At work despite a chronic health problem

by Kelly Cranswick

Being employed is one of the central aspects of a person's life. It offers a sense of identity and purpose, and provides the means by which people can support themselves and their families. However, for Canadians with a chronic health problem, performing the daily activities required at work may be difficult. The 1996 General Social Survey (GSS) found, in that year, over 3% of working-age Canadians had a long-term health problem sufficiently severe to warrant receiving some assistance with their day-to-day activities.

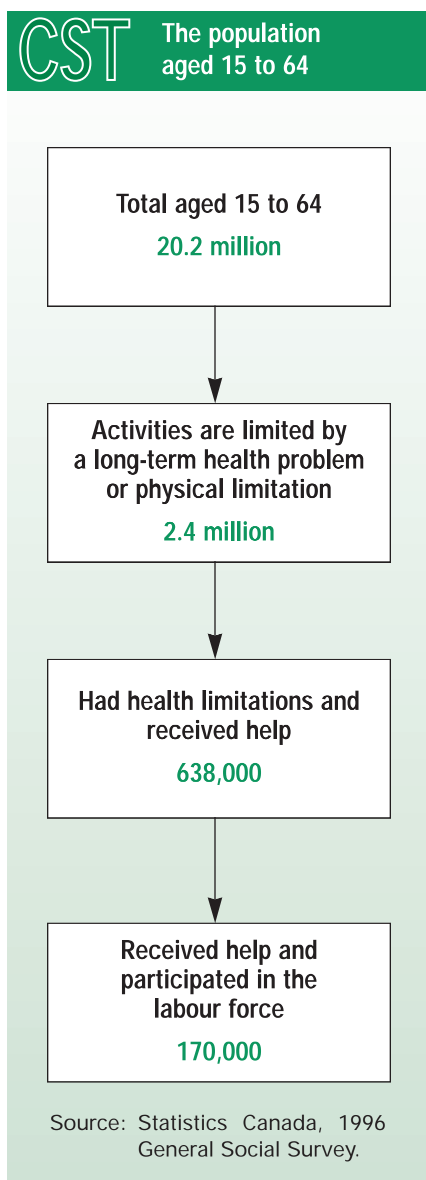
To date, most research about the labour force participation of people with long-term health problems has focused on employed individuals and the barriers they face in the workplace. However, only one in four working-age care-receivers getting help at home actually entered the workforce. An important question, then, is whether substantive barriers to employment must be overcome before a person with a long-term health problem even reaches the workplace. This article uses the 1996 GSS to identify some of the characteristics that determine whether or not a working-age Canadian receiving care for a long-term health problem would participate in the labour force.

Who were the working-age Canadians receiving assistance?

Almost 638,000 Canadians aged 15 to 64 — about 338,000 women and 300,000 men — received assistance for a long-term health problem or condition in 1996. The majority were between 45 and 64 years old (60%); the remainder were evenly split between younger adults aged 15 to 34 and those aged 35 to 44.

When asked to describe their main activity in the 12 months preceding the GSS, the largest proportion of working-age care-receivers (40%) reported they were not in the labour force because of their long-term illness or condition; another one-third said they had not been in the labour force because they were retired,[1] keeping house and/or caring for their children, attending school, or were engaged in other activities. Only about one-quarter (27%) said they had been active in the labour force, that is, either working, looking for work or on maternity/paternity leave.

1. It is difficult to untangle what "retired" actually means, since some care-receivers would have retired because of their health while others may have developed the problem after retiring.



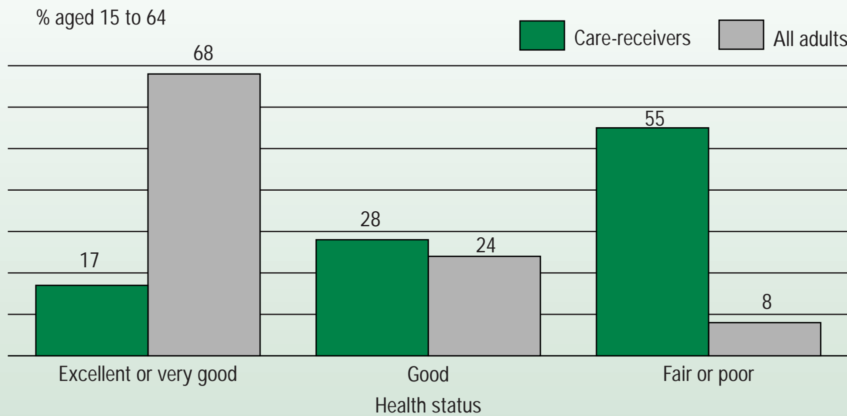
Source: Statistics Canada, 1996 General Social Survey.

