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**Women and Employment in Later Life: the impact of long-term health conditions on labour market participation**

Journal:	<i>Working with Older People</i>
Manuscript ID	WWOP-02-2021-0005
Manuscript Type:	Review

SCHOLARONE™  
Manuscripts

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9 **Women and Employment in Later Life: the impact of long-term health conditions**  
10 **on labour market participation**  
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13  
14 **Purpose**

15 There is increasing interest in long-term conditions experienced singly and in combination. This  
16 paper aims to address this by considering the impact of long-term conditions on female labour  
17 market participation in later life.  
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22 **Design/methodology/approach**

23 This literature review considers a variety of evidence and policy related to long-term conditions as  
24 experienced by women.  
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29 **Findings**

30 The review suggests the importance of gender when considering long-term conditions and when  
31 considering employment since this is often gendered. There are several long-term conditions  
32 affecting women in particular that need to be considered by employers and policy makers.  
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37 **Research limitations/implications**

38 This review scopes the literature offering some illustrative examples of long-term conditions.  
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42  
43 **Practical implications**

44 The review encourages practitioners and policy makers to include long-term conditions as people  
45 age in thinking about ways to prevent, alleviate and respond to long-term conditions and to  
46 consider them in age-related initiatives in employment.  
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49

50  
51 **Originality/value**

52 The review addresses long-term conditions among women in later life suggesting that multiple  
53 policy and practice responses may need to be considered together in the development of any  
54 strategies and guidance.  
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58  
59 **Introduction**  
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3 A recent report on the NHS response to long-term conditions gave the example of Ann, a woman  
4 who had retired early from her job as a deputy headteacher after decades of pain from an  
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A recent report on the NHS response to long-term conditions gave the example of Ann, a woman who had retired early from her job as a deputy headteacher after decades of pain from an unrecognised problem leading to severe back pain and other symptoms (Collins 2021). While this report focussed on new systems for recognition, this one example conveys a sense of the importance of the purpose and importance of this present study. The research question was ‘Do women begin to leave paid work because of health-related reasons that are more prevalent among women and, if so, what are these, how many are affected and how?’ The question relates to general health care including when working with older people as they may underpin pension inequalities and women’s limited resources in later life that have major impacts on wellbeing (Stafford et al 2018). Clarifying the evidence may also help individuals, employers and society address specific gender-related factors that affect labour market participation for possibly preventable or treatable health-related reasons.

This rapid review was commissioned by the Department of Health and Social Care in early 2020 prior to the Coronavirus being declared a global pandemic. It therefore provides a backdrop to the changes to employment that may result from the severe social shocks arising from the pandemic in the UK, such as increased unemployment, economic downturn, and the impact of distress and disability on many sections of the population. However, data are already emerging about the pandemic’s impact on working in later life. Crawford and Karjalainen (2020) examined data from the English Longitudinal Study of Ageing (ELSA) Covid-19 study (June–July 2020), taken from a sample of nearly 6,000 individuals in their 50s and over. They found older workers were affected by the pandemic in terms of disruption to their jobs like others in work, but found some differences in numbers who had taken retirement and seemed unlikely to go back to work; although others thought they would continue. Those in the age group that were mostly not yet approaching retirement, aged 54–59, were more worried about their job security than older groups, possibly anticipating the deleterious effect on their pensions and savings (p17). People with a health

1  
2  
3 condition or disability that limited the amount or type of work they could do were particularly  
4  
5 concerned about their jobs' future.  
6  
7

### 8 **Study design and methods**

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10  
11 In this context this present review addressed the question: what is the impact of long-term  
12  
13 conditions on labour market participation among women? It adopted a definition of a long-term  
14  
15 condition (LTC) as one lasting over a year and having no cure although it may be managed by  
16  
17 medication or other techniques. The condition may be physical but long-term mental health  
18  
19 problems can also be described in this way, or as a disability. The 2011 Census used another term,  
20  
21 referring to limiting long-term illness as a measure of health and measured this by asking 'Are your  
22  
23 day-to-day activities limited because of a health problem or disability which has lasted, or is  
24  
25 expected to last, at least 12 months?' (Becares 2013).  
26  
27  
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29  
30 This present review considered illustrative LTCs singly and in combination (sometimes referred to as  
31  
32 multiple LTCs or multi-morbidity (the term 'chronic' was previously often used to describe them).  
33

