

**The health impacts of the contemporary manufacturing and service
sectors on men and women**

List of Authors

Eleni Kampanellou*

Social Policy Research Unit

University of York

Email: eleni.kampanellou@york.ac.uk

Donald Houston

Urban Studies

School of Social and Political Sciences

University of Glasgow

KEYWORDS: gender, health, inactivity, longitudinal studies, morbidity, occupational hazards,
unemployment

ABSTRACT

Manufacturing and manual employment and, to a lesser extent, low-grade white-collar work have long been associated with poor health outcomes. This article reports important new findings based on longitudinal micro data that demonstrate important changes and gender-related patterns to this prevailing understanding. Specifically, manufacturing employment now has a protective health effect for men, and women's health is not strongly influenced by occupation. High-paid service sector employment is found to be bad for health, particularly among men. Changing industry within the service sector is linked to a deterioration in health, particularly among women, whereas changing employment from manufacturing to services is found to be bad for men's health. Confirming previous research, shifts from any sector of employment into unemployment and economic inactivity are strongly associated with a deterioration in health. The findings point to four conclusions: i) the emergence of new occupational hazards in the service sector; ii) the improvement of working conditions in manufacturing; iii) changing industry is damaging to an individual's health, possibly due to skills mismatches that may arise, although further research is required to further disentangle the direction of causation; and iv) the impacts on health of different industrial sectors and changes between industrial sectors vary between men and women.

INTRODUCTION

Manufacturing and construction employment, and to a lesser extent low-grade clerical work, have long been linked with poor health (Hedlund, Järholm & Lundbäck, 2006; Hein, Stayner, Lehman & Dement, 2007; Jones et al., 2009). The transition of developed economies from manufacturing towards services has been associated with mixed health implications (Ostry et al, 2000, 2002). On the one hand, the decline and automation of hazardous occupations and improved health and safety practices in manufacturing and construction have been hypothesised to reduce the incidence of ill-health and disability in the working-age population (Loomis, Richardson, Bena & Bailer, 2004). On the other hand, work intensification and flexibilisation prevalent in the expanding low-grade service sector may be producing new occupational hazards for health arising from pressure, lack of control and the sedentary nature of non-manual employment (Anderson, Schulte, Sestito, Linn & Nguyen, 2010; Sekine, Chandola, Martikainen, Marmot & Kagamimori, 2009).

Industrial decline and associated job destruction impacts adversely on health through unemployment, economic inactivity or re-employment in lower quality jobs in the service sector. Low-grade service sector jobs are often characterized by inferior salaries, the health impacts of which may be compounded if individuals coming out of manufacturing are less well suited or equipped to perform the tasks required, for example arising from skills and cultural mismatches (Danson, 2005; Power, 2008; Wessel, 2005). Unemployment and non-participation in the labour market (economic inactivity) are strongly associated with poor health, although the magnitude of causality in each direction remains uncertain – in other words, in some cases job loss comes first and subsequently impacts on health, while in other cases the onset of illness or other conditions subsequently lead to exits from employment (Korpi, 2001; Bambra & Eikemo, 2009; Booker & Sacker, 2013).

Previous research on the health implications for individuals of changing the industrial sector in which they are employed has tended to focus on individuals making the transition from manufacturing to services, particularly men, as a result of the deindustrialisation process producing forced job changes (Beatty & Fothergill, 1996; Rocha, 2001; Morris & Cook, 1991). Little is known about how other transitions between industrial sectors affect health, nor

about how the health impacts of changing industry may affect men and women differently. As with job loss, changes in the industrial sector of employment may be either cause or consequence of poor health – or both. Some individuals may change industry in response to a change in their health-related capacity to perform tasks in their previous job. In other circumstances, a change in industrial sector may occur for reasons unrelated to health but have subsequent impacts on health.

For instance, the transition, especially to less desirable types of employment, can increase the instantaneous exposure to different physical and psychosocial hazards not present to the previous occupation. Those hazards can be associated with the nature of employment as well as the overall working environment. Forced transitions to the same or different sectors of employment can result in physically intensive or non-manual repetitive jobs accompanied with insecurity and in many cases inferior salaries, especially for low-skilled or manual employees. These attributes not only limit career progression but also lower the socio-economic position of individuals. Subsequently more vulnerable employees undergoing this change, need to adapt to both an incompatible occupational identity and deterioration of living standards. Therefore, the effectiveness of the labour market and hiring process in matching workers and jobs in terms of skills and preferences is likely to be important in determining subsequent health outcomes.

This article has three research aims. First, to update evidence on the link between industrial sector of employment and health outcomes. Second, to assess the link between a change in industrial sector and a change in health, going beyond existing research that has focussed on men shifting from manufacturing to service-sector employment. Third, to investigate whether industrial sector and a change in industrial sector affect the health of men and women differently.

INDUSTRIAL SECTOR, GENDER AND HEALTH

Industrial sector and health

Traditional manufacturing industries have been associated with specific physical health conditions (respiratory-related diseases, various malignant neoplasms and injuries) for both males and females (Andersson, Persson, Bryngelsson, Magnuson & Westberg, 2010; Jones et al., 2009; Stout, Jenkins & Pizatella, 1996). Some parts of the service sector are characterised by casualization and low levels of training and career development, which may lead to 'job stress' and poor health outcomes for both men and women (Ferrie, Shipley, Stansfeld & Marmot, 2002). The service sector covers a range of sub-sectors associated with diverse health implications. More precisely, high rates of mortality are observed for employees in the wholesale and retail sector (Anderson et al., 2010). Occurrences of heart disease are more frequent among low-grade civil servants, where employees demonstrate higher blood pressure, smoking and limited physical activity (Van Rossum, Shipley, Van de Mheen, Grobbee & Marmot, 2000).

Additional factors contributing to the prevalence of certain morbidity outcomes are associated with the psychosocial nature of employment. Supplementary elements such as job insecurity and high work-related demands combined with low control and rewards at work are linked with the increase of incidents of coronary heart diseases, sickness absences, emotional exhaustion and overall life dissatisfaction (Sekine et al., 2009; Aronsson, Gustafsson & Dallner, 2002; Kuper & Marmot, 2003; Van der Hulst & Geurts, 2001).

Recent research has revealed that the nature of work in both manufacturing and in the service sector has changed (Murray, Baldwin, Ridgway & Winder, 2005; Ostry et al, 2001). Qualitative evidence suggests that these changes may be altering established employment-related patterns of health – but this has not been quantitatively tested (Ostry et al, 2002). Specifically, automation in manufacturing and construction and improved health and safety practices in hazardous industries may have reduced hazards, and certainly injuries and fatalities reported by industries have fallen (Loomis et al, 2004). Meanwhile, work intensification and flexibilisation prevalent in the service sector may have increased adverse impacts on health (Baumberg, 2014). Work intensification may have increased work-related

stress, while aspects of flexibilisation may have led to greater insecurity and an increase in involuntary job changes (Benach, Muntaner & Santana, 2007; Booth, Francesconi & Frank, 2002; Marmot & Bell, 2010).

