POLICY HEALTH IMPACT ASSESSMENT FOR THE EUROPEAN UNION:
PILOT Health Impact Assessment of the European Employment Strategy in Ireland

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Executive Summary

A. Background
This pilot Health Impact Assessment (HIA) exercise was conducted as part of the 'Policy Health Impact Assessment for the European Union', commissioned by the European Commission 's Directorate Generale Health and Consumer Protection (DG Sanco). The project is coordinated by Liverpool University and the research partners are from Ireland, Germany and the Netherlands. The aim of the European project is to develop a HIA methodology for assessing the health impacts of EU policies and activities.

B. Methodology
The purpose of the pilot HIA in Ireland was to test the methodology produced in the first phase of the project in 2002. The policy chosen for assessment was the European Employment Strategy. The Irish pilot used a range of methods suggested in the draft methodology but concentrated particularly on the participatory aspects of HIA. A key stakeholder group with knowledge of employment (including decision makers in labour market policy) was established to provide expert advice and support. Other methods used included policy analysis, information gathering from key informants, community profiling (including demographic and labour force data), data analysis, literature review, the production of a report and the development of recommendations.

C. European Employment Strategy and National Policy Context
The European Employment Strategy (EES) was launched in 1997 to combat unemployment and promote the convergence of employment policies in Europe. It aims to produce long-term economic growth, full employment, social cohesion and sustainable development in a knowledge-based society. The EES is implemented through Employment Guidelines that are reviewed annually. Each member state draws up an annual National Employment Action Plan (NEAP) to enable these guidelines to be implemented nationally. The Irish government has a comprehensive labour programme organised around the pillars of European Employment Guidelines and this forms the basis of the Irish NEAP. This incorporates programmes for the unemployed, education and training (including infrastructure development), lifelong learning, equality programmes and technical assistance.

D. Focus of the Irish study
After consultation with stakeholders, it was decided to concentrate on a manageable number of areas in the EES of relevance in an Irish context. These were Active and Preventive measure for the Unemployed and supporting integration and combating discrimination in the labour market for people at a disadvantage.

E. Links between employment and health addressed in HIA
The negative or positive health impacts of employment do not fall equally on all sections of society and these health inequalities are highlighted throughout this report.

E.1 Unemployment and health impacts
Unemployment affects both physical and mental health and is a major determinant of morbidity and premature mortality. The anticipation of the loss of a job or job insecurity generally also have impacts on mental health, self-reported ill health and heart disease. Long-term unemployment is associated with socio-economic deprivation and the links between poverty and poor health are well established. People in poverty die younger, have less healthy lifestyles and live in less healthy environments. Unemployed people have lower levels of psychological well-being ranging from symptoms of depression and anxiety to self harm and suicide and are more prone to some forms of health damaging

behaviour, such as smoking and drinking. The loss of status and self-esteem associated with unemployment are also important determinants of health.

E.2 Physical and psychosocial environment of work and health impacts
The reduction of accidents in the workplace in Ireland following interventions by the Health and Safety Authority (HSA) has contributed improved the health of workers. However, there is also a social gradient in the incidence of workplace accidents. Also, the number of women injured in the workplace has risen by 50% since 1998. Exposure to physical hazards in the workplace and in conditions such as musculo-skeletal disorders and fatigue are on the increase in Europe. Some of this is due to intensification of work and flexible employment practices. The potential dangers to health include high-level noise, physically repetitive work, carrying of heavy loads and working in painful positions.

Psychosocial risks are associated with stress and according to the World Health Organisation "accumulate during life and increase the chances of poor mental health and premature death". Employment plays a large role in inducing stress and that this is manifested by feelings of irritability, general tiredness and exhaustion, difficulty sleeping, depression and others. Many deal with this stress by increasing alcohol intake.

Health tends to suffer where the demands of a job are high but the ability to control these demands are low. A study of British civil servants showed that men and women with low job control were nearly twice as likely to report a new coronary heart disease than other workers. A person in a 'high-strain' job without the appropriate coping skills or job autonomy may experience negative health impacts. But levels of autonomy are unequally distributed, with more skilled workers experiencing more control.

The pace of work that an individual is exposed to has potential health impacts. People who work at high speed report greater health problems such as backache, muscular pain, stress and fatigue. Intimidation in the workplace, including violence, bullying and sexual harassment will have a direct impact on mental and physical health.

Consultation, social support and information provision in the workplace helps to offset negative health impacts of working conditions and organisational change

E. 3 The flexible labour market and health impacts
International trends in employment are demanding greater labour market flexibility and this has led to an increase in different types of 'atypical' employment. Where flexibility is freely chosen to improve work/life balance health impacts are more likely to be positive. Where it is non-voluntary it is more likely the health impacts will be negative.

Low job security is associated with poor health. Self-reported health deteriorates when people are anticipating job loss. A study of British civil servants showed significant declines in health among those anticipating job change in a period of privatisation, particularly among workers in lower positions. Insecure jobs also involve higher than normal exposure to work hazards. European research shows that people on fixed term and temporary agency contracts reported overall higher levels of fatigue, show less satisfaction with their working conditions, are more exposed to carrying heavy loads and working in painful positions and have less control over aspects of their working life.
At the same time are less likely to be absent from work than permanent workers.

Temporary workers are more likely to be exposed to poor working conditions such as vibrations, loud noise and hazardous products. They are more likely to be carrying out repetitive work and work to tighter deadlines than permanent workers, although they are less likely to receive training to build coping skills.

Teleworking is often designed to enable a better work/life balance and to enable some sections of the population greater access to the labour market. However, some aspects of teleworking, including inferior ergonomics and working in isolation, may have negative health impacts.

E. 4 The impacts of work on personal life

Employment is a major determinant of how a person's life is patterned and these life patterns in turn may have an impact on the health both of the individual and their families and other dependents. A suitable work/life balance is a vital component of health and patterns that undermine such a balance will likely have negative health impacts. For example, long working hours have been linked with cardiovascular disease, diabetes, poor self-reported health and fatigue. Nightwork and shift work is associated with a number of negative health impacts such as chronic sleep disorder, increased incidence of cardiovascular disease and an increase in late-onset diabetes.
Increased commuting to work adds to an individual's stress, reduces physical exercise and will increase air pollution, accidents and environmental noise.

F. People with disabilities, employment and health

In Ireland, just over 23% of those with a long lasting health problem or disability aged 15 to 64 are at work, compared to 53.1% at work for the total population.
This exclusion will lead to a number of negative health impacts associated with unemployment, low income, job insecurity and lower status employment.
The stigma attached to people with disabilities in the workplace and the social isolation it causes has a negative impact on health. Undervaluing of their potential contribution in the workplace can lower self-esteem and consequently affect health.

G. Older workers, employment and health

Increased participation of older people in the workforce is a central aim of the European Employment Strategy. Demographic ageing in Ireland is less marked than in other EU member states but this is likely to change over the next thirty years.

Older people will usually find it more difficult to withstand the negative health impacts of unemployment. A large proportion of older unemployed people will be suffering illness or disability before a job loss and the stress of unemployment may exacerbate this. A study in Britain showed that men who became unemployed or retired (regardless of previous health) were more likely to die than men who remained continuously employed. Older workers are more vulnerable to the negative health impacts of job insecurity and are particularly vulnerable to physical hazards in the workplace. They receive less training and therefore may have fewer coping mechanisms to deal with high demands in the workplace. They are also more exposed to monotonous work. They often require more time to attend to their own health needs and the health needs of dependents and ongoing or increased work commitments can reduce this time

H. Women, Employment and Health

Increased participation of women in the workforce is a central aim of the EES. Both the lower rate of employment among women and the lower rates of pay compared to men are pathways to poverty and consequent poor health. The greater proportion of part-time working among women may be detrimental to health when this option is not freely chosen. Narrower occupational opportunities and limited career advancement towards professional and managerial positions, may also be pathways to low work control and stress. Women's higher exposure to harassment in the workplace will have negative health impacts. Women have a greater share of domestic responsibility than men and the strain of a double workload is likely to be detrimental.

Many women not participating in the workforce provide valuable unpaid care to children, the elderly and others. The increased participation of women in the workplace needs to be accompanied by increased alternative affordable caring facilities of sufficient quality. For women on low incomes, the prohibitive cost of childcare may negate the monetary benefits of employment and impede the improvement of health through poverty reduction.

I. Ethnic Minorities, Employment and Health

I. 1 The Travelling Community

The health impacts of employment policy on the Traveller Community are poorly studied but some potential impacts are described here. Unemployment, in addition to being a pathway to poverty, affects their social links with other communities and contributes to their social exclusion. Poorer education and training expose them to high job strain or places them at risk from physical hazards. The frequent use of the home base as a workplace may lead to exposure to hazardous materials such as scrap metal. Negative attitudes to Travellers means they may experience poorer job security and their experience of racism in the workplace may have negative effects on mental health.

I. 2 Migrants

Limited information about the work circumstances of migrants in Ireland makes it difficult to assess potential health impacts in a systematic way. However, information emerging from a number of studies indicates a number of concerns. "Deskilling" due to a failure to recognise qualifications and experience of migrants may have negative effects on self-esteem and mental health and may lead migrant workers into jobs in poor physical working conditions, low job control and poor support from superiors and peers. Work permit holders tend to be concentrated in unskilled and semi-skilled occupations. Concerns over their legal status and right to remain in the country may produce job insecurity. Lower rates of pay, enforced overtime and experience of racism are other sources of potential poor health. Asylum seekers' inability to work adds to other sources of post-migratory stress, adding to anxiety and depression.

J. Conclusions & Recommendations

This report draws together for the first time the different ways that employment can impact on health in Ireland. Dissemination of this report will raise awareness of these links and provide a resource for further research.

Employment is a major factor in determining health. Inability to access employment and poverty resulting from unemployment can be very detrimental to health. Having a job is generally healthier than not having one. The type of work we do and the quality of our workplace affect our physical and mental health. Some people's work is healthier than others'. We also structure much of our lives around our employment and our ability to strike a satisfactory work-life balance is important for health.

J.1 Health Impacts of Employment

The Health and Safety Authority (HSA) have a work programme to protect and improve the health and safety of the Irish workforce in Ireland. The information in this report will inform the HSA's objective of promoting health in the workplace. Elements of this report could be used by the HSAHSA to promote actions that help to promote health, including:

- giving employees more variety in tasks
- building coping skills through training and education for individuals to deal with job strain

- introducing mechanisms to enable good ongoing two-way communication between employers and employees

J.2 People with disabilities, employment and health
The exclusion of people with disabilities from the labour market has negative health impacts and much of this exclusion is a result of negative societal attitudes. To combat attitudinal barriers to participation in the workforce, a campaign involving relevant social partners to tackle misconceptions about the productive capabilities of people with disabilities should be put in place.

J.3 Older workers, employment and health
FAS currently has a proactive engagement process for all young workers unemployed for 6 months or more, where they provide advice and assistance with potential employment and training needs and options. To help combat the relatively severe health impacts of unemployment on older workers, we recommend FAS considers a similar process for workers over 45 years of age after 6 months' unemployment. .

To help ensure continued participation rates of older people in the workforce in Ireland we recommend:

- Exploring within the Lifelong Learning policy and FAS's Competency Development Programme framework how to improve access to training opportunities for older people in the workplace and to enable them to cope better with workplace demands
- The social partners be asked to develop a national strategy to encourage more voluntary gradual retirement for people in the workplace to help maintain or increase participation rates.

J.4 Women, employment and health
In anticipation of increased female participation in the labour market as a result of the EES, comprehensive national research in Ireland on those aspects of women's work most likely to impact on health should be considered. These areas include:

- male-female wage differentiation
- incidence and nature of part time working
- harassment and bullying
- reasons for narrower occupational opportunities and limited career advancement towards professional and managerial positions.

This report indicates that increased female labour participation may lead to potential negative health impacts on women due to the pressure of combining dual roles in the household and in paid employment. We recommend therefore government and social partners

- promote and support initiatives to promote work life balance (such as the Work Life Balance Network) to promote harmonisation of these dual roles
- advocate for the provision of adequate low cost or subsidised childcare places for women moving into low income jobs in the workforce. This would promote equality of opportunity

J.5 Child care
In anticipation of a large increase in childcare places in coming years to meet EES objectives, we recommend the social partners work towards developing a minimum set of

standards to ensure all facilities promote the health of children and meet health and safety standards.

J.6 Travellers health
The health impacts of employment on Travellers should be included in future Travellers health studies. These include impacts of unemployment and related poverty, lack of access to education and training, risk of physical hazards and discrimination in the workplace.

J.7 Migrant workers
Given the relative scarcity of research on the health impacts of migrants' employment in Ireland we recommend the social partners consider a comprehensive study on the health and work circumstances of migrant workers in Ireland to look at issues such as:

- "deskilling" and its negative effects on self-esteem and mental health
- poor physical working conditions
- discrimination in the workplace and experience of racism
- low job control
- low pay

J.8 Commuting
This report highlights increased commuting times and the relative reduction in healthier routes to work such as cycling, walking and public transport compared to private car use. We recommend that social partners explore the following suggestions:

- A national Healthy Commuting campaign including health promotion and incentives to both employees and employers to increase cycling and walking to work. This should concentrate particularly on the large percentage of workers who drive short distances to work
- Targets and incentives to reduce commuting and improve work/life balance (such as teleworking and flexible working hours).

J.9 Data collection on employment and health
While writing this report, the scarcity of data showing direct impacts of employment on health in Ireland was noted. Data collection in this area needs to be strengthened in Ireland.

Possible approaches to doing this include:

Questions on health impacts of employment to be included in future surveys including

- National Employment Survey
- Quarterly National Household Survey
- Census

Questions on employment to be included in health surveys such as SLAN

1 Introduction & Methodology

1.1 Background on project

This HIA exercise was conducted as part of the 'Policy Health Impact Assessment for the European Union', commissioned by the European Commission's Directorate Generale Health and Consumer Protection (DG Sanco). This is to support Article 152 of the Amsterdam Treaty, which committed the European Union to human health protection

in the definition and implementation of EU policies. The International Health Impact Assessment Consortium based at Liverpool University successfully co-ordinated a bid with partners from Germany, Ireland and the Netherlands to undertake this work.

The aims of the European project are to:

- Develop a standardised HIA methodology for assessing the health impacts of EU policies and activities
- Apply this methodology to a selected EU policy (the policy chosen for assessment is the European Employment Strategy
- Disseminate findings and lessons learnt throughout Europe

In addition to a Europe-wide HIA exercise to assess the health impacts of the policy across Europe, each participant undertook a HIA exercise to assess the impact in their own country. This national report is part of this exercise.

1.2 Methodology used in the exercise

The purpose of the pilot HIA in Ireland was to test the HIA methodology produced by the research group 'Policy Health Impact Assessment for the European Union: A Generic Health Impact Assessment Methodology for the European Commission'. In particular the Irish project concentrated on the participatory aspects of HIA.
Following the format laid out in the methodology, the pilot HIA consisted of the following steps:

Assembling a key stakeholder/key informant group
The purpose of this group was to provide expert advice and support for elements of this exercise including opinion on potential health impacts of employment, support with collation and analysis of evidence and help with framing of recommendations. The group included representatives from SIPTU (trade union), IBEC (employers representatives), Department of Health and Children, Department of Enterprise, Trade and Employment, National Disability Authority, Equality Authority, National Economic and Social Council, Economic and Social Research Institute, The Health and Safety Authority.

Stakeholder meetings
Two stakeholder meetings were conducted. The first meeting discussed the links between employment and health in general and the potential impacts of the EES in particular. There was also a discussion about the logistics of conducting the relatively limited exercise and suggestions were given on areas to focus on. A Terms of Reference for the pilot HIA was produced and sent to all participants. Incorporation of the views of key informants and stakeholders In the second meeting, participants provided feedback on the draft Appraisal report. There was also a discussion about potential recommendations that could be made based on the information provided in the report. Details of the two meetings are provided in Appendix 1.

Undertaking assessment
Following the first meeting, a detailed assessment was conducted involving a number of methodological approaches including

- Profiling of the communities affected by these elements of the EES in Ireland, with particular attention to health inequalities
- Analysis of relevant policy (including the EES, European Employment Guidelines and national labour market policy)
- Collection and analysis of demographic and labour force data and evidence of health impacts from qualitative and quantitative data sources using multiple methods

- Analysis of the potential impacts on key health determinants and health and wellbeing from the assembled evidence
- Development of recommendations

Report on health impacts, policy context and

- Production of a draft report on potential health impacts and their distribution throughout the population
- Feedback on a draft version of this report from the second participatory meeting
- Production of a revised report following comments received from participants

Monitoring and evaluation

Evaluation of the methodology used in the Irish pilot exercise to add to the overall evaluation of the project

1.3 Background on European Employment Strategy

The European Employment Strategy (EES) was launched in 1997 to combat unemployment and promote the convergence of employment policies in Europe. It aims to produce long-term economic growth, full employment, social cohesion and sustainable development in a knowledge-based society.

In 2000 the Lisbon European Council of 2000 developed an "Agenda of Economic and Social Renewal for Europe" that is known as the Lisbon Agenda. The Lisbon Agenda outlined the main features of Europe's employment deficit and proposed the targeting of labour market, fiscal and structural policies to address them.

The Lisbon Agenda identifies a number of structural weaknesses in European employment including:

1. **A gender gap** – only half of the women in the EU are in work compared to two thirds in the US.
2. **A services gap** – the EU has a much lower level of employment in the service sector than in the US.
3. **Marked regional imbalances** – EU unemployment is concentrated in Germany, France, Italy and Spain and is the highest in the south, outlying regions and declining industrial areas.
4. **Long-term structural unemployment** – half of those out of work have been unemployed for more than a year.
5. **A skills gap** – particularly noticeable in Information Technology, due to under-investment in education and training.
6. **An age gap** – the rate of employment in the 55-65 age group is too low.

