workplace Implications, Oxford Institute of Ageing, 2006)*

- Verbal reasoning skills peak at 60, reasoning skills peak in the late 40s, numeracy skills decline from age 35 and perceptual speed declines steadily from age 25.

*(British Psychological Society, 2006)*

## 6. Health as a barrier to work

**Health conditions are a major cause of unemployment with barriers to returning to work increasing with age.**

- In a survey of 750 employers, 33% said they deliberately exclude people with a history of long-term sickness or incapacity when recruiting staff.  
(CIPD, 2006)
- More than 40% of employers surveyed believe long-term incapacity benefit claimants are less productive at work and 60% thought they would be more prone to absence.  
(*ibid.*)
- 60% of employers say they would not consider employing someone with mental health problems.  
(Kath Raymond, former adviser to David Blunkett, *The Times*, 27 Jan 2006)
- 48% of people aged 50 to state pension age who are economically inactive are inactive due to sickness, disability or injury.  
(Office for National Statistics, *Labour Force Survey, Quarter 4 2006*)
- 80% of people of working age with long-term mental health conditions are not in paid employment.  
(Office for National Statistics, *Labour Force Survey, Spring 2005*)
- The likelihood of someone who leaves work through ill-health or disability after age 50 re-entering the labour market is slim and declines rapidly as time out of the workforce increases.  
(Department for Work and Pensions *Research Report 299, 2005*)

- Men and women in paid work in 2002-03 who reported that their health was only fair or poor were more likely not to be in paid work in 2004-05 than those who had reported being in excellent or very good health.  
(ELSA, *Wave 2, 2004*)
- Those aged between 50 and state pension age who reported being in fair or poor health in 2002-03 were about twice as likely to have stopped working in 2004-05 as those who had reported being in excellent or very good health. The difference was greatest amongst men aged 50-54 in 2002-03.  
(*ibid.*)
- Those who were not in paid work in 2002-03 and who had reported worse health were less likely to have returned to work by 2004-05 than those who had reported being in excellent or very good health.  
(*ibid.*)

## 7. Sickness absence

**Rates of sickness absence differ across different types of organisations, by occupational category and by geographic region.**

- Sickness absence was estimated to cost around £13.4 billion with some 175 million working days lost in 2006.  
(CBI-Axa *Absence Survey, 2007*)
- Larger organisations report higher absence levels than smaller ones. Those employing more than 5,000 staff averaged eight days per employee in 2006 while those employing fewer than 50 employees averaged four days.  
(*ibid.*)
- Absence in the public sector, which represents a fifth of the workforce, rose in 2006 and outstripped private sector absence by 44%.  
(*ibid.*)

- Manual workers have higher absence rates than non-manual. But the gap, which stood at five days in the early 90s, has continued to narrow and was 2.2 days in 2006. Absence for non-manual employees has remained static while rates for manual staff have improved.

*(ibid.)*

- For manual workers, back pain is the leading cause of long-term absence while for non-manual workers stress is the main cause.

*(CIPD Absence Management Survey, 2007)*

- Almost half the 625 companies surveyed by the EEF cited surgery or medical tests as the highest cause of long-term sickness absence, followed by back problems and then by stress.

*(Sickness Absence and Rehabilitation Survey 2007, EEF)*

- An analysis of the absence records of 30,000 employees working across 40 organisations revealed mental ill health as the second largest cause of sickness absence with employees taking on average 21 days for each mental health related absence spell.

*(New Directions in Managing Employee Absence, CIPD, June 2007)*

- The analysis showed employees working in the public sector took on average 24 days for each mental health related absence against 20 days in the private sector.

*(ibid.)*

- Employees up to the age of 25 took on average 17 days for each mental health related absence compared with 21 days by those aged 25-54 and 36 days by those aged 55-65.

*(ibid.)*

- Stress accounts for 30% of sickness absence in the NHS, the UK's largest employer, and is estimated to cost between £300 million and £400 million a year.

