

Older and younger workers, the equalling effects of health

Abstract

Purpose: The paper considers the statistical evidence on the effects that ill health has on labour market participation and opportunities for younger and older workers in the East Midlands.

Design/methodology/approach: A statistical analysis of LFS data was undertaken to demonstrate that health issues affect older and younger workers alike. This has an equalling effect on labour market opportunities, which should reduce any potential for intergenerational conflict within the workforce.

Findings: Although health problems that limit activities and affect the amount and kind of work an individual can undertake increase with age, there are high levels of ill health of these kinds within all age groups, including the youngest workers.

Research limitations/implications: The regional statistical analysis can only provide indications, and further research is required to differentiate which groups of younger and older workers suffer from which types of illnesses as this has direct implications for their employment.

Practical implications: A more direct consideration of health in employment, education and training policy is required to enable the development of healthy and long-term working lives that benefit individuals and the economy.

Social implications: The consideration of the effects of health issues on the labour market should lead to a reconsideration of the rhetoric, and the reality of intergenerational conflict. There might be less reason for such competition than is generally perceived.

Originality/value: The paper considers intergenerational conflict in a labour market context and suggests that health issues have an equalising effect for the relative positions of older and younger workers.

Key words: older and younger workers; health; intergenerational conflict

Introduction

Public perception has established a dichotomy between older and younger workers. They are, in the main, based on stereotypes (Hassell and Perrewe, 1995): older workers being more experienced but tiring easily; younger workers having high rates of absenteeism (Shen and Dicker, 2008); older workers are found to be more reliable and to have better social skills but may lack the motivation or ability to continue learning (McNair, 2006, 2011); young people are said not to fulfil the expectations and requirements of employers (Furlong *et al.*, 2012). Whilst such characteristics may apply to some, the older and younger workers groups are heterogeneous and not easily categorised (Loretto *et al.*, 2007, MacDonald, 2011). Health issues, for example affect individuals across both groups. Older and younger workers have nevertheless been seen to be competing for the same jobs and for a limited amount of available funds for benefits and support, thus ending up in a supposed intergenerational conflict with each other. During the current economic downturn and in regions where the job market is stagnant and low skilled, this competition is exacerbated. The root causes for this situation are seen, on the one hand in the pressure for older workers to carry on working for

longer and, on the other hand in the poor labour market outlook for younger workers or those transitioning into the labour market.

The abolishing of the state pension age (SPA) and increased pressure to work for longer has substantially changed the outlook for older workers (TEAN, 2011). According to the Department for Business the developments were to benefit individuals and 'boost the UK economy' (BBC, 2011). Yet Felstead (2011) demonstrates for the UK context that older workers tend to receive fewer training and learning opportunities than younger workers. Engagement in training can extend working lives though in some countries this is countered by early retirement incentives (Fouarge and Schils, 2009). In the UK the number of older workers in employment has increased, with those aged 65 and over doubling their participation from 1.5% in 2001 to 3% in 2010 despite the onset of the recession (Nomis, 2011). There is discrimination of older workers (Krings *et al.*, 2011) though, and not everybody who now has to work longer wants to do so (compare Vickerstaff, 2010) or is healthy enough to continue to work. The rhetoric of older people as an (economic) burden on society (Walker, 1990) therefore continues.

In contrast, younger workers are facing an increasingly competitive labour market. The economic downturn since 2008 resulted in raising youth unemployment to 22.2% at the end of 2011, an increase from 9% in 1992 and the highest rate since 1986/87 (ONS, 2012). In addition, there is a substantial group that are not in education, employment or training (Furlong *et al.*, 2012). As MacDonald (2011) outlines, key concerns about this group include that, in policy terms, NEETs are considered to be a homogenous and static group of young people who have problems. There is considerable research to show such a position to be misguided, as there are a range of constantly changing routes to attempt entry into a tight labour market. Looking at health and related issues emphasises how varied and transient are the factors that contribute to young people being NEET. There are reports of mental health issues; drug and alcohol abuse; low confidence and self-esteem due to experiences of bullying at school; and for girls, pregnancy as decisive influencing factors (Sissons and Jones, 2012, Sheehy *et al.*, 2011). The potential combination of health issues and periods of being NEET have punitive long-term effects such as a higher likelihood of later unemployment and social exclusion (Yates and Payne, 2006).