After a review of the first 5 years of the EES and a wide-ranging debate involving European institutions, social partners and stakeholders, the strategy has been redesigned as a tool to underpin the Lisbon Agenda in the enlarged EU and contribute to economic and social cohesion. The revised EES identifies and examines 10 priority areas that need to be addressed.

Priority areas

1. Active and preventive measure for the unemployed and the inactive
2. Making work pay – providing financial incentives to work
3. Fostering entrepreneurship to create more and better jobs
4. Transforming undeclared work into regular employment

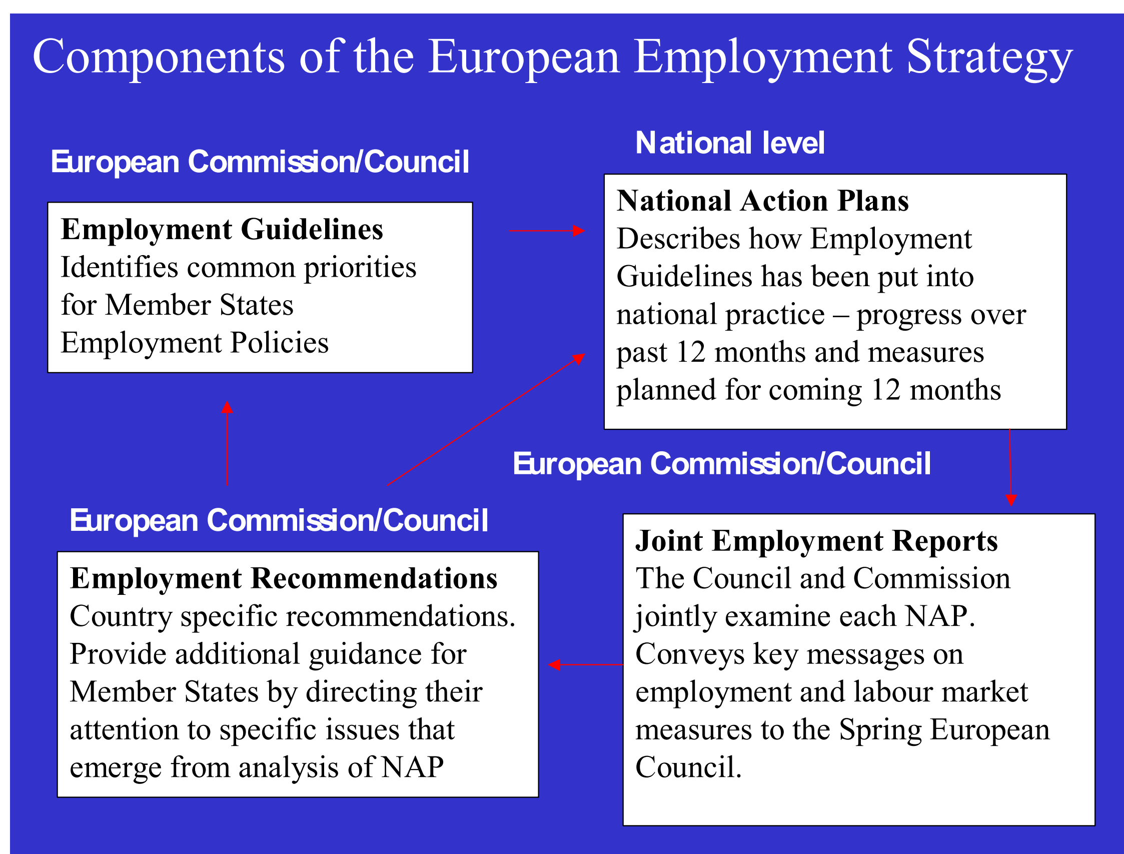
5. Promoting active ageing
6. Promoting adaptability in the labour market
7. Investment in human capital and strategies for lifelong learning
8. Promoting gender equality
9. Supporting integration and combating discrimination in the labour market for people at a disadvantage
10. Regional employment disparities.

A detailed description of the EES is available on the following European Commission website. http://europa.eu.int/comm/employment_social/employment_strategy/

1.4 The relationship between the EES and national labour market policy

The EES is implemented through Employment Guidelines that are reviewed annually during the spring European Council. Following the production of Employment Guidelines from the European Council, each member state draws up an annual National Employment Action Plan (NEAP) to enable these guidelines to be put into practice nationally. In Ireland, the production of the NEAP is coordinated by the Department of Enterprise Trade and Employment. The process is outlined graphically here.

Figure 1 Components of the European Employment Strategy



The Irish government has a broad ranging and comprehensive programme to address the labour market needs of the Irish economy and this forms the basis of the national NEAP.

The government's Employment and Human Resources Development Operational Programme (EHRDOP) is organised around the pillars of previous European Employment Guidelines. The objectives of EHRDOP are:

- Promote employment growth and improve access to, and opportunities for, employment
- Mobilise all potential sources of labour supply and enhance its quality in order to address skills and labour shortages across the economy as a whole
- Promote the development of a strategic lifelong learning framework
- Promote equal opportunities between men and women, in particular through a gender mainstreaming approach
- Promote social inclusion with particular reference to the reintegration of the socially excluded and the long term unemployed into the labour force
- Strive for balanced regional development, by addressing the existing and potential education, training and skills deficits of the Border, Midland and Western and Southern and Eastern regions

These objectives incorporate action programmes for the unemployed, education and training (including infrastructure development), lifelong learning, equality programmes and technical assistance. Expenditure on these programmes between 2000 and 2002 came to €5.96 billion. The NEAP is implemented through this comprehensive government programme. Implementation of the NEAP is undertaken by a number of bodies including FAS (the national employment and training agency), the Department of Education and Sciences, the Department of Social & Family Affairs and Area Based Partnerships. Details of actions under NEAP are provided in Sections 2 to 7 in the report.

1.5 Developing a strategy for the Irish national HIA exercise

Considering the broad-ranging nature of the EES and the relatively limited time and resources available for this exercise, it was suggested at the first meeting of key informants to concentrate on a manageable number of areas that were of relevance in an Irish context. Out of an initial list of 3 of the 10 priority areas (identified in point 3) suggested by the group, the Institute concentrated resources on the following two priority areas.

1. Active and preventive measure for the unemployed and the inactive
9. Supporting integration and combating discrimination in the labour market for people at a disadvantage

Choosing these areas enabled the Institute to address the potential health inequalities suffered by a number of disadvantaged groups in Ireland, including women, people with disabilities, older people and ethnic minorities. Addressing health inequalities is an integral part of Health Impact Assessment and is highlighted in the draft methodology for this project.

1.6 Framing recommendations

Following the production of a draft report, as second meeting was held on October 23rd 2003. Participants provided feedback on the draft report, which has been incorporated here. Potential recommendations for implementing the EES in Ireland in a way that would benefit the health of the population were also discussed. A set of draft recommendations were and agreed in early 2004 and these are included in this report. (These recommendations will be submitted as part of the annual consultation process on the National Employment Action Plan in 2004?)

2 The Health Impacts of Employment

2.1 Introduction

Employment is one of the most important socio-economic determinants of health as it will affect most people in society at some stage in their lives. The loss of a job or the threat of losing a job are detrimental to health [22]. Unemployed people and their families are more prone to the risk of premature death. The anticipation of the loss of a job or job insecurity generally also have an impact on mental health, self-reported ill health, heart disease and risk factors for heart disease [22].

The type of job a person has and the working conditions he or she are exposed to will also affect health. For example, health tends to suffer where the demands of a job are high but the ability to control the demands are low [22].

It is also important to consider the impact that employment has on other aspects of people's lives that are important for health– for example, family life, social life and caring responsibilities for family members.

While this report concentrates on the impacts of employment and health, it is also important to mention the impacts of health on employment. A healthy workforce is a major prerequisite for economic success and improvements in health will help to increase efficiency and productivity.

This section illustrates in general terms the potential impacts on health of employment. Some of these impacts will be explored in more depth in Sections 3 to 7. The negative or positive health impacts of employment do not fall equally on all sections of society. For example, less skilled workers are more prone to negative health impacts than more skilled workers. These health inequalities are highlighted throughout this report.

2.2 Work and health – Overview of Employees' perspectives

The European Foundation for the Improvement of Living and Working Conditions (EFILWC) showed that in Europe in 2000 60% of workers thought that their work affects their health. [1] In Ireland this percentage was relatively low at 29.2%. In Ireland, as in Europe, the most commonly reported health impacts were stress (11.9%) backache (10.8%), fatigue (8.6%) and muscular pains in the shoulder and neck (8.2%). In Ireland 5% said that they were absent from work due to a work-related health problem in the previous 12 months, lower than the European average of 9%. In Europe out of the 7.26 average days absence over 12 months,1.8 were due to occupational accidents, 1.8 were due to work-related health problems (with 4.2 that were not directly work related health problems).

2.3 Unemployment and Health

Unemployment affects both physical and mental health and is a major determinant of morbidity and premature mortality. It is a major cause of poverty and poor living conditions. It also has significant impacts on mental health. A detailed breakdown of these different health impacts is provided in Section 3. This suggests that the creation of jobs will lead to a net improvement in health and will help reduce premature mortality.

However, when considering the health impacts of employment it is important to consider the quality of the work available and also the effect that employment will have on the structure of people's lives and their potential health impacts.

2.4 Physical environment of work and health impacts

2.4.1 Accidents and Health and Safety

Accidents in the workplace is one of the most obvious ways that employment affects health. The reduction of accidents in the workplace in Ireland following interventions by the Health and Safety Authority (HSA) has contributed improved the health of workers. The HSA statistics in Ireland show a downward trend in workplace accidents and mortality since 1998. The rate of Occupational Injury Benefit claims has decreased by 9% and the rate of injuries that have resulted in more than 3 days' absence has fallen from 14% between 1998 and 2002.

However, the number of women injured in the workplace has risen by 50% since 1998. The HSA attribute this increase to the "significant increase in the number of women in the workplace together with a possible increase in the number of women in riskier industries."[(24)]

There is also a social gradient in the incidence of workplace accidents. Out of the 61 workplace fatalities in 2002, the majority were in construction and the agricultural, hunting and forestry sectors[(21)] .

2.4.2 Exposure to physical hazards

The EFILWC 2000 survey shows an increase in exposure to physical hazards in the workplace and in conditions such as musculo-skeletal disorders and fatigue are on the increase. Some of this is due to intensification of work and flexible employment practices. The potential dangers to health identified by workers include exposure to high-level noise, carrying of heavy loads and working in painful positions. The health impacts are distributed unevenly, with blue collar workers more likely to be exposed to health damaging impacts. The survey showed an increase in exposure to painful working positions for sales/services workers and for technicians between 1995 and 2000.

The European Survey showed that 31% of workers are exposed to physically repetitive work (repetitive movements of the arm or hand and repetitive tasks that took between 5 seconds and 10 minutes). Again, there is a social gradient with rates for blue collar workers much higher than for white collar (e.g. 54% for machine operators compared to 14% for professionals).

2.5 Psychosocial environment, stress and health impacts

The World Health Organisation states that the psychosocial risks associated with stress "accumulate during life and increase the chances of poor mental health and premature death" and cites work as one of the contributing factors [(24)]. Some Irish sources illustrate that employment contributes to stress In Ireland. The Health and Safety Authority in Ireland describe it as the "invisible disease of the modern organisation" and have a programme to address the issue. A survey on stress in Ireland [(12)] shows that having too much work, having responsibility for others at work and the physical working environment surrounding workers are work-related reasons for stress. Table 1 shows how stress manifests itself in the respondents.

Table 1: Manifestations of stress

Manifestations of Stress	%
Feelings of irritability	66
Generally tired and exhausted	63
Difficulty sleeping or waking early	49
Difficulty concentrating	46
Decreased motivation	46
Decreased confidence	41
Feeling anxious and panicky	40
Feelings of depression	36
Difficulty making decisions	34
Decreased productivity	33
Headaches	29
Avoiding social situations	27
Lots of aches and pains	26
Change in appetite	26
Upset stomach/problems with digestion	23

Source: Mental Health Association of Ireland Survey 2001

17% say they would deal with this stress by increasing their intake of alcohol. 1 in 10 have sought professional help for stress-related ailments, mostly from their GPs. The 2002 SLAN survey in Ireland[23] also identifies stress as the most important determinant of health. In 2002, 37% of respondents identified the reduction of stress as a top requirement for improved health. The Health and Safety Authority in Ireland organised seminars in 2003 for employers focusing on stress and psychological hazards in the workplace.

2.5.1 Level of control over work

The level of control that a person has over aspects of their work has an impact on health. Generally, the greater the level of control, the better someone's health is likely to be.

The Whitehall II longitudinal study[11] of over 10,000 civil servants in the U.K. showed that men and women with low job control were nearly twice as likely to report a new coronary heart disease than other workers. The report concluded that this "implies that giving subjects more variety in tasks and a stronger say in decisions related to work could have benefits for public health."

In Ireland, the Quarterly National Household Survey shows that 22% of people in employment plan their own work schedules and working time and that this increases with age.[18]. The EFILWC found that in Europe, 64% of workers have control over their methods of work, including the pace that they work at and the order in which they conduct their tasks.[1] However, these levels of autonomy are unequally distributed, with more skilled workers experiencing more control. Levels of control for temporary agency workers are lower than for permanent workers. The survey shows that 44% of workers have an influence over their working hours (47% in Ireland), although again this is higher for skilled than non-skilled workers.

The pace of work that an individual is exposed to has potential health impacts. The survey found a strong link between the degree of work intensity and reported health problems, particularly due to tiring and painful positions. Working at a high speed (1 in 4 in Europe say they work at a high speed all or almost all of the time and 18% in Ireland)

is also associated with reported health problems. 73% of those who say they work at high speed all or most of the time report resulting health problems (such as backache, muscular pain, stress and fatigue), compared to 50% of those who do not work at a high speed.

The job-demand-control model designed by Karasek and Theorell "proposes that the combination of heavy demands and limited decision latitude (or control) to moderate these demands results in job strain" [16], which in turn leads to negative health impacts. High (psychological) demand, low control working conditions (job strain model) are associated with health-related harm. Literature on changing labour market conditions and health[6,34] shows support for aspects of this model. Whether an individual in a 'high-strain' job will experience negative health impacts depends largely on the individual's coping skills and on the opportunities given within the workplace to deal with them. This suggests that increasing the capacity of individuals to cope through training or other methods will have health benefits

A survey on stress in Ireland in 2001[12] showed that the sense of being overwhelmed with work is highest among those in the 25-34 and 35-44 age brackets. Stress induced by having responsibilities for others at work is highest among 18 to 24 year olds and the report states that "this suggests that lack of training in how best to manage others can be a source of stress to young employees."

2.5.2 Consultation, social support and information provision in the workplace

Research indicates that the negative impacts on health of working conditions and organisational change can be offset when workers are provided with information and are given the opportunity to discuss possible changes. The EFILWC 2000 Survey shows that in Europe 71% of workers were able to discuss their working conditions with their employers (74% in Ireland). However, these opportunities are not evenly distributed across all types of workers, with unskilled workers being the least engaged in exchanges. The EFILWC 2000 survey also indicate that social support in the workplace ameliorates the effects of job strain and that low levels of social support and high job strain was associated with the greatest increase in psychological distress).

A culture of good two-way communication between employer and employee should also benefit health by enabling a joint approach to tackling the causes of poor health. For example, the EFILWC 2000 survey showed that 75% of those consulted by their employers believe that their discussions lead to improvements in their workplace (81% in Ireland) [1].

2.5.3 Intimidation in the workplace

Different forms of intimidation in the workplace will have a direct impact on health. Violence will have an obvious direct negative impact. Bullying and sexual harassment will cause psychological stress and may have an impact on mental and physical health. A national survey of workplace bullying in Ireland in 2000 showed that 7% of people experienced bullying in the 6 months previous to the survey and that the rate among women was 1.8 times higher than among men. [28] The European Survey of Working Conditions indicated that 9.7% of Irish workers were subjected to some form of intimidation (compared to an EU average of 8.5%). A SIPTU survey indicates the extent of bullying in the workplace, with 40% of respondents saying they believed that bullying was a regular occurrence. Following a government taskforce report on bullying in Ireland published in 2001, the Health and Safety Authority has been raising awareness of these issues and working towards prevention of workplace bullying.

2.6 The flexible labour market and health impacts

International trends in employment are demanding greater labour market flexibility and this has led to an increase in different types of 'atypical' or 'precarious' employment. These include some types of contract and temporary work, home based work or teleworking, on-call work, freelancing and informal work.

Before discussing the potential health impacts of job flexibility or atypical employment it is important to recognise the difference between cases where flexibility is freely chosen as a means of improving a person's work/life balance and cases where it is non-voluntary or 'imposed' by labour market conditions. The health impacts are more likely to be positive in the former than the latter. Many of the statistics quoted here do not make this distinction. References to negative health impacts here refer to non-voluntary atypical employment.

In Europe 'flexible' employment (defined as part time workers, workers with a temporary contract and self-employment) increased by 15% between 1985 and 1995.

