Institutional and Individual Factors Affecting Health and Employment among Low-Income Women with Chronic Health Conditions

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Abstract

Objectives: This qualitative study explored risk and protective factors affecting employment and health among low-income older women with chronic health conditions or physical disabilities.

Methods: The authors conducted a secondary data analysis of 14 intensive interviews with low-income older women with chronic health conditions who had participated in a federally funded training and employment program for workers ages 55 and older. Qualitative data were analyzed using thematic analysis (Braun & Clark, 2006).

Results: The physical nature of the work and discrimination were risk factors, with unaccommodating work environments, ageism and/or ableism, and internalized ageism identified as subthemes of discrimination. Protective factors, namely institutional supports (e.g., access to retraining, time management flexibility) enhanced health and self-confidence. Occupational demands matched with the capacity of the individual resulted in continued employment and improved health.

Discussion: Goodness of fit between the demands of the job and the capacity of the individual can result in a positive relationship between employment and health. Legislation designed to prevent discrimination, enhance opportunities for lifelong learning, and encourage flexible work arrangements among low-income women with chronic health conditions may facilitate healthier working lives. Recent legislation that mandates work without ensuring the goodness of fit will likely exacerbate and worsen health.

Keywords: chronic disease, physical disability, flexible work, ageism
Background and Objectives

Employment in later life can ensure the economic well-being of older adults (Munnell & Sass, 2008), as well as bolster cognitive (Andel et al., 2007), physical and psychosocial health (Staudinger, Finkelstein, Calvo & Sivaramakrishnan, 2016). Yet cumulative disadvantages due to gender, class, race, age and disability over the life course may render occupations and working conditions that support health inaccessible to older women. Chronic health conditions often hinder employment opportunities and work may agitate health conditions among low-income older women in occupations that are highly physically demanding (BLINDED FOR REVIEW). The purpose of this qualitative study is to give voice to a group of older women with chronic health conditions, enabling them to describe risk and protective factors that influence their work and health. Study participants were a diverse group of low income women enrolled in the Senior Community Service Employment Program, a federally funded employment and training program available to low income older adults who have experienced work loss and/or challenges reentering the workforce.

Health, Employment, and Poverty among Older Women

Cumulative inequality theory integrates key concepts of timing, onset and duration of an event or condition, and asserts that the uneven accumulation of risks and protective factors across ecological contexts (work, family, community) can lead to early onset and severity of morbidity and mortality (Ferraro & Shippee, 2009). Inequality is determined by structural factors via exposure to risk across multiple interacting life domains, including work and health (Ferraro & Shippee, 2009). Gender-based structural discrimination may expose women to accumulated risks across the lifespan in work and health domains, resulting in increased vulnerability to poverty and deteriorating health as women age. This risk is particularly pronounced for women...
of color and unmarried women. A lifetime of lower wages due to the gender wage gap, and years out of the workforce or working part-time – due to caregiving for their own children, partners, or older parents – result in lower earnings over a lifespan (Calasanti, 2010; Carr, 2010; BLINDED FOR REVIEW; Torres, 2014). Women earn less than men within the same fields, and work in female-dominated fields pay lower wages (Hegewisch, Liepmann, Hayes & Hartmann, 2010; Lips, 2018). The association between higher percentages of women working in an occupation and lower average earnings persists across occupations requiring low to high educational levels (Hegewisch et al., 2010). Female-dominated occupations tend to be undervalued in both status and pay (Hegewisch et al., 2010; Lips, 2018).

Lower wages and fewer years in the workforce lead to lower Social Security benefits for women in older adulthood (Carr, 2010) and greater risk of poverty (Lee, Tang, Kim, & Albert, 2015). Lower paying occupations and interrupted working years make women less likely to receive employer-based private pensions than men (Carr, 2010). Single mothers are more likely to live in poverty (Herd, 2005), with women living alone more vulnerable to poverty in older adulthood (Torres, 2014), a risk most pronounced for women of color, who are less likely to marry (Herd, 2005). A greater likelihood of working in lower paying occupations also exposes women of color to a greater risk of poverty: in 2015, 8.1% of white men were in poverty, compared to 28.8% of black women (United States Census, 2016).