Deindustrialisation has resulted in large amounts of job loss and redundancy, which are strongly linked with poor health (Brown et al., 2012). Unemployed individuals are more likely to demonstrate physical and psychological morbidity (Bambra & Eikemo, 2009; Bartley, 1994; Eliason & Storrie, 2009). On the one hand this association arises because pre-existing ill-health increases the probability of unemployment compared to healthy individuals (Arrow, 1996; Lindholm, Burström & Diderichsen, 2001; Stewart, 2001). On the other hand, unemployment increases unhealthy behaviour driven by anxiety and financial strain (Kessler, Turner & House, 1989; Montgomery, Cook, Bartley & Wadsworth, 1998; Morris, Cook & Shaper, 1994; Rocha, 2001). In addition to unemployment, the sharp decline of manufacturing jobs, pre-existing poor health, the lack of transferable skills of former manufacturing employees, and increased work demands in the service sector in combination led to the acceleration of inactivity rates and claiming of disability-related benefits (Baumberg, 2014; Beatty & Fothergill, 1996; Fieldhouse & Hollywood, 1999), initially mainly among men and later also among women (Beatty, Fothergill & Powell, 2008).

Gender, employment and health

The shift from a largely manufacturing-based to a largely service-based economy has been accompanied by an increase in the labour participation of women – especially in the lower-grade service sector (Marmot et al, 1991), which has been linked with poor health outcomes. In employment, men are more likely to experience higher demands for commitment and responsibility but also higher levels of control; women are more likely to experience higher emotional demands along with greater levels of routinisation, lower salaries and greater insecurity (Campos-Serna, Ronda-Pérez, Artazcoz, Moen & Benavides, 2013; Siegrist et al, 2004).

The gendered division of the labour market has led to an extensive literature looking at the nature and health consequences of the working environment for men and women. Women

tend to report higher levels of physical and mental ill-health arising from their job (Vermeulen & Mustard, 2000; Menéndez, Benach, Muntaner, Amable & O'Campo, 2007), particularly musculoskeletal health problems arising from repetitive tasks (Wijnhoven, De Vet & Picavet, 2006). Greater reporting of poor health could be due to the nature of the job, but also due to women more generally reporting poorer health than men, arising from differences in the self-perception of health and the biological attributes of males and females (Krieger, 2003). The greater reporting by women of employment-related poor health may be partly the result of the additional burden of domestic work, including mainly household responsibilities and caretaking activities, which can result in emotional burnout in an attempt to balance work and family obligations (Bartley, 1999; Campos-Serna et al., 2013; Madero-Cabib, 2015).

Experiences of working environments are gendered. Men and women are often treated differently in otherwise identical jobs, and men and women tend to place different levels of value on various aspects of the work environment. Specifically, women place more value on good working relationships and the absence of long hours, while men consider remuneration as more important (Bender, Donohue & Heywood, 2005). These gendered dimensions of the workplace can result in men and women experiencing ostensibly the 'same' job somewhat differently. Coupled with biological differences in susceptibility to different health conditions, men and women's health may be impacted differently in similar workplaces (Benach et al, 2007; Kreimer, 2004).

Job changes and health

Most of the literature on the health impacts of industrial sector of employment is quite static and does not consider the impact of switching employment between sectors. Workers are becoming more mobile across and within sectors, making the static approach increasingly problematic.

Research indicates that for men a shift from manufacturing to service-sector employment can lead to skills mismatches and be detrimental in terms of their identity and wellbeing (De Grip, Bosma, Willems & Van Boxtel, 2008). The notion that job shifts between industrial sectors more generally (i.e. not only from manufacturing to services), including at a finer

scale within broad groupings such as 'manufacturing' and 'services', has not been assessed in existing literature. In addition, existing literature considering the impact of a shift from manufacturing to service-sector employment has (to some extent justifiably given the dominance of men in manufacturing) focussed on men and largely ignored women (Nixon, 2006; Sayce, Ackers & Green, 2007).

The effectiveness of the labour market and hiring decisions in achieving good matches between workers and jobs in terms of skills, experience and preferences is likely to impact on subsequent health outcomes. Similarly, training provision and support for staff development once in post is likely to impact on skills mismatches, skill deficiencies and job satisfaction (Stier & Yaish, 2014; Zou, 2015). Hiring practices, labour market tightness, credentialism and staff development vary by industry and are gendered (Fernandez & Mors, 2008; Hampson & Junor, 2010; Hoque & Kirkpatrick, 2003; Scherer, 2004). Some existing studies have detected a link between skills mismatch and job satisfaction (Jones, Jones, Latreille & Sloane 2009; Liljegren & Ekberg, 2010), and job satisfaction is likely to subsequently influence health outcomes.

Changing sector of employment may represent a beneficial adjustment mechanism in response to health-damaging or otherwise unsatisfactory employment. A change in the sector of employment may in some circumstances lead to a better match between the skills, preferences and capabilities of an individual and the nature and demands of their job. In other circumstances, however, the decision to change sector of employment may lead to a deterioration, rather than improvement, in the fit between the worker and job. Poor matches between worker and job could be expected to be more likely when the decision to change sector is, at least to some degree, forced upon an individual, for example in response to job loss (Gesthuizen & Dagevos, 2008; Kristensen & Westergaard-Nielsen, 2004).

In the case of re-employment following involuntary job loss, existing evidence points towards mixed health outcomes. Re-employment of former industrial employees to similar jobs contributed to the formation of a positive physical and psychological health experience compared to employees absorbed to less desired jobs (Ostry et al., 2002; Riva, Terashima,

Curtis , Shucksmith & Carlebach , 2011). Consequently, the nature of job, in the case of re-employment, combined with elements of job satisfaction and the level of skills mismatch, has significant health impacts. The training and qualification credentials required to enter an industry and the level of training and staff development offered once hired are likely to play a role in minimising 'job stress' and associated adverse health outcomes.

An important distinction between changing sector and exiting employment (the latter has been linked with adverse health outcomes) is the degree of agency involved. Although many exits from employment involve the exercise of agency on the part of the (former) worker and may even be positive choices or in others necessitated by a deterioration in health, in many cases leaving employment is involuntary, for example as the result of compulsory redundancy. In contrast, changing occupation (almost by definition) requires some agency on the part of the worker to choose and secure employment in an alternative sector – even if the initial trigger was an external factor such as job loss. An individual changing sector of employment may be voluntary or involuntary – or a constrained choice lying somewhere in-between. The degree of voluntariness, the extent to which agency can be exercised and the level of opportunities available in a given local labour market, all influence the likelihood that a change in occupation will lead to an improvement or deterioration in the goodness of fit between worker and job, and the attendant health impacts that may arise from that goodness or badness of fit.