Table 2: Breakdown of Full Time and Part Time in Ireland 2002

Types of Employment	%
Permanent employment	51.8%
Small employers	6.0%
Self-employed	13.6%
Non Permanent	
Fixed term full time	3.5%
Fixed term part time	2.2%
Temporary full time	1.7%
Temporary part time	2.9%

Source: CSO

Non-permanent work is on the increase in Ireland. A benchmarking exercise in 2001[(9)] showed a 42% increase in Ireland in the proportion of employees with 'atypical' employment conditions between 1988 and 1998.

The EFILWC 2000 survey indicates that throughout Europe different types of flexible employment have negative impacts on health compared to more 'standard' types of employment.

2.6.1 Job insecurity

One of the by-products or consequences of increased flexibility this is increased job insecurity. Virtanen et al [(14)] show that low perceived employment security was associated with poor health, particularly among those who are in permanent rather than temporary or fixed term employment. They show that the negative effects of job insecurity on physical health may increase with time and the perceived intensity of job insecurity is strongly associated with symptoms such as aches and pains.

Research shows that self-reported health status deteriorateswhen people are anticipating job change or job loss. For example, the British Whitehall study [11] evaluated the health of civil servants in a period of privatisation and showed significant declines in health among those anticipating job change. These health impacts are not evenly distributed. The position or status of the worker within the organisation was important. In another example, a study of a British water company (Nelson et al, cited in EFILWC Literature

review) showed that the health impacts of anticipating job loss was particularly marked for manual workers.

The EFILWC shows that job insecurity is associated with negative attitudes to work and negative impacts on health, including mild depression and poor self-reported health status. Insecure jobs tend to involve higher than normal exposure to work hazards of various kinds[1]. As the less skilled, manual workers tend to be most exposed to low paid, temporary or insecure jobs, their health will tend to be more adversely affected than more skilled workers. People on fixed term contracts and temporary agency contracts reported overall higher levels of fatigue. They also showed less satisfaction with their working conditions (80% and 77% respectively compared to an average of 84% for permanent wokers). They are significantly more exposed to carrying heavy loads and to working in painful positions. They have less control over aspects of their working life (as discussed in point 2.5.1) than permanent workers.[1]

2.6.2 Part time work

Where part-time work is desired and it enables a satisfactory work/life balance, it is likely to have a positive health impact. However, as the EFILWC indicates, part time work is not always voluntary. In Europe, 23% of those working part time would prefer to work full time. This may have negative health impacts associated with low income and share some of the characteristics of psychological stress associated with unemployment. [1]

Table 3 illustrates the increase in part time working, compared to full time working in Ireland since 1998. While male part time employment has fallen in recent years, female part time working increased by over 23% between 1998 and 2002.

Table 3: Breakdown of Full Time and Part Time Employed in Ireland 1998-2002 (1,000s)

	1998(Q4)	1999 (Q4)	2000(Q4)	2001 (Q4)	2002 (Q4)
Employed Full Time - Men	863	908	939	958	966
Employed Part Time - Men	65	69	68	66	65
Employed Full Time - Women	432	469	492	507	512
Employed Part Time - Women	183	201	211	220	226

Source: CSO

The EFILWC also examined cases where people would prefer to work part time rather than full time to gain a better work/life balance. They analysed in 1998[25] reasons that people in Ireland gave for not working part time. Table 7 shows these reasons and compares the answers to EU averages (respondents were allowed to give more than one answer, bringing the total to over 100%). The impression that part time workers have worse employment rights in Ireland is considerably higher than in the rest of Europe

Table 4: Reasons for not working part time

(although these attitudes might have changed since 1998).

Reasons for not working part time	Ireland	EU
Not possible to do my current job part time	59	58
Employer would not accept it	61	59
Would damage career prospects	55	48
Part timers have worse employment rights	63	43
Could not afford to work part time	53	44

Source: EFILWC

2.6.3 Teleworking

Teleworking is often designed to enable a better work/life balance and to enable some sections of the population greater access to the labour market (e.g people with disabilities or parents looking after children.

The Quarterly National Household Survey in Ireland[12] indicates that nearly 10% of people in non-agricultural employment work from home to some extent and around 40% of these use a computer with a telecommunications link. The EFILWC shows that in Ireland, 4% of all employees telework for at least one quarter of their time.

Where teleworking enables an improved work/life balance or enables access to the labour market where it did not exist before, the health impacts are likely to be positive. The ability to telework in Ireland is not evenly distributed socially. The national household survey shows that nearly 80% of teleworkers are from the managerial, professional or technical occupations.

However, some of the potential negative health impacts of teleworking include inferior ergonomic arrangements outside of the workplace and working in isolation and without the benefit of teamwork and consultation.[7]

2.6.4 Temporary work

The EFILWC found that, even taking into account working conditions, the temporary status of a worker was still an important determinant of health. [1] In other words, regardless of the type of work being done, just being a temporary worker increased the chances of experiencing poor health. Temporary workers are more likely to report fatigue, backache and muscular pains. They are also less likely to report health related absenteeism than permanent workers. The patterns are similar regardless job category, economic sector or country. Temporary workers are more likely to be carrying out repetitive work and have to work to tighter deadlines than permanent workers. [1] They are less likely to receive the type of training that would enable them to deal with workplace demands and may therefore be less capable of dealing with the stress of job strain (see point 2.5.1). They are also more likely to be exposed to poor working conditions such as vibrations, loud noise and hazardous products.[24]

The EFILWC interviewed 138 non-permanent workers in Ireland about their experience of a range of health-related indicators in 2000. [1] The results are summarised in Table 4.

Table 5: Health indicators exhibited by Irish Non_Permanent Workers

Job dissatisfaction	8.1
Health related absenteeism	7.7
Stress	13.1
Fatigue	8.9
Backache	11.3
Muscular pains	10.5

Source EFILWC 2000

2.7 The role of Employment in Structuring a Person's Life

Employment is a major determinant of how a person's life is patterned and these life patterns in turn may have an impact on the health of the individual and their family. For example, irregular working patterns and long commuting times are becoming more common. The EFILWC defines work/life balance as "an individual's attempt to find suitable time arrangements and time options that allow the best possible coordination of requirements of work with requirements for personal life. To this extent, work/life balance is not automatically about working less but about having control and flexibility over when, where and how to work .." [1]

2.7.1 Increased Commuting

The 2002 census shows that 55% of all workers now drive to work, up from 46% in 1996. The percentages using public transport, cycling and car sharing have fallen.

Table 6: Travel to Work in Ireland

Means of travel	1986	1991	1996	2002
	%	%	%	%
On foot	12.6	11.1	11.5	11.4
Bicycle	5.6	4.4	3.6	2.1
Bus	8.6	7.7	7.6	6.7
Train	1.5	1.7	1.7	2.1
Motor cycle	1.4	1.1	0.9	1.1
Car driver	37.2	38.9	46.3	55.1
Car passenger	8.3	8	8.7	6.7
Other (incl lorry or van	3.1	4	4.3	7.1
None	17.2	19.8	12.3	6.1
Not stated	4.5	3.2	3.1	1.7

Source: CSO, Census 2002 [(35)]

Workers travelled on average 9.8 miles to work in 2002, up from 6.7 miles in 1996, with and the average journey took 28 minutes. More than 13% of car journeys to work were a mile or less. In addition to the stress-related health impacts of commuting (increased traffic jams, increased distances) and the health cost in terms of reduced physical exercise this will have wider health implications for society in general through increased air pollution, accidents, noise and other factors.

A European comparison in 2000[1] showed that 17.1% of the Irish workforce spent between 1 and 2 hours travelling from home to work and back, the second highest in the EU.

2.7.2 Working hours

Statistics on working hours in Ireland varies. The 2002 census put the average at 38 hours, with men working 42.3 hours and women working 32.2.[35] A comparative European survey calculated that men worked an average of 44.7 hours per week in Ireland, the highest in the European Union, which has an average for men of 41.6 hours.[1] For women, the Irish figure of 33.4 hours was closer to the EU average of 33.2.[1] Those involved in agriculture worked the longest hours followed by mining and construction.

Long working hours can impact on health negatively. Spurgeon [30] et al say that despite the restricted nature of research to date there is “sufficient evidence to raise concerns about the risks to health and safety of long working hours”. Van Der Hulst [31] refers to links between long working hours and cardiovascular disease, diabetes, poor self-reported health and fatigue. Hoshuyama [32] in a Japanese study and Park et al [33] in South Korea demonstrate negative effects of regular overtime on the cardiovascular system.

2.7.3 Irregular work patterns

Irregular working time patterns (where people do not work the same number of days every week or the same number of hours every day) also has the potential to disrupt family life. Table 5 illustrates the pattern of the working week.[1]

Table 7: Working patterns in Ireland

Working patterns	Male- Ireland	Male - Europe	Women- Irl.	Women- EU
Standard Weekdays	26%	28%	42%	37%
Some long days	19%	17%	8%	9%
Regular long days	19%	14%	3%	6%
Some evening/nights	5%	6%	6%	6%
Shifts/nights	15%	19%	21%	18%

Source: EFILWC[1]

In particular it illustrates the high percentage of men who work regular long days (19% compared to the EU average of 14%).

The same survey asked whether workers felt their working hours were compatible with their family and social commitments. Not surprisingly the percentage that reported that their working hours fit ‘poorly or not at all’ increases as working hours increase.

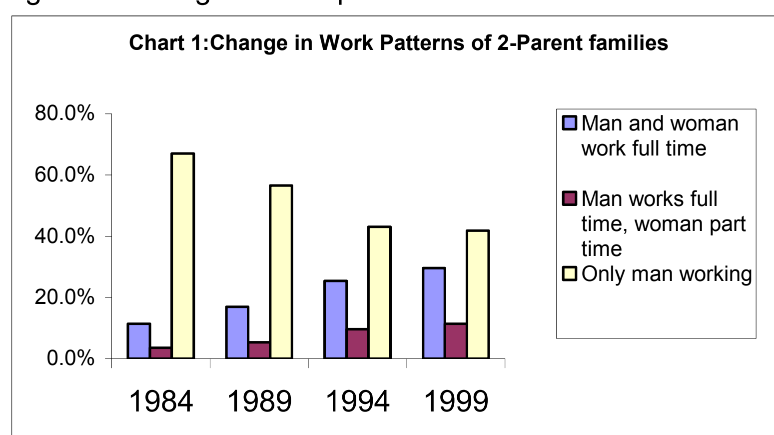
Table 8: Compatibility of working hours with family and social commitments in Ireland

Volume of hours	Doesn't Fit family/social commitments
20 or less	11%
20<30	8%
30<35	16%
35<40	16%
40<48	23%
48+	40%

Source: EFILWC

Data from the OECD demonstrates the changing work patterns of 2 parent families with children, as illustrated in Figure 2.[9]

Figure 2: Change in work patterns of 2-Parent families



Source: OECD

2.7.4 Nightwork and shift work

The EFILWC 2000 Survey shows that in Ireland 20% of people work at least 1 night per month (the EU average is 19%) and that 20% do shiftwork. The Quarterly National Household Survey in 2001[18] indicated over 200,000 people worked shift work. Over half of these worked shifts because there was no similar job with regular hours available. Rajaratnam [20] discusses a number of health impacts on night shift workers, including "poorer daytime sleep, reduced night time alertness and performance and an increased accident rate compared to those on day shift". This can lead to health problems such as chronic sleep disorder, increased incidence of cardiovascular disease and an increase in late-onset diabetes. Harrington[31] cites a strong link between cardiovascular illness and mortality and shift work. He states that the "inherent conflict between the interest of the worker and the enterprise over unsocial hours can be mitigated by improvements in working conditions and by advice to the worker on coping strategies." [31]

In a survey on stress levels in Ireland [12], 71% of respondents said they were satisfied with their balance between working and non-working life, with 24% dissatisfied. 11% say that workplace stress interferes 'a lot' with their family life.

2.8 Action in Ireland to address work/life balance

The NEAP states that a balance between job flexibility and security is a priority for the government in Ireland and the social partners. Recent legislative changes on

employment rights aim to address some of the issues discussed in this report. The Employees Fixed-Term Work Act in 2003 gives employment rights to the 4% of the Irish labour force on fixed term contracts. Health and safety legislation is undergoing a review to further improve working conditions. A number of measures have been taken to promote a better work/life balance in recent years. Maternity leave entitlements have been increased and, following a period of consultation with social partners, legislation to strengthen parental leave is expected in 2004. A National Framework Committee for Family Friendly Policies has been established to support and facilitate the development of work/life balance policies. An e-Work Action Forum was established to support e-working. More generally, The Forum on the Workplace of the Future has been set up to "provide a framework for addressing issues of workplace change in a comprehensive forward looking way. [36]

3 Health Impacts of Unemployment

3.1 Unemployment in Ireland

In the 1990s, following a period of rapid economic growth unemployment in Ireland was reduced dramatically from 15.2% in 1992 to more recent rates in the region of 4%. Total employment grew by 46% between 1993 and 2001. Considering the range of severe negative health impacts discussed below, this growth in employment is likely to have had considerable health benefits in Ireland.

However, the economic slowdown in recent years has seen the total numbers of unemployed rise since late 2001. 4.7% of the population or approximately 85,000 people are registered as unemployed in Ireland at the end of 2003. The burden of unemployment also falls hardest on the most disadvantaged sections of society and this leads to health inequalities.

3.2 Health Impacts of Unemployment

Unemployment affects both physical and mental health in a variety of ways. This section will firstly look at the impact of unemployment on mortality rates. Then, (following a format suggested by Bartley[38] the health impacts of unemployment are analysed here using four criteria – poverty, unemployment as a stressful life event, health related lifestyle behaviour and the effect of a spell of unemployment on subsequent employment patterns.

3.2.1 Mortality

International research has indicated that unemployment is a cause of premature mortality. [47] A number of longitudinal studies in the UK and other European countries showed strong links between unemployment and mortality.[40] For example, a UK study showed that unemployed people with no previous illness were 37% more likely to die over the following 10 years than the general population.[40] A study in Denmark showed a 40% to 50% excess death rate among the unemployed after taking into account occupation, housing, geographical region and employment status.[40] A study in the UK[39] indicated that stably employed middle aged men who experienced loss of employment were twice as likely to die in the following 5.5 years than their counterparts who remained permanently employed.

Brenner[37] analysed the relationship between unemployment rates and mortality for main causes of death in EU countries and the United States and showed that these rates had an independent and damaging effect on health nationally. He also showed that

increased employment rates were associated with decreased mortality in EU countries and the United States.

3.2.2 Unemployment and Poverty

Unemployment generally entails a reduced income and long-term unemployment is associated with socio-economic deprivation. The links between poverty and poor health are well established and universally accepted. [47] People in poverty die younger, have less healthy lifestyles and live in less healthy environments. Many studies link the health effects of unemployment directly to financial strain. For example, studies by White et al[38] suggest that people who borrow money are twice as prone to depression as those who do not have to borrow.

In Ireland the Social Capital and Health Survey conducted by the Institute of Public Health [46] in 2001 shows a severe inequality in Ireland in self-assessed health when broken down by income groups. People in the highest income groups are twice as likely to report excellent or very good health than people in the lowest groups.

Table 9: Self reported health of people by annual income Expressed as pounds sterling but based on equivalent buying power of £1stg and IR£1 in 2001

	Excellent/Very Good Health	**Free of long term illness**
≤ £7,000	40%	69%
£7,000 - £14,999	57%	89%
£15,000 - 25,999	68%	94%
≥ [illegible]	82%	97%

Source: Inequalities in Perceived Health: Institute of Public Health in Ireland

The National Anti-Poverty Strategy[48] participation process in Ireland also identified income levels and inequalities in income as a central target for improving the health of people who are living in poverty.

3.2.3 Unemployment as a stressful life event

Employment is beneficial for health by virtue of the structure and personal fulfilment that it gives a person and the social contact that it enables. The World Health Organisation identifies a number of ways in which employment benefits mental health. [50] These include:

- Structuring time – the absence of such a structure can be a major psychological burden
- Social contact – work provides a linkage for the person to work colleagues, friends, family and society in general
- Involvement in a collective effort or an activity associated with certain contributions to society
- Regular activity.

The psychological impact of unemployment and the loss of these factors has a negative effect on health. Unemployed people have lower levels of psychological well-being ranging from symptoms of depression and anxiety to self harm and suicide. For example, research in Ireland [42, 43] illustrates the psychological distress caused by unemployment in Ireland. The Social Capital and Health Survey conducted by the Institute of Public

Health [47] shows that people in Ireland who are unemployed are only 66% as likely to score highly on a general mental health score than those who are employed.

Having a job or an occupation is an important determinant of self-esteem. It provides one of the most vital links between the individual and society and is viewed by many as a way in which they can contribute to society and achieve personal fulfilment. The loss of 'position' or status associated with unemployment and the related loss of self-esteem are important determinants of health in addition to loss of income. There are many studies that show the link between low self-esteem and depression, which can also lead to the "activation of biological stress mechanisms that increase risk of diseases such as coronary heart disease." [43]

3.2.4 Unemployment and Lifestyle

Unemployment is associated with some forms of health damaging behaviour, (although there is disagreement as to whether this behaviour or the loss of a job comes first).[38] In Ireland the Social Capital and Health Survey conducted by the Institute of Public Health [46] indicates that people who are unemployed are more likely to smoke and to drink to excess than people in other employment categories.

Table 10: Health damaging lifestyle by Employment Status in Ireland

	Currently smokes	Drinks excessively
Retired	22%	3%
Economically inactive	25%	5%
Unemployed	46%	14%
Employed	31%	10%

Source: Inequalities in Perceived Health: Institute of Public Health in Ireland

Research in England and Wales shows that a spell of unemployment may have knock on effects that increase stress and affect mental health such as loss of home and relationship breakdown.[38] International studies show suicide and attempted suicide is also higher among unemployed people.

