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Working conditions in mid-life and mental health in older ages

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ABSTRACT

This article illustrates the importance of previous working conditions during mid-life (between 40 and 55) for mental health among older retired men and women (60 or older) across 13 European countries. We link information on health from the second wave (2006–2007) of the Survey of Health, Ageing and Retirement in Europe (SHARE) with information on respondents' working life collected retrospectively in the SHARELIFE interview (2008–2009). To measure working conditions, we rely on core assumptions of existing theoretical models of work stress (the demand–control–support and the effort–reward imbalance model) and distinguish four types of unhealthy working conditions: (1) a stressful psychosocial work environment (as assessed by the two work stress models) (2) a disadvantaged occupational position throughout the whole period of mid-life, (3) experience of involuntary job loss, and (4) exposure to job instability. Health after labour market exit is measured using depressive symptoms, as measured by the EURO-D depression scale. Main results show that men and women who experienced psychosocial stress at work or had low occupational positions during mid-life had significantly higher probabilities of high depressive symptoms during retirement. Additionally, men with unstable working careers and an involuntary job loss were at higher risks to report high depressive symptoms in later life. These associations remain significant after controlling for workers' health and social position prior mid-life. These findings support the assumption that mental health of retirees who experienced poor working conditions during mid-life is impaired.

1. Introduction

Although life expectancy has steadily increased over recent decades in Europe, substantial inequalities in health remain for older men and women (Mc Munn, Breeze, Goodman, & Nazroo, 2006). Thus, for many people recent increases in life expectancy are accompanied by extended periods of morbidity or disability. In a context of rapidly ageing societies, these health inequalities at older ages have significant implications for European social policies. Additional scientific research is needed to identify the determinants of health in older ages. Whereas descriptive evidence of health inequalities in older ages is convincing, the explanations given so far are limited. In particular, core questions remain unanswered, e.g. to what extent do conditions during earlier stages of the life course, such as mid-life working conditions, contribute towards explaining health variations among men and women in later life (Elder & Johnson, 2002; Siegrist & Marmot, 2006)? For instance, it can be assumed that older people with poor

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health experienced more disadvantaged working conditions, and that these conditions may have had an impact on their health later on.

When looking at previous studies concerned with working conditions in mid-life and health, two shortcomings are apparent: first, the analytical time frame of a majority of studies is restricted to a short period of observation, without extension into stages where people are retired (Dragano, Siegrist, & Wahrendorf, 2011; Stansfeld, Fuhrer, Shipley, & Marmot, 1999). This state of the art, with some noticeable exceptions (Melchior et al., 2006; Westerlund et al., 2009), contrasts with recent evidence on the importance of early life and mid-life conditions in explaining health at old age (Blane, 2006; Power & Kuh, 2006). A second weakness of existing studies on work and health concerns the measurement of work-related factors, which is often restricted to one single time point of the working life and which lacks a conceptual basis (particular in case of psychosocial working conditions), thus preventing the comparability and cumulative knowledge of respective findings (for reviews see for example Antoniou & Cooper, 2005).

Current knowledge about a health-adverse psychosocial work environment mainly builds on two theoretical models of work stress, the demand–control–support model (Karasek & Theorell, 1990) and the effort–reward imbalance model (Siegrist, 1996). These models may be helpful in describing unhealthy working conditions throughout mid-life and, thus, to contribute to a better understanding of the afflictions of work on later health (see Section 1.1 for details). In short, to explain health inequalities in older ages there is strong need to consider the life course by including conditions of earlier life, such as working conditions during mid-life. Moreover, a theory-based approach towards measuring mid-life working conditions is needed.

This paper tries to overcome these limitations by using data from two waves of the Survey of Health Ageing and Retirement in Europe (SHARE) containing data from 13 European countries (Börsch-Supan et al., 2005). More specifically, we combine second wave data with information on health (collected in 2006–2007) and retrospective information on individual working life provided in the third wave of SHARE, called SHARELIFE (collected in 2008–2009). In the following paragraphs, we elaborate our theoretical perspective in more detail and describe existing evidence related to our research.

1.1. Theoretical considerations

Mid-life is considered as an important stage of the life course with long-term effects on standard of living and health in later life (Willis & Martin, 2005). This is mainly due to the fact that mid-life is the stage of life where highest levels of individual responsibilities are required (Willis, Martin, & Rocke, 2010). In terms of age, this time can be defined as the period between 40 and 55 years. During mid-life, core social roles (e.g. parenting, work) are acquired and executed, with opportunities of experiencing success and failure in pursuing important goals and in satisfying major material and non-material needs. Among these latter needs a sense of belonging to relevant social networks (Berkman & Glass, 2000), a continued experience of agency and autonomy (Haidt & Rodin, 1999), and a recurrent experience of social recognition for personal achievements (Siegrist, 2005) are of particular importance for health and well-being. In this context, the quality of people's psychosocial work environment is of outstanding significance, given the centrality of work in mid-life. These ideas lie at the core of the two work stress models mentioned above (the demand–control–support and the effort–reward imbalance model). However, their application so far has been mostly restricted to a single measurement point. It was therefore not possible to explore to what extent these models can be used to analyse working conditions and employment trajectories throughout mid-life. In order to define working conditions in mid-life from the perspective of these two models, we briefly describe the models in more detail including recent applications, and then present our research question.

The demand–control–support model was developed by Karasek (1979) and extended by Karasek and Theorell (1990) and by Johnson and Hall (1988). It posits that jobs with high psychological demands, low levels of autonomy and decision latitude (low control) and low social support at work are stressful and adversely affect health. This is due to the fact that these jobs limit the experience of autonomy at work, while exerting continued pressure. As a complementary work stress model, the effort–reward imbalance model (Siegrist, 1996) addresses the work contract and the principle of social reciprocity lying at its core. Rewards received in return to efforts spent at work include money, esteem, and career opportunities (job promotion and job security). The model proposes that the frustration of legitimate rewards (effort–reward imbalance) generates strong negative emotions and psychobiological stress responses with adverse long-term effects on health. Taken together, both work stress models cover different, but equally relevant aspects of the workplace, where lack of control and lack of reward matter most.

Several empirical studies demonstrate the importance of either model for health and well-being in a biopsychosocial perspective, as summarized in a number of systematic reviews using different health outcomes, including stress-related disorders (Nieuwenhuijsen, Bruinvels, & Frings-Dresen, 2010), mental disorders (Schnall, Dobson, & Rosskam, 2009; Stansfeld & Candy, 2006), and coronary heart diseases (Kivimaki et al., 2006; Steptoe & Kivimaki, 2012). In addition, studies indicate that levels of exposures and health-related effects differ between men and women (Messing et al., 2003). For instance, based on the British Whitehall Study, Stansfeld et al. (1999) found that effects of work stress on depressive symptoms are stronger for men compared to women – a result that can be attributed to a higher significance of the work role for men compared to women, as well as to the availability of alternative roles (e.g. family) among women. Furthermore, levels of exposure are different (e.g. higher control and more strenuous jobs for men), because men tend to work longer, in different sectors and generally higher occupational positions (Eurofound, 2007). In this perspective, the