34  
35 There is a vast literature on LTCs which is not surprising as they are estimated to affect over 26  
36  
37 million people in England (NHS England 2018) taking 50% of all GP appointments. Of those with  
38  
39 more than one LTC, estimated numbers range from 10 million (NHS England 2018) to 14.2 million  
40  
41 (Stafford et al 2018). This present review considered key policy documents and materials related to  
42  
43 older women and labour market engagement in context of English government policy-making in  
44  
45 LTCs (health policy is a devolved governmental responsibility in the UK) accessing documents  
46  
47 through internet searching (desk-top research).  
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49

### 50 **Women in the labour force**

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52  
53 Participation by women in the global labour force prior to the pandemic was recently collected by  
54  
55 Ortiz-Ospina and Tzvetkova (2017) who noted that '*The rise in female labor force participation has*  
56  
57 *been one of the most notable economic developments of the past century. In many countries, this*  
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1  
2  
3 *change has been driven by the large and sustained increase in married women's labor force*  
4 *participation'*. In the United Kingdom (UK) a House of Commons briefing paper (Powell 2019)  
5  
6 reported that UK women's employment rate stood at a record high at 71.4%, compared to 80.3% for  
7  
8 men. Of the 15.3 million women aged 16 in employment in the period October-December 2018, 9  
10  
11 million were working full-time and 6.3 million part-time. Explanations for these rising trends of  
12  
13 female employment were detailed by Roantree and Vira (2018) who linked them to alterations in  
14  
15 working patterns, for example, return to work after the birth of a first child, higher work  
16  
17 participation among wives of higher paid men, and far more women being in work in their mid-to-  
18  
19 late 20s and early 30s. Interestingly, this data synthesis (which concentrates on the 'prime' labour  
20  
21 market age range of 25-54) reported London as an outlier in that in 2017 74% of women in London  
22  
23 were employed making it the joint-lowest in the UK, together with Northern Ireland, compared to a  
24  
25 national average of 78%. For London, they ascribe this to different work patterns among some  
26  
27 minority ethnic communities. However, as the TUC (2013) commented, observations about work do  
28  
29 not always include women in later life and the participation of women over 55 is of particular  
30  
31 interest to human services work such as health and social care where there are many vacancies.

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36  
37 LTCs are often disabling so employment participation among disabled people provides an important  
38  
39 backcloth to thinking about women with LTCs in work. There is considerable overlap between LTCs  
40  
41 and disability, although some work on employment and disability concentrates on younger people  
42  
43 and entry to the labour market. The Equality and Human Rights Commission (2017) recently  
44  
45 reported that disabled people across Britain are less likely to be in employment than non-disabled  
46  
47 peers, noting that non-disabled people (35%) are more likely than disabled people (18%) to get a job  
48  
49 on the Work Programme; the disability pay gap in Britain continues to widen; disabled young people  
50  
51 (age 16-24) and disabled women have the lowest median hourly earnings, and very low numbers of  
52  
53 disabled people are taking up apprenticeships. Disadvantages may therefore start early in working  
54  
55 life. The next section points to some findings about LTCs' effects on working lives, starting with a  
56  
57 consideration of their impact on female sickness absences.  
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## Sickness at work

The Office for National Statistics (ONS) (2018) collects national data on sickness absence; it reported that:

The groups with the highest rates of sickness absence in 2018 were women, older workers, those with long-term health conditions, people working part-time, and those working in organisations with 500 or more employees.

However, the same report also observed:

The groups with the greatest reduction in sickness absence rates between 1997 and 2018 are workers with long-term health conditions, workers aged 50 to 64 years, and those in the public sector.