3.2.5 Unemployment as a recurring event

When considering the relationship between unemployment and health, it is important to consider the potential long term impacts of repeated episodes of unemployment. Bartley states that "a spell of unemployment is not usually a mere interlude, however unpleasant, which has no effect once it is over … it can precipitate a self-perpetuating series of negative events well into the future, even after work has been regained. "[38] People from lower socio-economic groups will spend a disproportionately large amount of time in unemployment or move more in and out of employment. A person who is unemployed once runs a greater risk of being unemployed again. The repetitive nature of unemployment may lead to chronic job insecurity, a higher than normal exposure to poor quality jobs and a lack of control over working life, all of which have health implications (detailed in Section 2). Bartley[38] refers to studies in the UK that show that the health status of people in insecure work was similar to the unemployed. Insecure work will also increase exposure to hazardous work conditions.

Research in Ireland in the 1990s[44] showed that 12% of men and 7% of women experienced recurrent spells of unemployment and that people without formal qualifications and older workers will tend to be unemployed for longer periods of time.

Unemployment will have a particularly detrimental effect on older or middle-aged workers. Many are unable to find work subsequent to recession or industrial structural change and have a tendency to drop out of the workforce. Some who do return to the workforce may do so at a lower occupational status or level of seniority and on lower wages.

3.3 Action in Ireland to tackle unemployment

The tackling of unemployment is central to the government's employment strategy. There are a range of prevention and activation measures in place for the unemployed and inactive

Active engagement with the unemployed
Since 1998 young unemployed people (under 25) who are unemployed for 6 months undergo a process of 'engagement' with FAS, who provide advice and assistance with potential employment and training needs and options. Engagement with all adults (from 22-55) after 9 months unemployment is being introduced in 2003. In 2002, 25% of those interviewed by FAS entered employment, 12% entered a FAS training programme. The Pathways programme and High Supports programme provide assistance for clients with more acute needs and the High Unemployment Area Programme has been introduced to address unemployment in socio-economically deprived areas. FAS also engages with people facing imminent unemployment through company closures and layoffs.

Tax incentives
Tax and welfare policy has substantially altered in recent years, partly with a view to increasing financial incentives to work and getting rid of poverty traps. Rates of income tax have been lowered. For example, by 2002 about two thirds of employees has a tax rate below 30% compared to one third in 1998.

Active Labour Market Programmes
There is a range of active labour market policies to facilitate access to employment. These include training schemes of people from the Live Register, Tourism Training and the Vocational Training Opportunities Scheme. The Community Employment Scheme has provided substantial opportunities for the unemployed, although participation has dropped from a high of 40,000 in 1999 to 20,000 in 2003, reflecting a government "shift in emphasis … towards measures that have a greater emphasis on employability". Financial incentives in the form of welfare allowances are also offered, including the Back to Education Allowance, Back to Work Enterprise Allowance and the Back to Work Allowance.

More generally, the government's broad strategy for Lifelong Learning also aims to minimise unemployment. A report on the Taskforce on Lifelong Learning in 2002 and a white paper on adult education provides a framework for "ensuring basic skills for all." The National Adult Learning Council was established in 2002 to coordinate implementation of the strategy.

Job creation
Indirectly, the government's policies of job creation through encouraging entrepreneurship through indigenous and foreign investment and through the expansion of science, technology and innovation capabilities

FAS, the government agency with responsibility for labour force development, has a range of measures to promote access by the long term unemployed to the labour market. These include training of people on the live register, community employment, back to work allowances and vocational training. These interventions include:

- *'High Supports' Process* – aimed to meet the needs of people who because of age, literacy or other barriers are unlikely to succeed in getting a job in the open labour market.
- *RAPID Programme* – A government programme aimed at areas of high unemployment in the most disadvantaged urban areas
- *Community Employment* - Over 20,000 registered long-term unemployed participated in Community Employment in 2001.
- *Social Economy* - Launched in 2000 to support the development of social economy enterprises, focusing on people over 35 and over 3 years unemployed
- *Schemes for people with disabilities* - There are a number of schemes targeted at improving access to the labour market for people with disabilities. These are detailed in Section 4 below.
- *Lifelong Learning Strategy* – A government policy to enable the continuous adaptation and upgrading knowledge, skills and competencies throughout the lifetime of all workers

4 People with disabilities, employment and health

4.1 Labour market involvement of people with disabilities

The Irish Census in 2002 showed 8.3% of the population (or almost 324,000 people) with a long lasting health problem or disability. European statistics[53] indicate that in Ireland 2.7% of men and 2.2% of women report a severe chronic illness or disability (compared to European averages of 4.7% and 4.3% respectively) while 8.1% of men and 8.8% of women report moderate disability (compared to 9.3% and 10.6% European averages).

The 2002 census shows that just over 23% of those with a long lasting health problem or disability aged 15 to 64 are at work, compared to 53.1% at work for the total population.[35] The gap in participation rates widens with age.

Table 11: Rates of participation in the labour market of people with a longstanding illness or impairment compared to the general population

age group	total% at work	% with impairment at work
15-24	38	23
25-34	78	37
35-44	72	31
45-54	66	25
55-64	46	15

Source:CSO, Derived from 2002 Census, 2002

European statistics from 2001 indicate that the employment rates for people with both moderate and severe illnesses or disability in Ireland are below European averages (27% compared to 43% EU average for severe and 13% compared to an EU average of 22%).[53]

The *Quarterly National Household Survey* in 2002 [(54)] conducted research into disability in the workforce. It showed people with a impairment or health problem in Ireland working an average of 36.1 hours a week compared to a 37.7 average for the general population.

Table 11 provides a breakdown of the type of illness or impairment encountered by the population as a whole and indicates the extent to which each type of impairment impedes employment. The most commonly reported illness or impairment were Chest or Breathing related problems. The type of illness or impairment that provides the largest obstacle to employment is mental, nervous or emotional.

Table 12: Breakdown of type of health problem or impairment and percentages of respondents employment (Note: Some respondents provided more than one answer, hence the total greater than 100%)

Type of illness or impairment	Percentage	Percentage in employment
Arms or hands	14.9	34
Back or neck	37.8	43
Chest or breathing	41.5	50
Diabetes	12.2	59
Epilepsy	5.9	44
Hearing difficulty	5.6	46
Heart, blood pressure	39.2	41
Legs or feet	20.9	35
Mental, nervous or emotional	28.4	22
Seeing difficulty	4.7	*
Skin conditions	4.5	*
Speech impediment	1.3	*
Stomach, liver, kidney or digestive	11.7	48
Other progressive illness	15.4	*
Other longstanding problems	26.1	36

Source:CSO, QNHS Report on Disability in the Workforce, 2002

* Sample occurrence too small for estimation

Around 15% of all people with a impairment or longstanding illness have had their condition since birth. Just under a third have had it for 10 years or more. There is a similar pattern for people in employment. While most people's illness or impairment were either non-work related or birth related, the survey indicates that 5.2% of them (or 5,700) were work related accidents and 8.6% (or 9,300 people) were due to work related diseases.

The survey indicates that of all people with an impairment or illness (either in or out of employment) 44.5% say that their impairment restricts them considerably in the kind of work they do or could do and 21% say it restricts them only to some extent. Regarding the amount of work they can do, 42% say they are restricted considerably and 21% are restricted to some extent. Of the people with a an impairment or illness in employment, 19% say that their impairment restricts them considerably in the kind of work they do or could do and 28% say it restricts them only to some extent. 15% say they are restricted considerably in the amount of work they can do, and 26% are restricted only to some extent.

8.2% of people in employment with a chronic illness or impairment say that some form of assistance is provided to facilitate the work they do. Meanwhile 13.4% of those with an impairment but not in employment 13.4% (or 22,000 people) said that they would need some form of assistance to enable them to work.

The survey shows that the occurrence of impairment or illness is consistent across occupations, as illustrated in Table 12.

Table 13: Breakdown of occurrence of impairment or longstanding illness by occupation

Occupation	% with Illness/Impairment
Managers and Administrators	6.8
Professional	4.8
Associate Professional and Technical	6.1
Clerical and Secretarial	5.6
Craft and Related	5.5
Personal and Protective Service	7.2
Sales	5.6
Plant and Machine Operatives	6.5
Other	8.9

4.2 Health Impacts of Employment on People with an Impairment or Chronic Illness

4.2.1 Unemployment

As explained in detail in Section 3, unemployment is associated with a range of negative health impacts. Low income is a major problem. A recent survey of European member states(53) shows that around 94% of disabled people receive inadequate disability benefit and that a large proportion are in the bottom 10th of the spectrum of income distribution. A survey in Co. Kerry in 2000 showed that the most important aspects of employment for respondents were independence and financial security. (57)

The health impacts identified above will fall disproportionately on people with disabilities and create health inequalities. As illustrated in 4.1 above they are nearly twice as likely to be unemployed and will be particularly badly hit by the economic consequences of unemployment. Their coping mechanisms for dealing with the financial and psychological burdens of unemployment may not be as good as those of people free from disability or chronic illness. This may in turn exacerbate the existing illness or impairment and may prompt an accumulation of disadvantage and a downward spiral of poor health.

4.2.2 Job insecurity

Job insecurity has significant adverse effects on self-reported psychological and physical health outcomes(53) . Loss of job security has adverse effects on self-reported health and minor psychiatric morbidity, which are not completely reversed by removal of threats to jobs. People with disabilities will be more prone to job insecurity than the rest of the population.

4.2.3 Lower status employment

Where people with disabilities or a chronic illness are prevented from doing work commensurate with their abilities, or where they have a low level of control in their jobs, they will be more prone to ill health (see section 2.5). Studies described in Section 2 show links between employment grade and health, with monotonous work and a lack of control over work highlighted as important determinants of health.

4.2.4 Stigma

The stigma that is attached to people with disabilities in the workplace, (in particular those with mental health disabilities) has a negative impact on health. People with disabilities are frequently regarded solely as objects of care. These attitudes create social isolation, which can undermine health. Also, as data from an Irish Public Attitude survey (see 4.3 below) illustrates, many people have preconceptions about the ability of people with disabilities to be productive in the workplace. Undervaluing of their potential contribution in the workplace can lower self-esteem and consequently affect health.

4.2.5 Work place accident or disease

Many people are not born with their illness or impairment but develop it at some stage over the course of their lives and frequently they are avoidable. A report from EFILWC [53] estimated that in Europe sickness, work accidents and socio-economic factors increase the rate of disability and chronic illness from 5% at the beginning of working life to 40% at retirement age. Some of this is caused directly by work-related diseases or accidents. Data from Ireland suggest this may be the case for 14% of people with an impairment or chronic illness currently in employment. Accidents at work and professional diseases are the main reason for impairments and disabilities for people aged 45 to 54. [53]

4.2.6 Impacts on people with mental health difficulties

Studies (Ferrer I Carbonell et al, 2001. M.L. Baldwin et al, 1993, described by EFILWC[53]) find that people with mental health problems have more problems than people with other forms of impairment. They also tend to have the greatest difficulty finding employment, as indicated by Irish statistics in 4.1 above.

A regional Irish study on Employment and Depression[57] indicates the difficulties faced in the workplace by people with mental health difficulties. 54% of respondents felt that they had lost a job due to their depression. 55% said that their employers didn't know about their depression and 65% said that they would not tell their employers (although in 82% of the cases where their employer was told, the reaction was helpful). In the workplace the most common problems experienced were a lack of concentration (50%), tiredness and lethargy (35%) and a lack of confidence (25%). 53% felt that their pay and work status did not reflect their experience and education and 75% felt this was due to their depression. Half of the respondents also thought their depression adversely affected their chances of promotion.

A study of participants in the WorkLink rehabilitation programme in Ireland [57] between 1994 and 1999 is revealing about the extent of the difficulties experienced by people with mental health disabilities. Over half of the participants were in some form of employment. While 87% thought that they needed some form of ongoing vocational support in the workplace, only 53% said that this support was available to them.

4.3 Barriers to integration of people with disabilities in the labour market

The Equality Authority in Ireland identified a number of barriers for people with disabilities. [58]

Attitudinal - These include misconceptions and unfounded assumptions about the workplace capabilities of people with disabilities that prevent acceptance and deny them the opportunity for advancement commensurate with their abilities. In a recent survey commissioned by the National Disability Authority in Ireland [(56)] people were asked whether they thought people with disabilities should have the same employment opportunities as those without them. 81% said yes for physical disabilities, while 75% said yes for people with a learning disability and only 55% for people mental health impairment. 30% said people with a mental health impairment should not have the same opportunities as everyone else. Many believe employers were not willing to hire people with an impairment - nearly 60% in total. Of these 63% said it was because of special needs considerations, such as work facilities needing to be specially modified, need for additional medical insurance/expenses and the requirement for more sick leave. 44% believed that it was because of work ability and 38% thought it was because of safety considerations.

Another example is provided by a Royal College of Psychiatrists survey into schizophrenia and stigma. [(60)] 52% of people still believe schizophrenia entails a split personality and 57% believe that people with schizophrenia are dangerous, despite studies that show they are no more likely to be violent than someone from the general population.

In the Kerry survey on the needs of people with disabilities[(57)], 71% of employed respondents said their ability to progress as expected in their employment was due to reasons other than the physical limitations imposed by their impairment. One of the main reasons cited was the attitude of employers and colleagues.

Environmental - These barriers include the lack of proper access to buildings and facilities, toilets and sanitary facilities, canteen facilities, lack of signage and others.

Institutional – This refers to the lack of positive action that would encourage people with disabilities to apply for jobs and the lack of recruitment strategies, flexible working arrangements and other factors that would make accessing the labour market easier.

External – These include, for example, lack of transport that would enable people with disabilities to access employment, lack of access to information on work schemes and confusion among employers and employees about how schemes work.

4.4 Measures to address disadvantage in Ireland

The NEAP outlines a three-dimensional approach to integrating people with disabilities into the workplace. This comprises skills development, encouraging companies to hire people with disabilities and the provision of employment supports.

4.4.1 Employment Supports for People with Disabilities

FÁS is the main state organisation with responsibility for providing labour market services for people with disabilities and for achieving their integration into the labour market. Around 5,000 use their services each year and they have contracts with 20 agencies to provide specialist training.

The Employment Support Scheme offers financial assistance for the employment of people with disabilities whose work productivity levels are between 50-80% of usual performance. The Workplace Equipment/Adaptation Grant supports additional costs to

an employer in employing with an impairment. It also supports any additional costs of self-employment for people with disabilities. The Employee Retention Grant Scheme aims to keep people in employment if they acquire an illness, condition or impairment that puts their continued employment at risk. The Disability Awareness Training Support Scheme provides funding towards the cost of delivering in-company training to educate and inform staff about people with disability. The Job Interview Interpreter Grant funds interpreters to attend interviews for job seekers with a hearing or speech impairment. The Supported Employment scheme provides a job coach for people with disabilities who require initial support in the workplace. The Personal Reader Grant is for blind or visually impaired who need assistance with job related reading.

The regional Health Boards in Ireland also fund rehabilitative and lifestyle training Programmes. These include CAMUS, run by the National Training and Development Institute (NTDI), Worklink, run by Schizophrenia Ireland, Reach, run by Hospitalier Order of Saint John and Clubhouse, run by EVE Ltd.

The Programme for Government 2002 makes a commitment to “legislate for the achievement of the employed quota for people with disabilities in the civil and public service”. This target is to have 3% of the workforce with an impairment, creating 3,000 extra employment opportunities.

4.4.2 Legislative action to combat discrimination

There is a range of legislation in existence to help combat discrimination. The Employment Equality Act 1998 outlaws discrimination in employment on a number of grounds, including disability. Under this Act the Equality Authority has the power to conduct Equality reviews in some organisations. The act imposes a duty on employers to do all that is reasonable to accommodate the needs of a person who has a disability.

The Safety, Health and Welfare at Work Act 1989 states that ‘places of work shall be arranged to take account of people with disabilities’ and the Building Regulations Act 2000 provides for considering people with disabilities when constructing new buildings. A forthcoming Disability Bill aims to “underpin mainstreaming and provide for positive action measures to advance the participation of people with disabilities in society.” [51]

5 Older workers, employment and health

5.1 Demography and labour market involvement

Population ageing is a phenomenon across Europe that is driven by lower fertility rates, longer life expectancy and baby boomers’ ageing.[64] Demographic ageing in Ireland is less marked than in other EU member states. The old age dependency ratio (the number of people aged 65 years and older expressed as a percentage of the working population aged 15-64 years) in 2000 was 17%. This was the lowest in the European Union where the average in 2000 was 24%.

The population structure as at the 2002 census is presented in Table 13.Those aged over 65 years currently represent 11.1% of the Irish population compared to 16% of the total EU population.

