Older Black Workers' Resilience: Navigating Work and Health Risks with Chronic Conditions[1]

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Abstract

Older Black workers are overrepresented in low-wage essential work, earn less income over their lifetime, and are less likely to have insurance in comparison to their white counterparts. With experiences shaped by racism and ageism, they face more health challenges and increased risks for COVID-19 inflection. However, older Black adults remain in the workforce for financial support, where they face unique challenges in meeting work-related responsibilities. Research has yet to fully address the role of the workplace as it relates to the complexity of working as an older Black adult with multiple chronic conditions (MCC). Drawing on data from a workplace case study with interviews from 15 low-wage Black workers aged 50+ with MCC in the Southern U.S., this study aims to identify workplace supports that enable vulnerable workers to remain in the workforce and identify other buffers (i.e., resilience) to working with MCC that enable work engagement. Findings suggest that workplaces can better support older, low-wage Black workers by offering better pay and health benefits. Supervisor and co-worker support, flexible work arrangements, and less stressful work environments also enable sustained work engagement. Policy and practice recommendations are offered to alleviate disparities in work and health outcomes for vulnerable workers.

Keywords: Black Workers, Low-Wage Workers, Chronic Illness, Older Adults, Workplace

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Introduction

There are currently over 40 million Americans aged 50 years and older in the labor market (Toossi and Torpey 2017), with nearly half (46.9%) working full-time. For those aged 55+, workforce participation increased from 34% to 40% from 2002-2012; and participation rates for those aged 55-64 are expected to increase to 68% by 2022 (Toossi 2013). However, a striking 50% to 80% of these older adults have multiple chronic conditions (MCC) — two or more conditions likely to lead to disability (i.e., high blood pressure, cancer, lung disease, heart disease/condition, stroke, diabetes, or arthritis). Although many Americans actively participate in the labor force at older ages, it is evident that health is an influential factor in work experiences and participation. Older workers with chronic illness face several work-related challenges, including meeting physical, social, and cognitive work demands (Lerner, Allaire, and Reisine 2005). They also face barriers when it comes to communicating health needs (Full and Raman 2019), ageism (Perron 2018), and early departure from paid work (Jason, Carr, Washington, Hillard, and Mingo Hillard, 2017).

Many studies on work and retirement in the U.S. have focused on the lives of white, middle-class men and women, but virtually nothing is known about workplace supports for the most vulnerable of workers who must continue to work with chronic illness — Black low-wage workers. The U.S. Bureau of Labor Statistics (2019) reports that Black workers disproportionally face challenges in labor market compensation and retirement benefits (e.g., income, healthcare, pensions, union representation, fringe benefits). For instance, Black men earn about $.87, and Black women earn about $.63 for every $1.00

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white men earn (Economic Policy Institute 2020). The wage gap continues to grow, and older Black adults are working longer for financial support and access to healthcare. This leads Black adults to remain in the workforce longer for financial support, where they must battle unique physical and psychosocial challenges in order for them to meet work responsibilities (Wagner and Neal 1994). Research shows that as the number of chronic conditions increases for an individual, work productivity decreases, going to work sick but not being able to fully function or perform well increases (Schultz and Edington 2007). Further, the likelihood of transitioning out of the labor force altogether increase (Alavinia and Burdorf 2008). However, this relationship is compounded when the individual is a low-wage worker and cannot afford to retire (Jackson and Gibson 1985).

Black adults are overrepresented in low-wage service work, such as cashiers, janitors, and laborers (Brookings Institute, 2021). As essential workers, Black adults are at greater risk for exposure to SARS-Cov-2, the virus that causes COVID-19, since they work directly with the public, cannot work from home, and do not have paid sick days (CDC, 2020). In addition, older Black adults are in "double jeopardy" with experiences shaped by racism and ageism, putting them at higher risk for COVID-19 inflection and poor health outcomes (Chatters, Taylor, and Taylor 2020) including MCC. Given the exceptionally high rate of MCC among Black adults (McKinnon 2002; Bodenheimer, Chen, and Bennett 2009), this article seeks to identify critical factors that enable older, low-wage Black workers to better navigate work and health risk factors and remain engaged in the workforce.