A lifetime of exposure to health risks shaped by gender, class and/or race may render women increasingly susceptible to poor health and disability as they age. Chronic disease is the leading cause of disability in the United States, with heart conditions and cancer as the most common chronic diseases (Centers for Diseases Control and Prevention, 2017). Older women are more likely to have chronic diseases and functional limitations than older men, with women of
color experiencing earlier onset of chronic health conditions and the highest levels of disability (Chrisler, Rossini & Newton, 2015; Hinze, Lin & Andersson, 2012; Warner & Brown, 2011). Low-income women working in female-dominated fields with lower pay and higher physical demands, such as housekeeping, may have difficulty sustaining employment at older ages, as such work may compound or cause chronic disease (Payne & Doyal, 2010). Low wage, low status jobs have been associated with the development of a variety of chronic health concerns over the life course (Berkman et al., 2014). For older women forced to withdraw from the labor market due to chronic health conditions, Social Security Disability Insurance (SSDI) does not alleviate risk of poverty – individuals receiving SSDI benefits are more likely to be in poverty than their age peers without disabilities (Livermore and Roche, 2011).

As women age, age-based discrimination may expose women to still additional risks within the workplace, which can interact with other risk factors to increase disadvantage and resulting inequality. Lahey (2008) found that younger applicants were 40% more likely to be invited for an interview than older workers, in an experiment examining hiring for entry-level jobs in American cities. Analysis of a national survey of older workers indicated that 81% of surveyed older workers reported experiencing workplace discrimination at least once in the previous year (Chou & Choi, 2011) and a U.S. population-based longitudinal quantitative study linked perceived age discrimination at work with depression, declined self-rated health, and job dissatisfaction (BLINDED FOR REVIEW). A recent review of research underscored the prevalence of ageism among employers and younger coworkers, as well as the presence of internalized ageism for some older workers (Harris, Krygsman, Waschenko & Rudman, 2017). Scientists (BLINDED FOR REVIEW; Harris et al., 2017) have called for research to provide a more nuanced understanding of how older workers manage the experience of discrimination in
the workplace and internalized ageist beliefs, asserting that improved understanding can inform strategies to counteract it. Discrimination due to age can be compounded by the presence of disability: discrimination in the form of inaccessible or inflexible work environments, and/or employers’ failure to provide accommodations can be key environmental barriers to sustained employment (Blinder, Eberle, Patil, Gany & Bradley, 2017; Christian, 2015; Livermore, 2011).

Conversely, supportive coworkers and employers and access to workplace accommodations can enable continued employment in the context of chronic disease and disability (Blinder et al., 2017; Nevala, Pehkonen, Koskela, Ruusuvuori & Anttila, 2015). Disease severity alone is an insufficient predictor of employment status: the quality of the work environment can be a barrier or a facilitator to continued employment (Bautista & Wludyka, 2007; Dyck & Jongbloed, 2000; Nevala et al., 2015). Cumulative inequality theory emphasizes that while the accumulation of disadvantage can mold trajectories via exposure to risk, life course trajectories are not fixed: exposure to resources can positively affect trajectories (Ferraro & Shippee, 2009; Ferraro, Shippee, & Schafer, 2009). Additionally, human agency matters: inequality is not the result of personal choices, but human agency combined with access to resources can work to mitigate risks and alter outcomes (Ferraro & Shippee, 2009; Ferraro, Shippee, & Schafer, 2009). This study aimed to examine how risk and protective factors influenced women’s life course trajectories in the domains of work and health, exploring how exposure to risk and/or access to resources either increased or mitigated inequalities related to health and work. The qualitative methods provided insights into the role of human agency in conjunction with social structures.

**Research Design and Methods**

**Data Sources**
This study involved secondary data analysis of 14 intensive qualitative interviews with low-income older women participating in a federal training and employment program, the Senior Community Service Employment Program (SCSEP). The university IRB designated this study as exempt. SCSEP is authorized by Title V of the Older Americans Act and provides job training and employment assistance to jobless low-income workers ages 55 and older who have less than 125% of the federal poverty level. SCSEP participants are assigned to part-time, minimum-wage jobs in nonprofit and public service agencies. The ultimate goal is for the participants to find an unsubsidized job.

The authors selected the 14 interviews for the present study from a larger dataset consisting of 26 interviews with both male and female SCSEP participants interviewed as part of a larger study to understand the possible health and economic outcomes for SCSEP participants. To recruit study participants, the research team contacted program directors in selected areas about the study and asked them to assist in recruiting volunteer study participants among current and former SCSEP participants, to participate in confidential and anonymous semi-structured interviews. The second, third, and fourth authors conducted one-on-one interviews, which lasted approximately one hour. The interviews were audio-recorded and transcribed verbatim. The second, third and fourth authors examined the original dataset of 26 interviews using a content analysis approach to produce a final report. Gender, health, and work emerged as key themes that required additional qualitative analyses.