METHODS

Research Design

Previous studies of the impacts of employment sector and changes in industrial sector of employment are characterized by selection effects and short-term duration of follow-up, and focus mainly on former male manufacturing employees (Morris & Cook, 1991). This is problematic because less healthy workers might not have the same chances of becoming re-employed or entering their favoured alternative occupations compared to their healthy counterparts. In the same context, the short duration of follow-up of those studies does not allow for long-term effects.

This study employs a longitudinal design, with a cohort of employed individuals observed at the beginning and end of a 10-year period, in order to mitigate these limitations in the existing literature. Our research design seeks to explain the probability of an individual reporting poor health at the end of the ten-year period. The key variables of interest on our models relate to industry and change in industry of employment. We control for the existence of a health condition at the beginning of the ten-year period that limits activities, which goes some way to combatting uncertainty in the direction of causation by isolating the effect of employment change on health as opposed to the effect of health in inducing change in employment.

The ideal research design would involve repeated observations at a number of points in time in order to identify the sequencing of changes in sector of employment and health. Unfortunately, such data available in British Household Panel Survey (BHPS) at the time of analysis had insufficient numbers of observations of persons moving between industrial sectors. Therefore, we used the larger number of longitudinally linked Census records available in the Scottish Longitudinal Study (SLS). Future research could make use of the expanded sample size in the UK Household Longitudinal Survey (UKHLS) which replaced the BHPS in 2009, although the SLS, at least for the time being, retains the advantage of spanning a longer time period.

Scotland was chosen as a region that has experienced substantial industrial restructuring, including large numbers coming out of manufacturing throughout the 1990s and growth of a low-paid service sector, and suffers from extensive poor health. Scotland has the added benefit of the availability of the SLS, which has a large sample drawn from Census records (a much larger proportion of the Scottish population is included than in the English Longitudinal Study) and tracks individuals over a long period. At the time of analysis, the 1991 and 2001 Censuses of Population were linked and available within the SLS.

Sample

The Scottish Longitudinal Study represents 5.3% of the Scottish population and information is collected from the Scottish Census and administrative sources (SLS-DSU, 2013). The analysis reported in this article includes two time points, 1991 and 2001. The sample used in

this analysis involves the working age employed population in the secondary and tertiary sectors in the year 1991 (i.e. the primary sector comprising agriculture, forestry and fishing was excluded). The sample selection incorporated only those employed in the year 1991.

The inclusion only of the employed population instead of the unemployed as well is relevant to the objective of the study. This study intends to move beyond the current and extensive literature centered on the health effects of unemployed industrial workers, especially older former employees, and their transition towards employment into other low-grade service sector and inactivity. Instead of focusing on these familiar pathways, this study explores a different angle of the industrial sector by looking at the link between employment transitions and health. Therefore, it seemed more relevant to include the employed in 1991 and monitor the occupational histories of previously engaged individuals.

The employed population in 1991 is confined to 20-54 year olds for two reasons. First, the choice of this age frame minimizes the inclusion of those still in full time education. Second, because of the ten year interval of the Scottish Longitudinal Study, it seemed more appropriate to include the employed individuals up to 54 years old, since they were more likely to be in employment until the next census. This resulted in the exclusion some of the older, close to retirement, individuals in 1991. The classification of Individuals as employed unemployed or inactive is based on their response to a single census question: 'Which of these things were you doing last week?' (SLS-DSU, 2013).

Those who died or left the sample for other reasons were not incorporated into the analysis. Mortality is recorded in the SLS but was not modelled as an adverse health outcome due to insufficient numbers of observations. Employees in full or part-time employment, self-employed with or without employees and those on a government scheme were included in the baseline sample of employed individuals. The sample of the individuals appearing in both the 1991 and 2001 Censuses comprised of 63,150 persons. The number of males was 32,968 and covered 52% of the sample, whereas the number of women was 30,182 (48%).

Health Measures (outcome or dependent variable)

Health is captured in the 2001 Scottish Census by self-assessed health over the previous 12 months. The question is: 'Overall the last twelve months would you say your health has on the whole been?' (SLS-DSU, 2013). There are three possible responses: 'good', 'fairly good' or 'not good'. For binary logistic regression analysis, the self-assessed health responses have been transformed into a binary dependent variable: 'good/fairly good' or 'not good'. Self-assessed health is widely used in epidemiological research and longitudinal studies as a good indicator of premature mortality (Burström & Fredlund 2001) and has been chosen for two reasons. First, it may indicate aspects or symptoms of ill-health not always detectable or yet diagnosed in formal medical procedures (Idler & Benyamini, 1997). Second, it reflects physical and mental conditions related to lifestyle choices and psycho-social influences on health (Eriksson, Undén & Elofsson, 2001; Mackenbach, Van den Bos, Joung, Van de Mheen & Stronks, 1994). Overall, the use of self-assessed health in other studies has shown good reliability (Lahelma, Maritkainen, Laaksonen & Aittomäki, 2004; Lundberg & Manderbacka, 1996). Regarding the Scottish census, a cognitive question testing was conducted by Ipsos MORI Scotland and it was concluded that this question is effective (Scotland's Census, 2015). Unfortunately, the self-assessed health question was not introduced in the 1991 census.

Also captured is limiting long-term illness (LLTI), which is based on binary (yes/no) responses to the question, 'Do you have any long-term illness, health problem or disability which limits your daily activities or the work you can do?' (SLS-DSU, 2013). We modelled outcomes based on both self-assessed health and LLTI, which produced very similar results. We report the results for self-assessed health in the main body of the article and the results for LLTI in annexes.

Sectoral Stability and Change (key explanatory variable of interest)

The manufacturing sector was sub-divided into 'mining and manufacturing' and 'energy and construction' (Table A). The service sector was sub-divided into high and low-paid occupations (see Annex 3 and Holdsworth, 2010). Employed individuals in the year 1991 were followed up in 2001 and this formed an indicator based on stability or change between four employed states (two manufacturing sectors and two service sectors). The influences

of leaving employment for unemployment or economic inactivity were also modelled, but these have not been reported in the interests of clarity and length and because the health impact of employment exits are well documented. The indicator of stability or change is based on four possible states in 1991 (the four occupational groups) and six possible states in 2001 (the four occupational groups plus the two non-employed states of unemployed or inactive). This produces a 4x6 matrix of possibilities, i.e. 24 possible combinations of states across the two years of observation. All groups are mutually exclusive.