*(Steve Barnett, NHS Employers, Risks Magazine, 2007)*

- Absence levels vary across the UK. The regions with the lowest levels in 2006 were South East England, Scotland and Greater London. The regions with the highest levels were North West England, Southern England and the West Midlands.

*(CBI-Axa Absence Survey, 2007)*

***There is some debate as to whether older workers take more time off than their younger counterparts. Sickness absence does not necessarily increase with age, but the pattern of absence changes.***

- Younger workers are more prone to short-term absences while older workers have fewer but longer periods off.

*(Office for National Statistics, 2002)*

- Sickness absence is highest in 16-24 age group (3.2%) and stays constant from age 35 to state pension age (2.8%). It is lowest amongst workers over state pension age.

*(Labour Market Trends, April 2005)*

- A study of sickness absence patterns of 1,000 adults over a three-month period found that those aged 16-24 had taken the most days off with a third missing at least one day through ill health, compared with only 17% of the 55-64 year olds.

*(Benenden Healthcare, April 2007)*

#### **Absence due to work-related ill health**

- In 2005/06, 24 million days were lost due to work-related ill-health and 6 million due to workplace injury.

*(Health & Safety Executive, 2006)*

- For men, the estimated rate of days lost per worker due to work-related ill health was higher for the 55+ age group than the average rate for all males and for the youngest age groups. For women the same estimated rate was higher for the 45-54 year age group than for the youngest age groups.

*(Self-reported work-related illness and workplace injuries in 2005/06, Health and Safety Executive, 2007)*

- Men aged 55+ carried the lowest rate of absence due to workplace injury. However for women age-specific rates were of a similar order to the overall female rate.  
(*ibid.*)

## 8. Disability and incapacity benefit

### Disability

#### ***Disabled people continue to be disadvantaged in employment and education despite efforts to reduce inequalities.***

- There are 6.9 million disabled people of working age in Britain - one-fifth of the working age population - according to Labour Force Survey estimates.
- Rates of disability increase with age from 9% of adults aged 16-24 to 44% in the 50 to state pension age category.  
(*Disability Briefing, Disability Rights Commission, May 2007*)
- The employment rate of disabled people and those with long-term health conditions was 50% in 2006, compared with 75% for the working age population as a whole.  
(*Disability, Skills and Work, The Social Market Foundation, June 2007*)
- The North East of England and Wales have the highest proportions of disabled people of working age (at around 25% of the local working age population). London, the South East and East of England have lower than average proportions at 17%.  
(*ibid.*)
- More than a million disabled people without a job would like to work.  
(*Disability Briefing, Disability Rights Commission, May 2007*)
- Disabled people with mental health problems have the lowest employment rates, at only 21%.  
(*ibid.*)
- Disabled people are more likely to work in manual and lower-skilled occupations than in managerial, professional and high-skilled occupations.  
(*ibid.*)
- Disabled people are only half as likely as non-disabled people to be qualified to degree level and are twice as likely as non-disabled people to have no qualification at all.  
(*ibid.*)
- Labour Force Survey data shows having low skills holds a greater labour market penalty for disabled people. The employment gap between disabled adults and non-disabled adults without any qualifications is 38%. Where both have NVQ level 2 skills, the gap is 22%.  
(*Disability, Skills and Work, The Social Market Foundation, June 2007*)
- There are significant concentrations of low skills among certain groups of disabled people and those with long-term health conditions, particularly among those aged over 50.  
(*ibid.*)
- The employment rate for disabled people in the 50+ age group is 43%, compared with 71% for the age group as a whole. For ethnic minority disabled people over 50, the rate is 30%.  
(*Select Committee on Work and Pensions Third Report, February 2007*)

### Incapacity benefit

#### ***There are 2.7 million people on incapacity benefits, representing 7% of the working age population. Of the total, 85% have been on benefit for more than a year.***

- The annual expenditure on incapacity benefit annually is £12.5 million.  
(*Reducing dependency, increasing opportunity, Department for Work and Pensions, 2007*)