The total number of days lost through sickness absence has remained largely unchanged since 2010 but the sickness absence rate for women remains higher than for men. Indeed, sickness absence rates have been falling among men more than women since 1995, although rates for both are falling. Relevant to gender, in terms of occupation, workers in caring, leisure and other service occupations have the highest sickness absence rates and these are likely to be female dominated. However, the four main reasons given for sickness absence (in terms of the percentage of its occurrence) are described by ONS as being fairly consistent for both sexes in 2018 and consist of:

- minor illnesses (coughs, colds, flu) (36.5% for men; 33.3% for women)
- musculoskeletal problems (eg back pain, neck and upper limb problems) (18.5% for men; 14.2% for women)
- other conditions (including accidents, poisonings, and diabetes) (13.3% for men; 12.6% for women)
- mental health conditions (including stress, depression and anxiety) (8.5% for men; 8.8% for women)

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Sickness absence rates are higher for older workers and lower in London (followed by Northern Ireland) than in other regions of the UK. The ONS attributed regional variations to differing worker age profiles and occupations across the UK. However, it also observed that: *'The gap between sickness absence rates for workers who report having a long-term health condition and those who do not is narrowing'*.

While having a LTC is not necessarily the reason for the sickness absences reported by the ONS (2018), unsurprisingly sickness absence rates are higher among workers with a LTC than those who do not. The ONS reported that:

The sickness absence rate for those with a long-term health condition was 4.4% in 2018, compared with 1.1% for those without such a condition. The latter was the lowest rate since records began in 1997. However, the sickness absence rate for people who suffer from a long-term health condition increased by 0.5 percentage points in 2018 from the record low of 3.9% in 2017.

The Centre for Ageing Better (2018) argued that support for workers with LTCs was highly relevant to older workers and necessitated specific governmental and employer action; it observed:

The slower onset and unseen nature of many of the conditions older workers develop mean they are far too frequently overlooked and left unaddressed, with disastrous consequences for people's health and ability to work (p. 24).

The next section explores some specific LTCs to illustrate their particular impacts and possible policy options followed by observations from studies that focussed on a variety of conditions. They are organised under headings of musculo-skeletal, respiratory, neurological and metabolic, although, as noted LTCs, these may be experienced in combination.

### **Working with specific or multiple LTCs**



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3 A report from the Work Foundation (Bajorek et al 2016) examined the various employment  
4 problems facing people with one of six conditions: psoriasis, diabetic macular oedema (DMO),  
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A report from the Work Foundation (Bajorek et al 2016) examined the various employment problems facing people with one of six conditions: psoriasis, diabetic macular oedema (DMO), asthma, schizophrenia, heart failure and multiple sclerosis (MS) but did not investigate by gender. It noted however that men are 60% more likely to have heart failure than women, and women are almost three times more likely than men to experience MS. This observation points to the importance of considering gender as well as other personal characteristics.

However, it is also important to consider if people with LTCs are in work. From the Netherlands, Boot et al (2016) drew on a three-year longitudinal survey and a small number (14) of interviews with older (58–65 years) workers who had one of three different chronic diseases: depression, cardiovascular disease, and osteoarthritis. Common factors important for work participation among these groups were: working at baseline (having a job previously); being male; lower age; having partner in paid work; better physical and mental health; and higher 'mastery' scores.

Majeed et al (2015) found that women with chronic diseases (diabetes, asthma, depression, and arthritis) were less likely to be in paid work than their peers. This study drew on a large study of middle-aged women from the 1946-1951 birth cohort Australian Longitudinal Study on Women's Health. In another paper drawing on a middle-aged cohort data set, Majeed et al (2017) reported that the odds of "mostly full-time work" were lower for men reporting depression or arthritis, whereas, among women, depression was associated with "increasing part-time work" after adjusting for early and adult life factors. They highlighted the importance of gender focused policies that could promote and preserve the health of young and middle-aged workers and the creation of supportive environments for people with chronic health problems over the life course.