For all young people there have been a number of policy changes that further complicate transitions through education and into employment. These include the removal of the Educational Maintenance Allowance (EMA), the increase in Higher Education fees, and the movement of graduates into areas of the economy that were previously largely inhabited by non-graduates (compare Braconier, 2012). Increasing the age of compulsory participation in education or learning opportunities to 17 (18 from 2015, DfE, 2012) will add to the pressure on the changing education system. Such regulation of individual choices within educational pathways may also backfire, especially as prolonged education does not necessarily increase the chance of a job in an insecure labour market (Furlong *et al.*, 2012). The cost of those young people who drop-out, move in and out of being NEET or have difficulties in transitioning from education to employment may therefore also be considered a burden on society.

Positioned at opposite ends of working lives, older and younger workers experience similar sentiments. Although older workers' and younger workers' problems might superficially look to be linked, older workers "tend not to be doing the jobs young unemployed people might expect to get" (Brendan Barber quoted in TAEN, 2011, 4). Nevertheless, the underlying ideas of self interest and scarce resources, here jobs, has lead to the assumption that ageing societies must give rise to intergenerational conflict (Emery, 2012). As Dumas and Turner (2009, 46) state "at the heart of the question of generational conflict is the contrasting perception of generations regarding the distribution of resources in periods of scarcity". Rather than considering the potential tension in intergenerational relationships within families

(Erber, 2010), the main focus here is on the potential for conflicts within the labour force and how health problems may counter such conflicts.

This paper criticises the dichotomy that has been set up between older and younger workers and, instead, considers health to have a unifying effect. To this end, the following sections will examine the idea of an intergenerational conflict in the workplace and then move on to look at the impact of health on employment in the East Midlands. The paper aims to demonstrate that contrary to common perceptions there are considerable similarities between older and younger workers and that health acts as an equalising factor. This is due to a number of reasons. Health issues tend to develop over the long-term and become more severe as individuals age. This means that attempts to reduce or prevent serious health issues that affect labour market participation would have to be targeted at younger workers. More statistical information is available on the health problems of older workers but this serves to highlight the potential problems and harmful nature of some forms of employment to long-term health prospects of younger workers. Rather than being a source of intergenerational conflict, health issues bear potential for intergenerational solidarity. The key policy message to be taken from this paper is that the overall aim of employment, education and training policy should be sustainable, 'good' jobs that allow young workers to remain healthy and not retire early due to ill health.

Intergenerational conflict

Emery (2012, 8) states that "political conflict is eminent between the generations as age cohorts fight for their own respective self-interests with regard to welfare state redistribution" but as Lüscher (2011) points out, intergenerational relationships can occur at a personal, social and political level. This paper suggests the labour market as a further arena for conflict. The importance of considering the potential for such conflict is evident in recent discussions considering welfare state redistribution. They include those on pension contributions and calculations, which ultimately resulted in the abolishment of the SPA, and the pressure on older workers to remain in the labour market for longer. A further example is the individualisation of the cost of education via the increase of HE tuition fees and the abolition of the EMA. Policy developments have thus put both older and younger cohorts under pressure, increasing the potential for individuals to pay more attention to their self-interests. Concern about the resulting potential for conflict between generations has been long-standing (see *inter alia* Walker, 1996) and pre-dates the most recent policy developments. These have, however, increased the danger associated with pitting one generation against the other (Dumas and Turner, 2009). A brief consideration of whether intergenerational conflicts are what they are thought to be, and who benefits from their existence will allow the proposition of an alternative position on older and younger workers which takes health issues amongst both groups into account.