Table 14: Irish population structure as of census 2002

Age group	Total		Male		Female	
	N	%	n	%	N	%
0-14	827,428	21.1	424,044	21.8	403,384	20.5
15-19	313,188	8.0	160,413	8.3	152,775	7.9
20-24	328,334	8.4	165,292	8.5	163,042	8.4
25-44	1,180,259	30.1	588,308	30.4	591,951	30.0
45-54	480,447	12.4	241,566	12.5	238,881	12.2
55-59	197,294	5.0	99,827	5.3	97,467	5.0
60-64	154,252	3.9	77,559	3.5	76,693	3.5
≥ 65	436,001	11.1	189,155	9.7	246,846	12.5
Total	3,917,203	100.0	1,946,164	100.0	1,971,039	100.0

Source: CSO

However, demographic projections from the CSO anticipate that this relatively favourable situation in Ireland will change over the next thirty years and a population structure that more closely resembles the rest of the EU is likely to emerge.(65)

The Irish employment rate for workers aged 55-64 is 45.1% compared to an EU average of 37.5%. The male employment rate in Ireland exceeded that for females (47.6% vs. 27.7%).(64) Table 14 presents the employment rates in Ireland classified by age group and sex for the first quarter of 2003.(63)

Table 15: Irish employment rates first quarter 2003, by age group and gender

Age group	Employment rate (%)		
	Males	**Females**	**Total**
15-19	26.4	21.0	23.7
20-24	70.2	61.6	65.9
25-34	87.1	72.6	79.9
35-44	89.0	64.1	76.5
45-54	83.8	55.3	69.6
55-59	72.5	39.6	56.2
60-64	54.2	22.9	38.6
Total	74.4	55.0	64.8

Source: CSO

5.2 Employment policy and older people: potential health impacts

5.2.1 Health impacts of unemployment

As discussed in detail in Section 3, unemployment has multiple negative effects on physical health including excess mortality, stress, depression and low self esteem. Older people will usually find it more difficult to withstand these negative health impacts. A large proportion of older unemployed people will be suffering illness or disability even before a job loss. The stress of unemployment may exacerbate this, making it even more difficult to regain access to the labour market. In addition, negative attitudes of employers

towards older workers in general, (see Section 5.3) will impede re-entry to the workforce and place older people at greater risk of poor health.

An analysis of duration on the Live Register in Ireland (which includes the unemployed and part-time and casual workers entitled to benefits) on Table 15 shows an age gradient that indicates older workers find it harder to regain access to full time employment.[83]

Table 16: Percentage in each age group continuously on Irish Live Register for 1 Year or More

Age	% on Live Register 1 Yr +
Under 20	12%
20 -24	19%
25-34	24%
35-44	32%
45-54	38%
55-59	33%
60-64	31%

Source: CSO, Derived from Live Register Age by Duration Analysis October 2003

Morris et al assessed the effect of unemployment and early retirement on mortality in a group of middle aged British men in a longitudinal study.[35] Those who experienced unemployment or early retirement tended to be older and come from lower occupational classes. These men were twice as likely to die as those continuously employed. Men who became unemployed or retired for reasons other than ill health were still more likely to die than men who remained continuously employed. Mortality was principally due to cancer and cardiovascular disease. The effects observed in this robust study were independent of age, social class, health-related behaviour or pre-existing health status, and provides strong evidence that moving out of employment can have a detrimental effect on older people's health.

5.2.2 Health impacts of early retirement

The health impacts of early retirement are poorly researched. This is partly due to the difficulty of distinguishing between early retirement which is truly voluntary from that which is coerced. Early retirement may be used as a means of reducing the workforce in harsh economic times and so its health effects may be mixed with those of unemployment.

Evidence from the Whitehall II study of British civil servants aged 54-59 found that mandatory retirement at the age of 60 had no effects on physical health. [74] A small improvement in mental health was found for workers who retired from high and medium grade job. However, these benefits did not extend to workers in low-grade jobs indicating that material circumstances may modify the positive effects of retirement on health.

5.2.3 Health impacts of job insecurity

Older workers are more vulnerable to the negative health impacts of job insecurity resulting from changes in the labour market. A Finnish study looked at the health impacts of a period of downsizing on local government employees who were continuously employment over this time.[77] While downsizing has a negative impact on health for all employees, older workers (44 years and older) were more likely to suffer long periods of sick leave (over 3 days) than younger employees. Sickness absence is a

recognised measure of ill health and has been shown in other studies to be an effective predictor of future mortality.[78]

5.2.4 Health impacts of the work environment

As discussed in Section 2, the physical and psycho-social work environment can have negative health impacts. Outlined below are some specific effects on older people.

Physical environment

In 2000, a survey on working conditions in Europe highlighted problems encountered in the workplace with "painful positions" and "heavy loads" featuring prominently.[79] Older workers are particularly vulnerable in this regard and have particular needs of protection from physical hazards in the workplace. For example, the recent Quarterly National Household Survey (health module) showed that the proportion of people with musculoskeletal problems rose with age.[68] 70% of workers aged between 45 and 54 years attribute the back problems that they suffer to work.[82]

Psycho-social environment

As outlined in Section 2, the more able a person is to deal with the demands of the workplace, the healthier they are likely to be. However, research suggests that older workers may be disadvantaged in this regard. A European survey showed that the proportion of employees who were not in receipt of training over the previous 12 months rose steeply with age. Older people are also more exposed to monotonous work, with the proportion that declared that their work did not enable them to learn new things rising steeply with age. The absence of task rotation rose with age.[82]

5.2.5 Health impacts of work-life balance

Attending to health needs

Older people often require more time to attend to their own health needs, for example to prepare nutritious meals, to exercise, and in some cases to attend to particular medical needs such as taking medication. Common ailments such as diabetes require a strong commitment to lifestyle changes. Ongoing or increased work commitments can reduce the time older people have to care both for themselves and for possible dependents. Employment policies that consider an appropriate work-life balance for older workers would be beneficial to health and would help to prolong people's working life by reducing the need to exit the workplace on the grounds of ill health.

Caring responsibilities

Many older people report the need to care for a dependent as the reason for leaving the workplace.[71]Others may be engaged in the care of extended family such as grandchildren. The 2002 census shows that while people over 50 make up 33% of the population over 15, they make up 40% of people providing unpaid help for a family member or friend with a long term illness or disability. They also make up 54% of those spending more than 43 hours a week doing so.[83] The wider health impacts of a reduction in the caring capacity of older people due to existing work circumstances or activation for work is unevaluated. Accommodation of older people's needs in this regard is recognised as important in Ireland by the recent NESF report on labour market issues for older workers. Improved access to Carer's Allowance and Benefit was recommended.[73]

5.3 Barriers to older people's participation in the workforce

5.3.1 Public Attitudes

In a European survey in 1992 on attitudes to ageing and older people the view that older people were discriminated against in job recruitment, promotion and training was frequently expressed (78.7%, 61.5% and 67.1% respectively). [72] In an Economic and Social Research Institute in Ireland survey of employers in Ireland on the participation of older people in the work place, negative attitudes were infrequent and preferences for recruitment was generally age neutral. [73] However, where a preference was expressed it more frequently favoured younger workers than older workers (29% versus 18% respectively);

5.3.2 Misconceptions about compulsory retirement

The National Council on Ageing and Older People in Ireland say that there is a common belief that retirement at the age of 65 is compulsory. However, there is no legal requirement to do so. The Equality Authority in Ireland has recommended raising awareness about this issue. In their report on implementing equality for older people they acknowledge that, while it is possible to work beyond the age of 65 years, obstacles may exist to people exercising this right. They also call for the review of upper age limits which exist in employee protective legislation.[65]

5.3.3 Attitudes towards early retirement

Many workplaces operate policies that facilitate the early exit of employees from the workplace. This is in line with the preferences of many employees. For example, in the Public and Corporate Economic Consultants survey in Ireland,[71] 50% of respondents said they retired to spend more time with family and friends and 36% felt that they had done enough paid work. However, 28% said that they left work because they felt they had no choice owing to their reaching "retirement age" or their company wanting them to retire. Employment policies may contribute to a workplace culture or an attitude in society as a whole that early retirement is 'expected'. This may create an environment that is hostile to the needs of older workers or devalues their contribution. As a result, some older people may be tacitly forced into retirement.[66]

A survey by the National Council on Ageing and Older People in Ireland in 2001 examined the preferences for employment and retirement of 55-69 year olds in Ireland.[67] Around 70% of those currently retired were happy with their decision. However, 26% of those not employed expressed a wish to take up some kind of work. A strong preference for more gradual retirement practices was also expressed. This suggests that some older people are ready and willing to work and more gradual retirement policies could be one way of retaining their contribution to the workforce.

Perceived barriers to return to employment expressed in the Public and Corporate Economic Consultants survey included difficulty getting to work because of age, difficulty finding work with suitable hours and the absence of financial reward. Flexible and part-time working arrangements and increased pay were identified as key potential inducements. The ESRI survey showed that provision of special supports for retention of older workers (such as flexible working, retraining and protection from shift work) was rare (12%).[73]

5.3.4 Ill health and disability

Poorer health is a potential barrier to older people's employment in Ireland.
The occurrence of ill health and disability increases with age in the general population and in the workforce. A recent survey on health [68] and disability in the workplace

illustrates the extent of chronic illness and disability in Ireland. For example, it showed that only 15.1% and 8.0% of those aged 55-64 years and 65 years and over respectively perceive their health as excellent compared with between 24.3% and 47.0% in younger age categories. Almost a quarter of those aged 55-64 years have a longstanding illness or disability, much higher than for those in younger age groups.

Early retirement on health grounds is common for older people. Illness and disability was the most common cause of early retirement in a recent study by the National Council on Ageing and Older People's.(67) A study on labour participation rates of the over 55's in Ireland, conducted for the Expert Group on Future Skills Needs found that 18% of retirement was due to health problems or disability.(71)

As illustrated in more detail in Section 4, it is important to consider the partial role that the workplace might play in causing or exacerbating chronic illness or disability in the first place. Disability may in some cases be a product of the workplace environment. Therefore, addressing health issues for the workforce as a whole regardless of age is one way of removing this barrier to a longer working life.

Regardless of the origins of the illness or disability, there is still a need to improve how employers accommodate the needs of older people with disabilities. The employment rate for older people with disability or chronic illness is lower than for older people without these problems. The issue of breaking down labour market barriers for people with disabilities is addressed in more detail in Section _.

5.3.5 Social inequalities in exit from the labour market

Social class as measured by occupational grade may also be a factor in the early exit from or difficulty gaining entry to the labour market. Whelan et al found in Ireland that 1 in 4 manual workers retired before the age of 60 compared with 1 in 7 professional and managerial workers. Manual workers also cited health reasons and redundancy more commonly as reasons for retirement than other occupational classes.(70)

5.4 Action for older workers in Ireland

In the National Employment Action Plan, although Irish employment rates for older people are acknowledged to compare favourably with EU targets, it is recognised that demographic and social change will require a "strategic approach towards recruiting, retaining and facilitating this groups need". (51) The Department of Social and Family Affairs "intends to review how older people can extend their working life without being financially or socially penalised and will seek to remove financial disincentives and the requirement on those aged 55-65 to retire in order to qualify for pension." (51)

Older people are also seen to benefit from existing equality structures, employment-friendly taxation for over-65's to improve the financial reward of working and changes in the Pre-retirement Allowance Scheme (PRETA) to include those who leave retirement for employment and subsequently become unemployed.

The Equality Authority issued recommendations on implementing equality for older people and protecting and promoting the status of older workers.(65) While asserting the right to retire with attendant entitlements, they recommend that obstacles to continuing work after 65 should be removed. Measures to remove obstacles to employment for those aged over 50 are also recommended.

The National Economic and Social Forum reported on labour market issues for older workers and referred to a number of programmes to attract and retain older workers.(73) These include the Task Force on Lifelong Learning (which includes promoting the employability of older people), the Cluster on Recruitment and Retention of Older

Workers, the SLM Food and Beverage Skillnet, the Flexible Training Unit in Tallaght, the Northside Partnership's Expanding the Workforce Programme and The Flexiwork Project (funded by the European Social Fund and coordinated by Trinity College Dublin).

6 Women, Employment and Health

6.1 Demography and labour market participation

In the 2002 census in Ireland there was an almost equal division of the population across gender, although females outnumbered males in older age groups, reflecting their longer life expectancy (Table 15).

Table 17: Irish population structure as of census 2002

Age group	Total		Male		Female	
	N	%	N	%	N	%
0-14	827,428	21.1	424,044	21.8	403,384	20.5
15-19	313,188	8.0	160,413	8.3	152,775	7.9
20-24	328,334	8.4	165,292	8.5	163,042	8.4
25-44	1,180,259	30.1	588,308	30.4	591,951	30.0
45-54	480,447	12.4	241,566	12.5	238,881	12.2
55-59	197,294	5.0	99,827	5.3	97,467	5.0
60-64	154,252	3.9	77,559	3.5	76,693	3.5
≥ 65	436,001	11.1	189,155	9.7	246,846	12.5
Total	3,917,203	100.0	1,946,164	100.0	1,971,039	100.0

Source: CSO[84]

Despite improvements in total workforce participation across Europe over the last decade, women continue to be under-represented.[85] In 2000 the EU average employment rate for men exceeded women (72.5% versus 54%). Table 16 shows the Irish employment rates for the first quarter of 2003 by age and gender and shows an even larger gap (70.4% versus 48.9%). This gap increases considerably in the older age groups. Married women experience lower employment rates than unmarried women.[86]

Table 18: Irish labour force participation rates first quarter 2003, by age, group and gender

Age group	Employment rate (%)				
	Males	Females			Total
		Single	Married	All	
15-19	30.3	23.4	…	23.5	27.0
20-24	76.3	66.1	47.9	65.3	70.8
25-34	92.0	83.7	64.3	75.5	83.8
35-44	92.8	79.5	63.0	66.2	79.4
45-54	87.1	72.9	54.5	57.2	72.1
55-59	74.9	53.4	38.3	40.7	58.0
60-64	55.2	32.9	21.5	23.2	39.2
Over 65	13.9	4.7	3.5	3.2	7.9
Total	70.4	58.6	47.8	48.9	59.5

Source: CSO[86]

Despite lower labour force participation women officially have lower unemployment rates than their male counterparts. This is partly due to recording mechanisms in Ireland which mean that women are less likely to be identified as actively seeking work.

Across Europe, women are more frequently employed in the service sector and on a part-time basis and they remain under-represented at a management level. Gender segregation also affects Irish women in paid employment. They work more frequently in the hotel/restaurant, education, health, and other service sectors. Women constitute a significantly smaller proportion of higher occupational groups such as managers and professionals.[86]

Women's working patterns are also different. On average, women work almost 10 hours less per week than men, and are 7 times more likely to identify themselves as part-time workers. They less frequently plan their own work and shifts, although the shift pattern of their work is similar to men.[87]

6.2 Health impacts of employment policy for women

6.2.1 Unemployment

The general link between unemployment and ill-health is established and has been discussed earlier in Section 3. An analysis of national surveys in Norway from 1968-1991 looked at inequalities in health related to women's marital, parental and employment status.[91] Health differences amongst women were found to be widening. Women in full-time employment enjoyed better health than women outside full-time employment but marital or parental status did not appear to make any difference to health. The authors suggest that social changes which occurred over the period of the study, including reduced esteem for homemaking and alleviation of the strain of combining domestic and workplace roles (including childcare facilities), may help explain the health advantage of women in full-time employment.

The gap in female-male employment rates is a pathway to women's poverty as identified by the National Women's Council of Ireland.[100] They suggest that harmonisation of employment with motherhood may be a mechanism to protect not only against their own

poverty, but also against that of their children. Policies that promote women's employment may improve health and reduce health inequalities. In Ireland, a health survey in 1998 showed better self-rated health amongst women in employment compared with those not employed.[92]

6.2.2 Job insecurity

In a cohort study of British civil servants during 1990s all workers who experienced job insecurity reported a significant worsening of self-rated health compared with those who experienced continuing job security. [93] Women who experienced reduced job security also reported an increase in long standing illness, something that was not observed in the male study participants. This suggests women may be particularly vulnerable to the effect of job insecurity. Women also showed a larger elevation in blood pressure associated with reduced job security, marking them at risk for cardiovascular disease.

In a study of local-government employees in Finland women suffered ill-health (as measured by work absenteeism) associated with downsizing. [77]

Part-time working and a shorter working week are common features of women's employment. Where these options are voluntarily chosen to improve work-life balance, the health impacts are likely to be positive. However, where part-time working is due to a limitation of occupational choices available to women, the danger of negative health impacts increase.

6.2.3 Workplace environment

The potential negative health impacts of the physical and psycho-social work environment are discussed in detail in Section 2. Women were found in a European survey to be relatively shielded from many of the physical working hazards as they participate less in more dangerous sectors such as agriculture or construction. [97]

The Whitehall II study of British civil servants showed that high job strain (including intensive working patterns, low control over work, and the absence of support from seniors and peers) was associated with increased risk of coronary heart disease in women (although the effect was less pronounced than in men).[94] The negative health impacts of low job control has been shown to impact differently across occupational classes in women, with those in middle or lower occupational classes most at risk for depression and anxiety.[95] In Ireland, a survey on the length and pattern of working time found that the proportion of women who plan their work themselves was lower than for men. [87] Narrower occupational opportunities and limited career advancement towards professional and managerial positions, may also be pathways to low work control, stress, and reductions in well-being.

The incidence of harassment, including sexual harassment (as outlined in Section 2) has potential health impacts. With over 3% of women reporting experience of sexual harassment in the workplace in Europe compared with less than 1% of men, health impacts will fall disproportionately on women.[88]

Shift work has been shown to be associated with negative health behaviour in women. A cross-sectional survey of Finnish nurses showed that those who worked shifts smoked more and were more obese than their day-working counterparts.[96]

6.2.4 Gender pay gap

Women who work earn less than men. Women in Europe earn 84% of the average gross hourly wage of men.[103] In Ireland this gap is larger. In 1998 women's earnings in Ireland were 80% of that of men, falling below the EU average.[85] This gender pay gap may is

an important pathway to poverty for women, with negative repercussions for their health and also for the health of their dependents, particularly in single parent households headed by women.