Data were derived from a qualitative study of the experiences of full-time, Black workers in low-wage, physical jobs with MCC in which resilience — the ability to recover from adversity — emerged as a significant theme. Given that the workplace is where most adults spend a significant percentage of their time, daily and over their lives, the relationship between resilience and work is of great interest. However, previous studies have not adequately examined the mechanisms related to race and health that may lead to constrained choices regarding work outcomes. This research seeks to help fill this gap. I conclude with policy recommendations and strategies to help alleviate the compounding effects of racism and ageism on older Black workers' health and work experience. I also provide recommendations for limiting the dire effects of COVID-19 on this population.

Theoretical and Empirical Background

Black Health Burden

Black adults suffer from more chronic illnesses, poor health outcomes, and death at higher rates than nearly all other racial groups (McKinnon 2002; Boedenheimer, Chen, and Bennett 2009). They also report high rates of depression (Green, Baker and Sato 2003, Erving 2017). Black Americans, in particular, have higher rates of diabetes, hypertension, asthma, arthritis, and obesity compared to most other racial groups (Boedenheimer, Chen, and Bennett 2009). The association between populations with high vulnerability (e.g., older adults, racial/ethnic minorities, impoverished or medically underserved groups) and chronic health problems. Racial/ethnic and socioeconomic disparities in the prevalence and outcomes of MCC are well-documented (Tucker-Seely et al. 2011), often showing that minority groups and low-income Americans are consistently disproportionately burdened by MCC and often face complex challenges which limit their ability to succeed (Ward and Schiller 2013).

Social scientists have long examined how perceived racial/ethnic discrimination can adversely affect health (Williams and Williams-Morris 2000; Williams, Neighbors, and Jackson 2003). Generally, studies have found that discrimination is associated with poor health status, and the association is strongest in the case of mental health (e.g., distress, self-esteem, life satisfaction, depression). Research demonstrates that experiences with discrimination are stressful events that disrupt life development and may have cumulative impacts on health and daily life functioning (Fraser and Terizan 2005). These experiences influence an individual's mental, physical, and social health. These experiences also play an essential role in their health and work behaviors (Chae et al. 2014), such as attendance, performance, organizational citizenship, and exit. Those who face regular discrimination are also disproportionately burdened by MCC and experience greater challenges concerning continued employment (Shadmi, 2013a, 2013b; Ward and Schiller, 2013).

Racial and socioeconomic disparities (e.g., those related to education, occupation, income, and wealth) are related to more experiences with discrimination, lower levels of financial security, and poorer outcomes (e.g., mortality, mental health issues, lack of access to healthcare) and a higher likelihood of having MCC (Marengoni et al. 2011; Shadmi, 2013b; Starfield 2011; Tucker-Seeley et al. 2011). Even perceived discrimination produces frequent stressful experiences that trigger fear, anxiety, stress, feelings of injustice, and insecurity that increase risks related to the

deleterious effects of MCC on the ability to function in later life. The literature is replete with information on how racial differences in socioeconomic status (i.e., income, education, and occupation), neighborhood segregation, and medical care contribute to health disparities (Williams and Brayboy Jackson 2005). Nevertheless, we have little insight on how workplace factors may impact the relationship between ill-health (e.g., MCC) and workforce participation.

Resilience

Resilience as a social concept began in the late 1970s as researchers encouraged the field to move away from clinical-based assessments related to medical diseases and focus more on stress management and strength (Rak and Patterson 1996). There was a new emphasis on triumph over adversity — shifting theoretical, empirical, and policy debates to health, thriving, and protection and away from illness, vulnerability, and deficit (O'Leary 1998). Resilience is now primarily understood as a multidimensional process, acknowledging the role of social systems (e.g., family, community, institutions, culture, and social support systems) and centering adaption on stressing or changes in response to adversity (Herrick et al. 2014), including the ability to access and use 'available internal and external resources' (Pooley and Cohen 2010: 34). The current study follows the tradition of population research that started in the 1990s, which focused on resilience to understand how it buffers the effects of trauma on health outcomes, particularly in vulnerable populations (Luthar, Cicchetti, and Becker 2000).

