
Original Article

Institutional and Individual Factors Affecting Health and Employment for 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 aged 55 and older. Qualitative data were analyzed using thematic analysis.

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: Working conditions can degrade health through exposure to mental and physical health risks, or support health through access to financial and interpersonal resources. Institutional supports such as workplace flexibility and retraining are crucial to obtaining a good fit between occupational demands and the capacity of individuals, enabling 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.

Keywords: Ageism, Chronic disease, Disability, Flexible work

Employment in later life can ensure the economic well-being of older adults (Munnell & Sass, 2008), as well as bolster cognitive (Andel, Kåreholt, Parker, Thorslund, & Gatz, 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 physically demanding occupations (Gonzales, Matz-Costa, & Morrow-Howell, 2015). The purpose of this qualitative study is to give voice to a group of older women with

chronic health conditions enrolled in a federally funded program, the Senior Community Service Employment Program (SCSEP), enabling them to describe risk and protective factors that influence their work and health.

Women's Employment, Health, and Poverty

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 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 life span 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 life span (Calasanti, 2010; Carr, 2010; Gonzales, Lee, & Brown, 2017; Torres, 2014). Women earn less than men in the same occupations, and work in female-dominated fields pays lower wages (Hegewisch, Liepmann, Hayes, & Hartmann, 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). Women living alone are 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 (United States Census, 2016).

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 Disease 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, Kawachi, & Theorell, 2014).

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. Eight out of 10 older workers reported experiencing workplace discrimination at least once in the previous year (Chou & Choi, 2011) and perceived age discrimination at work was strongly associated with depression, declined self-rated health, and job dissatisfaction (Gonzales, Lee, Padula, & Jung, 2018; Marchiondo, Gonzales, & Williams, 2019). Scientists (Gonzales et al., 2018; Harris, Krygsman, Waschenko, & Rudman, 2017; Marchiondo et al., 2019; Marchiondo, Gonzales, & Ran, 2015) have called for a more nuanced understanding of how older workers manage the experience of discrimination in the workplace and internalized ageist beliefs. The presence of disability may compound age-based discrimination: 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).

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.

Method

Data Sources

We performed secondary data analysis of 14 intensive qualitative interviews with low-income older women participating in a federal training and employment program, the SCSEP. The Boston University institutional review board 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 aged 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 14 interviews are from a larger data set consisting of 26 interviews with both male and female participants. The research team contacted program directors in selected areas to recruit participants in confidential and anonymous semi-structured interviews. The second, third, and fourth authors conducted one-on-one interviews, which lasted between 1 and 2 hr. Interviews were audio-recorded and transcribed verbatim. The second, third, and fourth authors examined the original data set of 26 interviews using a

content analysis approach to produce a final report. The original analysis highlighted that individuals with many protective factors (e.g., stable work histories in white-collar jobs, long-standing marriages) are still at risk of poverty, unemployment, and homelessness. Key patterns around gender, health, and work emerged that required additional analysis, in order to better understand the risk and protective factors specific to a more vulnerable subset: women (who largely lacked certain protective factors such as long-standing marriages), and who had additional potential risks (chronic health conditions). The original study investigated the fluidity of health with an emphasis on employment and health outcomes, whereas the secondary analysis examined how health affects employment.

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. More than 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 secondary data 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 authors 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 first within and across the 14 interview transcripts, and next with codes that the second, third, and fourth authors identified for the original study, to identify and revise initial themes the subsample participants discussed as affecting their work and health. Once themes were agreed upon as a team, we loaded the data set into NVivo qualitative software to code for finalized themes within the context of original transcripts. This iterative process ensured the validity and reliability of the results, and the authors utilized participants' words verbatim within this article to provide evidence of theme validity. Our collaborative analysis highlighted areas of significant agreement between the original and the secondary analyses, while also uncovering themes unique to low-income women with chronic health conditions.

Results

We identified five themes, 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.