## **Musculoskeletal conditions**

### ***Osteoarthritis, arthritis and others***

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3 Some LTCs are more often experienced by women. According to the World Health Organisation  
4  
5 (2019), 'musculoskeletal conditions are the leading contributor to disability worldwide, with low  
6  
7 back pain being the single leading cause of disability globally' and contribute to early retirement.  
8  
9 LeResche (2011), among many others, reported that 'the prevalence rates of most musculoskeletal  
10  
11 pain conditions are higher among women than men'. In addition to concerns about unemployment  
12  
13 among people with musculoskeletal conditions, Walker-Bone and Black (2016) suggested a need to  
14  
15 develop new measures of presenteeism that more accurately reflect impairment of productivity due  
16  
17 to musculoskeletal disorders to incentivise employers and governments to invest resources in  
18  
19 enabling people with musculoskeletal disorders to remain in work. Moreover, as the population ages  
20  
21 and people are expected to lead longer working lives, a greater proportion of the working  
22  
23 population will have musculoskeletal conditions (p. 5). Arthritis Research UK (2016) reported that  
24  
25 back pain alone costs the economy an estimated £10 billion annually.  
26  
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29  
30 A recent conference abstract reported the findings of a systematic review of the impact of  
31  
32 osteoarthritis (OA) on work participation (Secchie et al 2018); this located 22 relevant studies that  
33  
34 concluded that working people with OA experience employment instability due to pain, reduced  
35  
36 physical functioning, activity limitation, and lack of co-worker and workplace support, placing them  
37  
38 at increased risk of 'work disability'. Of interest from the US is a study that reported young adults  
39  
40 with arthritis may start work earlier than their non-disabled peers and may be less likely to  
41  
42 participate in education (Jetha et al 2017), indicating the importance of work opportunities as well  
43  
44 as work participation alone.  
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## 49 **Respiratory diseases**

### 50 ***COPD (Chronic obstructive pulmonary disease)***

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52 As an example of respiratory disease, COPD is increasingly prevalent among women, although rates  
53  
54 are low among people aged 45 years and under but rise with age. Rai et al (2017) reported findings  
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56 from the Birmingham COPD Cohort about the factors associated with the likelihood of people with  
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3 COPD being in paid employment. This was the first study to comprehensively assess the  
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5 characteristics associated with employment in a community sample of people with COPD. Of the 608  
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7 members of the cohort of working age, 248 were in employment of whom 147 (42.9%) were men  
8  
9 and 101 (38.3%) were female. Rather than gender the factors associated with reduced probability of  
10  
11 being in work were being older, having a lower educational level, worse breathlessness, and high  
12  
13 occupational exposures to workplace vapours, gases, dusts, or fumes (VGDF). The researchers found  
14  
15 that the level or type of symptoms of COPD affected employment participation, with breathlessness  
16  
17 being one such symptom that could perhaps be better controlled by self-management, smoking  
18  
19 cessation and treatment. Interestingly they pointed to aspects of employment that could be  
20  
21 modified, including reducing occupational exposures to VGDF, concluding:  
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26 Therefore, health care professionals have a role to work alongside patients and focus on  
27  
28 improving the management of their breathlessness, in particular among the working age  
29  
30 population. Within the workplace, patients (alone or in conjunction with their employer)  
31  
32 may want to consider modifying aspects of their job, which may otherwise exacerbate their  
33  
34 breathlessness, for example, carrying heavy loads, regular use of stairs, or tasks that involve  
35  
36 lifting and bending. (page 240)  
37  
38  
39

40  
41 In a further analysis of this same data, Rai et al (2017) also found that increasing breathlessness  
42  
43 (dyspnoea) was associated with taking more days off work sick and with presenteeism (poorer work  
44  
45 performance).  
46  
47