6.2.5 Work-life balance

The EFILWC states "the double workload remains a feature of women at work, due to their more active participation in the home and family".[88] They indicate a very sharp gender inequality in caring for children and in household tasks across Europe (with 86% of women compared to 25% of men being the main contributors in this area). They show that women spend more time on their children's education than men and women have a much larger role in caring for elderly or disabled relatives.

Given this gender inequality, the increased participation rate of women in the workforce (to the European target of 60%) may have a number of potential health impacts if it does not occur in a way that enables a work/life balance. A survey of Swedish women in employment showed that "double exposure" to a combination of job strain and greater domestic responsibility had a negative effect on health.[99] Initiatives which promote harmonisation of these dual roles, such as more flexible working arrangements and improved access to childcare facilities may help to promote health.

Many women not participating in the workforce provide valuable unpaid care to children, the elderly and others. For example, a recent Irish survey showed the significant proportion of childcare provided on a voluntary basis by relatives to parents who were working (31% for preschool children and 46% for primary school children).[98] The increased participation of women in the workplace may have negative health impacts on the recipients of care if it is not accompanied by increased alternative affordable caring facilities of sufficient quality, an appropriate work-life balance for carers joining the workplace or increased caring responsibilities for men. For women on low incomes, the prohibitive cost of childcare may negate the monetary benefits of employment and impede the improvement of health through poverty reduction.

6.3 Barriers to women's participation in the workplace

Combining household and paid employment

Evidence from the Third European survey on working conditions[88] illustrates the strain which female workers bear in combining duals roles in the household and in paid employment. They carry the main responsibility for shopping and household chores (85%, versus 25% of men), the care and education of children(41% of women spend greater than one hour per day at these tasks versus 24% of men) and the care of elderly/disabled relatives (16% of women provide this care at least once or twice a week compared with 8% of men). Failure to allow harmonisation of these dual roles is a potential barrier to women's employment and has been the target of recommendations by the National Women's Council of Ireland[89] and the National Economic and Social Forum.[90]

Low paid work

Women's hourly earnings are less than that of their male counterparts.[85]
This may be a potential disincentive for some women to join or remain engaged in the workforce.

Tax and social welfare disincentives

In their consideration of the capacity to alleviate labour shortages through activation of women workers, the National Economic and Social Forum (NESF) identify the current tax and social welfare system as potential barriers.[90] Means-testing of unemployment

payments against family income and joint assessment for tax for married women are identified in this report as potential disincentives. Individualisation of taxation has overcome some of these problems, but the detachment from the workplace to which it contributed to may still be hard for women to overcome.

The National Economic and Social Forum also points out that the operation of the live register may in itself provide a disincentive to women's working. Firstly, it does not accommodate the signing on of women who are only available for part-time work leading to their relative invisibility for policy makers. Secondly, their absence from the live register may leave women at a relative disadvantage in accessing opportunities for training and employment offered to those who are unemployed.[90]

Detachment from the workplace

Women's experience of prolonged detachment from the workplace is itself identified by the National Economic and Social Forum as a disincentive to re-integration into the workplace due to de-skilling and loss of confidence.[90]

Societal attitudes

Poorer female participation in the labour market, poorer remuneration and a workplace environment hostile to their specific needs exist in a wider context of societal attitudes that tend to marginalise women, for example, through the gender stereotyping of particular occupations and preconceptions about the role of women as homemakers.

6.4 Action in Ireland for women in the workplace

Following a report to the United Nations in 2002, a 5-year National Women's Strategy to advance the position of women in Ireland is now being planned by the Department of Justice, Equality and Law Reform (DJELR). The DJELR's Equality Unit provides training and advice on gender mainstreaming across Ireland's National Development Plan.

The Employment Equality Act 1998 prohibits discrimination in employment on a range of grounds including gender. In 2002 the Equality Authority dealt with 489 case files under this act. A Consultative Group on Male/Female Wage Differentials under the national Programme for Prosperity and Fairness is proposing actions to address the pay gap. The Equality Authority published a Code of Practice on sexual and other forms of harassment in the workplace. The individualisation of taxation has removed a disincentive to married women engaging in paid employment. The Department of Social, Community and Family Affairs' Working Group on Women's Access to Labour Market Opportunities made recommendations to promote the position of women. A childcare allowance by FAS was implemented subsequent to this report. County Enterprise Boards actively target women through, for example, "Women-In-Business" initiatives.

The government's commitment to the provision on childcare services is outlined in the National Employment Action Plan (NEAP). [51] The Department of Justice Equality and Law Reform is bringing key players together to promote delivery of childcare places as part of the National Development Plan. The government's Equal Opportunities Childcare Programme provides funding of €436 million up to 2006 that aims to provide 24,000 new childcare places. However, the NEAP states that "despite this investment, the attainment of the EU targets certainly presents a challenge." City and County Enterprise Boards provide further assistance for childcare projects.

The National Economic and Social Forum, in its report on measures to alleviate labour shortages, made a number of recommendations,[90] including a national support programme for women returners to address training needs and improve access to labour market programmes. A study by the National Women's Council of Ireland recommended

better reconciliation of women's caring role with paid employment through childcare and more flexible work practices, provision of a national support programme, enforcement of equal pay and action to combat sexual harassment and bullying. [102] The Combat Poverty Agency recommend measures to improve employment, education and training opportunities for women and childcare provision.[103]

7 Ethnic Minorities, Employment and Health

The Travelling Community

7.1 Demography and Labour Market Participation of the Travelling Community

The travelling community is Ireland's largest single ethnic minority. The Central Statistics Office attempted to describe the Traveller Community in 1996.[104] Results are shown in Table 17 which compares their population structure with that of the total population in the same period.

Table 19: Number and age structure of the Traveller Community in 1996.

Age group	Travellers		Total Population	
	N	%	N	%
0-14 years	5,454	50.1	859,424	23.7
15-64 years	5,290	48.6	2,352,781	64.9
Over 65 years	147	1.3	413,882	11.4
Total	10,891	100.0	3,626,087	100.0

Source: CSO[104]

The total number of Travellers counted in the 2002 census was higher, at 23,681.[105] However, this may reflect better counting rather than an actual doubling of their population size. The Traveller population is generally younger than the total population and are concentrated in the areas of Offaly, Fingal and Galway. A greater proportion of the travelling community is married, the age of marriage is generally younger and households tend to be larger.[104]

Travellers experience worse health than the general population. They have a lower life expectancy at birth with traveller men and women living on average 10 and 12 years less than men and women in the general population respectively. The infant mortality rate in the travelling community is 18.1 per 1,000 compared with a national figure of 7.4 per 1,000.[106]

Traveller participation in mainstream paid employment or identification on the Live Register as unemployed is hard to measure because these routine data sources do not specifically identify travellers. Employment of travellers outside mainstream economies in the so-called "Traveller economy" (see below) may also go unmeasured by usual data sources. The recent census allowed travellers to provide information for themselves and may provide useful insights into their employment experiences.

7.2 Health impacts of employment policy on travellers

The health impacts of employment policy on the Traveller Community are poorly studied. As routine data in these areas do not record their ethnic status, they cannot be

specifically identified and remain relatively “invisible” unless dedicated studies are undertaken. While this makes precise connections difficult to make, some of the potential impacts are described here.

Unemployment is an important pathway to the poverty that Travellers’ suffer. Unemployment also affects their social links with other communities and contributes to their social exclusion. Travellers’ representatives say that employment opportunities that promote Traveller culture (such as support for the Traveller economy and employment in community development programmes around issues such as health and youth) may benefit the health and well-being both of participants and of the wider Traveller community. [(122)]

Once in employment, Travellers may occupy positions in the workplace which have negative impacts on health. For example, poorer education and training means they may work in jobs with high job strain, or which place them at risk from physical hazards, e.g. construction. Negative attitudes to Travellers means they may experience poorer job security. Pavee Point’s series of in-depth interview on Travellers experience of mainstream employment show that sometimes respondents’ work was downgraded on discovery of their ethnic status. Many respondents saw this as a tacit policy to force them out of employment.[(121)] The offering of casual exploitative work to younger travellers was also noted in this research.

Their unique culture in terms of family size and accommodation circumstances leads to different work-life balance needs from the total population, which may not be recognised. This may be an added source of stress to Travellers who are adapting to employment. Use of the home base as a workplace, sometimes a feature of the Traveller economy, may lead to exposure to hazardous materials such as scrap metal in the absence of storage facilities[(122)] .

Their experience of racism in the workplace may have negative effects on Traveller’s mental health and well-being. Pavee Point shows Travellers hide their ethnic identity to secure and retain employment.[(121)] Respondents identified this as “very stressful and emotionally draining”. Positive experiences of mainstream employment are also noted in the Pavee Point report, including increase in self-esteem and better social mixing.

7.3 Barriers to Travellers’ participation in the workplace

Education and Skills

A report of the Task Force on the Travelling Community pointed to extremely low participation among traveller children in education.[(107)] Illiteracy levels in this group are also high. Not only is this a barrier to employment, but once employed, it may limit the nature of work which travellers are engaged in, for example in terms of earnings, security, and physical safety.

Training and employment support services

Failure to meet distinctive Travellers needs in terms of training and employment support is a barrier to their integration into the workplace. A number of potential problems were identified in a report promoting equality in the workplace in Ireland[(108)] and by Pavee Point. Staff training in Traveller relations was identified as a particular need. Early marriage among traveller women was a barrier to their signing on the Liver Register and receiving the associated benefits (although more individualisation of taxation will go some way to overcome this). Allowances paid on community employment schemes are more suited to young single people without dependents and fail to accommodate a

younger age at marriage and larger families which are more common in the Travelling community.

Support for the "Traveller Economy"

The "Traveller Economy" refers to work initiated by travellers and usually includes casual trading and recycling and involves self-employment and families working together and incorporates a lifestyle of mobility (personal communication, Pavee Point September 2003). Failure to support these initiatives, that are key in sustaining and promoting the Traveller community, is a barrier identified in a report on equality in the workplace in Ireland.[(108)] Pavee Point also reported on the importance of market trading to the Traveller economy and have called for its support by local and central government.[(120)]

Employer Attitudes

A recent survey on behalf of the Equality Authority in Ireland [(109)] highlighted the dearth of workplace infrastructure to support and promote equality on the basis of ethnic grounds. It surveyed 300 private sector organisations across a range of activities and sizes, and 100 public sector organisations excluding government departments. Only 11% of organisations singled out the Traveller Community for specific mention in written policies and nine in every ten organisations reported no specific action to promote equality or avoid discrimination against Travellers. In an introduction to its report on the inclusion of Travellers in the mainstream labour market. , Pavee Point highlights the results of a 2000 survey in which 15% of Travellers said they had experienced discrimination by employers[(121)] and their in-depth interviews with Travellers also highlighted a pervasive sense of discrimination.

Social Exclusion

The lower participation of Travellers in mainstream is part of a wider social context wherein negative stereotyping results in prejudice and social exclusion. While concerted inter-sectoral efforts are underway to promote their inclusion in all areas of Irish society (ref NAPS), prejudice remains an important barrier.

7.4 Action in Ireland for travellers

The marginalised position of Travellers in the workplace may be improved by equality legislation and by the establishment of the Equality Authority, which in its document "Building an Intercultural Society" highlights the importance of equality in employment.[(111)] The National Anti Poverty Strategy also has targets to increase traveller participation rates in education.

A 1997 report on good practice to promote equality in the workplace in Ireland identified the Local Employment Service and Community Employment Scheme as important to Traveller integration into the workplace.[(109)] For example, an initiative between the Tallaght Partnership, Local Employment Service and the Traveller Interest Group of the Tallaght Partnership promotes Traveller inclusion including the employment of a Mediator/Outreach worker. Specific changes were also made to the FAS Community Employment Schemes to target Travellers. These included changes to limits on age and time spent unemployed and the development of special community employment projects.

Pavee Point has highlighted a number of initiatives to promote employment opportunities for Travellers. Under the EQUAL initiative (an EU funded project to identify and address forms of discrimination and inequality in the labour market), a project is currently running to promote the Traveller economy. Through the Vocational Education Committees, Senior Traveller Training Centres have been established to promote skills development. Promotion of community development work, in particular in the areas of health and younger people, is a source of employment for Travellers to provide services to their own

community. FAS also operate advocacy services to help to integrate Travellers into mainstream training and employment.

Migrants

7.5 Demography and Labour Force Participation of migrants

Ireland has experienced an increased inflow of non-EU and non-US immigrants a over the last decade with as illustrated in Table 18.[112]

Table 20: In migration to Ireland 1995-2002 by source area

Year	In migration (thousands of persons)			
	From UK	From rest of EU	From USA	From Rest of the World
1995	15.6	6.3	3.8	5.5
1996	17.6	7.2	6.4	8.0
1997	20.0	8.1	6.6	9.3
1998	21.1	8.7	4.9	9.3
1999	21.6	10.0	5.7	10.2
2000	16.4	9.8	4.6	11.5
2001	15.5	8.7	4.4	17.5
2002	13.1	8.5	4.1	21.8

Source: CSO[112]

The number of asylum seekers has also increased from approximately 400 in 1995 to approximately 10,300 in 2001, with Nigerians and Romanians forming the largest groupings.[113]

Table 19 illustrates the breakdown of those counted in the 2002 census by nationality.[114]

Table 21: Distribution of nationalities across the total population in 2002.

Nationality			n	%
Total Irish			3,584,975	92.9
Non Irish	*of which*		224,261	7.1
	EU	*of which*	133,436	3.5
		UK	103,476	2.7
	Rest of Europe	*of which*	23,105	0.6
		Romania	4,978	0.1
	Africa	*of which*	20,981	0.5
		Nigeria	8,969	0.2
	Asia	*of which*	21,779	0.6
		China	5,842	0.2
America			15,383	0.4
Australia			3,706	0.1
Not Stated			48,412	1.3
Total			3,858,495	

Source: CSO[114]

The share of all non-nationals in the labour force increased from 3.3% in 1998 to 5.6% in 2002. [123] The number of work permits issued to non_EU nationals increased from 5,750

in 1990 to 40,504 in 2002[123]. Almost two thirds of these were to newly arrived workers.[113]

Some sources of routine data do not record ethnic status and this is an obstacle to further exploring ethnic experiences of employment and health in Ireland. Also, ethnic minorities who are seeking asylum are not permitted to be available for work and so cannot sign on to appear on the live register.

7.6 Health impacts of employment on migrants

Ruhs highlights the "very limited availability of information about the characteristics, employment conditions … and the trends and patterns of employment of foreign workers in Ireland." [123] This makes it difficult to assess potential health impacts in a systematic way. However, information emerging from a number of studies indicate a number of concerns about potential health impacts.

In a study on the public health of asylum seekers in Ireland [115] 89% of respondents reported "not being allowed to work" and 76% reported "loneliness and boredom" as sources of post-migratory stress. Symptom checklists identified over half of the participants suffering from anxiety and 47% as depressed. Lack of occupational activity was identified as a key concern for health and well-being, both by asylum seekers and by health service providers. Employment is a key source of social networks, which are proven to be beneficial for health. Study participants frequently experienced social alienation.

For those who do find work, problems unique to their migrant status may affect their health. An Equality Authority report on the experiences of migrant workers[117] in Ireland highlights how concerns over their legal status and right to remain in the country may produce job insecurity.

"Deskilling" due to a failure to recognise qualifications and experience also has important effects on health as highlighted in a Europe-wide report.[118] This can have negative effects on self-esteem and mental health. It may also lead migrant workers into 'unhealthy' jobs in poor physical working conditions, low job control and poor support from superiors and peers. An analysis in Ireland showed that work permit holders tend to be concentrated in unskilled and semi-skilled occupations. [123] For example, 24.5% of non-EU nationals are plant and machine operatives in 2002 compared to 10% in 1998. The percentage working in the higher skills categories (professionals, managers and administrators and associate professionals and technicians) has fallen from 54% in 1998 to 35% in 2002. Only 3% of workers from EU accession countries are in these higher skilled jobs.

Enforced overtime was also common, which may negatively impact on their health (as outlined above in point 2.7.2). Rates of pay less than the hourly minimum were identified in this study, increasing the likelihood of poverty and poor health both for their workers and dependents. Also, their experience of racism as reported by a number of sources[115,116,117,118]is a feature of work life for migrants which may negatively affect their mental health and wellbeing.

Barriers to migrants participation in the workplace

Legislative barriers

Migrants from outside the EU area cannot work in Ireland without a work permit. Permits are usually only issued in cases wherein an Irish or EEA citizen is unable or unwilling to accept the work. Since July 2000, incoming asylum seekers, and those who were not

present in the country for one year, do not receive the right to work. Recommendations for legislative change in this regard have proceeded from a number of reports.[115,116]

Skills and Training
A study on behalf of the Irish Refugee Council examined asylum seekers right to work in Ireland.[115] The report points out that asylum seekers with the right to work were not considered eligible for welfare schemes until they had been in receipt of unemployment assistance for more than twelve months. In addition, they were not entitled to third level education or Post Leaving Certificate courses without paying fees applicable to those from outside EU areas. Neither were they entitled to attend state-funded English languages courses or to attend state-funded employment training courses. It showed that asylum seekers had poor knowledge of their rights and entitlements for education and training. 83.8% of respondents in this study felt they needed training to find work in Ireland, but few were receiving it. Barriers to training identified included inaccurate information about eligibility and language difficulties.