As would be expected from self-interested individuals, Emery (2012) shows that support for welfare for the elderly increases with age. However, this effect is not enhanced in countries that have a high old age dependency ratio. Rather than there being evidence of a polarisation of opinion or societal reaction to the ageing of the population, changes in attitudes happen as a result of individual ageing processes (Emery, 2012). Individuals' ageing trajectories may include various experiences of health problems, which therefore also influence values and attitudes. These findings question the assumption that there should be an increase in intergenerational conflict the older a population is as a whole. It should also be considered that attitudes are influenced by socio-economic factors such as income (Busemayer *et al.*, 2009), gender, political persuasion, education and other variables (Emery, 2012). By considering that ageing is thus not necessarily a linear process based purely on demographics (that is chronological or biological age) but influenced by individual and socio-historical conditions (functional, psychological or social age, Erber, 2010), we arrive at very different conflicts. It is conceivable that those with poor health who might require more welfare state

support are in conflict over resources with those who are healthy and active late in life. The heterogeneity of any cohort makes the concept of intergenerational conflict look like a superficial assessment. Health has similar effects on the labour market situation of older and younger workers and is likely to result in a potential shift in their relationship; away from intergenerational conflict and towards intergenerational solidarity.

Doubts concerning the definition of intergenerational conflict also raise questions about why the term has been in use. The role of the state is crucial here. The state provides welfare and/or determines individuals' capacity to provide care and support (Walker, 1996). For example, if an unhealthy individual is not provided for via the welfare state (e.g. in the form of benefits), are relatives, carers or other support networks enabled in financial and practical terms to look after them? Writing at the time of a previous conservative government, Phillipson (1996) links the reduction of welfare state provisions to considering older and younger groups as burdens on society. It entails an individualisation of responsibility, such as for employability or the welfare of the workforce (Moore, 2006) that has been on going. It is conceivable that the pressure associated with individualisation leads to an increase in self-interest, for example in the form of increased intergenerational conflict within ageing societies. To enhance the perception of overall austerity or scarcity it is in the government's interest to portray the struggle for an adequate and affordable welfare state as a conflict between the generations. In contrast, it has been suggested (Lüscher, 2011) that the actual practice of intergenerational relationships is dominated more by ambivalence than by conflict. As previously indicated, this may equalise the situation for older and younger workers. The following discussion on health adds further support to this position. The fact that health and the provision of health care has been one of the most contentious policy issues of the current Coalition Government is a further justification to look at the importance of health for older and younger workers in more depth.

Health and the East Midlands

Health is a very broad concept, which includes mild and moderate mental health issues (Walker and Fincham, 2011) as well as disability. Partially as a result of the complexity of health problems, it is difficult to pin down their interrelationships with work, education and training. Moreover, health influences employment but the relationship also has a reverse effect. Loretto and White (2006) thus report that workplace stress and implications for health can lead to early retirement but also show that remaining in work can have positive health benefits. There are on-going discussions about the extent to which age-related decline might influence older workers' ability to remain in the labour market (Wrenn and Maurer, 2004) but there are clear indications that health issues generally increase with age. Health can thus have a levelling effect on members of all social classes. Blane *et al.* (2007) show that individuals who are unemployed or permanently sick towards the end of their working lives, even if they are from higher managerial and professional occupations, are excluded from a high quality of life. Considering the effects of education and learning opportunity in these situations adds further layers of complexity as the link between participation in learning and health is not clear-cut. There is evidence that some forms of learning, in particular those that are not formal or job-related, such as music, arts and evening classes, enhance well-being, but learning can also undermine psychological well-being (Jenkins, 2011). Focussing specifically on the relationship between health and employment shows that the quality of work, biological, economic and social factors are crucial (Beck *et al.*, 2008, Beck and Quinn, 2011). Health and well-being are linked to socio-economic status and therefore to employment (Marmot, 2010) and it is therefore conceivable that young people experience long-term health problems that are similar to those evidenced amongst older workers. Changes in health issues would be expected as a result of industrial restructuring but the statistical evidence presented in the next sections raises the question whether new industries or occupations have less severe or merely different health implications.