### 48 ***Asthma***

49  
50 Zein and Erzurum (2015) found asthma presents differently in women in terms of its incidence,  
51  
52 prevalence and severity, after about the age of 14 years/puberty. They cited studies indicating that  
53  
54 possible different workplace exposures between men and women when at work. In a US study of  
55  
56 8239 people with confirmed work-related asthma cases, 60% were female (White et al 2015). In this  
57  
58 study women with possible work-related asthma seemed to be affected by the presence of  
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3 miscellaneous chemicals (20.3%), cleaning materials (15.3%), and/or indoor air pollutants (14.9%)  
4  
5 which are items often found in healthcare, educational services, retail trade, and education jobs. The  
6  
7 authors cautioned that these findings may not be generalisable but they do indicate the importance  
8  
9 of seeing women's workplaces as worth investigating for their possible cause or exacerbation of  
10  
11 problems.  
12

## 13 14 15 **Neurological and mental health disorders**

### 16 17 18 ***Multiple Sclerosis (MS)***

19  
20  
21 As with several other autoimmune diseases, MS affects more women than men (Habro et 2013).  
22  
23 Nearly four times as many women than men have MS and a US survey of 1248 women with MS  
24  
25 (Working Mother Research Institute 2015) found many worried about being able to continue  
26  
27 working with MS. Of those in work, 60% reported trying to hide their symptoms. In a literature  
28  
29 review Bevan and Steadman (2015) reported how the symptoms of MS affected employment  
30  
31 participation but did not link to any gendered factors. They noted the presence and possible impact  
32  
33 of symptoms such as:  
34  
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- 36  
37 • Fatigue, anxiety and depression affecting work patterns and ability to concentrate;
- 38  
39 • Pain and heat intolerance affecting interactions and comfort with the work environment;
- 40  
41 • Limitations in mobility place restrictions on physical access to work environment;
- 42  
43 • Reduced dexterity complicates handwriting, working on a keyboard, performing manual  
44  
45 tasks;
- 46  
47 • Slurred speech impacts communication, use of phone and presentation skills;
- 48  
49 • Urinary and faecal frequency and urgency with fear of incontinence presents emotional  
50  
51 challenges;
- 52  
53 • Visual impairment affects reading;
- 54  
55 • Cognitive impairment causing memory and concentration difficulties. (page 10)
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3 While employment participation is linked to the severity of MS symptoms, another review by  
4  
5 Vijayasingham and Mairami (2018) concluded that little is known about whether gender predicts or  
6  
7 determines employment among people living with MS. Overall they proposed that:  
8  
9

10 To achieve better work outcomes in MS patients, there is a need to equip them with early  
11  
12 assessment, advice and resources to manage their work futures. Health care providers  
13  
14 should consider the benefits of encouraging continued employment and the psychological  
15  
16 impact of nonemployment.  
17  
18

### 19 ***Mental health problems***

20  
21  
22 Women's experience of mental health problems can affect their employment and employment can  
23  
24 affect mental health. The Mental Health Foundation (n/d) cited evidence that women in full-time  
25  
26 employment are nearly twice as likely to have a common mental health problem as full-time  
27  
28 employed men. According to the World Health Organisation (WHO):  
29  
30

31  
32 Gender differences occur particularly in the rates of common mental disorders - depression, anxiety  
33  
34 and somatic complaints. These disorders, in which women predominate, affect approximately 1 in 3  
35  
36 people in the community and constitute a serious public health problem ...There are no marked  
37  
38 gender differences in the rates of severe mental disorders like schizophrenia and bipolar disorder  
39  
40 that affect less than 2% of the population. Gender differences have been reported in age of onset of  
41  
42 symptoms, frequency of psychotic symptoms, course of these disorders, social adjustment and long  
43  
44 term outcome. The disability associated with mental illness falls most heavily on those who  
45  
46 experience three or more comorbid disorders. Again, women predominate.  
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50  
51 As with the approach developed by the Department of Health and Social Care's (2018) Mental  
52  
53 Health Taskforce, the WHO recommended formulation and implementation of health policies that  
54  
55 address women's needs and concerns from childhood to old age in relation to mental health. It  
56  
57 noted the need promote effective responses within primary healthcare so it can recognise and treat  
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3 the mental health consequences of domestic violence, sexual abuse, and acute and chronic stress  
4  
5 among women.  
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8 A recent UK paper (Weston et al 2019) reported on the possible association of long work hours,  
9  
10 weekend working and depressive symptoms in a large nationally representative sample of working  
11  
12 men and women. They found: 'increased depressive symptoms were independently linked to  
13  
14 working extra-long hours for women, whereas increased depressive symptoms were associated with  
15  
16 working weekends for both genders, suggesting these work patterns may contribute to worse  
17  
18 mental health'. A commentary from the NHS (2019) cautioned that this should not be interpreted as  
19  
20 meaning that women who "overwork" are more likely to be depressed, contending: 'The study  
21  
22 cannot prove beyond doubt that long working hours are to blame for the reported higher levels of  
23  
24 depression symptoms'.  
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### 29 **Metabolic disease or syndromes**