For moves in and out of manufacturing, the two manufacturing groups have been combined in order to maintain an adequate sample size. Again because of sample size constraints we have not differentiated between upward and downward mobility within manufacturing or within services (although our sub-division of manufacturing is not hierarchical in any case), but rather created categories that indicate whether there has been a change in occupation within the broad manufacturing and services categories. These amalgamations of cells in the 24-cell matrix reduces the total number of stability or change categories to 16. Six of these are exits from employment which have not been reported, leaving the 10 occupational stability and change groups reported in each model in the results section. The models include a number of control variables relating to demographic, socio-economic and pre-existing (1991) health (see next section), but these have not been reported in the interests of clarity and space

Table A Population Groups

<i>Groups</i>	<i>Description</i>	<i>Total</i>
Employed in Mining/Manufacturing both years	Same sector both in 1991 & 2001	6162
Employed in Construction/Energy both years	Same sector both in 1991 & 2001	3246
Changed Industry	From/To: Mining/Manufacturing 1991/2001 To/From: Construction/Energy 2001/1991	1059
Employed in High-Paid Services in 2001 (From Industry 1991)	From: Industry 1991 To: High Paid Services in 2001	3017
Employed in Low- Paid Services in 2001 (From Industry 1991)	From: Industry 1991 To: Low-Paid Services in 2001	2195
Employed in Industry in 2001 (From High-Paid Services 1991)	From: High Paid Services 1991 To: Industry in 2001	1294
Employed in Industry in 2001 (From Low-Paid Services 1991)	From: Low- Paid Services 1991 To: Industry in 2001	1542
Employed in High-Paid Services both years	Same sector both in 1991 & 2001	19449
Employed in Low-Paid Services both years	Same sector both in 1991 & 2001	7670
Changed Services	From/To: High-Paid Services 1991/2001	5383

Control variables

The analysis controlled of socio-economic and demographic indicators that acted as confounding factors when examining the influence on health of sector and change in sector of employment. The determinants of health cover a range of factors that encompasses the social and economic environment, the physical environment as well as the individual level characteristics and behaviour. Age and gender are well-known determinants of health. The younger the age of an individual, the higher the probability of him/her being healthy and being part of the labour market. Moreover, gender plays an additional part, since men and women tend to suffer from different morbidity events, have diverse health expectations and be frequently involved in different occupational tasks (WHO, 2016).

An important socio-economic factor across the life course is education. Low levels of education are linked to poor health, fewer career prospects and therefore challenging economic circumstances. The lack of adequate educational qualifications can hinder the accessibility to additional necessities such as housing (Bambra, Gibson, Sowden, Wright, Whitehead & Petticrew, 2010). Housing assets, especially building type, number of rooms and ownership have been frequently used as indicators of wealth, instead of income, and have been linked to reduction in injuries, increase in overall well-being and social participation (Macintyre, EllawayHiscock, Kearns, Der & McKay, 2003).

As with high living standards, personal relationships, especially marital affairs, can positively influence health. Being married can act as a source of health-promotion, where individuals tend to adopt healthier lifestyle choices and through social support improve their overall well-being (Kiecolt-Glaser & Newton, 2001). Moreover, marriage can enhance household income and therefore provide accessibility to additional material resources and protection against individual level poverty (Lahelma et al., 2004).

More precisely, as well as gender, age was divided in five year intervals, and marital status contained three categories (single, married/remarried, divorced/widowed). Additional indicators such as educational qualifications and car ownership controlled for differences

between individuals in socio-economic status. Educational qualifications were split in three categories: First/Higher, other and no qualifications. The first category includes all the individuals with professional or university degrees/diplomas and those with Higher National Certificates (HNC/HND/SVQ level 4 or 5). Other category refers to those with a Certificate of Sixth Year Studies (CSYS), A levels together with vocational qualifications (GSVQ/SVQ) and Ordinary National Certificates (ONC/OND Level 3). The final category involves all those without any qualifications, those with General Certificate of Secondary Education ('O' Grade) and those with vocational qualifications (Level 1).

Likewise, housing conditions such as tenure, number of rooms and heating facilities were supplementary indicators of economic status (Annex 4 includes additional descriptive information). Finally, some models controlled for pre-existing limiting long-term illness in 1991, on the basis that ill-health that limits activities could accelerate the transition towards inactivity and induce health-related changes in occupation (Table B). In addition to initial models with gender as a control variable, separate models were also run for men and women.

Table B Control Variables

<i>Variables</i>	<i>Categories</i>	<i>Description</i>
Age and Sex	20-24 25-29 30-34 35-39 40-44 45-49 50-54 / Males Females	Age and Sex 1991
Marital Status	Single Married-Remarried Widowed-Divorced	Marital Status 1991
Education	.First or Higher Education Other Non-Degree .No Qualifications	Qualifications 1991
Housing Tenure	Owner/Private rented/ Social rented	Housing Tenure 1991
Rooms	Two or less / Three /Four or more	Number of Rooms 1991
Cars	Owns a car /Does not own a car	Car ownership 1991
Central Heating	Has central heating / No central heating	Central Heating 1991
LLTI	No/Yes	Limiting long-term illness 1991

Analysis

Logistic regression was used for the analysis. The dependent variable is coded as 1 if health is reported as 'not good' and 0 if 'good' or 'fairly good'. Therefore, odds ratios reported relate to the probability of reporting poor health – the higher the odds ratio, the more likely that health is poor. The reference category in relation to the sector and sectoral change categories is 'remained in manufacturing' – odds ratios less than 1 mean poor health is less likely than for those who remained employed in manufacturing over the 10-year period, while odds ratios greater than 1 mean poor health is more likely than for those who remained employed in manufacturing over the 10-year period.

Table 1 reports three models. Model 1 controls for demographic measures (age, gender and marital status). Model 2 also controls for the socio-economic indicators mentioned in the previous section. Model 3 adds a control for pre-existing limiting long-term illness. Coefficients and odds ratios are stable across the three models, suggesting the model is robust. Table 2 reports separate models for men and women, which included the full suite of control variables (i.e. as Model 3 in Table 1, excluding the gender variable of course).

RESULTS

The results indicate that manufacturing employment has a protective effect on health compared to employment in any part of the service sector. With all controls in place, those who remained in high-paid service sector employment over the 10-year period are most likely of all sectoral stability and change groups to report 'not good' health, and are 1.45 times more likely to report poor health than those who remained in the manufacturing sector (Model 3, Table 1). Even only controlling for demographic factors and not socio-economic characteristics, high-paid service workers remain 1.20 times more likely to report poor health than manufacturing workers (Model 1, Table 1). After manufacturing, stable employment in low-paid services offers the second-best protective effect for health, with an odds ratio not statistically significantly different to stable manufacturing (Model 3, Table 1). However, without controlling for socio-economic factors (Model 1, Table 1), low-paid service workers are 1.22 times more likely to report poor health than manufacturing workers and this is statistically significant at the 95% level.

Although not shown in the table, men have a higher odds ratio (1.51 $p < 0.05$, Model 3, Table 1) of reporting poor health compared to women., Descriptive statistics without any controls indicate that women report slightly more poor health than men (8.31% of women in our sample compared to 8.18% of men reported their health was 'not good' in 2001).

