



Review article

The effects of exit from work on health across different socioeconomic groups: A systematic literature review

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ABSTRACT

Exit from work leads to different effects on health, partially depending on the socioeconomic status (SES) of people in the work exit. Several studies on the effects of exit from work on health across socioeconomic groups have been performed, but results are conflicting. The aim of this review is to systematically review the available evidence regarding the effects of exit from work on health in high and low socioeconomic groups. A systematic literature search was conducted using Pubmed, Embase, Web of Science, CINAHL and PsycINFO. Search terms related to exit from work, health, SES and design (prospective or retrospective). Articles were included if they focused on: exit from work (early/statutory retirement, unemployment or disability pension); health (general, physical or mental health and/or health behaviour); SES (educational, occupational and/or income level); and inclusion of stratified or interaction analyses to determine differences across socioeconomic groups. This search strategy resulted in 22 studies. For general, physical or mental health and health behaviour, 13 studies found more positive effects of exit from work on health among employees with a higher SES compared to employees with a lower SES. These effects were mainly found after early/statutory retirement. In conclusion, the effects of exit from work, or more specific the effects of early/statutory retirement on health are different across socioeconomic groups. However, the findings of this review should be interpreted with caution as the studies used heterogeneous health outcomes and on each health outcome a limited number of studies was included. Yet, the positive effects of exit from work on health are mainly present in higher socioeconomic groups. Therefore, public health policies should focus on improving health of employees with a lower SES, in particular after exit from work to decrease health inequalities.

1. Introduction

A rising life expectancy and decreasing birth rates causes a demographic transition in which Western society is confronted with an ageing population (Harbers, 2008; Vaupel, 2010). This means, relatively fewer workers to compensate for the elderly not being active in the workforce. The percentage of retired elderly compared to the active working population is expected to increase further in Europe, i.e. from 28% in 2014 to 50% in 2060 (Helminger et al., 2016). This poses great challenges for the welfare state, such as providing pensions and long-term healthcare. To keep the welfare state affordable, many Western countries raised their statutory retirement age (Cooke, 2006).

Exit from work can be viewed as a major life transition, as it is accompanied by social, psychological and environmental changes in

one's life (Kim and Moen, 2002). Social changes may involve the increase of social contact, because more time can be spent with family and friends; psychological changes could be role loss, as people's identity might be determined by their job; and environmental changes could be loss of adverse or favourable work characteristics, such as high mental demands or receiving appreciation at work. Two recent systematic literature reviews on the effects of exit from work on health concluded that exit from work has both positive and negative effects on health (van der Heide et al., 2013; Zantinge et al., 2013). For example, people with work related low back pain, will likely benefit from the work exit, because it can take away the source of their pain (i.e. physical health) or physical activity may increase, because exit from work provides more time for leisure-time physical activity (i.e. health behaviour). Otherwise, exit from work can also have adverse health effects,

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such as the increase of stress caused by the loss of income and work responsibilities (i.e. general health and mental health). Hence, exit from work holds different effects on health, depending on the circumstances in which a transition takes place (Leijten et al., 2015; Shultz et al., 1998; van der Heide et al., 2013; Wang and Shultz, 2010; Zantinge et al., 2013). Moreover, effects may be different for various health outcomes, such as general, physical or mental health and health behaviour (van der Heide et al., 2013; Zantinge et al., 2013).

The effects of exit from work on health may also be different across people from low or high socioeconomic groups (Platts et al., 2015; Schuring et al., 2015; Wang and Shultz, 2010), which is determined by occupation, education and income (Mackenbach and Kunst, 1997; Shavers, 2007). Until now, studies have shown contradictory results regarding the effects of exit from work on health for different socioeconomic groups. Previous research demonstrated that people with a higher SES experience a larger decline in general health compared to people with a lower SES (Rijs et al., 2012). Conversely, other studies demonstrated that people with a higher SES experience an increase in mental and physical health compared to people with a lower SES (Berchick et al., 2012; Chung et al., 2009a). Thus, evidence with regard to the relationship between health and exit from work among different socioeconomic groups remains inconclusive. Therefore, the aim of this review is to systematically review the available evidence regarding the effects of exit from work on health in high and low socioeconomic groups.