#### 30 ***Diabetes***

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32 Slightly higher proportions of adult men (56%) than women (44%) have the metabolic syndrome of  
33  
34 diabetes (Diabetes UK 2020). In the major Whitehall II study, psychosocial work stress was linked to  
35  
36 higher risk of type 2 diabetes (T2DM), with the effect being consistently higher among women than  
37  
38 men. Among women, work stress was associated with higher risk of T2DM among obese people but  
39  
40 not in the non-obese. The researchers concluded that 'gender and body weight status play a critical  
41  
42 role in determining the direction of the association between psychosocial stress and T2DM'  
43  
44 (Heraclides et al 2012). Not just confined to diabetes risks are findings that suggest that increased  
45  
46 sedentary (sitting) time at work is potentially harmful, with Kazi et al (2014) recommending  
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48 workplace health interventions should be developed to reduce sitting times.  
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#### 55 ***Lupus***

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3 The impact of LTCs on work is also felt personally. As one example of research on metabolic disease  
4 that has focussed on work experiences, lupus (systemic lupus erythematosus (SLE)) is a rare but  
5 chronic, autoimmune disease or condition that affects more women than men (Pons-Estel, et al  
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9  
10 2017). A recent UK online survey of people with lupus seeking their employment experiences was  
11 completed by 393 people, of whom 97% were women (Booth et al 2018). It found evidence of the  
12 difficulties of working (and of career damage) with a fluctuating LTC such as lupus; participants  
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14  
15 reported fear and anxiety were overshadowing their work and family life; but some felt they could  
16 remain in part- or full-time employment if working patterns could be modified and managerial and  
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19 collegiate support was available. This paper offered several suggestions such as providing more  
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21  
22 information to employers about the condition, and early intervention to help newly diagnosed  
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24  
25 people to sustain their roles in education or employment, adding:

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28 Supporting individuals to combine some work with benefits may enable people to increase their  
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31 work, income and tax receipts at a point when their condition allows, but receive the necessary  
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33  
34 financial support when it does not. Current approaches seem predicated on a binary condition of  
35  
36  
37 health and a constant, quantifiable level of disability, which can be overcome with a piece of  
38  
39  
40 equipment or simple change in a work schedule (p. 2289).

### 41 **The Menopause**

42  
43 Finally, the subjects of menopause and urinary incontinence are mentioned, for while the  
44  
45  
46 menopause is not itself a LTC, the menopause for some women is typically a transition of four to  
47  
48  
49 eight years. It may be relevant to health and employment strategies but is often under-recognised.

50 Griffiths et al (2013) surveyed 896 UK women undertaking non-manual jobs. They reported:

51  
52  
53 Menopausal transition caused difficulties for some women at work. The most problematic  
54  
55  
56 symptoms were: poor concentration, tiredness, poor memory, feeling low/depressed and  
57  
58  
59 lowered confidence. Hot flushes were particularly difficult. Some women felt work  
60  
performance had been negatively affected. The majority of women were unwilling to

1  
2  
3 disclose menopause-related health problems to line managers, most of whom were men or  
4  
5 younger than them. (page 155)  
6  
7

8 A follow up brief awareness training programme for UK managers (Hardy et al 2019) was recently  
9  
10 tested. It was found to be 'a feasible and effective way to help managers become more  
11  
12 knowledgeable about menopause-related problems and more confident in discussing and exploring  
13  
14 solutions with their staff'.  
15  
16