Table 1 Sectoral Transitions and Self-Assessed Health

<i>Activity 2001</i>	<i>Model 1</i>	<i>Model 2</i>	<i>Model 3</i>
Employed in Mining/Manufacturing both years (base)			
Employed in Construction/Energy both years	0.85(0.65-1.11)	0.83(0.64-1.09)	0.85(0.65-1.11)
Changed Industry	0.49(0.28-0.83)**	0.46(0.27-0.79)**	0.47(0.27-0.80)**
Employed in High-Paid Services 2001 (from Industry 1991)	0.92(0.69-1.21)	0.97(0.73-1.28)	0.96(0.72-1.26)
Employed in Low-Paid Services 2001 (from Industry 1991)	1.31(0.99-1.73)*	1.26(0.95-1.66)	1.24(0.94-1.64)
Employed in Industry 2001 (from High-Paid Services 1991)	1.01(0.69-1.46)	1.07 (0.74-1.55)	1.06(0.73-1.53)
Employed in Industry 2001 (from Low-Paid Services 1991)	1.00(0.70-1.42)	0.94(0.66-1.34)	0.94(0.66-1.34)
Employed in High-Paid Services both years	1.20(1.01-1.43)*	1.46(1.23-1.74) **	1.45(1.22-1.73)**
Employed in Low-Paid Services both years	1.22(0.99-1.49)*	1.17(0.96-1.43)	1.15(0.94-1.41)
Changed Services	1.39(1.12-1.72)**	1.40(1.13-1.74)**	1.38(1.11-1.71)**
<i>Diagnostics (for full models including control variables and non-employed outcomes not reported)</i>			
Pseudo R-squared	0.2381		
N	63,150		
LR Chi-Square(33)	8,096.70		
Prob > Chi-Square	<0.0000		

SLS *.01< $p < .05$ ** $p < .01$. Model 1: age and sex controls; Model 2: age, sex and socio-economic controls; Model 3: age, sex, socio-economic and LLTI controls.

For women, there are no statistically significant differences between occupational groups in likelihood of reporting poor health. Nevertheless, despite not being statistically significant, low-paid services appear to be the best type of employment for women's health (on the basis of having lowest odds ratio (0.92) of all the stable occupational groups for women in Table 2). This is in contrast to manufacturing or construction which appears to be best for men's health (on the basis of both stable service sector groups for men having odds ratios greater than 1.0 compared to stable manufacturing – 1.40 and 1.13 for high- and low-paid services, respectively in Table 2).

The R-squared for the model for women in Table 2 is lower than that for men (0.197 for women compared to 0.288 for men) – in other words, sector of employment explains less health variation among employed women than it does among men.

Men and women who change sector within manufacturing are less likely to report ‘not good’ health than those who remain within the same manufacturing sub-sector (odds ratio of 0.47 for men and 0.65 for women – although only statistically significant for men – Table 2). The opposite is true in the service sector, where changing sector is associated with a 1.38-times increase in the probability of reporting poor health (Model 3, Table 1).

In terms of moves between manufacturing and services, there are again differences between the two broad sectors. A move from manufacturing to low-paid services is associated with a deterioration in health (odds ratio of 1.24 in Model 3, Table 1 – not statistically significant in Model 3 but significant in Model 1 when socio-economic controls are removed), and this is true for men and women (Table 2). In contrast, a move in the opposite direction from low-paid services to manufacturing appears to have little or no impact on health, although a small but not statistically significant benefit for men is detectable (odds ratio for men in Table 2 is 0.82 compared to 1.13 for men remaining in low-paid services). Although not statistically significant, a move from high-paid services to manufacturing appears to be beneficial for men’s health (odds ratio 0.92 compared to 1.40 if remaining in high-paid services) but damaging to women’s health (odds ratio of 1.29 compared to 1.15 if remaining in high-paid services).

Table 2 Gendered Sectoral Transitions and Self-Assessed Health

<i>Activity 2001</i>	<i>Men</i>	<i>Women</i>
Employed in Mining/Manufacturing both years (base)		
Employed in Construction/Energy both years	0.90(0.68-1.20)	0.96(0.37-2.48)
Changed Industry	0.47(0.26-0.85)**	0.65(0.15-2.77)
Employed in High-Paid Services 2001 (from Industry 1991)	0.94(0.67-1.32)	0.93(0.56-1.54)
Employed in Low-Paid Services 2001 (from Industry 1991)	1.22(0.88-1.70)	1.11(0.67-1.85)
Employed in Industry 2001 (from High-Paid Services 1991)	0.92(0.57-1.47)	1.29(0.69-2.40)
Employed in Industry 2001	0.82(0.52-1.31)	0.99 (0.56-1.76)

(from Low-Paid Services 1991)		
Employed in High-Paid Services both years	1.40(1.13-1.75)**	1.15(0.82-1.59)
Employed in Low-Paid Services both years	1.13(0.88-1.47)	0.92(0.64-1.31)
Changed Services	1.15(0.84-1.58)	1.16(0.81-1.67)
<i>Diagnostics (for full models including control variables and non-employed outcomes not reported)</i>		
Pseudo R-squared	0.2877	0.1967
N	32,968	30,182
LR Chi-Square(32)	5,080.68	3,213.83
Prob > Chi-Square	<0.0000	<0.0000
SLS *.01<p<.05 **p<.01. Model includes age, socio-economic and LLTI controls		

DISCUSSION

This study has identified changes in established employment-related patterns of health and trends across different sectoral categories. The sample was confined to the employed individuals in industries and services in the year 1991. In order to reduce possible selection bias of healthy individuals, the analysis took into account several major determinants of health also related to the continuity of work. The analysis included and controlled for pre-existing limiting long-term illness in employees of both industries and services. Therefore, less healthy individuals in employment were also part of the analysis. Furthermore, additional demographic factors, like age and gender, associated with the likelihood of being in or out of employment are accounted for. Further socio-economic sample dissimilarities such as educational qualifications and material assets are also included. Nevertheless, it is acknowledged that despite these efforts it is impossible to completely eliminate selection bias. Due to data constraints, it was not possible to directly control for additional factors like lifestyle choices, such as alcohol consumption, smoking and exercise, that may contribute to the continuity or termination of occupational engagement. However, the use of self-

assessed health, as an indicator of morbidity, indirectly captures a variety of health behaviours.

By adopting a longitudinal approach, it has revealed that in the case of self-assessed morbidity, which acts as a proxy of premature mortality (Bentham, Eimermann, Haynes , Lovett & Brainard , 1995), employment in the manufacturing sector has a protective effect (Kampanellou, 2013), even before socio-economic controls are in place – but this only applies to men. This could be due to the fact that this study covers a relatively contemporary time period (the 1990s) which captures changes to industrial sub-sectoral composition and improved safety practices across the manufacturing sector. More technologically advanced industries can possibly provide safer working environments and the time frame included in the analysis captures this change. In addition, industrial working environments include a more highly educated labour composition than in the past. More precisely, contemporary manufacturing industries, in an effort to be more innovative and remain internationally competitive, employ highly qualified individuals in posts where manual effort may be present but is minimal and sits alongside an increased premium on problem-solving and communication skills. This trend demonstrates a transition from traditional manual heavy engineering towards lighter and less labour-intensive manufacturing industries that lead to a reduction in physical risks. In construction, there has also been automation of some heavily physical tasks, but here improvements in health and safety practices may have had a transformative effect in reducing occupational hazards.