The following analysis of the Labour Force Survey (LFS) conceptualises the relationships between age and employment through a consideration of health issues. In the process, it is argued that the existence of intergenerational conflict has been overstated and that instead, health has an equalling effect on individuals across age cohorts. Health has for example, a direct impact on whether workers can or want to enter the labour market or continue working longer. We have undertaken our analysis at the regional level in the East Midlands, where industrial restructuring shows the importance of health, education, and training. Workers that have suffered ill health as a result of their previous job are not necessarily able to carry on working or be retrained. In particular the types of ill health that they suffer may not allow them to be retrained into new sectors or occupations where there are job openings. (Re-)education and training within the physical and psychological capabilities of the individual is required. Some work has been done in this respect (see Beck, 2009, Beck and Quinn, 2011) but the role of ill-health in restricting the (re-)employment prospects of adults is one that needs more exploration. If health is a limiting factor on the type of employment that people are able to obtain then employment and training policies need to reflect this and broad initiatives to encourage businesses to replace fading industries need to be mindful to ensure that the jobs created are ones that local workers of all ages are able to do.

The data for this paper was collected for a report for the East Midlands Development Agency (EMDA) (Beck *et al.*, 2008). It considered the relationship between health (mental and physical), employability, labour market participation and the overall performance of the East Midlands' economy. A particular focus of the statistical and literature review was the causal direction of the relationships. The report used each quarterly Labour Force Survey sweep from 2007 to produce a comparison of the East Midlands and UK working age populations. The East Midlands Public Health Authority provided added local area data. The data was first split to exclude those not of a working age and then again to only include those who had reported they were economically inactive due to health to produce the statistics on previous jobs and industries. Here the data is re-analysed to demonstrate that there are age specific results that have not previously been considered. There are obvious limitations to the extent to which this focus can be pursued with existing literature and data and further research should explore why there are such considerable health issues across the population.

The East Midlands region is generally seen to have an economy that can be categorised as 'low-wage, low-skill, high employment' (Felstead *et al.*, 2002, EMDA 2006). While justified by the region's headline statistics, this assessment masks significant variations at the sub-regional level and this poses challenges for policy makers looking to develop the region's skills base and counter falling employment rates (see EMDA, 2009, Champion *et al.*, 2007 and Quinn 2012). EMDA was particularly keen to drill beyond the headline statistics in a number of areas such as skills, housing and employment and our 2008 project on health formed part of this effort (Beck *et al.*, 2008). The particular areas of deprivation in the region tend to share key characteristics such as high unemployment rates amongst both older and younger workers and a failure to recover from the loss of previously significant industries (e.g. textiles or mining). The three cities (Derby, Leicester and Nottingham) all have higher than average unemployment rates and each has been traditionally reliant on manufacturing such as textiles for Leicester and engineering in Derby. In addition, the region had a sizeable coalfield concentrated around North Nottingham, North West Leicestershire and the Chesterfield area. Each of these areas now suffers from high levels of unemployment and low wages. They share these characteristics with former coalfields across the UK (Quinn, 2012). The implications and conclusions drawn from this region are thus relevant for the broader population.

Health and economic inactivity

An overview of those who are economically inactive because of ill health provides insights into the causes and effects of employment and health issues. As would be expected, the