Failure to recognise qualifications or skills was an experience voiced in interviews with asylum seekers. Accreditation of overseas skills and qualifications along with specific education and training services to target asylum seekers have been recommended.[115]

Employer Attitudes
An overview of equality infrastructure, on behalf of the Equality Authority, in organisations in Ireland revealed poor attention to the possibility of racially based discrimination.[109] It surveyed 300 private sector organisations across a range of activities and sizes, and 100 public sector organisations excluding government departments. It found, for example, that only 64% of public organisations and 46% of private organisations had “taken any steps to promote equality and/or avoid discrimination” in the area of race. 18% of all organisations had an all-embracing written equality policy which specifically mentions race/ethnic minority group membership and only 11% had organised anti-racism training for staff.

Racism
Those migrants with the right to work may experience racism as a barrier to integration in the workplace. This was an experience voiced in the qualitative component of the Irish Refugee Council study on asylum seekers and the workplace.[115]

For those in employment, their experience of recruitment and the workplace also indicate the racially based hostility.[117] However, this experience is not uniform, and some workers were satisfied with their working relationships and environment.

7.7 Irish initiatives for migrant workers

Migrant workers are not a specific focus in the National Employment Action Plan. A number of sources have recommended the extension of working and training rights to asylum seekers.[115, 116] However, initiatives to promote employment for migrants, and in particular for asylum seekers are scarce.

Equality structure and anti-racism policies and programmes aim to prevent discrimination against this group and to promote better integration into the workplace.[110, 111] KNOWRACISM, the national anti-racism awareness programme was established by the government in 2000 and has a steering group which includes members from governmental departments, voluntary organisations, including those run by ethnic minorities, representatives of the four social partners, non-governmental nominees and national bodies such as the Equality Authority. It runs a national anti-racism in the

workplace week.[119] SONAS, an initiative established under the EU scheme EQUAL, aims to support the social needs of Asylum Seekers and to influence policy.

References

1 European Foundation for the Improvement of Living and Working Conditions (2000), The Third European Survey on Working Conditions, 2000, EFILWC. http://www.eurofound.eu.int

2 European Foundation for the Improvement of Living and Working Conditions (2002), Employment Status and Health, EFILWC, Dublin

3 European Foundation for the Improvement of Living and Working Conditions (2002), Gender, Jobs and Working Conditions in the EU, EFILWC, Dublin

4 Benach, J., Gimeno, D. and Benavides, F. G. (2002), Types of Employment and Health in the European Union European Foundation for the Improvement of Living and Working Conditions, Dublin

5 European Foundation for the Improvement of Living and Working Conditions (2001), The Impact of New Forms of Work Organisation on Working Conditions and Health, EFILWC, Dublin

6 Platt, S., Pavis, S. and Akram, G. (1998), Changing Labour Market Conditions and Health: A Systematic Literature Review (1993-98) - New Approaches to Improve the Health of a Changing Workforce, EFILWC, Dublin

7 European Foundation for the Improvement of Living and Working Conditions (1998), The Social Implications of Teleworking, EFILWC, Dunlin

8 European Foundation for the Improvement of Living and Working Conditions (2003), Working Time Preferences and Work/Life Balance in the EU: Some Policy Considerations for Enhancing the Quality of Life, EFILWC

9 European Foundation for the Improvement of Living and Working Conditions (2003), A New Organisation of Time over Working Life, EFILWC

10 European Foundation for the Improvement of Living and Working Conditions (2002), Temporary Agency Work: National Reports, EFILWC, Dublin

11 Bosma, H., Marmot, M., Hemingway, H., Nicholson, A., Brunner, E. and Stansfeld, S. (1997) British Medical Journal, Low Job Control and Risk of Coronary Heart Disease in Whitehall Ii (Prospective Cohort) Study

12 Irish Marketing Survey's (2001), Do You Feel Stressed? A Survey of the General Public Mental Health Association of Ireland

13 O'Connell, P. and Williams, J. (2000), The Incidence and Correlates of Workplace Bullying in Ireland, Economic and Social Research Institute

14 Virtanen, P., Vahtera, J., Kivimaki, M., Pentti, J. and Ferrie, J. (2002), Journal of Epidemiology and Community Health, Employment Security and Health, 56, 569-574

15 Economic and Social Research Institute (2002), Impact Evaluation of the European Employment Strategy

16 Mausner_Dorsch, H. and Eaton, W. (2000), American Journal of Public Health, Psychosocial Work Environment and Depression: Epidemiologic Assessment of the Demad-Control Model, 90

17 Marmot, M., Bosma, H., Hemingway, H., Brunner, E. and Stansfeld, S. (1997), The Lancet, Contribution of Job Control and Other Risk Factors to Social Variations in Coronary Heart Disease Incidence

18 Central Statistics Office (2000-2002), Quarterly National Household Survey Ireland:
- Travel to Work: 1st Quarter 2000,
- Length and Pattern of Working Time: 2nd Quarter 2001,
- Module on Teleworking: 3rd Quarter 2002, Central Statistics Office, Cork.
http://www.cso.ie

19 Marmot, M. and Wilkinson, R. (Eds.) (2003), The Solid Facts - Social Determinants of Health, Oxford University Press
20 Rajaratnam, S. and Arendt, J. (2001), The Lancet, Health in a 24 Hour Society, 358
21 Health and Safety Authority (2002), Annual Report 2002 Health and Safety Authority. http://www.hsa.ie
22 Marmot, M. and Wilkinson, R. (Eds.), The Solid Facts, World Health Organisation - Social Determinants of Health
23 Centre for Health Promotion Studies (2003), The National Health and Lifestyle Surveys University College Galway, Galway
24 European Foundation for the Improvement of Living and Working Conditions (1998), Precarious Employment and Working Conditions in the EU, EFILWC,
25 European Foundation for the Improvement of Living and Working Conditions (2000), Employment Options and Labour Market Participation, EFILWC,
26 Health and Safety Authority (2003), HSA Annual Report Reveals Significant Decrease in Workplace Injuries Dublin. http://www.hsa.ie
27 Health and Safety Authority (March), Health and Safety Authority Webpage. http://www.hsa.ie
28 Health and Safety Authority (2001), Launch of Landmark Report on Bullying in the Workplace. http://www.hsa.ie
29 Harrington, J. (1994) Academic Medicine Singapore, Shift Work and Health - a Critical Review of the Literature on Working Hours, 5
30 Spurgeon Harrington and Cooper (1997), Occupational and Environmental Medicine, Health and Safety Problems Associated with Long Working Hours, 6, 367-375
31 Van Der Hulst, M. (2003) Scandinavian Journal of Work and Environmental Health, Long Workhours and Health, 3, 167 - 169
32 Hoshuyama, T. (2003), Sangyo Eiseigaku Zasshi, Overwork and Its Effects - Current Status and Future Approach Regarding Karoshi, 5, 187 - 193
33 Park, J., Kim, Y., Cho, Y., Chung, H., Iwasaki, K., Oka, T. and Hisanaga, N. (2001), Industrial Health, 3, 244 - 249
34 Malinauskiene, V., Theorell, T., Grazuleviciene, Malinauskas, R. and Azaraviciene, A. (2004), Journal of Epidemiology and Community Health, Low Job Control and Myocardial Infarction Risk in the Occupational Categories of Kaunas Men, 131-135
35 Central Statistics Office (2003), Census 2002 - Principal Socio-Economic Results, Cork. http://www.cso.ie
36 The Department of Enterprise Trade and Employment (2003), National Employment Action Plan 2003-2005, The Department of Enterprise Trade and Employment, Dublin. http://www.etemp.ie
37 Brenner, H. Dg Employment and Public Health. Final Report to European Commission Directorate General Employment, Industrial Relations and Social Affairs Dg Empla/a/1 (Vc2001/0224) Berlin University of Technology, Yale University and Johns Hopkins University,
38 Bartley, M. (1994), Journal of Epidemiology and Community Health, Unemployment and Ill Health: Understanding the Relationship,
39 Morris, J., Cook, D. and Shaper, A. (1994), British Medical Journal, Loss of Employment and Mortality,
40 Mathers, D. and Schofield, D. (1998), Medical Journal of Australia, The Health Consequences of Unemployment: The Evidence. http://www.mja.com.au41
41 Whelan, C. (1994), European Sociological Review (The Economic and Social Research Institute, Ireland), Youth Unemployment and Psychological Distress, 10
42 Hannon, D., O'Riain, S. and Whelan, C. (1997), Journal of Adolescence (The Economic and Social Research Institute, Ireland), Youth Unemployment and Psychological Distress in the Republic of Ireland, 20, 307-320

43 Marmot, M. (2003), British Medical Journal, Self Esteem and Health,
44 Layte, R. and O'Connell (2001), Moving On? The Dynamics of Unemployment in Ireland during the 1990's, Combat Poverty Agency, Dublin
45 The Institute of Public Health in Ireland (2002), Giving People a say on Poverty and Health, The Institute of Public Health in Ireland, Dublin. http://www.publichealth.ie
46 Balanda, K. and Wilde, J. (2003), Inequalities in Perceived Health: A Report on All-Ireland Social Capital and Health Survey, The Institute of Public Health in Ireland, Dublin. http://www.publichealth.ie
47 Marmot, M. and Wilkinson, R. (Eds.) (2003), The Social Determinants of Health: The Solid Facts, Oxford University Press
48 The Institute of Public Health in Ireland (2001), Report of the Working Group on the National Anti Poverty Strategy and Health, The Institute of Public Health in Ireland, Dublin. http://www.publichealth.ie
49 World Health Organisation (02/10/2003), World Health Organisation. www.who.int/mentalhealth/en
50 FÁS (02/10/2003), Fás Website. http://www.fas.ie
51 Department of Enterprise Trade and Employment (2003) National Employment Action Plan 2003-2005. http://www.entemp.ie
52 Knight, S. and Wishart, T. (2001), A Comparison of Employment Initiatives by Three European Partners to Combat Social Exclusion of Mentally Ill Persons and Their Families
53 Grammenos, S. (2003), Illness, Disability and Social Inclusion - European Foundation for the Improvement of Living and Working Conditions Centre for European Social and Economic Policy, (CESEP)
54 Quarterly National Household Survey (2002), Quarterly National Household Survey - Disability in the Workplace, Second Quarter 2002 Quarterly National Household Survey
55 FÁS (2002), The Irish Labour Market Review FÁS. http://www.fas.ie/FASREVIEW
56 NDA (2001), Public Attitudes to Disability in the Republic of Ireland NDA
57 Kerry Network of People with Disabilities in Ireland (2000), Visualising Inclusion: Summary Research Report on the Needs of People with Disabilities in Kerry, Kerry Network of People with Disabilities in Ireland
58 Equality Authority Positive Action for the Recruitment and Retention of People with Disabilities in the State Sector, Equality Authority
59 Murdoch, H. (2003), Mental Health in Ireland: The Law and the Reality; an Overview of Recent Legislation, Statistics and Rehabilitation Mental Health in Ireland
60 Equality Authority (2001), Research Project on the Effective Recruitment of People with Disabilities into the Public Service 2000, Equality Authority
61 Office for the Official Publications of the European Communities (2002), Eurostat and European Commission Directorate for Employment and Social Affairs. The Social Situation in the European Union Office for the Official Publications of the European Communities, Luxembourg
62 Central Statistics Office (26/08/03), Regional Population Projections 2001-2031. http://www.cso.ie/publications/labour/qnhs.pdf
63 Central Statistics Office (26/08/03,) Quarterly National Household Survey, First Quarter 2003, Central Statistics Office, Dublin. http://www.cso.ie/publications/labour/qnhs.pdf
64 National Council on Ageing and Older People (2003), Ageing in Ireland Fact File No. 4: Work and Retirement, National Council on Ageing and Older People. http://ncaop.ie/researchpub/factfiles/ff4work.pdf
65 Equality Authority (2002), Implementing Equality for Older People The Equality Authority, Dublin. http://www.equality.ie/stored files/PDF/Implementing%20Equality%20for%20Older%20People.pdf

66 European Foundation for the Improvement of Living and Working Conditions (1999), Active Strategies for an Ageing Workforce, Conference Report Office for official publications of the European Communities, Luxembourg. http://www.eurofound.eu.int/publications/files/EF9962EN.pdf

67 Fahey, T., Russel, H. and The National Council on Ageing and Older People (2001), Older People's Preferences for Employment and Retirement in Ireland, The National Council on Ageing and Older People, Dublin

68 Central Statistics Office (2002), Quarterly National Household Survey, Health - Third Quarter 2002, Central Statistics Office, Dublin. http://www.cso.ie/publications/labour/health.pdf

69 Central Statistics Office (2002), Quarterly National Household Survey, Disability - Second Quarter 2002, Central Statistics Office, Dublin. http://www.cso.ie/publicatios/labour/disability.pdf

70 Whelan, C. and Whelan, B. (1988), The Transition to Retirement Economic and Social Research Institute, Dublin

71 Forfás (2001), Labour Participation Rates of over 55's in Ireland: A Study for the Expert Group on Future Skills, Needs and the National Competitiveness Council Public and Corporate Economic Consultants, Dublin. http://www.forfas.ie/futureskills/reports/over_55s/over_55s.pdf

72 European Commission and Directorate-General for employment industrial relations and social affairs (1993), Age and Attitudes: Main Results from a Eurobarometer Survey, Office for official publications of the European Communities, Luxembourg

73 The National Economic and Social Forum (2003), Labour Market Issues for Older Workers - Forum Report No. 26, The National Economic and Social Forum, Dublin. http://www.nesf.ie/nesf_pub26.pdf

74 Mein, G., Martikainen, P., Hemingway, H., Stansfeld, S. and Marmot, M. (2003), Journal of epidemiology and Community Health, Is Retirement Good or Bad for Mental and Physical Health Functioning? Whitehall Ii Longitudinal Study of Civil Servants, 57, 46-49

75 European Foundation for the Improvement of Living and Working Conditions (1997), Precarious Employment and Working Conditions in the European Union, European Foundation for the Improvement of Living and Working Conditions, Loughlinstown. http://www.eurofound.eu.int/publications/files/EF9742EN.pdf

76 Central Statistics Office (2001), Quarterly National Household Survey Length and Pattern of Working Time - Second Quarter 2001, Central Statistics Office, Dublin. http://www.cso.ie/publications/labour/working.pdf

77 Vahtera, J., Kivimaki, M. and Pentti, J. (1997), The Lancet, Effect of Organisational Downsizing on Health of Employees, 350, 1124-1128

78 Kivimaki, M., Head, J., Ferrie, J., Shipley, M., Vahtera, J. and Marmot, M. (2003), British Medical Journal, Sickness Absence as a Global Measure of Health: Evidence from Mortality in the Whitehall Ii Prospective Cohort Study, 327, 364-370

79 European Foundation for the Improvement of Living and Working Conditions (2001), Third European Survey on Working Conditions 2000, Office for the Official Publications of the European Communities, Luxembourg. http://www.eurofound.eu.int/publications/files/EF0121EN.pdf

80 Kuper, H. and Marmot, M. (2003), Journal of Epidemiology and Community Health, Job Strain, Job Demands, Decision Latitude and Risk of Coronary Heart Disease within the Whitehall Ii Study, 57, 147-153

81 Department of Enterprise Trade and Employment (2002,) Employment Action Plan 2002, Department of Enterprise Trade and Employment, Dublin. http://www.eurofound.eu.int/publications/files/EF02106EN.pdf

82 Molinie, A. and European Foundation for the Improvement of Living and Working Conditions (26/09/2003), Age and Working Conditions in the European Union. http://www.eurofound.eu.int/publications/files/EF02106EN.pdf

83 Central Statistics Office (2003) Live Register Age by Duration Analysis, Central Statistics Office, Cork. http://www.cso.ie

84 Central Statistics Office (02/09/2003), Principal Statistics. http://www.cso.ie/principalstats/pristat2.html

85 Eurostat and European Commission Directorate for Employment and Social Affairs (2002), The Social Situation in the European Union 2002, Office for the Official Publications of the European Communities, Luxembourg

86 Central Statistics Office (2003), Quarterly National Household Survey, First Quarter 2003, Central Statistics Office, Dublin. http://www.cso.ie/publications/labour/qnhs.pdf

87 Central Statistics Office (2001), Quarterly National Household Survey Length and Pattern of Working Time, Second Quarter 2001, Central Statistics Office, Dublin. http://www.cso.ie/publications/labour/working.pdf

88 European Foundation for the Improvement of Living and Working Conditions (2001), Third European Survey on Working Conditions 2000, Office for the Official Publications of the European Communities, Luxembourg. http://www.eurofound.eu.int/publications/files/EF0121EN.pdf

89 Murphy, M. A Women's Model for Social Welfare Reform, National Women's Council of Ireland. http://www.nwci.ie/documents/swr.doc

90 The National Economic and Social Forum (2000), Alleviating Labour Shortages - Report No. 19, The National Economic and Social Forum, Dublin. http://www.nesf.ie/!NESFLAB.PDF

91 Elstad, J. (1996) Social Science Medical, Inequalities in Health Related to Women's Marital, Parental, and Employment Status - a Comparison between the Early 70's and the Late 80's, 42, 75-89

92 Kelleher, C., Friel, S., NicGabhainn, S. and Tay, J. (2003), Social Science Medical, Socio-Demographic Predictors of Self-Rated Health in the Republic of Ireland: Findings from the National Survey on Lifestyles, Attitudes and Nutrition (Slan), 57, 477-486

93 Ferrie, J., Shipley, M., Stansfeld, S. and Marmot, M. (2002), Journal of Epidemiology and Community Health, Effects of Chronic Job Insecurity and Change in Job Security on Self Reported Health, Minor Psychiatric Morbidity, Physiological Measures, and Health Related Behaviours in British Civil Servants: Whitehall Ii Study, 56, 450-454