Sectoral and gender differentiation of the results have implications for our understanding of the health impacts of employment. High levels of customer pressure and employer productivity demands, leading to imbalance of work and personal life as well as physical impacts of long periods of sitting in sedentary jobs, such as musculoskeletal disorders and increased levels of obesity (Biddle et al., 2010; Lundberg, 1999; Sekine et al., 2009; Stansfeld, North, White & Marmot, 1995) can explain some of the health impacts in the service sector. Consequently, daily and long-term exposure in a sedentary working environment combined with an overall sedentary lifestyle is linked to cardiovascular mortality, diabetes, cancer and metabolic dysfunction (Biddle et al., 2010). The high-paid service sector appears to be particularly harmful to men's health. This finding is in contrast

to numerous studies which have repeatedly shown that women report greater levels of poor health than men. Our finding that men are more likely to report poor health, however, arises after controlling for industry of employment, indicating that men are more likely than women to work in industrial sectors that are protective of health.

There are important differences between the manufacturing and service sectors in the impact on health of changing industry within each of these sectors. Specifically, changing industrial sector within manufacturing is associated with lowered probability of an individual reporting poor health, whereas the opposite is the case in the service sector, where those changing sector within services are more likely to report poor health. This may reflect effective labour market matching taking place within the manufacturing sector, i.e. job changes result in better matches between worker and job. It may also be that training for new entrants to an industry is more effective in manufacturing than in services.

This is true for men and women (although the results for women are not statistically significant, the odds ratios point in the same direction as for men). On the one hand, the sample size of women in some groups, especially manufacturing, may not be sufficient to produce significant results. On the other hand, domestic rather than occupational aspects of women's lives may have a greater influence on their health compared to men, as suggested in existing literature.

There are two possible interpretations of this finding. One is that job matching and training are better in manufacturing, which minimises job stress that can result from poor hiring decisions or inadequate training perhaps more prevalent in the service sector. Therefore, the health impact of changing sector within services may reflect poor labour market matching within the service sector, for example arising from labour shortages and/or poor screening and hiring practices. It may also be the result of low levels of training producing 'job stress' and subsequent adverse health outcomes. An alternative interpretation, however, is that in manufacturing there are barriers to entry which make it more difficult for those with poor health to change industry of employment, for example arising from physical demands of jobs and/or health and safety or productivity concerns with hiring

people with poor health – whereas there may be more opportunities to change sub-sector of employment in response to deteriorating health within the service sector.

In conclusion, the results suggest that employment in the manufacturing sector has a protective impact on health, especially for men, whereas employees in the service sector are more likely to report morbidity. Likewise, the relocation from manufacturing to low-paid service sector is associated with health deterioration. The gendered variations of occupational transitions imply that male employees are more susceptible to the health implications of these changes. Finally, this study demonstrates important health-related transformations in former sectoral norms of employment. Consequently, investigating the scope for re-employment in response to changes in health in different industries is an important area for further research, including the role of employers' occupational health practices.

Acknowledgements

The LSCS is supported by the ESRC/JISC, the Scottish Funding Council, the Chief Scientists Office and the Scottish Government. The authors alone are responsible for the interpretation of the data. Census output is Crown copyright and is reproduced with the permission of the Controller of HMSO and the Queens Printer for Scotland.

REFERENCES

Anderson, V., Schulte, P., Sestito, J., Linn, H., & Nguyen, L. (2010). Occupational fatalities, injuries, illnesses, and related economic loss in the wholesale and retail trade sector. *American Journal of Industrial Medicine*, 53(7),673–685.

- Andersson, E., Persson, B., Bryngelsson, I.L., Magnuson, A., & Westberg, H. (2010) Cancer mortality in a Swedish cohort of pulp and paper mill workers. *International Archives of Occupational and Environmental Health*, 83(2), 123–132.
- Aronsson, G., Gustafsson, K., & Dallner, M. (2002) Work environment and health in different types of temporary jobs. *European Journal of Work and Organizational Psychology*, 11(2),151–175.
- Arrow, J.O. (1996) Estimating the influence of health as a risk factor on unemployment: a survival analysis of employment durations for workers surveyed in the German Socio-Economic Panel (1984-1990). *Social Science and Medicine*, 42(12),1651–1659.
- Bambra, C., & Eikemo, T.A. (2009) Welfare state regimes, unemployment and health: a comparative study of the relationship between unemployment and self- reported health in 23 European countries. *Journal of Epidemiology and Community Health*, 63(2),92–98.
- Bambra, C., Gibson, M., Sowden, A., Wright, K., Whitehead, M., & Petticrew, M. (2010) Tackling the wider social determinants of health and health inequalities: evidence from systematic reviews. *Journal of Epidemiology and Community Health*, 64(4), 284-291.
- Bartley, M. (1994) Unemployment and ill health: understanding the relationship. *Journal of Epidemiology and Community Health*, 48(4),333–337.
- Bartley, M. (1999) Measuring women's social position: The importance of theory. *Journal of Epidemiology and Community Health*, 53(10),601–602
- Baumberg, B. (2014) Fit-for-Work – or Work Fit for Disabled People? The Changing Role of Job Demands and Control in Incapacity Claims. *Journal of Social Policy*, 43(2),289-310.
- Beatty, C., & Fothergill, S. (1996) Labour Market Adjustment in Areas of Chronic Industrial Decline: The Case of the UK Coalfields. *Regional Studies*, 30(7),627– 640.
- Beatty, C., Fothergill, S., & Powell, R. (2008) *Women on Incapacity Benefits: New Survey Evidence*. Sheffield: CRESR.
- Benach, J., Muntaner, C., & Santana, V. (2007) *Employment conditions and health inequalities. Final Report to the WHO Commission on Social Determinants of Health*. Geneva: WHO.
- Benach, J., Vives, A., Amable, M., Vanroelen, C., Tarafa, G., & Muntaner, C. (2014) Precarious employment: understanding an emerging social determinant of health. *Annual Review of Public Health*. 35, 229-253