incidence of economic inactivity due to ill health increases with age, even within the working age population (see Table 1). Around a fifth of respondents over 55 years old in the East Midlands reported health as the reason for being economically inactive. However, this figure is lower than it might be as those who retired early due to ill health are not included. The overall effect of ill health is therefore likely to be higher. Even in the younger age bands (aged 25 to 40) around one in twenty adults were not in work due to ill health and this figure rose to one in ten for those in their 40s. The overall picture for the East Midlands is not dissimilar to that of the UK as a whole in terms of the level of economic inactivity and the types of ill health. Of those who reported having health problems the most common complaints related to the back or the neck (13.9%), chest and breathing problems (12.7%) and heart and blood pressure related issues (15.0%) (unless indicated otherwise, all statistics are from the LFS 2007, own calculations). There is thus a significant group across the age bands who are not able to participate in the labour market due to their health problems. It is likely that this group is seen to be part of the burden on welfare expenditure that needs to be reduced, i.e. via the 2008 move from Incapacity Benefit and Income Support allowances to the Employment Support Allowance (Piggott and Grover, 2009). The initial picture suggests, however, that health is more problematic for older individuals.

Table 1 about here

To provide further information on those that are economically inactive due to ill health, Table 2 provides an overview of the sectors and occupations that these individuals last worked in. Manufacturing, previously the dominant sector for the East Midlands, is responsible for more than a third of those who are economically inactive due to ill health. Due to the decline of this sector, we can assume that this group consists mainly of older people, reinforcing the stereotype that this group is more problematic. The same is likely to be true for those individuals who are economically inactive who previously worked in elementary occupations and as process plant and machine operatives, although these occupations are only partly tied in with the fate of manufacturing. Marmot (2010) has confirmed that social inequality in the incidence of ill health is created by inequity of access to power, money and resources. Ill health is therefore more likely to occur amongst those who worked at the bottom of occupational hierarchies and in low skilled sectors. Although there is not necessarily a causal relationship, the lower qualified also tend to receive less training (Mason and Bishop, 2010). Energy, mining and manufacturing still make a bigger contribution to East Midlands' GVA (Gross Value Added) than in any other region but the financial and real estate; hotels, retail and transport; and the services sectors are now more significant (ONS, 2009). Much smaller groups report being economically inactive after working in these sectors. Health issues are nevertheless likely to occur, raising the question whether the employment opportunities now available in the East Midlands are 'better' for health or whether health issues are merely different to those in the past. Mental health issues and obesity related health problems, for example, seem to have increased (Eckersley, 2011).

Table 2 about here

One indicator of the quality of a job is the LFS question whether a previous job was left due to ill health. Although the job itself may not be the cause for the health problems, the fact that individuals are seeking a change does seem to suggest some relationship. Age is an additional factor with around a third of those aged between 55 and 59 saying health was the reason then left their last job compared to 6.2 % of 20 to 24 year olds. While the figures for older workers are considerably worse than those for younger workers, health is a consistent contributor for people of all ages leaving their jobs and workforce overall.

Health and employment

The fact that parts of the population have health issues is not necessarily in itself an area of concern for their participation in employment. The previous section focussed on those who

are economically inactive but a significant proportion of workers with health issues continue to work. As Tables 3 and 4 demonstrate the particular health issues that are being reported do not always result in those individuals being lost to the economy but they do limit the amount of work and the kind of work that they are able to undertake. Table 3 shows that just over half of those reporting that they had a health problem consider themselves limited in the activities they were able to undertake. No information is provided on what these limiting effects may be and it must be assumed that there is a broad spectrum: a peanut allergy, mild to moderate mental health issues and a physical disability all make certain jobs impossible. When breaking down this data by age bands, it is clear that health problems limit activities more in older people as those below the age of 30 make up less than 7% of those who indicate that health problems limit their activity. Considering this within age bands still suggests an increase of health problems: just under 40% of those aged 16 to 19 state that health problems limit activity. This proportion increases to just under 60% for 60 to 64 year olds. Yet considering health within age bands shows that significant proportions of all workers are affected.

Table 3 about here

Moving on to the specific question of the impact of health issues on work capability the data in Table 4 shows that more than one in four found their health problems affected the amount of work they were able to do and half found that it affected the kind of work they were able to do.

