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OCCUPATIONAL ACTIVITY AND HEALTH OF WARSAW INHABITANTS. PART II. WORK IN RETIREMENT AGE: A PRELIMINARY ANALYSIS*

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ABSTRACT

INTRODUCTION. In the situation of rapid population ageing, it is necessary to encourage the older people to work longer. This requires a recognition of health conditions that cause the decision to continue working in retirement age.
OBJECTIVES. The aim of the study was to determine differences in health status and health security between working and non-working retirees involved in the program of social participation in healthcare reform.
MATERIAL AND METHODS. Of 406 participants of the program of social participation in healthcare reform, 161 non-working retirees and 21 working retirees were involved to analysis. Eight indicators of health status and eight components of health security were adopted.
RESULTS. Our findings showed the weak relationship between health and the working continue in retirement age. The considerable differences between the groups were reported only for physical well-being; the working retirees felt better. They continued work despite the fact that most of them perceived their health poorly and almost all suffered from chronic diseases. The working in retirement age was related with financial and social benefits to a greater extent. The working retirees rarely reported financial problems, the medical expanses was less onerous for them, they had the great opportunity to use the private physician services, and they more often perceived social support. The negative effect of working in retirement age, however, was related with the lack of time to rest, more negative assessment of existing healthcare system and less satisfaction with health information received from family doctor.
CONCLUSIONS. Our finding would indicate that health status influences the work in retirement age to a limited extend. Financial motivation and social factors seems to be the main determinants of working continue. The recommendations for future more extensive research were presented in detail.

Key words: *health, work, retirees*

INTRODUCTION

The ageing of population is one of the most serious worldwide challenges of the twenty-first century (1, 2). The increase of life expectancy and low fertility rate are the two main sources of population ageing in the developed countries. According to *The 2012 Ageing Report* prepared by European Commission, life expectancy at birth for men in the European Union is projected to increase by 7.9 years for men and by 6.6 years for women by 2060. Fertility rates decreased dramatically since the sixties of the twentieth century, from 2.70 in 1960 to 1.48 in 2000. Although the rate has slightly increased since 2005, nevertheless in all EU countries it is expected to remain below the natural replacement rate of 2.1 in the period to 2060. As a result of these unfavourable trends, the demographic old-age dependency ratio (people aged 65 or above relative to those aged 15-64) is projected to increase from 26% in 2010 to 52.5% in 2060 (3). Furthermore, in EU countries the average actual retirement age is shorter than statutory retirement age by 1 to 6 years in men and by 1 to 4 years in women (4). Demographic situation in Poland is particularly difficult, because fertility rate is one of

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the lowest in the European Union. Moreover, the rise of old-age dependency ratio between 2010 and 2060 in Poland is expected as the highest in EU (3).

The negative changes in population structure are serious burden for public expenditure. During the last half century the life expectancy after pensionable age in Europe increased by 5 years for men and by over 6 years for women. As a consequence, the public spending on providing the benefits for retirees has risen successively, and in 2005 accounted for from 3% (Ireland) to 14 % (Italy) of GDP. In Poland the growth between 1990 and 2005 was as much as twice, from 5,5% to 11,5% of GDP (4). Moreover, the old Europeans are more and more healthier. About 40% of persons aged 65 years or above perceive no limitation due to health problems (5). Paradoxically, although the life expectancy after pensionable age increased and health of old people became better, up to the nineties of the last century in many European countries the statutory retirement age was decreased both for men (France, Ireland, Italy, Sweden) and for women (Austria, Czech Republic, Denmark, France, Ireland, Portugal, Slovakia, Sweden) (6). Therefore, in the last decade various actions concerning pension reforms were undertaken in all EU countries, also in Poland (3, 7). Regardless of country-specific differences in legislation, the statutory retirement age is usually extended to between 65 and 68 years, as well as the minimum contribution period, and it will be equated for men and women.

The financial incentives are undoubtedly the most important factor causing the work continue in retirement age (8), while as regards the health status, the relationship seems to be more complex and depends largely on how the health is measured (9-11). The aim of presented paper is to explore initially the differences in both the health benefits and difficulties between working and non-working retirees in Warsaw in order to formulate recommendations for future more comprehensive research. Such study are especially needed in the time of the public debate related to the extension of the retirement age.