For the present study, the authors selectively examined the stories of women with chronic health conditions or disabilities within the context of work, to better understand the experiences of this specific subgroup. Inclusion criteria included female gender and participant’s discussion of working with a chronic health condition or disability. We reviewed the transcripts of all
female participants, excluding transcripts if participants did not disclose any health conditions, or if the interview lacked sufficient discussion of health conditions.

Table 1 provides the demographic characteristics of the 14 participants. Participants had a range of chronic health conditions including breast cancer, chronic pain disorders, eye disease, diabetes, stroke, hearing loss, and impaired mobility. This sample consisted of women who both chose to participate in SCSEP and to participate in this study. As Table 1 demonstrates, over half of study participants were women of color, none of the women were married and the majority lived alone.

**Data Analysis**

The first author led analysis of the 14 interviews using a thematic analysis approach aimed at examining risk and protective factors for women, related to having a chronic health condition or disability in a work context. Thematic analysis is a qualitative method for finding, analyzing and interpreting patterns of meaning across a data set based on theory driven and/or data-driven approaches (Braun & Clarke, 2006). A thematic analysis approach allowed the researchers to be guided by the research question while simultaneously looking for new or unexpected insights from the data.

Thematic analysis consists of six stages: becoming familiar with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes and producing a report (Braun & Clarke, 2006). During the first stage of coding, we read the 14 transcripts multiple times, noting preliminary patterns in the data related to work and health. Next, the first author searched for and identified circumstances wherein the individual’s health status interacted with employment, within each individual’s story, developing initial codes. The first author then began to compare and contrast initial codes with codes that the other authors
identified for the original study to identify and revise initial themes regarding the factors participants discussed as affecting their work and health. Once initial themes were identified and revised, the data set was loaded into NVIVO qualitative software to code for themes within the context of original transcripts. We discussed emerging results and agreed on final themes for this present study. The findings of this secondary data analyses are unique to low-income women with chronic health conditions while corresponding to the themes identified in the final report of the larger study. This team process ensured the validity and reliability of the results, and the authors utilized participants’ words verbatim within this manuscript to provide robust evidence of theme validity.

Results

Five themes were identified, with two risk factors and three protective factors that influenced participants’ employment outcomes, within the context of having a chronic health condition or physical disability. The physical nature of the work and discrimination were identified as risk factors, with unaccommodating work environments, ageism/ableism, and internalized ageism identified as subthemes of the discrimination risk factor. Accommodating, flexible work environments, access to retraining and other work-supportive resources, and work itself were established as protective factors in the data.

Risk Factors: The Physical Nature of the Work

Participants indicated that after the onset of illness or disability, they were no longer able to continue in the same line of work due to its physical requirements. For many participants, this physically demanding work was the majority of their lifetime occupational experience, leaving them without the skills and experience necessary to qualify for alternative employment. Mary, a 58-year-old divorced Black woman with an Associate’s degree, had worked as a paid caregiver
prior to her breast cancer treatment, but she knew she could not return to this line of work: “It is a lot of lifting and stuff like that and I can’t lift like I used to.” Despite her efforts to regain employment, finding work she was qualified for that was also physically appropriate proved challenging. Deborah, a 61-year-old divorced Black woman with a high school diploma and some years of college, indicated that she had worked as a secretary 28 years ago, but left to pursue better paying work in custodial services. She would like to return to less physically demanding work, but:

I knew I did not have the skills to pursue a clerical job again. Because all the programs that I learned…don’t exist anymore. So, I knew I couldn’t be a secretary again, but I just could not do the physical job anymore. I am just in too much pain to do it anymore. Deborah

Despite the desire and/or the financial need to continue working after the onset of illness or disability, these participants found that the work they were qualified for was no longer physically possible, and they lacked the experience or qualifications for alternative employment.

**Risk Factors: Discrimination**

Participants faced overt and subtle forms of discrimination by previous and potential employers, through failure to provide appropriate accommodations after the onset of illness/disability, being fired due to illness/disability, or facing discrimination in the job market. Participants perceived ageism and/or ableism from external sources, and internalized ageism was evident as well.

**Unaccommodating work environments.** The onset or worsening of an illness/disability often interacted with an unaccommodating work environment to create negative employment outcomes, including job loss. For some participants, the work environment caused or exacerbated medical conditions, which in turn further jeopardized the participant’s continued employment because the employer was unable or unwilling to provide accommodations.
Deborah described how her work at a retail clothing chain involved lifting heavy boxes, which exacerbated chronic pain from an on-the-job injury that occurred in her past work as a custodian. She used up most of her ten annual sick days by taking the day off or leaving early due to significant pain exacerbated by her work.