Table 1. Participant Demographics

Pseudonym	Age	Race/ethnicity	Education	Marital status	Living alone
Mary	58	Black/African American	Associate's degree	Divorced	Yes
Linda	61	Black/African American	High school diploma/GED	Divorced	Yes
Patricia	57	White	Some college	Single	Yes
Deborah	61	Black/African American	Some college	Divorced	No
Karen	62	White and Native American	High school diploma/GED	Divorced	No
Nancy	65	Black and Native American	4 year degree	Divorced	Yes
Donna	61	Black/African American	Some college	Divorced	No
Cynthia	63	Black/African American	Less than high school	Single	No
Sandra	61	Black/African American	4 year degree	Divorced	Yes
Susan	74	White	Some college	Divorced	Yes
Pamela	65	White	4 year degree	Divorced	Yes
Carol	67	White	Some college	Widowed	Yes
Diane	81	White	4 year degree	Divorced	Yes
Janet	68	White	Associate's degree	Single	Yes

Note: GED = General Education Diploma.

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. When physically demanding work was the majority of participants' occupational experience, they lacked 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

Risk Factors: Discrimination

Participants faced overt and subtle forms of discrimination by employers, through failure to provide appropriate accommodations after the onset of illness/disability, firing 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, further jeopardizing employment because the employer was unable or unwilling to provide accommodations. Deborah described how her retail work involved lifting heavy boxes, exacerbating chronic pain from an on-the-job injury that occurred in her past work as a custodian. She used up most of her 10 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

Carol, a widowed 67-year-old White woman with some years of college, had significant hearing loss after recovering from bacterial meningitis. Both of her jobs at the time "involved dealing with people on the phone and coming in 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. Carol expressed fear that this lack of needed accommodations would occur again as she pursued reemployment. She indicated that enrolling in the 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:

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 imposed further risks to her health. The risk-accumulating domino effect of work loss was 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

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 indicated that she enrolled in the training and employment program because "it is kind of hard to find anything at my age." 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 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 affected 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

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-hr work week a good fit. Patricia, a 57-year-old single White woman with some years of college, reported:

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

Patricia was 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 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.

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

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.

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 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. 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

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

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

This study enhances our 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. Work environments proved relevant as both risk and protective factors for study participants, demonstrating how working conditions can increase inequity 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.

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. 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](#)).

Our findings add to the quantitative literature on job quality ([Berkman et al., 2014](#); [Welsh et al., 2016](#)) 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). 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. 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.

Participants described 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. The majority of the women were divorced and living alone, and more than 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.

We were surprised not to hear of race-based discrimination among this sample of women. Evidence stemming from selective incivility theory (Cortina, Kabat-Farr, Leskinen, Huerta, & Magley, 2011) suggested that women of color experienced worse treatment within workplaces, among a relatively young sample of employees. 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 (Gonzales et al., 2018). It may be that our participants' experiences of overt bias due to age and ability lead to a myopic focus on age as a determinant of employment. Participants explicitly identified age- and ability-related discrimination as risk factors. Several of the women 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 (Harootyan & Sarmiento, 2011; Sum, Khatiwada, & Trubsky, 2011).

De-accumulation and halting are key concepts in 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 in 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 affect 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

Existing legislation intended to safeguard workers against age discrimination and ensure accommodation in the case of disability and/or compromised health includes 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, employers are not always compliant with the law. 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 cause of discrimination in an employment decision, proof of which may be difficult to provide (Gonzales et al., 2017). 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.

Workplace flexibility policies may improve outcomes for both employers and employees alike, by reducing turnover (Moen, Kelly, & Hill, 2011), aiding recruitment (Richman, Burrus, Baxbaum, Shannon, & Yai, 2009), and decreasing absences due to ill health and reductions in work-related impairments over time (Casey & Grzywacz, 2008). Case studies of multinational corporations have investigated the implementation of workplace flexibility policies for lower

waged, hourly workers, with strategies that enhanced employee control over their schedules (Richman et al., 2009). 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 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).