17  
18 Urinary incontinence

19  
20 A recent Australian study reported urinary incontinence (UI) to be a condition of high prevalence and  
21  
22 significant severity among female nurses and midwives: 'In this workforce, severe UI was associated  
23  
24 with intentions related to future employment' (Pierce et al 2017). A systematic review and meta-  
25  
26 analysis found that lower urinary tract symptoms (LUTS) were significantly associated with work  
27  
28 productivity loss, presenteeism, and activity impairment but found 'no significant difference in the  
29  
30 probability of absenteeism between females with and without LUTS' (Lin et al 2018). This subject is  
31  
32 not often referred to in the wider LTC literature.  
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### 36 37 **Discussion and Conclusion**

38  
39 This rapid review has identified some of the impacts of LTCs in affecting labour market participation  
40  
41 among women. Not all the studies accessed contain detailed information relevant to gender or make  
42  
43 observations about differences related to it that might steer policy development. Reasons for leaving  
44  
45 work were not clear in many studies but there were indications of the pressing need for employers,  
46  
47 health services and the government policy makers to not only consider the impact of LTCs and make  
48  
49 adjustments for individuals but also to change work environments, attitudes and practices. Such  
50  
51 imperatives are likely to continue following the height of the Covid-19 pandemic.  
52  
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55  
56 The rapid time scale of the review means that there are limitations on its inclusiveness and some  
57  
58 LTCs are used as illustrative of the evidence about gendered dimensions while other LTCs are not  
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1  
2  
3 addressed. However, it provides illustrative examples of the wide range of studies underway and the  
4  
5 underlines the need to collect gender detail but also other demographic information including  
6  
7 educational and work histories where relevant. UK statistics are helpful in reporting employment  
8  
9 data, sickness absences and disability but there will likely be regional and local variations.  
10  
11

12  
13 There is general awareness that as the workforce is ageing, then LTCs associated with ageing may  
14  
15 need to be addressed more prominently. Gender is an important factor to consider in terms of  
16  
17 different individual experiences and risks of LTCs but there is also the gendered nature of  
18  
19 employment and the differential risks of employment settings and practices. Future research will  
20  
21 need to explore new employment patterns in the context of Covid-19 but also arrangements such as  
22  
23 zero-hours contracts, shift working, IT work, hot-desking and other changes in working environments  
24  
25 which impact on women's health and wellbeing and decisions about employment participation.  
26  
27 Future research will also need to be more careful about including people of different ethnicities  
28  
29 since these variations were not always reported. The 2011 Census found that among older UK  
30  
31 women, those from Pakistani, Bangladeshi and White Gypsy or Irish Traveller, Arab and Indian,  
32  
33 groups had of their elderly populations had a limiting long-term illness or LTC compared to the total  
34  
35 female older population with Chinese older women being an exception (Benares 2013). Such  
36  
37 differences require greater inclusivity in research to better inform policy developments.  
38  
39  
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41

42  
43 The relevance of societal ageing to the labour market suggests a need to look both at how  
44  
45 organisational policies and individual factors affect individuals' decisions about working in later life,  
46  
47 particularly if individuals are experiencing ill-health or need to leave the labour force to care for  
48  
49 others, since family caregiving is still often undertaken by women. Older workers may have a  
50  
51 particularly valuable role in supporting societal recovery and renewal following Covid-19 (Centre for  
52  
53 Ageing Better 2020), bringing with them experiences and skills. Recruitment practices are being  
54  
55 encouraged to be anti-ageist in this context (Centre for Better Ageing 2021). Policy change may  
56  
57 involve the building up of age-inclusive professional and organisational cultures, age-positive Human  
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3 Resource Management, support from line managers, fair working conditions, and the ability to  
4  
5 manage health and wellbeing, to meet government ambitions to extend working lives (McFadden et  
6  
7 al 2020) and different models should be developed and tested for people with LTCs who are part of  
8  
9 the older workforce.  
10  
11  
12

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