When she ran out of sick leave, no attempts were made to provide accommodations; such as adapting her job responsibilities, moving her to a different position within the company, or reorganizing her workspace: “Well, they can’t because their issue is ‘You have a quota to get out. If you can’t perform the job, you can’t work here.’ They don’t have a program for if you are disabled.” Deborah indicated that the company was a “great company to work… for a younger person in better health.” At the same time, she discussed how the workspace could have been set up differently to better accommodate her physical needs:

If they had just done away with that very top shelf… You have to climb or step on your stool, but you don’t have time to use the stool, because you have a quota. So, if I have to pull out the stool every time I get up there, I am going to not make quota… So, I am just trying to reach up there and climb and I am reaching up and there is boots up here, there are heavy coats up here. Where, if those things were on the bottom, I probably could have been successful…

Deborah

The manner in which the workspace was arranged and the requirement for moving at a certain speed created a work environment destined to exacerbate Deborah’s pain, making it increasingly difficult for her to meet the job’s requirements. Her astute observation of making a small but significant rearrangement to work appears feasible, yet was unattainable, resulting in unemployment.

Carol, a widowed 67-year-old White woman with some years of college, had significant hearing loss after recovering from bacterial meningitis. She reported that both of her jobs at the time “involved dealing with people on the phone and coming in you know and taking payments
and so on and so I lost both of those jobs.” Despite the existence of technological accommodations to make phone work feasible for hard-of-hearing people, her employer did not allow the use of these accommodations. Having had this experience, Carol expressed fear that this lack of needed accommodations will occur again as she pursued re-employment: “So I said that could happen again you know.” Carol indicated that enrolling in the federally funded training and employment program was “my best bet because nobody would hire me because of my hearing loss.”

Sandra, a 61-year-old Black divorced college graduate, described how she was fired because her employer would not provide additional medical leave as an accommodation:

When I had the surgery last year. I came back to work too soon… I needed more time off from work to recover, ‘cause I had complications from the surgery. When I requested the time off, then they fired me. They said it was too much time off, I didn't get benefits or anything…Then, no income and no insurance, so I couldn't finish the treatment for my foot… Also, because I didn't have money, I couldn't keep the rent, so I was like that far from being homeless. Yeah, and couldn't even walk.

Sandra

Sandra’s job loss exposed her to a chain of risk factors including loss of health insurance and therefore lack of access to needed medical treatment; her joblessness thus imposed further risks to her health. This risk-accumulating domino effect of work loss was also apparent in other participants’ job-loss stories, including loss of health insurance, limited access to needed medical care or medications, and other losses such as jeopardized housing and personal transportation.

**Perceived Ageism/Ableism.** Sandra also discussed facing discrimination due to age and disability when looking for employment:

The potential employer would call; we would have telephone interviews and it would be marvelous… At the times I went in [for interviews], I didn't walk as well as I do now. I was walking with a cane. I was still in pain and when they saw me, they act like they didn't know who I was, or why I was there. They didn't know about the position I was there to discuss. They didn't want to hire an old lady that could barely walk.

Sandra
Sandra identified her experience as age discrimination, expressing her belief that if she was a young person with a cane she would be expected to recover, and thus her mobility would not be a concern to potential employers. Other participants reported age discrimination as a factor in their job loss. Susan, a 74-year-old divorced White woman with some years of college, reported:

People say there’s not age discrimination out there, but that’s why I was let go from the nursing home where I had been for 10 years was because of my age. The person that let me go just came right out and said, “You’re old enough to be drawing Social Security so you need to draw Social Security so we’re going to let you go.”

Susan

She discussed instances of similar age discrimination experienced by other older workers at the same organization. She indicated that she enrolled in the federally funded training and employment program because “it is kind of hard to find anything at my age.” Other participants made similar assertions. Donna, a 61-year-old divorced Black woman with some college experience, reported:

A lot of people have just lost their jobs and finding it very hard because a lot of people don't want to hire seniors unless you have really, really good skills. Even some of the degree seniors are finding it very difficult to get a job.

Donna

**Internalized ageism.** In addition to facing discrimination from external sources, participants expressed doubts about their own capabilities due to their age, or expected to be passed over for work because of age. When asked about her expectations prior to enrolling in the employment program, Deborah indicated: “Well, to tell you the truth, I didn’t have high expectations. I was really kind of discouraged, because I really did feel I was too old to learn [current computer] programs.” Deborah doubted her ability to learn new skills because of her age: “I really thought I was too old to catch on.” Carol expressed that involvement in the
employment and training program enables older people to “feel useful again,” explaining that:

“when you get older I think there are so many people that just don’t feel useful anymore.”