This qualitative study has highlighted SCSEP’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 that 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 (Anderson, Richardson, Fields, & Harootyan, 2013; Johnson et al., 2007). This study also highlights the association between employment and 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 (Department of Labor, 2018). The survey’s mental health results ($N = 11,673$) were encouraging, with 47% reporting their outlook on life was “much more positive,” 26% “a little more positive,” and 20% “about the same.” (Department of Labor, 2018). Our findings provide insight into this quantitative data by illustrating one pathway through which reengagement in supportive employment may improve mental health—by counteracting ageist stereotypes and improving self-esteem. Future mixed methods or longitudinal research should aim to examine further the physical, cognitive, psychosocial health or labor force preferences of SCSEP participants.

Limitations

This convenience sample of volunteer interviewees is not representative of all low-income older women with chronic

health conditions. 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 in order 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, whereas workplace accommodations and flexibility, access to retraining or other work-supportive resources, and high-quality work itself were discussed as protective factors. 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. 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).

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Conflict of Interest

None reported.

Author Contributions

E. Gonzales and R. Harootyan were the principal investigators on this study. K. Lee, E. Gonzales, and R. Harootyan led data collection. K. Carolan led secondary data analysis for this study, with E. Gonzales, K. Lee, and R. Harootyan. All authors contributed to the article and revisions. K. Carolan led the writing of the initial manuscript and revisions, with E. Gonzales contributing especially to the background, theoretical framework, and policy implications; K. Lee to the Methods, Results, and Discussion section; and R. Harootyan to the policy implications.