Resilience is a burgeoning area of interest in aging and health research (Wiles et al. 2012). For example, Lydia Manning (2013) conducted a qualitative study examining the relationship between spirituality and resilience in later life in a small sample of older women. She argued that her sample used spirituality as a resource to promote and maintain resilience. Using a sample of over ten thousand Americans aged 51-98 from the Health and Retirement Study, Manning, Carr, and Kail (2016) found that higher levels of resilience protect against increases in limitations associated with aging (such as dressing, eating, toileting, balancing a checkbook, and managing medications), and could buffer the negative impacts of chronic illness and disability in later life.

Social scientists have advocated for structural explanations of inequality to understand the socio-environmental risks that lead to long-term consequences in life chances, well-being, and workforce engagement (Brown et al. 2016). Life-course inequalities contribute to health and work outcomes in later life (Ferraro and Kelley-Moore 2003; Brown et al. 2016), as aging patterns are shaped by social conditions and social change (Dannefer 2003; Elder, Johnson, and Crosnoe 2003). Following this trend, and guided by the risk and resilience model (Fraser and Terzian 2005; Bronfrenbrenner 1979), Jason et al. (2017) designed research examining the impact of MCC on changes in workforce participation in later life and developed an adapted socio-ecological risk and conceptual resilience model (SERRM) (See Figure 1) to examine the relationship between individual and contextual risks, including MCC, and workforce transitions. Findings demonstrated that those who have experienced discrimination are more likely to work fewer hours.

Specifically, Jason et al. (2017) pooled a sample of 4,861 older workers from the Health and Retirement Study and demonstrated that MCC is associated with moving out of the paid workforce in later life. However, despite the challenges MCC imposes on older workers, having higher levels of resilience may provide the psychological resources needed to sustain work engagement in the face of new deficits. The findings further showed that resiliency has a significant, independent relationship with staying in the workforce longer and working more hours despite health, personal factors, contextual factors, and stressful events.

--FIGURE 1 ABOUT HERE--

These findings by Jason et al. (2017) suggest that identifying ways to bolster resilience may enhance the longevity of productive workforce engagement. Yet, no studies to my knowledge have examined a particular contextual site, such as the workplace, as a significant structural exemplar of how resilience operates. Bowling, Jason, and colleagues (2021) conducted a scoping review on resilience in health literature (N=1,727 articles), and based on those findings; no one has approached understanding resilience in this way. In this study, I aimed to learn the challenges of working with chronic illness and, even more, the strategies of remaining in the workforce with chronic illness. This approach provides a deeper understanding of how resilience is sourced and can be developed or diminished through organizational practices.