Susan described how the expectation of facing age discrimination has impacted her:

I have had lots of interviews come through, but some of them I don’t take, because I know once that I go up to the interview and they see that I’m an older person – It doesn’t matter if I’m qualified or not, they’re not going to hire me… You get tired of being turned down, especially when you know that your qualifications are just what they’re looking for. So you really do get tired of that. You can only take so much disappointment.

Susan

Susan indicated that the expectation of being “turned down” for work due to her age prevented her from pursuing potential employment possibilities. Susan’s previous experience of being let go from a long-term position due to her age left her discouraged about the job search process.

Susan identifies the emotional toll experiencing ageism has had on her: “you can only take so much disappointment.”

**Protective Factors: Workplace Flexibility**

Participants noted that accommodating work environments in the program allowed them to be successful at work. A number of participants expressed surprise that their supervisors had allowed for time off to recuperate from health issues, or provided flexible scheduling to accommodate medical appointments. Several participants reported that part-time work was most appropriate for them because of their health conditions, making the training program’s 20 hour work-week a good fit. Patricia, a 57-year-old single White woman with some years of college, reported that her supervisor’s accommodations made work feasible for her:

Since I have got back problems and I have had cancer and I have got some health issues… yes, I was nervous because I was thinking, “Can I do this?” Then, that was what I was worried if I could be on my feet that long. But then, after I got there and they said, “Well, you can do this job. Just switch back and forth. Make the sandwiches, sit down, get up.” That all helped.
Patricia described how her supervisors provided a good fit with her capacities by encouraging role flexibility with job responsibilities to reduce fatigue. She was also able to share job tasks with a coworker. She stressed that she “can’t work eight hours a day. There is no way.” Thus, her food service training job with short work days at an elementary school was a good fit for her needs and capabilities.

**Protective Factors: Access to Retraining and Other Work-Supportive Resources**

Participants discussed how enrolling in the federally funded training and employment program provided access to training in new skills and work experience that was often necessary to jobs that did not require difficult physical labor. Access to retraining, and resources such as assistance with job-seeking skills and resume building, left participants feeling more prepared to reenter the workforce. Donna describes how enrolling in the program gave her access to desired training:

I wanted the opportunity to try and convert from being an administrative assistant into the world of IT. It's kind of difficult trying to make that transition. [The program] has given me the opportunity to take classes... Being a senior and not really being in a formal classroom for over 35 years, this gives me the opportunity where what I do here helps my director, and it also helps me when I leave by still having the energy to study.

Donna asserted that access to retraining is necessary for older adults who are no longer able to work physically stressful jobs, but do not have the necessary skills to access more appropriate work:

They [older adults] need to get out and learn how to use computers, because in this day and age you cannot get by with not. I mean there are some that, you know, our bodies are breaking down on us. We're not as young as we were. Working on our feet, lifting heavy loads, those things are hindering seniors now. They feel the aches and pains of getting older. And so now they need some re-training to help them still be able to earn a living.

Donna
Several participants indicated that receiving training for free, or paid as part of their job-training assignment, allowed them to engage in retraining while still earning income, an option that would not otherwise have been available to them. Participants reported that access to retraining increased their work-related self-confidence. Deborah described how access to new work experience opened up vital new opportunities for her:

Without [the program] I would have been fired and I don’t know what I would have done, because I would have had to keep on pursuing physical jobs that I couldn’t perform. Because I would have needed paid training. I couldn’t just go to school. Only through the program, am I getting paid to learn the profession that I want to be in. They put me in a secretary position, so my body is healing from all that physical work, while I am learning, and I am getting experience.

Deborah

Deborah’s statement highlights how engaging in retraining and new work experience acted as a protective factor in several ways. She gained the skills needed to seek out employment appropriate to her physical needs, and in finally getting respite from physical labor, her body was able to recover, further safeguarding her ability to succeed in future employment.

**Protective Factors: Work as a Protective Factor**

The data presented a compelling argument that when there is a good fit between individual capacity and the demands of the job, the act of working itself can be a protective factor, with participants reporting improved mental health and, in some cases, improved physical health since returning to work. The experiences shared by these participants demonstrate the reciprocal relationship between employment and health across time. Optimal work arrangements can protect mental and physical health, and improved mental and/or physical health may bolster participants’ ability to continue working longer, particularly in the context of chronic health conditions/disability. Mary was asked if her health had changed since returning to work through the program:
To be honest with you, it changed a little bit better… Because if I am not out there doing anything, I think I will be feeling worse. So, as long as I am finding myself doing something and I can see that I am, “Oh, wow. I can accomplish this. This can happen.”