- The proportion of people on incapacity benefits has risen from around 3% on equivalent benefits in the 1960s to 7%.  
*(Department for Work and Pensions, 2006)*
- Almost 60% of people who started to receive incapacity benefits in 2004 left within a year. But only 22% of those claiming for a year will leave within the next year and 29% of them will still be receiving benefits after eight years.  
*(ibid.)*
- One million people take sick leave every week: 3,000 of these will not return within six months, and of these 2,500 will still be on incapacity benefit five years later.  
*(Lord McKenzie, Department for Work and Pensions Minister, June 2007)*
- 95% of incapacity benefit (IB) claimants face at least one and 60% three or more barriers to return to work in addition to their health condition.  
*(Conceptual Basis of Incapacity Benefits, Waddell, Aylward, 2005)*
- In 2006 mental health conditions accounted for 40% of IB claims, musculoskeletal disorders for 18%, circulatory and respiratory system conditions for 8%, conditions of the nervous system for 6%, and injury for 6%.  
*(Reducing dependency, increasing opportunity, Department for Work and Pensions, 2007)*

### **Claimants aged over 50**

- In Britain 1.2 million people claiming incapacity benefit are aged 50 to state pension age, representing 14% of people of that age. For men the percentage is 15% and for women 12%.  
*(Work and Pensions Longitudinal Survey, Department for Work and Pensions, August 2006).*
- But only around a third of the inflow of IB claimants is aged 50+.  
*(Department for Work and Pensions, 2006).*

- There has been a decline in the proportion of men in the older age group claiming IB. The proportion of 60-64 year old men claiming IB fell from 27% in 1997 to 20% in 2006.  
*(Reducing dependency, increasing opportunity, Department for Work and Pensions, 2007)*

### **Mental health conditions**

- The number of people claiming IB for mental health conditions has risen from 16% in 1996 but the absolute inflow of mental health conditions has remained stable since 1996 while the inflow of other conditions has fallen by 40%.  
*(Conceptual Basis of Incapacity Benefits, Waddell, Aylward, 2005)*
- IB claimants with mental health conditions, however, have much lower outflow (around half in 12 months compared with three-quarters for other conditions) and longer than average duration claim.  
*(ibid.)*
- The majority of mental health IB claimants are long-term; 84% have been claiming for more than a year and 73% for two years or more.  
*(Centre for Economic and Social Inclusion, 2006)*
- The number of IB claimants with mental health conditions varies geographically. The highest percentages, as a proportion of the population, are in Scotland, the North of England and Wales while the lowest are in the East and South East of England.  
*(ibid.)*
- The age profile for IB claimants with mental health conditions is different for men and women: for men claims peak in the 30-45 age band and then decline; for women they rise steadily through to age 60.  
*(ibid.)*

## Pathways to Work

- An evaluation of the Pathways to Work package of reforms, aimed at encouraging employment among people claiming incapacity benefit, has shown a difference in impact between the over-50s and the under-50s.
- The evaluation was based on a survey focusing on employment, earnings, receipt of incapacity benefits, and a potential indicator of the extent to which individuals' health affects their everyday activities.
- Pathways has stronger effects on employment and benefit receipts among those aged under 50. It also reduced the probability of individuals under 50 reporting their ability to carry on everyday activities was limited 'a great deal' by their health conditions or disability. There was no such effect among those aged 50 and over.  
*(Department for Work and Pensions Research Report 435, June 2007)*

## 9. Health inequalities and socio-economic status

***There is a clear link between health inequalities and socio-economic status. Geography, occupational category, education and ethnicity have an impact.***

- The disability gap between social classes is equivalent to the gap between age groups 10 years apart.  
*(ELSA, Wave 1, 2002)*
- In every age group home owners reported higher rates of 'good' health in the 2001 Census than those living in rented social housing.  
*(Focus on Health, Office for National Statistics, 2006)*
- Half of the most severe pockets of deprivation in Britain are contained within the 100 constituencies that have the largest number of incapacity benefit claimants.  
*(Department for Work and Pensions, 2006)*