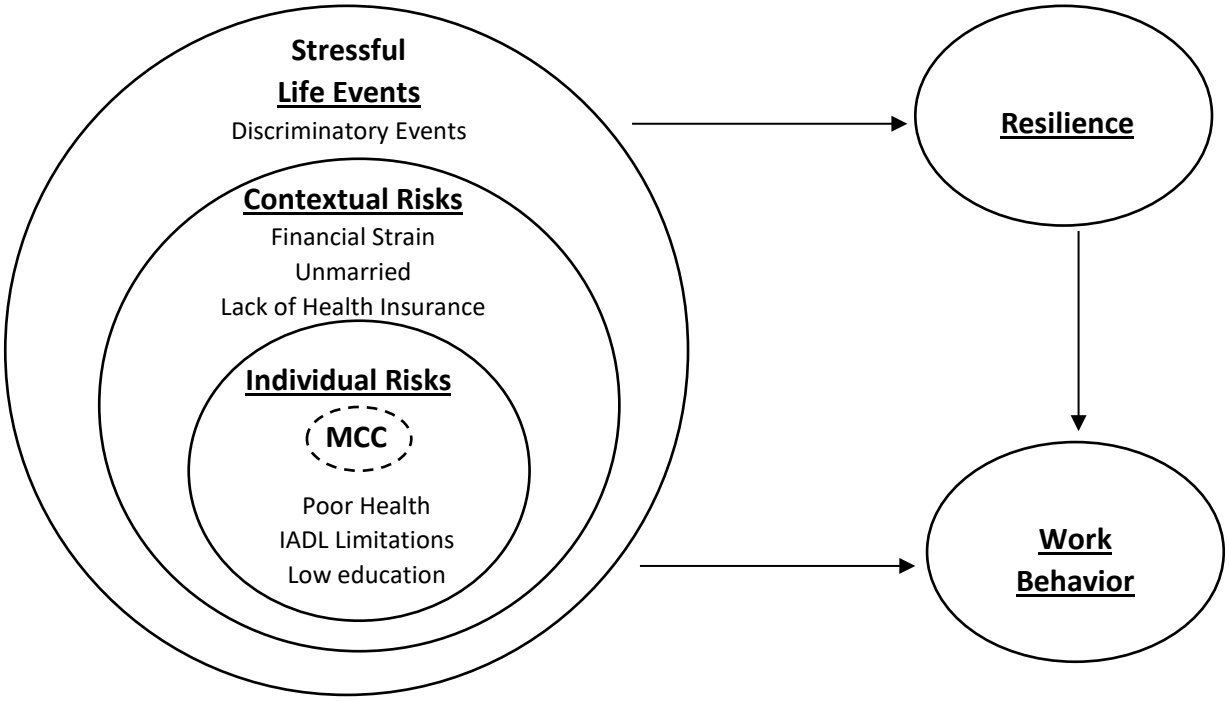
Methods and Data

Data

The data were derived from 15 interviews with Black full-time non-faculty staff aged 50 and over with at least two chronic medical conditions at a large state university in the Southeast. Participants were recruited through four primary means: 1) physical and

electronic mail with attached recruitment flyer was sent to all directors and supervisors of low-wage, physical labor staff employees who announced or posted the flyer in a visible place (e.g., breakroom, common area); 2) a recruitment flyer was electronically distributed in the weekly employee

Figure 1: Adapted Socio-Ecological Risk and Resilience Model (SERRM)



newsletter; 3) I handed out flyers to potential respondents and recruited on-site and; 4) snowball sampling. Unfortunately, randomized sampling was not an option since there was no list of employees by race, gender, and health status and no accessible list of employees in this wage category. Thus, I was dependent on potential respondents to self-identify.

Sample

Recruitment was active from August 2016 - July 2017, although the last interview was conducted in March 2017. I initially aimed to interview 20 respondents — 10 Black men and 10 Black women. After recruiting 10 Black women and five men, I extended the IRB-approved protocol to recruit more men, but no additional recruitment was successful. (See UyBico, Pavel, and Gross 2007 for more on difficulties recruiting Black men in health research). Table 1 displays the sample's demographic characteristics. The sample ranged from 50-70 years of age. Twelve respondents had a high school diploma or college, and three had less than a high school education. All listed their primary employer as their source for health insurance, three were on Medicare, and three received social security benefits. Three respondents had another job and then reported their household income as equal to or less than $40,000. Two respondents were born outside of the United States. Table 2 provides details of the chronic conditions of the sample.

The interviews were semi-structured, open-ended, and conducted in person. The interview questions were based on the SERRM model and focused on self-perceived health, health management, daily job experiences, work history, perceived discrimination, and retirement plans. In addition, I asked about access to medical care, social support, and financial resources were discussed. I captured data related to age, race, sex, household income, employment status, work history, and health status with a demographic survey. I conducted all interviews at the respondents' place of employment, usually during a lunch break or after their shift had ended, and provided a $20 gift card to a large chain pharmacy after the interview. Interviews lasted between 45 minutes to 1.5 hours. Pseudonyms are used here.