MATERIAL AND METHODS

The presented analysis is a part of the wider scientific project on the improvement of social participation in health reforms in Poland (12). Data were collected from April to June 2011 in Warsaw by self-administered questionnaires. Four hundred six correctly completed questionnaires were included in the analysis. Demographic characteristics of the sample and the content of questionnaire were presented in detail in our previous publications (12). The group of non-working retirees covered the respondents who had reached retirement age (in Poland in 2011 – for women 60 years and for men 65 years), received a pension and they did not work (n=161). The group of working retirees consisted of the participants at retirement age who voluntarily delayed the retirement and continued the work or those who received the pension and additionally carried out a paid job (n=21).

The original questionnaire for the research was constructed in Health Promotion and Postgraduate Education Department of the National Institute of Public Health – NIH. In order to examine positive as well as negative health determinants and health consequences of working in retirement age the eight indicators of health status and eight components of health security were assumed. Health status was measured by: 1) self-reported health, 2) physical well-being, 3) mental well-being, 4) social support, 5) staying at home due to illness in the last year, 6) being in contact with physicians in the last year, 7) occurrence of chronic diseases, and 8) hospitalisation in the last year. The assessments of: 1) existing retirement system, 2) health care system, 3) medical expenses, 4) type of health care utilisation, 5) care from the public family doctor, 6) difficulties in getting to physicians, 7) understanding the information about health received from family doctor, and 8) care from the private physicians, were used to gather information on perceived health security. The following negative life events that occurred in the past year were considered: 1) family problems, 2) lack of money, 3) lack of opportunity to relaxation, 4) difficult housing conditions, 5) encountering with violence, 6) reduction of social life. Each item was dichotomised.

The Epi Info statistical software package for PCs was applied for establishing database. The chi-square test was used for analysis the differences between working and non-working retirees in health status and health security. The significance was accepted at the level of $p<0.05$, however, due to preliminary nature of the study and a limited number of working retirees in the sample, the noticeable differences (more than 5%) were considered, even thought they did not show statistical significance.

RESULTS

Out of the all participants, who had reached retirement age (n=182), paid work performed 11.5% (n=21). Socio-demographic characteristics of the both groups was presented in tab. I. Significantly more the high educated participants and visibly (but insignificantly) more women in retirement age undertook paid work.

Statistically significant differences were not found in health status due to limited number of the sample (tab. II). It is, however, worth noting that considerably fewer working retirees perceived their physical well-being (13% less) and social support (13% less) as worse.

Table I. Demographic characteristics of the sample (%).

Demographic characteristics	Working retirees (n=21)	Non-working retirees (n=161)	p value[1]
Gender			
Male	6.1	93.9	0.081
Female	14.7	85.3	
Education			
Secondary or lower	6.7	93.3	0.019
High	17.9	82.1	
Marital status			
Single	16.7	83.3	0.664
Married	11.8	88.2	
Divorced	16.7	83.3	
Widowed	7.1	92.9	

[1] chi-square test

Differences in health security were also insignificant (tab. III). Nevertheless, noticeably fewer working retirees assessed healthcare system positively (7% less), declared very high medical expenses (14% less) and used only public healthcare (18% less), while more of the non-working retirees well understood information about their health received from family doctor (17% more).

As regards the life factors, the working retirees, as expected, were less likely to declare the lack of money (17% less), while relatively more of them perceived the lack of opportunities for relaxation (7% more). However, the both differences were insignificant (tab. IV).

DISCUSSION

Due to preliminary nature of our study, some observed differences, even visible, were not confirmed statistically. Nevertheless, our findings would suggest that association between working in retirement age and health status was weak, and it concerned particularly the physical well-being perceived subjectively. The differences in self-rated health and mental well-being were low, and health were similar in the both groups, if "hard" indicators were used for evaluation (staying at home due to illness, being in contact with physicians, occurrence of chronic diseases and hospitalisation). Interestingly, the working retirees continued the work, even though most of them assessed their health negatively, and almost all suffered from chronic diseases. The previous studies focused on examining the impact of health status on early retirement yielded inconclusive results, and the findings depended largely on a measure which has been applied. The subjectively perceived poor health was found to be the important cause of early retirement, however, the same studies did not confirm such relation with regard to occurrence of chronic diseases, which shows objectively poor health (11, 13, 14). It should be added that the general economic conditions and country specificity may modify the relation between perceived health and early retirement. Of the two surveys on Health and Aging in Europe (SHARE), the earlier investigation, conducted before the outbreak of the economic crisis (2005), confirmed that the self-rated health is the significant risk factor of withdrawal from work by the elderly (15), while no such dependence was observed in the later survey (2009), which was carried out during the crisis (9). Moreover, the differences were large in the countries surveyed, and the difference between France and Denmark in risk values was up four times (OR 1.07 and 4.40, respectively) (15). The prospective studies conducted in the United Kingdom and France provided the evidences that retirement improves health perceptions, but it largely relates to mental well-being (16, 17). In our sample the non-working retirees presented slightly better mental well-being, however, a reliable confirmation of this difference would be necessary. In summary, the subjective dimension of health seems to