94 Kuper, H. and Marmot, M. (2003), Journal of Epidemiology and Community Health, Job Strain, Job Demand, Decision Latitude and Risk of Coronary Heart Disease within the Whitehall Ii Study, 57, 147-153

95 Griffin, J., Fuhrer, R., Stansfeld, S. and Marmot, M. (2003), Social Science Medical, The Importance of Low Control at Work and Home on Depression and Anxiety: Do These Effects Vary by Gender and Social Class, 54, 783-798

96 Kivimaki, M., Kuisma, P., Virtanen, P. and Elovainio, M. (2001), Work Stress, Does Shift Work Lead to Poorer Health Habits? A Comparison between Women Who Had Always Done Shift Work and Those Who Have Never Done Shift Work, 15, 3-13

97 European Foundation for the Improvement of Living and Working Conditions (1998), Gender and Working Conditions in the European Union, European Foundation for the Improvement of Living and Working Conditions, Loughlinstown. http://www.eurofound.eu.int/publications/files/EF9759EN.pdf

98 Central Statistics Office (2003), Quarterly National Household Survey, Childcare - Fourth Quarter 2002, Central Statistics Office, Dublin

99 Krantz, G. and Ostergren, P. (2001), European Journal of Public Health, Double Exposure: The Combined Impact of Domestic Responsibilities and Job Strain on Common Symptoms in Employed Swedish Women, 11, 413-419

100 The National Women's Council of Ireland (2000), Out of Sight: The Hidden Poverty of Women - NWCI Policy Discussion Paper, The National Women's Council of Ireland, Dublin. http://www.nwci.ie/documents/out_of_sight.doc

101 Department of Enterprise Trade and Employment (2002), Ireland's Employment Action Plan, Department of Enterprise, Trade and Employment, Dublin. http://www.entemp.ie/lfd/Eap2002.pdf

102 The National Women's Council of Ireland Millennium Report, Women and Work: Creating Opportunities, Making Choices, The National Women's Council of Ireland, Dublin. http://www.nwci.ie/documents/women_and_work.doc

103 Combat Poverty Agency (2002), Towards Equality for Women: Targeted Actions to Tackle Poverty, Combat Poverty Agency, Dublin. http://www.combatpoverty.ie/downloads/publications/Submissions/2002_Sub_NationalPlanWomen.pdf

104 Central Statistics Office (1998), The Demographic Situation of the Traveller Community in April 1996, in Statistical Bulletin, Central Statistics Office, Dublin. http://www.cso.ie/publications/demog/travelcomm.pdf

105 Central Statistics Office (09/09/2003), Population and Vital Statistics. http://www.cso.ie/principalstats/centravellers.html#travellers

106 Barry, J., Herity, B. and Solan, J. (1989), The Travellers' Health Status: Vital Statistics of Travelling People 1987, The Health Research Board, Dublin

107 Task Force on the Travelling Community (1995), Report on the Task Force on the Travelling Community, Dublin

108 Collins, E. (2003), Case Studies of Good Practice for the Prevention of Racial Discrimination and Xenophobia and the Promotion of Equal Treatment in the Workplace, European foundation for the improvement of living and working conditions. http://www.eurofound.eu.int/publications/files/WP9741EN.pdf

109 Brown, M. (2003), Towards a Workplace Equality Infrastructure: An Overview of the Equality Infrastructure in Organisations with Special Reference to Minority Ethnic Workers Including Members of the Travelling Community Equality Authority, Dublin

110 Department of Enterprise Trade and Employment (26/08/2003), Irelands Employment Action Plan. http://www.entemp.ie/lfd/Eap2002.pdf

111 Equality Authority (2003), Building an Intercultural Society Equality Authority, Dublin

112 Central Statistics Office (09/09/03). http://www.cso.ie

113 The Department of Justice Equality and Law Reform (2003,) Annual Report 2001, The Department of Justice Equality and Law Reform, Dublin. http://www.justice.ie/802569B20047F907/vWeb/flMJDE5JAEJW/$file/justice_a_report2001.pdf

114 Central Statistics Office (09/09/2003), Persons, Males and Females, Usually Resident and Present in the State on Census Night Classified by Nationality 2002. http://www.cso.ie/principalstats/cennat.html#nationality

115 Fanning, B., Loyal, S. and Staunton, C. (2000), Asylum Seekers and the Right to Work in Ireland Irish Refugee Council, Dublin

116 Egley, M., Garavan, K., Condon, M., Kelly, M., Holland, K. and Staines, A. Asylum in Ireland: A Public Health Perspective Dublin. http://phm.ucd.ie/publications/Asylum.pdf

117 Conroy, P. and Brennan, A. (2002), Migrant workers and their experiences, Equality Authority. http://www.equality.ie/stored-files/PDF/Migrant%20Workers%20report.pdf

118 Wren, K. and Boyle, B. (2002), Migration and Work-Related Health in Europe - a Pilot Study. http://ebib.arbetslivsinstitutet.se/saltsa/2002/wrl2002_01.pdf
119 National Anti-Racism Awareness Programme. http://www.knowracism.ie
120 McCarthy, D. and McCarthy, P. (1998), Market Economies: Trading in the Traveller Economy, Pavee Point, Dublin
121 Murphy, P. (2001), Job Vacancies... Vacant Jobs: Traveller Inclusion in the Mainstream Labour Market, Pavee Point, Dublin
122 Pavee Point (2003), Personal Communication (Eds, Doyle, C.), Dublin
123 Ruhs, M. (2003,) Emerging Trends and Patterns in the Immigration and Employment of Non-EU Nationals in Ireland: What the Data Reveal (Working Paper), The Policy Institute at Trinity Collage, Dublin

Appendix 1: Notes of HIA Participatory Workshops at Institute of Public Health, July 10th 2003 and October 23rd 2003

1. July Meeting

Present
Rita Bergin, Services Industrial Professional and Technical Union, Chairwoman of SIPTU National Women's Committee
Niall Crowley, Chief Executive, Equality Authority
John Devlin, Deputy Chief Medical Officer, Department of Health and Children - Chair
Cathal Doyle, Public Health Development Officer, Institute of Public Health in Ireland
Iris Elliott, Senior Policy and Public Affairs Advisor, National Disability Authority
Richard Layte, Senior Research Officer, Economic and Social Research Institute
Owen Metcalfe, Associate Director, Institute of Public Health in Ireland
Rory O Donnell, Director, National Economic and Social Council
Ronan O' Reilly, Administrative Officer, Department of Enterprise, Trade and Employment

Apologies
Tony Briscoe, Assistant Director, IBEC
European Foundation for Living and Working Conditions representative

Brainstorming session
After introductions and brief presentations on HIA, the DG Sanco project and the European Employment Strategy, the group conducted a brainstorming session to explore the participants' views on the impacts of employment on health. The following issues were highlighted:

Quality of work and the work environment
While job creation generally is beneficial to health, the quality of work and the working environment and its impact on health needs to be considered. For example, harassment or bullying will have a detrimental impact on health. There are associations between low skills levels and a lack of control over the working environment and poor health.
While more jobs are important, it is also important to consider the quality of those jobs.

Gender issues
Improving access to employment for women involves increasing affordable childcare places. Access at the moment is limited and the current cost of childcare is prohibitive for many. The quality of available childcare also needs to be carefully monitored as it will affect the cognitive development of children. Also, the increased participation of women in the workforce will entail less time for 'traditional' caring roles normally undertaken by women – for example, care of older people or people with disabilities – with potential impacts on those people's health.

It is also important that actions to increase the participation of women in the labour market do not facilitate or exacerbate inequalities in the domestic sphere.

Active ageing
The potential health impacts of an active ageing policy are complex. Lengthening the working life sometimes can be either beneficial or detrimental, depending on the circumstances. An active ageing policy as it relates to employment will only be healthy if it builds in the needs and aspirations of older people. It is important that a policy on

active ageing is not just designed to keep people in the workforce for longer regardless of the circumstances.

One participant thought that an active ageing policy should start in schools. For example, there is a tendency in schools for children to opt out of physical exercise.

Commuting
Increased commuting times in Ireland leads to increased stress and fatigue. This may contribute to road and other accidents and loss of life.

House prices
The financial pressure of increasing house prices necessitates two-income households and has an effect on family life in Ireland, leading to stress on both parents and children.

Workplace accidents
There are a large number of workplace accidents in Ireland, particularly in the construction industry and health and safety policies need to be sharpened.

Equality
The issue of equality needs to be a central focus of the HIA. For example, with regard to disability, it is very important that people with disabilities have more control over their working environment. Creating adequate access to the labour market for traditionally disadvantaged groups will be key to improving health.

Education
It was commented that the labour market in Ireland is structured in favour of people with degrees and that education is therefore pivotal for determining status and type of employment and consequent health impacts.

Teleworking
One development that may contribute to improved health is teleworking or working from home. An increase in teleworking and a reduction in commuting may lead to a better work/life balance and reduced stress. This would be particularly helpful in rural areas. In addition to benefitting family life it would potentially benefit communities, contributing to increased social capital. It could be a particularly useful method of improving access to the labour market for women and people with disabilities and could be an effective way of promoting active ageing. However, the information technology infrastructure at the moment may not be adequate in all geographical areas to enable an expansion of teleworking.

Long working hours
The long working hours culture, or ‘presenteeism’ has a negative impact on health, affecting eating habits and exercise levels and causing disruption to home life. The input of IBEC on this issue would be very helpful for the HIA

Exploitation of migrant workers
This was identified as an increasing problem in Ireland.

Practicalities of conducting the HIA
Following the brainstorming session, the group discussed the practicalities of conducting the HIA exercise at national level. It was agreed that feasibility criteria were needed, given the time and resource constraints.

There was a discussion to clarify what the specific aims of the HIA were. The European Employment Strategy has laid out general goals (through the Employment Guidelines) that are translated into specific actions at national level through the national Employment Action Plan. The HIA will use the general goals or guidelines as a starting point to assess the potential positive and negative health impacts in these areas. The results of this appraisal will then inform recommendations that the HIA will make about implementing the guidelines in Ireland in a way that will maximise health.

Although the European Council identified three priority areas for Ireland to concentrate on in the near future – gender equality, regional imbalances in employment and lifelong learning and investment in human capital – the Department of Enterprise, Trade and Employment say that these are not necessarily the areas that should form the focus of the HIA.

It was agreed that out of the 10 priority areas identified in the revised EES, it would only be feasible for this rapid HIA exercise to concentrate on a small number of these. Two important criteria for choosing were the availability of evidence and the ability to address health inequalities. Out of the 10 areas identified in the EES, the group suggested the HIA concentrate initially on the following 3 priority areas:

1. Active and preventive measure for the unemployed and the inactive
2. Making work pay – providing financial incentives to work
9. Supporting integration and combating discrimination in the labour market for people at a disadvantage

It was also suggested that a Terms of Reference for this national HIA exercise be written and distributed to all participants. This would provide clarity for participants on the focus of the exercise and enable others that may have input to understand the purpose of the HIA.

Participants also felt it important to be as inclusive and creative as possible in gathering evidence. For example, it should include qualitative as well as quantitative data. It should make use of available relevant written material such as position papers or similar material.

The impacts of employment on health are many and complex. To help impose some order on the analysis of the material, one participant suggested adopting a sociological perspective or an overarching structure that distinguished between the Manifest and the Latent impacts of employment on health. Manifest elements refer to the health benefits derived from having a job – e.g. material benefits, a better lifestyle, better nutrition – and can be directly compared to the damage of health caused by unemployment. Latent elements could include the health impacts of, for example, the quality of work, the working environment, social capital and the way that work structures home or family life.

Useful information sources identified by the group
The ESRI can provide data on a range of issues related to employment and
Health and will provide a parcel of literature. The ESRI's evaluation of the national Employment Action Plan will be particularly useful
Department of Finance
FAS
National Disability Authority can offer access to their library and Christine White in policy and training would be a useful source of data
Frank Tracy at Department of Health
Equality Authority has a range of data
Travellers groups (e.g. Pavee Point)

Organisations representing disadvantaged groups may have grey literature, position papers etc that could provide useful input
The Department of Enterprise, Trade and Employment
Gender equality report – John O' Callaghan
National Council on Ageing and Older People

Terms of Reference
The Institute wrote a Terms of Reference and distributed to all participants. This is included as Appendix 2.

2. October Meeting

Present
John Devlin, Deputy Chief Medical Officer, Department of Health and Children - Chair
Cathal Doyle, Public Health Development Officer, Institute of Public Health in Ireland
Richard Layte, Senior Research Officer, Economic and Social Research Institute
Owen Metcalfe, Associate Director, Institute of Public Health in Ireland
Rory O Donnell, Director, National Economic and Social Council
Eamon O' Halloran, Administrative Officer, Department of Enterprise, Trade and Employment
Paul Kavanagh, Researcher, Institute of Public Health in Ireland
Peter O Connell, Inspector, Health and Safety Authority

Apologies
Niall Crowley, Chief Executive, Equality Authority
Iris Elliott, Senior Policy and Public Affairs Advisor, National Disability Authority
Rita Bergin, Services Industrial Professional and Technical Union, Chairwoman of SIPTU National Women's Committee

Feedback on draft report
Participants provided feedback on all sections of the draft report. These included comments both on the overall approach of the report and on detailed precise aspects of the text. Comments were also invited from participants that were unable to attend the second meeting.

Discussion on potential recommendations
Based on the information provided in the report, participants were asked to consider what recommendations could be made to implement aspects of the European Employment Strategy in a way that would maximise health.

The discussions were centred around scenarios provided by the Institute, based on the achievement in Ireland of targets set out in the European Employment Strategy. For example, participants were asked to assume that by 2010, a 50% employment rate for workers between the ages of 55 and 64 would be employed and then to consider how this could be done in a way that would address potential health concerns outlined in the draft report.

There were discussions on what types of recommendations would be likely to be accepted by decision makers and some examples (e.g. in the area of active ageing) were considered. Following this discussion it was agreed that the Institute would draft a number of recommendations to sent to the participants. These recommendations will be sent to participants in February 2004 for consideration.

Appendix 2

Terms of Reference for Health Impact Assessment (HIA) exercise on European Employment Strategy in Ireland conducted by the Institute of Public Health (IPH)

1. Background
This HIA exercise is being conducted as part of the 'Policy Health Impact Assessment for the European Union', commissioned by the European Commission's Directorate Generale Health and Consumer Protection (DG Sanco). This is to support Article 152 of the Amsterdam Treaty, which committed the European Union to human health protection in the definition and implementation of EU policies. The International Health Impact Assessment Consortium based at Liverpool University successfully co-ordinated a bid with partners from Germany, Ireland and the Netherlands to undertake this work.

The aims of the European project are to:

Develop a standardised HIA methodology for assessing the health impacts of EU policies and activities
Apply this methodology to a selected EU policy (the policy chosen for assessment is the European Employment Strategy
Disseminate findings and lessons learnt throughout Europe

In addition to a Europe-wide HIA exercise to assess the health impacts of the policy across Europe, each participant will undertake a HIA exercise to assess the impact in their own country. This is the purpose of this exercise.

2. Aims of the exercise
To assess the potential positive and negative health impacts of the European Employment Strategy in Ireland and to make recommendations on how it can be implemented in a way that will maximise health.

3. Objectives of the exercise

To analyse the potential health impacts of selected elements of the European Employment Strategy in Ireland
To define and profile the communities affected by these elements of the EES in Ireland, with particular attention to health inequalities
To incorporate the views of stakeholders from affected populations
To collect and analyse data from qualitative and quantitative data sources using multiple methods
To analyse the impacts on key health determinants and health and wellbeing from the assembled evidence
To prioritise impacts and develop recommendations to be incorporated into the overall DG Sanco project

4. Methods and procedures

4.1 Support group
Representatives of key stakeholder and key informant groups are providing expert advice and support to the IPH for elements of this exercise. Their input includes attending meetings to provide opinion on potential health impacts of employment, providing support on collation and analysis of evidence and helping to frame recommendations.

Membership of the group includes representatives from SIPTU, IBEC, Department of Health and Children, Department of Enterprise, Trade and Employment, National

Disability Authority, Equality Authority, National Economic and Social Council, Economic and Social Research Institute and Institute of Public Health.

4.2 Other methods

The exercise will use a range of methods to gain maximum feasible coverage of the affected population groups in a limited time. These may include:
interviews
surveys
email discussion groups
gathering of existing quantitative data
gathering of existing qualitative data – to include, for example, output from completed focus groups or community meetings, position papers
study of existing literature

5. Groups to be contacted for input

The exercise will seek the input of organisations representing groups currently identified as being at a disadvantage in the labour market – e.g. the unemployed, women, people with disabilities, travellers, ethnic minorities. The input of other stakeholder or key informant organisations will be incorporated, including FAS, Trade unions, Employers Groups, Health and Safety Authority, Department of Health and Children, Department of Enterprise, Trade and Employment, National Organisation for the Unemployed, National Disability Authority, ESRI, NESC, Equality Authority, Department of Finance, European Foundation for Living and Working Conditions. Others may be added to this list as the exercise develops.

6. Feedback of results

The results of this exercise will form part of the final project report for DG Sanco and will be fed back to all participants on completion.

7. Timetable

This HIA exercise aims to be completed by November 2003.

This report was produced by a contractor for Health & Consumer Protection Directorate General and represents the views of the contractor or author. These views have not been adopted or in any way approved by the Commission and do not necessarily represent the view of the Commission or the Directorate General for Health and Consumer Protection. The European Commission does not guarantee the accuracy of the data included in this study, nor does it accept responsibility for any use made thereof.