References

- Andel, R., Kåreholt, I., Parker, M. G., Thorslund, M., & Gatz, M. (2007). Complexity of primary lifetime occupation and cognition in advanced old age. *Journal of Aging and Health, 19*, 397–415. doi:10.1177/0898264307300171
- Anderson, K. A., Richardson, V. E., Fields, N. L., & Harootyan, R. A. (2013). Inclusion or exclusion? Exploring barriers to employment for low-income older adults. *Journal of Gerontological Social Work, 56*, 318–334. doi:10.1080/01634372.2013.777006
- Autor, D. H., & Duggan, M. (2010). *Supporting work: A proposal to modernize the U.S. disability insurance system*. Washington, DC: Center for American Progress and the Hamilton Project.
- Berkman, L. F., Kawachi, I., & Theorell, T. (2014). Working conditions and health. In L. F. Berkman, I. Kawachi, & M. M. Glymour (Eds.), *Social epidemiology* (2nd ed., pp. 153–181). New York, NY: Oxford University Press. doi:10.1093/med/9780195377903.003.0005
- Blinder, V., Eberle, C., Patil, S., Gany, F. M., & Bradley, C. J. (2017). Women with breast cancer who work for accommodating employers more likely to retain jobs after treatment. *Health affairs (Project Hope), 36*, 274–281. doi:10.1377/hlthaff.2016.1196
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77–101. doi:10.1191/1478088706qp063oa
- Calasanti, T. (2010). Gender relations and applied research on aging. *The Gerontologist, 50*, 720–734. doi:10.1093/geront/gnq085
- Carr, D. (2010). Golden years? Poverty among older Americans. *Contexts, 9*, 62–63. doi:10.1525/ctx.2010.9.1.62
- Casey, P., & Grzywacz, J. (2008). Employee health and well-being: The role of flexibility and work-family balance. *The Psychologist-Manager Journal, 11*, 31–47. doi:10.1080/10887150801963885
- Centers for Disease Control and Prevention. (2017). *Chronic disease overview*. Atlanta, Georgia: Center for Disease Control and Prevention.
- Chou, R., & Choi, N. (2011). Prevalence and correlates of perceived workplace discrimination among older workers in the United States of America. *Ageing and Society, 31*, 1051–1070. doi:10.1017/s0144686x10001297
- Chrisler, J., Rossini, M., & Newton, J. (2015). Older women, power and the body. In V. Muhlbauer, J. Chrisler, & F. Denmark (Eds.), *Women and aging: An international, intersectional power perspective* (pp. 9–30). New York, NY: Springer. doi:10.1007/978-3-319-09306-2_2
- Christian, J. (2015). *Establishing accountability to reduce job loss after injury or illness*. Washington, DC: Mathematica Policy Research.
- Cortina, L. M., Kabat-Farr, D., Leskinen, E. A., Huerta, M., & Magley, V. J. (2011). Selective incivility as modern discrimination in organizations: Evidence and impact. *Journal of Management, 39*, 1579–1605. doi: 10.1177/0149206311418835
- Department of Labor. (2018). *PY2017 Participant Evaluation of SCSEP*. Washington, DC: United States Department of Labor, Employment and Training Administration.
- Ferraro, K. F., & Morton, P. M. (2018). What do we mean by accumulation? Advancing conceptual precision for a core idea in gerontology. *The Journals of Gerontology, Series B: Psychological Sciences and Social Sciences, 73*, 269–278. doi:10.1093/geronb/gbv094
- Ferraro, K. F., & Shippee, T. P. (2009). Aging and cumulative inequality: How does inequality get under the skin? *The Gerontologist, 49*, 333–343. doi:10.1093/geront/gnp034
- Ferraro, K. F., Shippee, T. P., & Schafer, M. H. (2009). Cumulative inequality theory for research on aging and the life course. In V. L. Bengtson, D. Gans, N. M. Putney, & M. Silverstein (Eds.), *Handbook of theories of aging*, 2nd ed. New York, NY: Springer. doi:10.1017/s0144686x09990444
- Gonzales, E., Lee, Y., & Brown, C. (2017). Back to work? Not everyone. Examining the longitudinal relationships between informal caregiving and paid-work after formal retirement. *The Journals of Gerontology, Series B: Psychological Sciences and Social Sciences, 72*, 532–539. doi: 10.1093/geronb/gbv095
- Gonzales, E., Lee, J. Y., Padula, W. V., & Jung, L. S. (2018). *Exploring the consequences of discrimination and health for retirement by race and ethnicity: Results from the health and retirement study*. Chestnut Hill, MA: Center for Retirement Research at Boston College.
- Gonzales, E., Matz-Costa, C., & Morrow-Howell, N. (2015). Increasing opportunities for the productive engagement of older adults: A response to population aging. *The Gerontologist, 55*, 252–261. doi:10.1093/geront/gnu176
- Harootyan, B., & Sarmiento, T. (2011). The future for older workers: Good news or bad? *Public Policy & Aging Report, 21*, 3–10. doi:10.1093/ppar/21.1.3
- Harris, K., Krygsman, S., Waschenko, J., & Laliberte Rudman, D. (2018). Ageism and the older worker: A scoping review. *The Gerontologist, 58*, 1–14. doi:10.1093/geront/gnw194
- Hegewisch, A., Liepmann, H., Hayes, J., & Hartmann, H. (2010). *Briefing paper: Separate and not equal? Gender segregation in the labor market and the gender wage gap*. Washington, DC: Institute for Women's Policy Research. doi:10.1037/e686432011-001
- Herd, P. (2005). Reforming a breadwinner welfare state: Gender, race, class and social security reform. *Social Forces, 83*, 1365–1394. doi:10.1353/sof.2005.0067
- Hinze, S. W., Lin, J., & Andersson, T. E. (2012). Can we capture the intersections? Older Black women, education, and health. *Women's Health Issues: Official Publication of the Jacobs Institute of Women's Health, 22*, e91–e98. doi:10.1016/j.whi.2011.08.002
- Johnson, R. W., Mermin, G. B. T., & Resseger, M. (2007). *Employment at older ages and the changing nature of work (Report #2007–20)*. Washington, DC: Urban Institute.
- Katch, H., Wagner, J., & Aron-Dine, A. (2018). *Medicaid work requirements will reduce low-income families' access to care and worsen health outcomes*. Washington, DC: Center on Budget and Policy Priorities.
- Lahey, J. N. (2008). Age, women, and hiring: An experimental study. *Journal of Human Resources, 43*, 30–56. doi:10.1353/jhr.2008.0026
- Lee, Y., Tang, F., Kim, K. H., & Albert, S. M. (2015). The vicious cycle of parental caregiving and financial well-being: A longitudinal study of women. *The Journals of Gerontology, Series B: Psychological Sciences and Social Sciences, 70*, 425–431. doi:10.1093/geronb/gbu001