Given that they were experiencing a long-term health problem, it is unexpected that almost one in six care-receivers (17%) felt that, compared to other people their age, their health was very good or excellent. Over one-quarter assessed their relative health as good. But more than half rated their own health as only fair or poor compared to other Canadians. Not surprisingly, it was younger adults under 45 who tended to describe their health in more positive terms.

The greatest number of working-age care-receivers (75%) were getting help with tasks around the house. More than one-half (54%) had help running errands, and over one-quarter (28%) received assistance with their personal care, such as bathing and dressing.

Looking at the relationship between the type of care provided and employment status of care-receivers begins to illuminate the factors that influence labour force participation. For example, most care-receivers — 70% of those

CST The majority of care-receivers felt their health was only fair or poor



Source: Statistics Canada, 1996 General Social Survey.

CST What you should know about this study

This study is based on data from the 1996 General Social Survey (GSS) on social and community support. The GSS interviewed almost 13,000 Canadians aged 15 and over living in private dwellings in the ten provinces. Data were collected on help received in the previous 12 months due to a long-term health problem or physical limitation or due to a temporarily difficult time. Help could have been provided informally by family and friends or formally by paid employees, government and non-government organizations.

The article also draws on the 1991 Health and Activity Limitation Survey (HALS), which was conducted in order to develop a national database on disability. HALS interviewed over 91,000 Canadians aged 15 and over living in private dwellings in the ten provinces, and 26,000 respondents were identified as having disabilities. Included in the interview were questions on the barriers to employment faced by persons with disabilities. While it would have been helpful to have more up-to-date information than that collected in 1991, more recent data are not available.

Care-receiver: A person who received help with day-to-day tasks from another person or organization because of a long-term health problem or physical limitation lasting (or expected to last) more than six months. Care is divided into four basic sets of tasks: personal care, including bathing, dressing and toileting; household tasks, including meal preparation and clean-up, house cleaning, laundry and sewing, and house maintenance and outside work; running errands, including shopping for groceries or other necessities, providing transportation, and banking and bill paying; and childcare.

Labour force participant: A person whose main activity in the 12 months preceding the GSS had been working at a job or business, looking for work or being on maternity/paternity leave.

Health status: The respondent's perception that, compared with other Canadians the same age, his or her health is excellent or very good, good, or fair or poor.

who were in the labour force and 79% of those who were not — were getting help with tasks around the house. However, those not in the labour force needed considerably more help with daily tasks that are more demanding. Two-thirds (66%) of these care-receivers had help running their errands, compared with just over one-quarter (28%) of labour force participants. And the overwhelming majority of people receiving help with personal care were not in the labour force.

What factors influence the ability to work with a long-term health problem?

What was the likelihood that someone receiving assistance for a long-term health problem would be a member of the labour force? After controlling for other factors,[2] care-receivers under 35 were four times as likely to be labour force participants as those aged 45 to 64. Higher education also increased the likelihood of participation; compared with people with high school or less, people with at least some postsecondary education were more than twice as likely to be in the labour force.

But among working-age Canadians receiving help at home because of a long-term health problem, the strongest predictor of labour force participation was how healthy they perceived themselves to be. Compared with care-receivers who considered their health to be poor or fair, those in good health were more than two-and-one-half times as likely to be working or looking for work. And care-receivers who described their health as very good or excellent were 31 times as likely as those with poor or fair health to be in the labour force, after controlling for other factors.

Research suggests that having a spouse who is employed may reduce the pressure to find a job. However, this did not hold true for working-age care-receivers. They were two-and-one-half times as likely to be in the labour force if they had a working spouse than if they did not.