Mary

Mary described how engaging in appropriate work had improved her sense of well-being and mental health. Pamela, a 65-year-old divorced White college graduate, described the cognitive and mental health improvements she has experienced:

I think I wasn’t aware that… I know I needed the money…But, I guess I wasn’t aware that mentally I needed to be here and learn something all the time and get my mind going again. Even though I was doing things at home somewhat, I wasn’t actually really learning stuff. So, just being here and feeling better and learning has just taken all that stress and that depression out.

Pamela

Pamela needed to return to work for financial reasons, but found that she benefited from being mentally engaged again, which in turn she perceived as reducing stress and depression. Patricia described the physical and mental health benefits she experienced after she began her job-training assignment:

Before I started working? I was depressed…But, when I started working, I lost all of that. I was happy. I had a social life and working and I lost weight, too… I started feeling so much better. Physically, mentally, everything. I felt better.

Patricia

Discussion and Implications

The results of this study enhance understanding of how risk and protective factors associated with age, disability, gender, race and class can converge to affect the employment experiences and outcomes of many low-income women. The sample of low-income women with chronic health conditions presented unique differences compared to the larger sample. First, participants explicitly identified age and ability-related discrimination as risk factors although gender and race-based discrimination are an important implicit factor in understanding these women’s experiences. Several of the women in the sample lost their jobs as a direct result of
ableism and ageism, and expressed fears of discrimination preventing them from obtaining new work. Such fears are reasonable, given documentation of higher unemployment rates among older low-income workers (BLINDED FOR REVIEW; Sum et al, 2011).

Second, these women more frequently discussed their experience in cumulative inequality than the larger sample. The majority of the women in this sample were divorced and living alone, and over half of the participants were women of color. Single women are more vulnerable to poverty in later life due to a lifetime of lower earnings and lower Social Security benefits than men, and women of color are particularly disadvantaged due to a lower likelihood of marriage and a higher likelihood of working in lower paying fields (Calasanti, 2010; Carr, 2010; Torres, 2014). Evidence from this study supports this literature – participants such as Patricia had worked in low-paying female-dominated fields (e.g. home health aide) with job responsibilities that can damage the body over time. Other participants had college degrees, but still experienced work loss and financial hardship that qualified them as low-income, highlighting how other aspects of their identity (i.e. gender, race, health status, age) may have combined to expose them to risks that the advantage of education could not completely buffer against.

Lastly, vulnerability to the physical nature of the work was appeared in the subsample. The present findings add to the quantitative literature on job quality by demonstrating how specific aspects of the work environment can help or hinder in the context of both age and disability. Many participants described experiencing a low level of control in former workplaces (e.g., lack of control over the execution of job responsibilities, limited medical time off without risk of job loss) and high demands (e.g., fulfilling quotas within a strict timeframe, physically demanding tasks). These experiences align with research indicating that low control, high
demand jobs are associated with the development of chronic health issues and are more prevalent in low-wage, low-status fields (Berkman et al., 2014). Study findings demonstrated how flexible work environments promoted greater control via time off for illness or medical appointments, and workplace adaptations for how tasks are completed in response to a participant’s physical abilities and health needs. Improved locus of control allowed participants to safeguard their physical well-being, and the convergence of these protective factors likely contributed to the improved mental health reported. These findings underscore that work may not be health-producing, but a fit between institutional factors and individual capacity is likely to yield health and economic benefits.

Our findings illustrate the dynamic relationship between work and health, highlighting the importance of a good fit between the demands of an occupation and the capacity of individuals, capacity that may change over the life course. Work environments proved relevant as both risk and protective factors for study participants, demonstrating how working conditions can increase inequality in critical periods of the life-course through exposure to mental and physical health risks, or alternatively, support health by providing access to financial and interpersonal resources. In the context of chronic disease or disability, the quality of the work environment can determine the employment outcomes of workers, with loss of work due to lack of accommodations exposing the individual to snowballing risks such as loss of health insurance and financial hardship. A quantitative study by Welsh, Strazdins, Charlesworth, Kulik and Butterworth (2016) examined the relationship between job quality and health for older workers, defining job quality as related to job control and security, effort/reward balance, and skill use. Results indicated that while high-quality employment can have a protective effect on physical and mental health for older workers, poor quality work can be associated with declining physical
and mental health (Welsh et al., 2016), suggesting that when the demands of an occupation exceed that of the individual’s capacity this may result in deleterious health.

