An ageing workforce

Implications for occupational health

AGEING is a political, organisational and individual concern. Questions about how older people will live, what they will do and whose responsibility it is to look after an ageing society is now an international debate. Within the UK there have been changes in the demographic makeup of society, which will inevitably affect occupational health (OH) practice. Is the broad church of occupational health ready for this change and, more importantly, ahead of the game in helping organisations plan for the future workforce population? This article explores some of these issues.

DEMOGRAPHIC CHANGE

The population of the UK is ageing, with 23% of people projected to be aged 65 years and over by 2034, in contrast to an equivalent figure of 18% for those aged under 16 years[1]. The average entry age to the labourforce is getting later – owing to the increase in younger people entering higher education – and there is a growing group of 16–18 year-olds who are not entering the workforce at all, as many of the traditional craft and secretarial/clerical jobs typically held by school leavers have disappeared. And with the age to exit the workforce (due to retirement, ill health and inability to find suitable work) remaining at 64.5 years for men and 62.4 years for women, it follows that there will be a shortfall of productive working years for the UK economy and a rise in the old-age dependency ratio[1]. (The ratio measures the number of people over state pension age for every 1,000 people of working age.)

Politically, therefore, it makes good sense to raise the pension age to increase overall productivity rates, reduce the old age dependency ratio and mitigate the costs of the economic burden on the state. This will mean that the social expectations of future generations will need to change as the perception of society to be able to retire early, or at least 'on time', is now challenged by demographical change and social policy reform. As a consequence, OH practitioners will have a different population of workers to care for in the future; a population that is likely to have different motivating factors for working, which, in turn, will influence health behaviour and performance at work.

FUTURE TYPE OF WORKER

The demographic changes of young people entering the workforce, women and men having children later, and an increasingly ageing workforce is predicted to shape the future type of worker. Research in this area predicts that by 2020 there will be three types of worker; 'graduate', 'sandwich' and 'grey'[2].

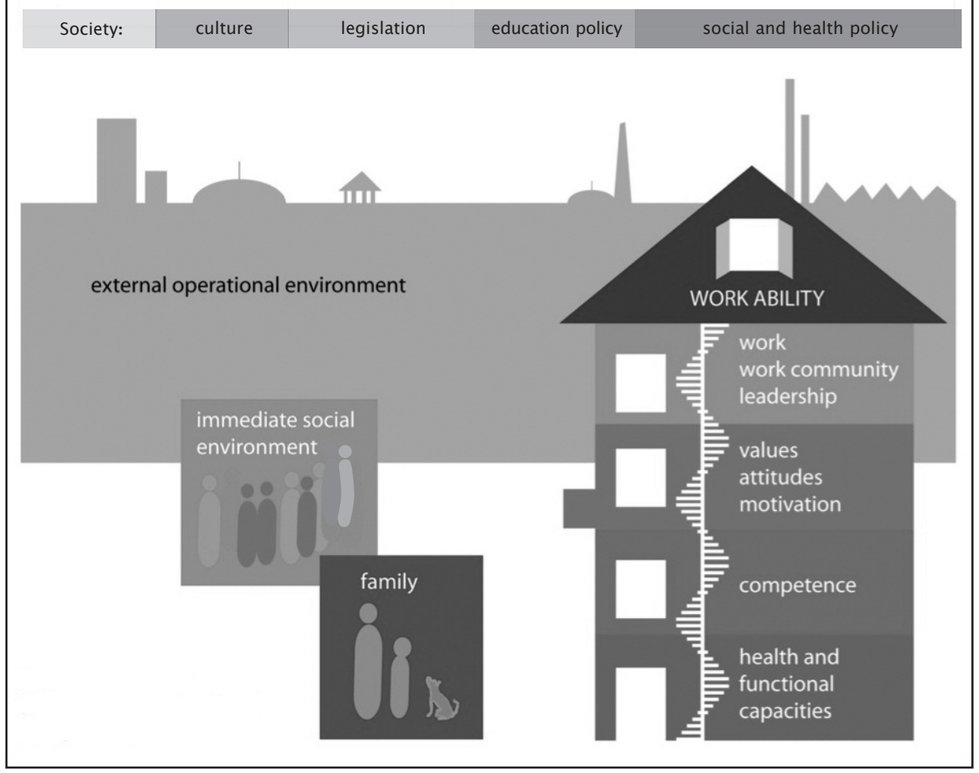
A 'graduate' worker is likely to be less secure in the workplace, with short-term contracts becoming reality. For this type of worker, traditional working patterns such as being visible within the organisation to improve their chance of progress will be a priority in order to maximise the financial return on their education. The pressure for this worker will be about paying off debts accrued during education and coping with the uncertainty of a job market that offers little stability and entry to traditional market opportunities, such as public sector working. It is, therefore, likely that flexible working will be of little interest to this worker and it may also mean that they will have more than one job with different employers.