Among working-age Canadians receiving help at home, the strongest predictor of labour force participation was health

Some characteristics that are often associated with labour force participation did not significantly influence care-receivers. For example, in the general population, men record higher labour force participation rates than women; however, among people receiving assistance for a long-term health problem, men were no more likely to be participants. Also, when other factors were controlled for, care-receivers without children were no more likely to be in the labour force than care-receivers with children.

Labour force participation is often lower in rural areas where job

CST The most important determinant of labour force participation for working-age care-receivers was their health status

	Odds ratio of being in the labour force	
Perceived health	**Fair or poor**	**1.0**
	Good	2.6
	Excellent or very good	30.8
Age	**45-64**	**1.0**
	35-44	2.5*
	15-34	3.7
Education	**High school or less**	**1.0**
	Some postsecondary or more	2.4
Working spouse	**No**	**1.0**
	Yes	2.6
Gender	**Male**	**1.0**
	Female	0.9*
Presence of children	**Yes**	**1.0**
	No	2.1*
Place of residence	**Urban**	**1.0**
	Rural	0.5*

Note: An odds ratio close to 1.0 means there is little or no difference between the groups, but a ratio of more than 1.0 means the odds of participation are higher for the comparison group (e.g., those in good health) than for the reference group (e.g., those in poor health). A ratio of less than 1.0 means the odds are lower for the comparison group. Reference group is shown in bold.

* Not statistically significant.

Source: Statistics Canada, 1996 General Social Survey.

2. The factors examined in this study are perceived health status, age, education, gender, working spouse, presence of children and place of residence (urban or rural).

opportunities are not as abundant. One might assume that this would be especially true for people with long-term health problems, but this was not the case. Care-receivers in urban areas were no more likely to be in the labour force than those in the country.

Where are workers with health problems employed?

In 1996, over one-quarter — 27% or 170,000 — of working-age care-receivers with long-term health problems were in the labour force. It might be assumed that their ill-health would limit their employment opportunities, or the extent of their time on the job, but in fact it does not. Care-receivers put in a full workweek, averaging 38 hours per week on the job, while the overall workforce averaged 42 hours. Nor was there any substantive difference in average personal income: workers with long-term health problems estimated their personal income to be almost $37,000, mostly from employment or self-employment, while the overall working population reported just under $36,000.

The most notable difference between workers receiving care for their chronic health problem and the general workforce was in the types of jobs they held. In 1996, the majority of working care-receivers (64%) were employed in white-collar occupations, working, for example, as architects, teachers and managers. This was almost twice as high as the percentage of the general workforce employed in white-collar occupations (35%). Most other care-receivers worked in clerical, sales and service jobs, but virtually none were employed in blue-collar jobs (compared with 30% of the overall workforce).

The occupational profile of care-receivers may be explained by the basic demands of each type of job. Clerical, sales and service occupations may require extensive travel or long hours on one's feet; blue-collar occupations can also be physically demanding. These requirements could be strenuous for a person with a long-term health problem, who may choose to avoid such jobs. On the other hand, professional and managerial occupations offer working conditions that are more manageable for someone with a chronic health problem. Since these occupations also tend to require higher levels of education, the occupational profile of care-receivers suggests that education may improve the employment effects of poor health.

Did employees with disabilities get what they needed?

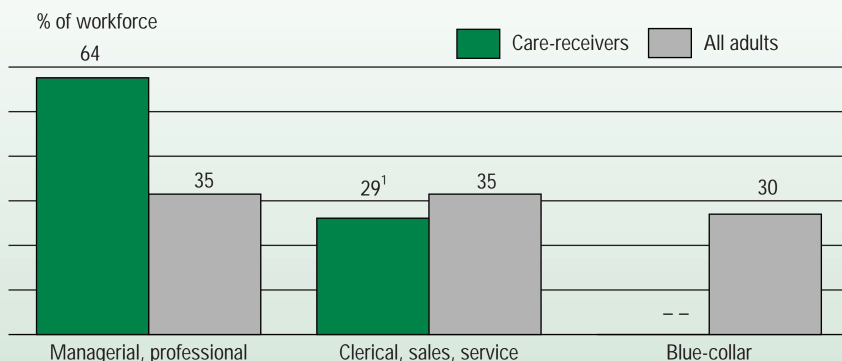
Once someone with a long-term health problem has found a job, special arrangements may be required in the workplace to enable them to work. While the GSS did not collect data about the workplace, the 1991 Health and Activity Limitation Survey (HALS) did ask employed people with disabilities if they required assistance in order to work.