Table 4 about here

Looking first at the responses indicating that health problems affect the amount of work that can be undertaken, the picture is similar to that provided above. There is a clear increase of the problem with age as the largest proportion of this group (19%) is made up of 55 to 59 year olds. Similarly, when focussing on the effect within age bands, a considerable number of young workers (i.e. 28% of 16 to 19 year olds) indicate that health problems affect the amount of work they can do but this increases steadily to 48% of 60 to 64 year olds. And again, the same picture applies for those who indicate that health problems affect the kind of work they can do. However, a subtle difference is evident here: the proportion of those indicating that a health problem affects the kind of work they can do in each age band increases less than for previous indicators. In the examples provided above there was a rounded 20% increase between the youngest group and pre-retirement age, here there is less than 10%. Table 5 details this within age group effect. The decline in the 60 to 64-year old age group is likely to reflect early retirements.

Table 5 about here

The suggestion here is that a broader spectrum of health issues now affects the workforce. Historically, poor working conditions may have led to severe illness that sometimes resulted in death. Extreme examples included accidents in factories or miners' respiratory diseases. The illnesses now may not be life threatening but chronic disease or mental health issues to name just two examples seem to have more of an influence on what kinds of work individuals can undertake. This is an important consideration for policy makers looking to stimulate new employment opportunities in deprived areas of the country as the kinds of work available may not be suitable even for younger sections of the local population if health is known to be an issue across the age bands.

Conclusion

This paper has argued that health has an equalising effect on the labour market situations of older and younger workers. An obvious point to make based on the above discussion is that there is a need to address the health problems of both groups. However as this paper demonstrates and due to the equalising effects health can have on a labour market, it would

be a mistake for policy makers to treat these groups in isolation and use separate policy interventions. There is the potential for younger workers to be in the same position as those older workers who have had to leave the labour market because of their health problems. If it is merely assumed that older workers health deteriorates and that policy interventions need to be made for those over 50 in order to keep them in some form of employment, then problems are likely to reoccur. Rather than wait for current younger generations to develop health problems caused by employment, policy makers need to act now at both ends of the age spectrum, especially if Government aims to extend working lives are to be met. There is little point increasing the retirement age if this merely extends the amount of time large numbers of over 50s will receive benefits before they reach a delayed retirement age. If nothing else, a preferential treatment for either older or younger workers' health problems increases the potential for conflict and competition for resources between generations. It could be questioned whether this could lead to heightened social tension and increase the likelihood of a repeat of demonstrations and other activity opposing austerity measures that have been evident in the recent past. In contrast, there is an opportunity to use health as a mechanism to close rather than exacerbate intergenerational conflict through integrated training and work-based education that promotes healthy working.

However two specific and related findings from the statistical analysis undertaken suggest that addressing the health symptoms alone is not only insufficient but also already too late. First, the statistics indicate that health problems of varying nature have a considerable effect across the age bands of the workforce. Although the overall tendency is for health issues to increase with age, there are also significant proportions of younger workers who experience health problems that affect the amount and the kind of work that they can undertake. Second, a different narrative on the issue of youth is that young workers are not necessarily healthy and display considerable levels of chronic ill health including in particular mental health issues. Health has been shown to be an important contributing factor towards the high rates of young NEETs and older workers. A more holistic approach to health at work is needed from policy makers rather than splitting policy interventions into silos based on factors such as age.

These findings are in line with research (Eckersley, 2011) suggesting that the overall improvements in medicine do not necessarily mean that workforces are healthier overall. There is no doubt that death rates caused by or at work have decreased but this may have been replaced by a more varied and differentiated situation which requires tailoring jobs and individuals to each other. The indication is that this is necessary not only for older workers when their health decreases but as early as the first transition into employment. This means that health issues have a levelling effect on the labour market: rather than potential competition for jobs and resultant intergenerational conflict, older and younger workers pursue "good" jobs equally. This requires a variety of occupational opportunities in each region and sub-region and a better range of working conditions and types of employment available from the point at which an individual enters the workforce. This may be the key to reducing the proportion who are no longer able to be economically active as they reach middle age and beyond.

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