Table II. Differences in health status in relation to occupational activity (%).

Health indicators	Working retirees (n=21)	Non-working retirees (n=161)	p value[1]
Self-rated health (not good)	71.4	76.7	0.592
Physical well-being (not good)	52.9	66.4	0.281
Mental well-being (not good)	43.8	37.6	0.633
Social support (not good)	68.4	55.2	0.273
Staying at home due to illness (2 times or more)	47.6	44.0	0.753
Being in contact with physicians (2 times or more)	61.9	58.0	0.730
Chronic diseases (at least 1 disease)	95.2	94.4	0.870
Hospitalisation (at least 1 time)	28.6	26.4	0.833

[1] chi-square test

Table III. Differences in health security in relation to occupational activity (%).

Components of health security	Working retirees (n=21)	Non-working retirees (n=161)	p value[1]
Retire system assessment (positive)	9.5	10.0	0.948
Healthcare system assessment (positive)	4.8	11.8	0.331
Medical expenses (very high)	9.5	23.9	0.136
Healthcare utilisation (only public)	10.0	28.8	0.072
Difficulties in getting to physicians (often)	23.8	18.6	0.571
Public family doctor assessment (positive)	88.2	92.6	0.530
Understanding of health information (yes)	35.3	52.7	0.173
Private physicians assessment (positive)	94.7	93.7	0.861

[1] chi-square test

Table IV. Differences in negative life events in relation to occupational activity.

Negative life events	Working retirees (n=21)	Non-working retirees (n=161)	p value[1]
Family problems	47.6	46.5	0.925
Lack of money	23.8	40.6	0.136
Lack of opportunity to relaxation	33.3	26.3	0.492
Difficult housing condition	9.5	4.4	0.307
Encountering with violence	9.5	10.6	0.876
Reduction of social life	28.6	33.1	0.675

[1] chi-square test

have a greater contribution to work continuing in retirement age than objective health disorders.

The decision to continue or exit from work in retirement age is determined by various factors, which simultaneously influence health. It should be emphasized that objective disturbances in workplace, such as heavy lifting, low temperature, vibration, noise are important for departure from work as well as for health deterioration (18).

The healthcare system in Poland does not meet the needs of the elderly (19). The better the health care for all older people, they will be more willing to continue working longer. Moreover, they will work longer, if they perceive the occupational environment as friendly to them. Actions aimed at adapting the working conditions to the capabilities of older workers in Poland are carried out to a very limited extent (20). The "Age Management" program is a part of the EU program of the strengthening of human capital. Although the Polish authorities have taken efforts to maintain employment by the elderly, but until now the effects of these activities are unsatisfactory (21).

CONCLUSIONS

The findings of our preliminary study would indicate that health status influences the work in retirement age to a limited extant. Financial motivation and social factors seems to be the main determinants of working continue. Our future research should recognise the health care system responsiveness to the old-age population, in particular:

1. to which extant the health care system at all its levels takes into consideration the specific needs and expectation of older people;
2. do the older people feel the active partner in health care reform;
3. is access to treatment and social care adequate to the needs of this age group and promotes continuing to work;
4. do treatment in medical centres occur with respect to dignity, confidentiality and autonomy, particularly due to this age group;
5. is the information on nurturing health and healthy lifestyle comprehensive and understandable for the elderly;
6. what factors in the workplace affect the health of the elderly and their decision to continue working;
7. what factors of social surroundings of the older people determine the decision to continue their work in retirement age.

A prospective study conducted on the same sample is planned to apply the causal inference.

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