We were surprised not to hear of race-based discrimination among this sample of women. Evidence stemming from selective incivility theory (Cotina, Kabat-Farr & Leskinen et al., 2011) suggested that women of color experienced worse treatment within workplaces, among a relatively young sample of employees. In a U.S. population-based study, older workers in the Health and Retirement Study report high levels of discrimination due to a number of factors, age being the first reason among Whites and Hispanics/Latinos and the second reason, behind race, for Blacks and African Americans (BLINDED FOR REVIEW). It may be that our participants’ experiences of explicit bias due to age and ability lead to a myopic focus on age as a determinant of employment.

Cumulative inequality theory asserts that social structures create inequality (Ferraro & Shippee, 2009). This study demonstrates how the combination of advancing age and health/ability status can interact and build on existing disadvantages associated with gender to exacerbate inequality later in life, via exposure to discrimination. Gender or race-based discrimination at the interpersonal level were not central themes in this data, but it is critical to consider how structural discrimination due to gender, race and class may have combined with ageism and ableism to contribute to later life inequality in the form of unemployment and financial hardship.

De-accumulation and halting are key concepts to cumulative inequality theory (Ferraro & Morton, 2018). SCSEP halted unemployment for these women, and offered them training, workplace flexibility, and subsidized jobs that led to perceived improvement with physical and mental health. These new, positive work experiences in the context of the job-training
environment directly contradicted earlier stereotypic, negative assumptions and the discriminatory actions of former employers, with participants describing increased self-esteem as a result of program participation. Cumulative inequality theory posits that an individual’s sense of their relative life successes and failures has the potential to directly impact their future trajectories, indicating that positive self-efficacy can help to mitigate the psychological consequences of other disadvantages (Ferraro & Shippee, 2009). Improved self-efficacy within the context of work has the potential to act as an additional resource and a sign of de-accumulating negative ageist beliefs, which may increase the individual’s likelihood of a more desirable work trajectory in the future. Participants perceived access to accommodating work environments and obtaining additional job skills as opening doors to new and more suitable work opportunities for the future. These outcomes support existing literature in productive aging on the potential of work as a protective factor for mental and physical health (Morrow-Howell, Hinterlong & Sherraden 2001).

**Implications for Public Policy**

Retirement security is a national priority (White House Conference on Aging, 2015) and a grand challenge among social work and social policy academies (REMOVED FOR BLIND REVIEW). These findings emphasize the need for intervention strategies that promote employment opportunities for older low-income women with chronic health conditions. Existing legislation intended to safeguard workers against age discrimination and ensure accommodation in the case of disability and/or compromised health include the Americans with Disabilities Act (ADA) and the Age Discrimination in Employment Act (ADEA). The ADA prohibits employment decisions due to disability status and requires that large employers provide reasonable accommodations to employees with disabilities. However, the experiences reported
by these women indicates that employers are not always compliant with the law, resulting in difficult work conditions and unemployment. Low-income workers in particular may not have the educational or legal resources to fight for their right to accommodations (Autor & Duggan, 2010) and it is unclear how many of our study participants knew of these legal protections. The ADEA, as amended, now requires proof that age was the main or sole cause of discrimination in an employment decision, proof of which may be difficult to provide (BLINDED FOR REVIEW). Thus, existing legislation provides limited support for older workers and/or persons with a chronic disease or disability. Adoption of proposed legislation to amend the ADEA, such as the Protecting Older Workers Against Discrimination Act (S. 443, 2017) would improve its effectiveness by clarifying the original intent of the law, enhancing its protections, and ensuring companies are compliant.

These study findings illustrate how flexibility regarding when, where and how job responsibilities are fulfilled enabled participants to succeed in their job-training settings, while protecting their health. Research has demonstrated that workplace flexibility policies may improve outcomes for both employers and employees alike, by reducing turnover (Moen, Kelly & Hill, 2011) and aiding recruitment (Richman, Burrus, Baxbaum, Shannon & Yai, 2009). Increased flexibility in the workplace has been associated with decreased absences due to ill health and reductions in work-related impairments over time (Casey & Grzywacz, 2008). Low-wage workers are less likely to have access to workplace flexibility policies (Office of Disability Employment Policy & Women’s Bureau, 2011). However, case studies of multinational corporations have investigated the implementation of workplace flexibility policies for lower-wage, hourly workers, with strategies that enhanced employee control over their schedules (Richman et al., 2009). The results are promising, with both employees and their managers
reporting positive impacts on team productivity and effectiveness, level of customer service, as well as improvements in employees’ job satisfaction, ability to fulfill family responsibilities and perceived sense of stress and well-being (Richman et al., 2009). Pioneering states and cities have recognized the potential of workplace flexibility by passing supportive legislation prohibiting retaliation against employees requesting flexible work options (e.g. New Hampshire, Chapter 182, S.B. 416, 2016; Vermont, No.31, H.99, Sec. 6. V.S.A. 309, 2014).