In 1991, almost 100,000 Canadian workers wanted to have their job redesigned or to be given different duties because they had a health condition or disability. Almost as many (90,000) wanted modified days or reduced work hours, while 30,000 needed accessible transportation to get to the workplace. And between 20,000 and 24,000 employed Canadians with disabilities wanted human support, such as a reader, an oral or sign language interpreter, or a job coach; appropriate parking; or accessible elevators and washrooms.[3]

CST Who helps care-receivers with daily tasks?

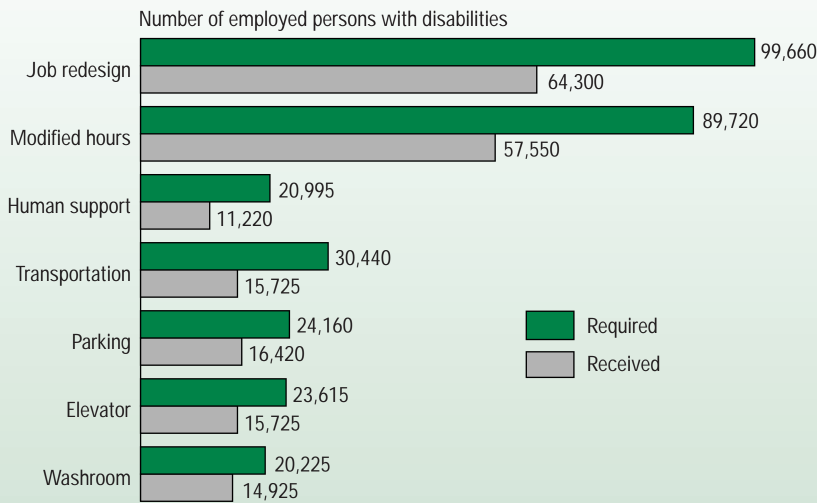
Working-age Canadians receiving help for a long-term health problem in 1996 most often turned to family members for assistance. Spouses (27%), children or children-in-law (24%), parents and siblings (16%) and other family members, friends and "others" (15%) provided help. A substantial amount of care (18%) was also provided by formal sources, such as paid employees and organizations.

CST Most care-receivers worked in white-collar jobs



-- Amount too small to be expressed.
1. High sampling variability.
Source: Statistics Canada, 1996 General Social Survey.

Workers with disabilities who needed workplace adaptations did not necessarily receive them



Source: Statistics Canada, Health and Activity Limitation Survey, 1991.

Because requiring some type of workplace adaptation is not the same as receiving it, HALS respondents were also asked whether their employer had accommodated their needs. Nearly three-quarters of the people requiring them got accessible washrooms; about two-thirds were provided with parking, elevators, redesigned jobs and modified hours. However, access to human support and transportation was less common, being offered to only about one-half of the workers who required such assistance.

Summary

In 1996, about 638,000 working-age Canadians received assistance for a long-term health problem. Only about one-quarter were members of the labour force; they tended to be younger and better educated than care-receivers outside the labour force, but most importantly, they were healthier. Even after other key factors are controlled for, the data show that a person's perceived health is the most important predictor of labour force participation among care-receivers aged 15 to 64. While there are definitely workplace barriers to the employment of people with long-term health problems, there are also barriers for which workplace adaptations cannot compensate. Analysis of the 1996 General Social Survey suggests that, in many cases, people with long-term health problems are simply too ill to work.

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3. It is likely that there is overlapping among these categories; for example, someone requiring reduced work hours might also want transportation to work.

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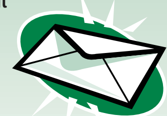

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