A 'sandwich' worker is defined as people who have both dependent children and parents who require care. These people are in the prime of their working life – aged 35–44 years – but with an ageing society, and the trend for having children later, it is estimated that this type of worker will inevitably grow in number. Flexible working will therefore be a demand on employers to help fulfil family responsibilities. The attempt to balance jobs and family and the fear that others, free of such commitments, will be more productive will be an added pressure, which may have adverse health affects.

A 'grey' worker is one who is aged between 55 and 70 years. In 2010, it is estimated that there were 5.14 million in this age group, but by 2012 it is expected there will be an increase to 7.16 million[2]. Flexible working will also be increasingly valued among this group as they may be involved with the childcare of the 'sandwich' generation. As pension policy changes their financial position may be less robust than they had originally hoped and so paid

Organisations are not fully prepared for the consequences of an ageing workforce, argues Karen Coomer. An age-managed approach focusing on the Work Ability Index is an appropriate response, but to be successful requires a wider public or organisational health approach in the workplace.

Figure 1: Work ability and the work environment



work after an individual retires and receives a pension, known as 'bridge employment', may therefore become more of a trend in the UK.

As societal norms about ageing change, so inevitably will OH practice. Are we therefore confident that the indicators currently used to identify, plan and evaluate the working population are fit for purpose? Do we understand the ageing process enough to design interventions that are effective and user-friendly in the workplace? Should OH be replaced by the broader concept of 'organisational health'? These questions are discussed below.

THE ABILITY TO WORK

In current OH practice performance indicators are largely based on measurements of ill health for all workers – sickness absence, accident rates, compensation claims – rather than wellbeing. It is simply easier to measure sick workers rather than healthy workers and in OH practice this is the foundation on which case management is practiced.

Is there another way?

There is an argument advanced by the Economic and Social Research Council[3] that future traditional indicators are no longer going to be satisfactory, and the success of strategies to improve the health and wellbeing of current and potential employees will need collective support from individuals, families, communities and employers. This fits in very well with the idea of 'work ability' by the Finnish Institute of Occupational Health.

THE WORK ABILITY MODEL

The four aspects considered as essential for the maintenance and promotion of work ability in an organisation is represented as a holistic model based on organisational health. The underlying principle is to react to adverse problems at an early stage and throughout the life of an employee's journey in employment, not just when there are poor performance indicators such as sickness absence. Personal resources available at each stage of a person's journey throughout life will inevitably change depending on their health, job skill, competency and values and beliefs – work demands will also change and so the challenge is to balance the two to promote the ability to work at an optimal level. This is all under the umbrella of societal, legal and cultural changes.

If the model is examined in more detail the relevance to OH practice at primary, secondary and tertiary level becomes very clear. It also questions whether the functional way in which OH often operates needs to change to a more integrated organisational health model to reflect the degree and quality of the interaction between work and the worker.

FUNCTIONAL ABILITY

The first floor of the work ability 'house' is the physical and psychological capacity to meet work demands (see figure on p.16). In current OH practice the provision of objective evidence-based advice is the assessment of functional capacity and workplace risk. This is a reactive intervention dependent on waiting for an employee health issue to arise. At times there are 'performance' cases for which there is no particular health issue; it is simply the ageing process. With the abolition of the default retirement age, referrals of this nature could increase alongside requests to provide 'crystal ball' advice on whether an employee will be fit to continue in his/her job beyond the age of 65 years. The danger is that if OH practitioners do not understand the ageing process or the test of objective justification these referrals could be 'medicalised' and discriminatory practice could occur.

So where does that leave the ageing worker who may feel physically and psychologically worn out by their job?

Pickvance argues that many processes employ a range of skills that have traditionally been organised on the assumption that everyone, regardless of individual capacity, can do them equally well[4]. However, as an individual ages physical strength, flexibility, reaction time, sight and hearing declines. Physiologically, body fat, systemic blood pressure and fatigue increase and so it is inevitable that manual workers, in particular, are going to experience difficulties if their job is designed for the capabilities of a fit, younger worker.

Workplace factors, such as shiftwork, working in extreme hot and cold temperatures and physically strenuous work are known to be less tolerant to an ageing worker. It therefore makes good business sense to redesign jobs and put control measures in place to accommodate different abilities, skills and tasks regardless of age.

Another more holistic approach is to use the Work Ability Index (WAI), a tool credited by Professor Juhani Ilmarinen from the Finnish Institute of Occupational Health. This is a well validated short questionnaire that assesses the worker's own evaluation of his/her work ability, demands of work, mental resources, as well as present illnesses and their impact on work. A poor score indicates poor work ability for which interventions are necessary for improvement[5].

A recent study by the Chartered Management Institute (CMI) and the Chartered Institute of Personnel and Development (CIPD) identified that only 14% of managers considered their organisation to be well prepared to deal with the issues raised by the increasing average age of the workforce[6]. The WAI could be one tool, which, if used across the workforce, could contribute towards strategic interventions to gain a deeper understanding of work ability and wellbeing. This is in line with the recommendations from the CMI/CIPD study, which highlighted the need to take account of individual employee's different needs and expectations about extending their working life for sustainable business performance[6].