2. Methods

2.1. Search strategy and study selection

A systematic literature search was conducted in the databases PubMed, Embase, Web of Science, CINAHL and PsycINFO up to November 1, 2016. Search terms related to: 1) exposure, i.e. exit from work, 2) outcome, i.e. health, 3) strata, i.e. SES and 4) design, i.e. prospective or retrospective. The search terms can be found in the [supplementary data](#). Articles identified in the databases were combined and duplicates were removed. For final inclusion, articles had to fulfil all of the following inclusion criteria. First, an article was eligible when the population had left the workforce at the end of the study period. Exit from work was defined as “*withdrawal of older workers (i.e. 55 years or older) from paid working life*” and was differentiated in three types of exit routes: 1) statutory retirement or early retirement taking place before the statutory retirement age – i.e. via an early retirement scheme, 2) unemployment and 3) disability pension (Denton and Spencer, 2009; Leijten et al., 2015; van der Heide et al., 2013). Hereby, older workers were 55 years or older, because on average workers were 55 years old when they left the workforce (Bongaarts, 2016). Second, an article had to report on at least one health component, before and after the work exit. Health was conceptualised as general, physical or mental health and/or health behaviour. General health refers to how people perceived their health in general (e.g. how do you rate your health in general), physical health refers to physiological body functions (e.g. pain and disabilities), mental health refers to psychological wellbeing (e.g. mental functioning and depression) and health behaviour refers to behaviours that will likely influence one's health either positive or negative (e.g. diet and physical activity) (Idler and Benyamini, 1997; van der Heide et al., 2013; Wallace and Herzog, 1995; WHO, 2017; Zantinge et al., 2013). Also, the health outcome BMI was categorized under health behaviours, because overweight and obesity are considered as a risk factor for non-communicable diseases and may result from the unhealthy behaviours having an unhealthy diet and physical inactivity (WHO, 2013). Third, an article had to include at least one indicator of SES (i.e. educational, occupational and/or income level) (Mackenbach and Kunst, 1997; Shavers, 2007), and included analyses to distinguish health effects across socioeconomic groups, either through stratification or an interaction term. This means that

articles were excluded that only included SES as a confounding factor. Fourth, only articles with a longitudinal study design (either retrospective or prospective) were included. Fifth, articles published from 2001 were included to only provide information on the effects of exit from work processes that are taking place right now. Sixth, only articles in English and published in a peer reviewed journal were included.

Two reviewers (RS and AdW) independently started with the screening of 600 articles on title and abstract. Thereafter, discrepancies were discussed in order to come to agreement on the interpretation and completeness of the inclusion criteria. When all discrepancies were discussed, the remaining articles (i.e. 4165) were screened by one reviewer (RS) on title and abstract. Screening of 4765 articles on title and abstract resulted in 108 articles that were screened on full-text. Screening of full-text articles was performed by two reviewers (RS and AdW) independently. Discrepancies were discussed until consensus was reached and a third reviewer (CB) was consulted in case consensus could not be reached. Finally, references of the included articles were checked for other possibly relevant articles.

2.2. Data extraction and quality assessment

One reviewer (RS) performed the data extraction by using a predefined data-abstraction form, extracting the following data per study: author, publication year and country, population (i.e. dataset, cohort or register, n , sex and age), design (i.e. type and follow-up period) statistical analyses (i.e. stratification and/or interaction term), assessment of exit route (i.e. early/statutory retirement, unemployment or disability pension), health and SES, and the results of the effects of exit from work on health across socioeconomic groups. In case of uncertainty about the extracted data a second reviewer (AdW) was consulted.

The quality assessment was performed by two reviewers (RS and AdW) independently and based on a set of nine predefined criteria (Table 1). The criteria were predominantly based on one review that focused solely on the relation between exit from work and health and on already existing criteria lists in the field of public health (Hayden et al., 2006; Hoogendoorn et al., 2000; National Institutes of Health, 2014; van der Heide et al., 2013). Each quality criterion was rated positive (+), negative (–) or not applicable (n.a.). Criteria 3, 4 and 5, were rated not applicable in studies with register data, because they could not provide information on participation rates. Differences in scores between reviewers (RS and AdW) were discussed and were resolved in consensus meetings. Studies with a minimum of 5 points (> 50%) were regarded as of high methodological quality (Hayden et al., 2006; Hoogendoorn et al., 2000; van der Heide et al., 2013). Studies in which criteria 3, 4 and 5 were rated not applicable and with a minimum of 3 points (> 50%) were regarded as of high methodological quality.

The data extraction and quality assessment were performed per study to avoid multiplication. This means that some articles resulting from the same dataset, register or cohort were merged. Nevertheless, many articles resulting from the same dataset, register or cohort were not merged as they differed with regard to the health outcome. Consequently, different (smaller) datasets were retrieved from one large dataset, resulting in different studies.

3. Results

3.1. Study selection

The flow chart, presented in Fig. 1, demonstrates the study selection. The search strategy yielded 8961 articles. After removing duplicates, 4765 articles were screened on title and abstract, and subsequently, 108 articles on full text. The search resulted in 19 articles (Chung et al., 2009a; Chung et al., 2009b; de Grip et al., 2015; Gallo et al., 2006, 2009; Gueorguieva et al., 2011; Hessel, 2016; Jokela et al.,

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