- Bender, K.A., Donohue, S.M., & Heywood, J.S. (2005) Job satisfaction and gender segregation, *Oxford Economic Papers*, 57(3),479-496
- Bentham, G., Eimermann ,J., Haynes, R., Lovet,t A., & Brainard, J. (1995) Limiting long-term illness and its associations with mortality and indicators of social deprivation. *Journal of Epidemiology and Community Health*, 49 (Supplement 2), S57–S64.
- Biddle, S., Cavill, N., Ekelund, U., Gorely ,T., Griffiths, M. D. & Jago, R. (2010). *Sedentary behaviour and obesity: review of the current scientific evidence*. London: Department of Health / Department For Children, Schools and Families.
- Booker, C.L., & Sacker, A. (2013). Labour force sequences, unemployment spells and their effect on subjective well-being set points. *Longitudinal and Life Course Studies*, 4(2), 88-104
- Booth, A.L., Francesconi, M. & Frank,J. (2002) Temporary Jobs: Stepping Stones or Dead Ends. *The Economic Journal*, 112(480), F189-F213
- Brown, J., Demou ,E., Tristram, M.A., Gilmour, H., Sanati, K.A., & MacDonald, E. (2012) Employment status and health: understanding the health of the economically inactive population in Scotland. *BMC Public Health*, 12,327.
- Burström, B., & Fredlund, P. (2001) Self-rated health: is it as good a predictor of subsequent mortality among adults in lower as well as in higher social classes? *Journal of Epidemiology and Community Health*, 55(11), 836-840.
- Campos-Serna, J., Ronda-Pérez, E., Artazcoz, L., Moen, B.E. & Benavides, F.G. (2013) Gender inequalities in occupational health related to the unequal distribution of working and employment conditions: a systematic review. *International Journal for Equity in Health*, 12,57
- Danson, M. (2005) Old Industrial Regions and Employability. *Urban Studies*, 42(2),285–300
- De Grip, A., Bosma, H., Willems, D. & Van Boxtel, M. (2008) Job-worker Mismatch and Cognitive Decline, *Oxford Economic Papers*, 60(2), 237-253
- Eliason ,M. & Storrie, D. (2009) Does job loss shorten life? *Journal of Human Resources*, 44(2),277–302.
- Eriksson, I., Unden, A.L. & Elofsson, S. (2001) Self-rated health. Comparisons between three different measures. Results from a population study. *International Journal of Epidemiology*. 30(2),326–333
- Fernandez, R.M., & Mors, L.M. (2008) Competing for Jobs: Labor Queues and Gender Sorting in the Hiring Process. *Social Science Research*, 37,1061-1080.

Ferrie, J.E., Shipley, M.J., Stansfeld, S.A. & Marmot, M.G. (2002) 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: the Whitehall II study. *Journal of Epidemiology and Community Health*, 56(6), 450-454

Fieldhouse, E. & Hollywood, E. (1999) Life After Mining: Hidden Unemployment and Changing Patterns of Economic Activity amongst Miners in England and Wales, 1981-1991. *Work, Employment & Society*, 13(3),483–502.

Gesthuizen, M. & Dagevos, J. (2008) Mismatching of persons and jobs in the Netherlands: consequences for the returns to mobility. *Work, Employment & Society*, 22(3),485-506

Hampson, I., & Junor, A. (2010) Putting the process back in: Rethinking service sector skill. *Work, Employment & Society* 24(3),526–545

Hedlund, U., Järholm, B., & Lundbäck, B. (2006) Persistence of respiratory symptoms in ex-underground iron ore miners. *Occupational Medicine*, 56(6),380–385

Hein, M.J., Stayner, L.T., Lehman, E., & Dement, J.M. (2007) Follow-up study of chrysotile textile workers: cohort mortality and exposure-response. *Occupational and Environmental Medicine*, 64(9),616–625.

Holdsworth, C. (2010) Patterns of pay: results of the Annual Survey of Hours and Earnings 1997 to 2009. *Economic and Labour Market Review*, 4(3),59–70.

Hoque, K. & Kirkpatrick, I. (2003) Non-standard employment in the management and professional workforce: Training, consultation, and gender implications. *Work, Employment & Society*, 17(4),67–689.

Idler, E.L. & Benyamini, Y. (1997) Self-rated health and mortality: a review of twenty-seven community studies. *Journal of Health and Social Behavior*, 38(1), 21-37.

Jones, M.K., Jones, R.J., Latreille, P.L. & Sloane, P.J. (2009) Training, Job Satisfaction, and Workplace Performance in Britain: Evidence from WERS. *Labour*, 23(s1), 139-175

Jones, D.R., Sutton, A.J., Abrams, K.R., Fenty, J., Warren, F.,& Rushton, L. (2009) Systematic review and meta-analysis of mortality in crop protection product manufacturing workers. *Occupational and Environmental Medicine*, 66(1),7–15.

Kampanellou, E. (2013). From Industries to Services: Occupational Mobility and Health in Scotland. *Journal of Epidemiology and Community Health*, 67, Suppl1, A5-A6 . Society for Social Medicine 57th Annual Scientific Meeting, Brighton.

Kessler, R.C., Turner, J.B. & House, J.S. (1989) Unemployment, reemployment and emotional functioning in a community sample. *American Sociological Review*, 54(4),648–657.

Kiecolt-Glaser, J. K. & Newton, T. L. (2001). Marriage and health: His and hers. *Psychological Bulletin*, 127(4), 472–503.

Korpi, T. (2001) Accumulating Disadvantage. Longitudinal Analyses of Unemployment and Physical Health in Representative Samples of the Swedish Population. *European Sociological Review*, 17(3),255–273.

Kreimer, M. (2004) Labour market segregation and gender-based division of labour. *European Journal of Women's Studies*, 11(2),223-246.

Krieger, N. (2003) Genders, sexes, and health: what are the connections—and why does it matter? *International Journal of Epidemiology*, 32(4),652-657.

Kristensen, N., & Westergaard-Nielsen, N. (2004) *Does Low Job Satisfaction Lead to Job Mobility?* IZA Discussion Paper No.1026. Accessed 25th September:

<http://ssrn.com/abstract=511722>

Kuper, H., & Marmot, M. (2003) Job strain, job demands, decision latitude, and risk of coronary heart disease within the Whitehall II study. *Journal of Epidemiology and Community Health*, 57(2),147–153.

Lahelma, E., Maritkainen, P., Laaksonen, M., & Aittomäki, A. (2004) Pathways between socioeconomic determinants of health. *Journal of Epidemiology and Community Health*, 58(4),327–332.

Liljegren, M., & Ekberg, K. (2010) Job mobility as predictor of health and burnout, *Journal of Occupational and Organizational Psychology*, 82(2),317-329

Lindholm, C., Burström, B., & Diderichsen, F., (2001) Does chronic illness cause adverse social and economic consequences among Swedes? *Scandinavian Journal of Public Health*, 29(1),63–70.

Loomis, D., Richardson, D.B., Bena, J.F. & Bailer, A.J. (2004) Deindustrialisation and the long term decline in fatal occupational injuries. *Occupational and Environmental Medicine*, 61(7),616–621.

Lundberg, U. (1999) Stress Responses in Low-Status Jobs and Their Relationship to Health Risks: Musculoskeletal Disorders. *Annals of the New York Academy of Sciences*, 896(1),162–172.

Lundberg, O., & Manderbacka, K. (1996) Assessing the reliability of a measure of self-rated health. *Scandinavian Journal of Public Health* 24(3),218-224.