- Healthy life expectancy shows bigger social differences than life expectancy. A comparison of areas of England showed healthy life expectancy at birth was 66 years for men and 68 for women in the most affluent area compared with 49 for men and 52 for women in the most deprived.  
*(ELSA, Wave 1, 2002)*

## Geography

- The South West, South East and East of England had the highest life expectancy in 2002-04 while Scotland and the North East and North West of England had the lowest.  
*(Office for National Statistics, 2005)*
- Of the 10 local authorities with the lowest life expectancy at birth in 2002-04, five were in Scotland, four in England and one in Wales.  
*(ibid.)*
- The lowest male life expectancy was in Glasgow City (69.3 years), the only area in the UK where life expectancy at birth for 2002-04 was less than 70. The highest life expectancy for men was in Kensington & Chelsea (80.8 years).  
*(ibid.)*

## Occupational category

***The 2001 Census and ELSA show health linked to occupational status.***

- 82% of higher managerial and professional groups report good health compared to 66% of those employed in routine occupations.  
*(2001 Census, Office for National Statistics, 2005)*
- There is an occupational class gradient in heart disease, respiratory illness, self-reported fair or poor health, having a longstanding-illness and mental health symptoms.  
*(ELSA, Wave 1, 2002)*

- In the 50-59 age group, men in managerial and professional occupations were much less likely to report a limiting long-standing illness (17%) than men in other occupations. Within the age band, 31% of men in intermediate occupations and 34% of men in routine occupations reported a limiting long-standing illness.

*(ibid.)*

- Social inequalities in health are more marked in mid-life than at older ages. In the 50-59 age group, men in routine and manual occupations were twice as likely to have a limiting long-standing illness as men in professional or managerial occupations, while among men aged 75+ there was little difference between the two groups.

*(ibid.)*

- A third of men in their 50s report a long-standing limiting illness. Similar rates for men from professional and managerial backgrounds are not reached until they are aged over 75, representing a 20-year 'illness gap'.

*(Department for Work and Pensions Research Report, December 2005)*

- Almost one in three male manual workers who reported having fair or poor health in 2002-03 had left paid work by 2004-05 whereas just one in five of male non-manual workers reporting fair or poor health had left paid work.

*(ELSA, Wave 2, 2004)*

- Health inequalities between the best and the worst off increase in later life, according to the Whitehall II study of 10,000 employed and retired British civil servants. Physical health deteriorated with age in all occupational grades but declined more rapidly amongst people from lower grades. The average physical health of a 70 year old from a high grade was similar to that of a person eight years younger from a low grade.

*(British Medical Journal, April 2007)*

- In the same study, mental health was shown to improve with age but improvement was slower amongst people from lower grades.

*(ibid.)*

## Education

### ***Years of education and highest qualifications are positively correlated with good physical and mental health.***

- The more education people had, the longer was their physical functioning preserved.
- In the 2001 Census 76% of those with a degree or higher level qualification reported their general health as 'good' compared with just 58% of those with no qualifications.

*(Focus on Health, Office for National Statistics, 2006)*

- Correspondingly, people with no qualifications are twice as likely to report poor health than those who have higher level education - 13% versus 6%.

*(ibid.)*

- When assessing memory, education and class have a more powerful effect than age.

*(ELSA, Wave 1, 2002)*

## Ethnicity

### ***Ethnicity has a bearing on general health. But the poor socio-economic status of some ethnic groups contributes to health inequalities.***

- In the 2001 Census, 12% of Asian people and 10% of black and mixed race said their health was not good. The lowest rates were found in the 'Chinese and other' group at 7% and in whites at 8%.

*(Focus on Health, Office for National Statistics, 2006)*

- Of people aged 50-64, 27% reported a long-term illness or disability. But the rates rose amongst Asian (40%), black (36%) and mixed (30%) groups. Amongst Asians, 54% of Bangladeshis and 49% of Pakistanis said they had had a limiting long-term illness.  
(Office for National Statistics, 2005)

TAEN

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