- Lips, H. (2018). Feminism, psychology, and the gender pay gap. In C. B. Travis, & J. W. White (Eds.), *APA handbook of the psychology of women: Vol. 1. History, theory, and battlegrounds* (pp. 417–433). Washington, DC: American Psychological Association. doi:10.1037/0000059-021
- Marchiondo, L., Gonzales, E., & Ran, S. (2015). Development and validation of the workplace age discrimination scale (WADS). *Journal of Business and Psychology*, *31*, 493–513. doi: 10.1007/s10869-015-9425-6
- Marchiondo, L. A., Gonzales, E., & Williams, L. J. (2019). Trajectories of perceived workplace age discrimination and long-term associations with mental, self-rated, and occupational health. *The Journals of Gerontology, Series B: Psychological Sciences and Social Sciences*, *74*, 655–663. doi:10.1093/geronb/gbx095
- Moen, P., Kelly, E. L., & Hill, R. (2011). Does enhancing work-time control and flexibility reduce turnover? A naturally occurring experiment. *Social Problems*, *58*, 69–98. doi:10.1525/sp.2011.58.1.69
- Morrow-Howell, N., Hinterlong, J., & Sherraden, M. (2001). *Productive aging: Concepts and challenges*. Baltimore, MD: Johns Hopkins University Press. doi:10.1353/book.3215
- Munnell, A. H., & Sass, S. A. (2008). *Working longer: The solution to the retirement income challenge*. Washington, DC: Brookings Institution Press. doi:10.1017/s1474747210000302
- Payne, S., & Doyal, L. (2010). Older women, work and health. *Occupational Medicine (Oxford, England)*, *60*, 172–177. doi:10.1093/occmed/kqq030
- Richman, A., Burrus, D., Buxbaum, L., Shannon, L., & Yai, Y. (2009). *Innovative workplace flexibility options for hourly workers*. Corporate Voices for Working Families.
- Staudinger, U., Finkelstein, R., Calvo, E., & Sivaramakrishnan, K. (2016). A global view on the effects of work on health in later life. *The Gerontologist*, *56* (Suppl 2), S281–S292. doi:10.1093/geront/gnw032
- Sum, A., Khatiwada, I., & Trubskyy, M. (2011). The labor market experiences and problems of America's low-income older workers in recent years. *Public Policy & Aging Report*, *21*, 18–28. doi: 10.1093/ppar/21.1.18
- Torres, S. (2014). Aging women, living poorer. *Contexts*, *13*, 72–74. doi:10.1177/1536504214533505
- United States Census Bureau. (2016). *Current population survey annual social and economic supplement (CPS-ASEC)*. Washington, DC: United States Census Bureau.
- Warner, D. F., & Brown, T. H. (2011). Understanding how race/ethnicity and gender define age-trajectories of disability: An intersectionality approach. *Social Science & Medicine (1982)*, *72*, 1236–1248. doi:10.1016/j.socscimed.2011.02.034
- Welsh, J., Strazdins, L., Charlesworth, S., Kulik, C. T., & Butterworth, P. (2016). Health or harm? A cohort study of the importance of job quality in extended workforce participation by older adults. *BMC Public Health*, *16*, 885. doi:10.1186/s12889-016-3478-y