Recently, legislators have tied receipt of Medicaid to employment, citing that work in and of itself bolsters health (Katch, Wagner & Aron-Dine, 2018). Such legislation ignores the ‘goodness of fit’ between the capacity of the individual and the work environment and assumes that any work can bolster health. Mandating employment for receipt of Medicaid, without ensuring flexible work options, training and safeguarding against discrimination, may result in worsening health conditions, loss of employment, and loss of Medicaid. Moreover, this legislation does not provide for additional support for retraining or assistance in finding work, but instead prohibits the use of federal Medicaid funding for work-supportive programming (Katch et al., 2018).

The employment and training program in which this study’s respondents participated (SCSEP) exemplifies a federal policy aiming to support the health of older adults in the context of employment. This qualitative study has highlighted the program’s role as a protective factor providing positive outcomes for its disadvantaged participants. Participants discussed how SCSEP provided paid on-the-job training to learn new skills – training participants described as necessary to obtaining new work. Workers with lower levels of education are more likely to be employed in physically demanding jobs (Johnson, Mermin & Resseger, 2007), which may become less suitable with age. Moving out of physically demanding occupations may require
additional education and training, yet older workers are less likely than their younger coworkers to be provided with on-the-job training to learn new skills (Johnson et al., 2007). Low-income adults may not have the time or financial resources to pursue further education outside of work (BLINDED FOR REVIEW). This study also highlights the association between employment and various dimensions of health. The results from the Department of Labor’s annual nationally representative sample survey of SCSEP participants mirror our participants’ perceptions of the mental and physical benefits of the program. In 2017, 32% of survey respondents (N = 11,630) reported their physical health was better than before entering SCSEP (DOL, 2018). The survey’s mental health results (N = 11,673) were even more encouraging, with 47% reporting their outlook on life was “much more positive,” 26% “a little more positive,” and 20% “about the same.” (DOL, 2018). Our findings provide insight into this quantitative data by illustrating one pathway through which re-engagement in supportive employment may improve mental health – by counteracting ageist stereotypes and improving self-esteem. Future mixed methods or longitudinal research should aim to further examine the physical, cognitive, psychosocial health or labor force preferences of SCSEP participants.

**Limitations**

This convenience sample of volunteer interviewees are not representative of all low-income older women with chronic health conditions. The study involved secondary data analysis, pursuing a research question specific to women. Health outcomes were of interest in the original study, which included questions about health before and after participation in SCSEP. The study data provided compelling evidence of the risk and protective factors discussed, however, the extent to which participants discussed their health status and/or how it interacted with past and present employment varied. Further research to examine employment outcomes for older women with chronic health issues and/or physical disabilities would benefit from targeted recruitment
and sampling of this population, and interview or survey protocols focused on the interaction between specific chronic health conditions or physical disabilities and employment.

**Conclusion**

This study aimed to give voice to low-income women with chronic health conditions, to enhance understanding of risk and protective factors affecting their employment and health. Women interviewed described the physical nature of the work and discrimination as risk factors, while workplace accommodations and flexibility, access to retraining or other work-supportive resources, and high-quality work itself were discussed as protective factors. The study highlights how the work environment is an essential factor in one's level of job quality in the context of advancing age and disability. It illuminates how flexible work arrangements after someone has experienced age and ability-related discrimination may provide a corrective experience, bolstering a workers’ self-confidence in her ability to sustain employment. These findings underscore the importance of understanding the contexts in which older women are working and how to support sustained employment that promotes rather than impairs physical and emotional health. The participants’ experiences illustrate how exposure to key resources during critical life periods can have a de-accumulating effect, positively affecting life course trajectories in the domains of work and health (Ferraro & Shippee, 2009; Ferraro, Shippee, & Schafer, 2009).
References


Katch, H., Wagner, J., & Aron-Dine, A. (2018). Medicaid work requirements will reduce low-income families’ access to care and worsen health outcomes. Center on Budget and


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Table 1. Participant Demographics

<table>
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<tr>
<th>Pseudonym</th>
<th>Age</th>
<th>Race/Ethnicity</th>
<th>Education</th>
<th>Marital Status</th>
<th>Living alone</th>
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<td>Associate’s degree</td>
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<td>Linda</td>
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<td>Single</td>
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