Competence

The second floor of the work ability 'house' represents the professional knowledge and the skill set needed to meet current and changing developments in work. At face value, this floor may not appear to be within the remit of OH practice and is perhaps seen as being more aligned to human resources functions. However, employees are often referred to OH for which the underlying problem is due to work-related factors, such as organisational restructuring resulting in changes to current skill level and knowledge.

It is therefore crucial that OH practitioners have an awareness of organisational, technological and globalisation changes to understand the impact they can have on present and future job fit. Individual and organisational stress risk assessments, job coaching and involvement with workforce training needs analysis are all examples of areas where OH practitioners can contribute at this level.

Values, attitudes and motivation

The third floor of the work ability 'house' is related to the values and attitudes of ageing, and is therefore influenced by factors beyond the workplace – this is represented by the 'balcony' in the model.

The proposed rise in the default retirement age is a direct example of how values and attitudes to exiting the workforce will need to change. Other examples, commonly seen in the workplace, relate to wellbeing and ageing self-efficacy, which in turn can influence how well someone prevents or exacerbates their own ill health. This is where the public health model of occupational health, focusing solely on the workforce, may need to be challenged as deeper understanding of the reasons why employees do not change health behaviour will inevitably be influenced by factors other than work.

By understanding the social parameters in which

CONCLUSIONS

- **The consequences** of demographic change will change the type of worker in the future
- **Organisational** health is a concept which will need different occupational health knowledge and skills
- **Indicators** of wellness are needed for future measurement of workplace performance
- **The Work Ability Index** has been recognised as a validated instrument to assess work ability at individual and workforce level.
- **All-age** life-course management is the key to managing ageing in the workplace

people live, and designing programmes and interventions that reflect real life, will lead to a participatory approach led by the employee rather than health professionals. This way of working will require skills in facilitation, motivational interviewing and qualitative research. It will also mean that OH practitioners may need to work outside the comfort zone of being the 'expert' and accept that not everyone is committed to avoiding poor health. Behaviour change in this context is about the employee being in control and stepping into their world to understand how they think and feel about the readiness to change, rather than an action-orientated approach centred on the assumption that the provision of expert knowledge should bring about change.

Work, community and leadership

The fourth floor of the 'house' summarises work conditions, demands, supervision, management and leadership.

'People are our best asset' is a phrase often used in organisations, but unless a framework is in place to utilise that asset effectively then the ability to work at an optimum level will be affected. Health and safety, the physical and psychological demands of the job, the operational style of management and leadership are all factors that result in control systems that limit, influence or determine behaviour at work and ultimately work ability. OH professionals frequently use a risk-assessment approach to understand and influence these control systems. However, if the concept of 'organisational health' is to be truly embraced, understanding informal (rumours, 'grapevine' communication) and formal (organisational goals driven by formal relationships and tasks) social structures is necessary to explore how employees perceive the control systems of an organisation. This can then help understanding in the form of positive or negative employee behaviour, such as absenteeism, bullying, discrimination and conflict.

In this model, a person's family and close community is also shown to affect work ability in different ways throughout their life course. Occupational choices, such as joining the armed forces, and working in industries such as fishing and offshore oil and gas are examples of how family life and communities are directly affected by the degree of job risk and prolonged absences from home. Macrostructures such as society, economic and political systems therefore need to create infrastructure, services and rules which determine how organisations and employees' work ability can both be supported to maintain employability.

LIFE-COURSE MANAGEMENT

OH practitioners are well trained in understanding ill health at work and measuring the impact this has on individuals and organisations. The question on behalf of the future worker is whether this will continue to be effective?

An understanding of the ageing process, a dynamic awareness of organisational factors – which contribute to the overall health of an organisation – and a greater political and strategic awareness are likely to be future determinants of OH practice. Using tools, such as the WAI, will assist in understanding future interventions necessary to maintain optimum work ability rather than solely managing ill health; and at the workforce level, this could lead to policy and strategic recommendations to benefit all ages of worker. The evidence suggests that if good work ability in midlife increases, and is maintained, the risk of disability in old age will decrease. The outcome will be positive for society, business and the individual. ■

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Notes

1 Population – ageing. London: Office for National Statistics, 2010. www.statistic.gov.uk

2 Visions of Britain 2020. London: Friends Provident, 2010, www.visionsofbritain2020.co.uk

3 Health and well-being of working age people. ESRC seminar series: mapping the public policy. Swindon: Economic and Social Research Council, 2006, www.esrcsocietytoday.ac.uk

4 Pickvance S. Ageing at work; workplace health for an ageing workforce. Occupational Health [at Work] 2005; 1(6): 18–21.

5. De Zart et al. Test-retest reliability of the Work Ability Index questionnaire. Occupational Medicine 2002; 52(4): 177–181.

6 Managing an ageing workforce – how employers are adapting to an older labour market. London: Chartered Management Institute & Chartered Institute of Personnel and Development, 2010.

7 Ilmarinen J (Finnish Institute of Occupational Health). Personal communication.