Macintyre, S., Ellaway, A., Hiscock, R., Kearns, A., Der, G., & McKay, L. (2003) What features of the home and the area might help to explain observed relationships between housing tenure and health? Evidence from west Scotland. *Health and Place*, 9(3), 207–218

Mackenbach, J.P., Van den Bos, J., Joung, I.M., Van de Mheen, H. & Stronks, K. (1994) The determinants of excellent health: different from the determinants of ill-health? *International Journal of Epidemiology*, 23(6),1273–1281.

Madero-Cabib, I. (2015) The life course determinants of vulnerability in late careers. *Longitudinal and Life Course Studies*, 6(1),88-106

Marmot, M., & Bell, R. (2010) Challenging health inequalities-implications for the workplace. *Occupational Medicine*, 60 (3),162 – 164

Marmot, M.G., Smith, G.D., Stansfeld, S., Patel,C., North, F., Head, J., White, I., Brunner, E., & Feeney, A. (1991) Health inequalities among British civil servants: the Whitehall II study. *Lancet*, 337 (8754), 1387–93.

Menéndez. M., Benach, J., Muntaner, C., Amable, M., & O’Campo, P. (2007) Is precarious employment more damaging to women’s health than men’s? *Social Science and Medicine*, 64(4), 776–781

Montgomery, S.M., Cook, D.G., Bartley, M.J. & Wadsworth, M.E.J. (1998) Unemployment, cigarette smoking, alcohol consumption and body weight in young British men. *European Journal of Public Health*, 8(1),21–27.

Morris, J.K. & Cook, D.G. (1991) A critical review of the effect of factory closures on health. *British Journal of Industrial Medicine*, 48(1),1–8.

Morris, J.K., Cook, D.G. & Shaper, A.G. (1994) Loss of employment and mortality. *BMJ*, 308(6937),1135–1139.

Murray, R., Baldwin, J., Ridgway, K. & Winde, B. (2005) Socio-economic Decline and Adaptation: South Yorkshire’s Former Coalfields. *Local Economy*, 20(4),344–359.

Nixon, D. (2006) I just like working with my hands: employment aspirations and the meaning of work for low-skilled unemployed men in Britain’s service economy. *Journal of Education and Work*, 19(2),201–217.

Ostry, A.S., Barroetavena, M., Hershler, R., Kelly, S., Demers, P.A., Teschke, K. & Hertzman, D. (2002) Effect of de-industrialisation on working conditions and self-reported health in a

sample of manufacturing workers. *Journal of Epidemiology and Community Health*, 56(7),506–509.

Ostry, A.S., Hershler, R., Kelly, S., Demers, P., Teschke, K., & Hertzman, C. (2001) Effects of de-industrialization on unemployment, re-employment, and work conditions in a manufacturing workforce. *BMC Public Health*, 1(1),15.

Ostry, A.S., Marion, S., Green, L., Teschke, K., Hershler, R., Kelly, S., & Hertzman, C. (2000) The relationship between unemployment, technological change and psychosocial work conditions in British Columbia sawmills. *Critical Public Health*, 10(2),179–192

Power, R. (2008) After the Black Gold: A View of Mining Heritage from Coalfield Areas in Britain. *Folklore*, 119(2),160–181.

Riva, M., Terashima, M., Curtis, S., Shucksmith, J. & Carlebach, S. (2011) Coalfield health effects: variation in health across former coalfield areas in England. *Health and Place*, 17(2),588–597.

Rocha, C. (2001) From plant closure to reemployment in the new economy: Risks to workers dislocated from the declining garment manufacturing industry. *Journal of Sociology and Social Welfare*, XXVIII(2),53–75.

Sayce, S., Ackers, P., & Green, A.M. (2007) Work Restructuring and Changing Craft Identity: The Tale of the Disaffected Weavers (or what happens when the rug is pulled from under your feet). *Work, Employment & Society*, 21(1),85-101

Scherer, S. (2004) Stepping-stones or Traps? The Consequences of Labour Market Entry Positions on Future Careers in West Germany, Great Britain and Italy. *Work, Employment & Society*, 18(2), 369-94.

Scotland's Census (2015). *Scotland's Census. Shaping our future*. Accessed 18th February from: <http://www.scotlandscensus.gov.uk/variables-classification/health>

Sekine, M., Chandola, T., Martikainen, P., Marmot, M., & Kagamimori, S. (2009) Socioeconomic inequalities in physical and mental functioning of British, Finnish and Japanese civil servants: role of job demand, control and work hours. *Social Science and Medicine*, 69(10),1417–1425.

Siegrist., J, Starke, D., Chandola, T., Godin, I., Marmot, M., Niedhammer, I., & Peter, R. (2004) The measurement of effort-reward imbalance at work: European comparisons. *Social Science and Medicine*, 58(8),1483-1499

SLS-DSU (2013) *Scottish Longitudinal Study Development and Support Unit (SLS-DSU)*.

Accessed 2nd November from: <http://sls.lscs.ac.uk/>

Stansfeld, S.A., North, F.M., White, I. & Marmot, M.G. (1995). Work characteristics and psychiatric disorder in civil servants in London. *Journal of Epidemiology and Community Health*, 49(1),48–53.

Stewart, J.M. (2001) The impact of health status on the duration of unemployment spells and the implications for studies of the impact of unemployment on health status. *Journal of Health Economics*, 20(5),781–796.

Stier, H. & Yaish, M. (2014).Occupational segregation and gender inequality in job quality: a multi-level approach. *Work Employment & Society*, 28(2), 225–246.

Stout, N.A., Jenkins, E.L. & Pizatella, T.J. (1996). Occupational injury mortality rates in the United States: changes from 1980 to 1989. *American Journal of Public Health*, 86(1),73–77.

Van der Hulst, M. & Geurts, S. (2001) Associations between overtime and psychological health in high and low reward jobs. *Work & Stress*, 15(3),227–240.

Van Rossum, C.T.M., Shipley, M., Van de Mheen, H., Grobbee, D.E. & Marmot, M. (2000). Employment grade differences in cause specific mortality. A 25 year follow-up of civil servants from the first Whitehall study. *Journal of Epidemiology and Community Health*, 54(3),178–184.

Vermeulen, M. & Mustard, C. (2000) Gender differences in job strain, social support at work, and psychological distress, *Journal Occupational Health Psychology*, 5(4),428-440

Wessel, T. (2005) Industrial Shift, Skill Mismatch and Income Inequality: A Decomposition Analysis of Changing Distributions in the Oslo Region. *Urban Studies*, 42(9),1549–1568.

WHO (2016) Health Impact Assessment (HIA). World Health Organization. Accessed 16 February from: <http://www.who.int/hia/evidence/doh/en/>

Wijnhoven, H.A., De Vet, H.C., Picavet, H.S., (2006) Explaining sex differences in chronic musculoskeletal pain in a general population. *Pain*, 124(1–2),158-166.

Zou, M. (2015). Gender, work orientations and job satisfaction. *Work, Employment & Society*, 29(1),3-22