Analysis

Interviews were recorded, transcribed, and managed through NVivo software. A graduate research assistant trained in qualitative methods was hired to assist with coding and thematic analysis to enhance the reliability and validity of the coding methods. The inductive analysis was developed using methods traditionally associated with grounded theory methods (GTM) (Charmaz 2014). We began by

Table 1: Sample Demographics

	N	%
Age	15	100 (50-70)
Sex		
Male	5	.33
Female	10*	.67
Education		
Less than High School	3	.20
High School	8*	.53
Some College	4	.27
Another Job		
Yes	3	.20
No	12*	.80
Retirement Status		
Previously Retired	2	.13
Not Retired	13*	.87
Health Insurance		
Primary Employer	15*	1.0
Medicare	3	.2
Social Security Benefits		
Yes	3	.20
No	12*	.80
Number of Chronic Conditions		
1	1	.07
2	5	.33
3	6*	.40
4	4	.20
Household Income		
$10,001-25k	3	.20
$25,001-40k	7*	.47
$40,001+	2	.13
Country of Origin		
USA	13*	.87
Other	2	.13

*Notes modal category

subjecting the interview transcripts to line-by-line open coding to conceptually tag the data (Lofland and Lofland 1995). These initial codes identified recurrent themes, then subsequent more focused coding, followed by memo writing, helped flesh out these themes and specify relationships. For example, these codes included "challenges," "daily experience," "(reasons to) stay," "co-workers," and "contradictions." Then, using axial coding, we created categories that linked data to general processes, conditions, and context. These included codes such as "how participant manages MCC," "how threats are discussed," and "discussion of resilience."

In GTM, data collection and analysis are a reiterative process, and reliability and validity of the data were maintained through comparative open and axial coding between the research team members for the project's duration. In this study, the author and graduate research assistant identified similarities and differences in how the workers described their experiences. We identified connections between themes and noted variations when they arose through this partnership. We identified core concepts and categories by comparing independent analyses followed by group consensus and mapped our final analytic scheme.

Trustworthiness and Reflexivity

We engaged in several methods to ensure trustworthiness and reflexivity. First, I designed an interview instrument to capture a thick description of the data (Geertz 2003). This was done by asking a few pointed questions, with a series of probes, clarifying questions, and reiteration back to the respondent to ensure accuracy of what was being said. Second, I engaged in personal triangulation (Kimchi, Polivka, and Stevenson 1991) by collecting data from several levels of workers within the inclusion category (i.e., entry-level workers, lead workers, workers with a range of time on the job, and job variability).

In data analysis, both research members are skilled and experienced qualitative researchers, with the author having subject matter expertise. We reviewed, coded, and analyzed over 75% of the data independently, then shared and discussed our analytic process. When applicable, we discussed discrepancies in coding until we achieved consensus. Finally, we engaged in member checking (Candela 2019) if, during transcription or analysis, we were unsure if we were adequately representing the participant's ideas. Through this in-depth and collaborative process, we are confident in the credibility and confirmability of this study.

Using the methods above, we discovered that resilience was central to the experiences of the older workers. Traditionally, resilience in an individual refers to successful adaptation despite risk and adversity (Masten 1994). In this case, I understood resilience as the successful management of health (challenges) and (hard) work. As the respondents detailed their strategies and ability to manage their health concerning their work environment, the research question emerged: What are the structural explanations for their resilience?

Table 2: Sample's Chronic Conditions

Pseudonym/ Name	Job title, Age	M	F	Arthritis	Asthma	Diabetes	High Blood Pressure	High Cholesterol	1 other illness	2 or more other illnesses
Mildred	Cashier, 65		X	X		X		X		
Charlie	Stock Person, 56	X					X			X
Sandra	Dining Room Attendant,56		X	X	X	X	X		X	
Larry	Custodian, 63	X					X			
Brenda	Custodian, NA		X						X	
Henrietta	Custodian, 70		X			X	X			
Mary	Custodian, 50		X			X	X	X		
Valerie	Custodian, 57		X				X			X
Sophia	Custodian, 55		X			X		X		
Rosena	Custodian, 60		X	X			X	X		
Susie	Custodian, 62		X	X				X	X	
Nettie	Custodian, 52		X	X	X					X
Saundra	Custodian, 60		X	X			X		X	
Will	Floor Tech, 62	X		X			X			
Henry	Auto Tech, 57	X		X			X			

Results

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Age, Race, and Resilience in the Workplace
Being Essential

Older, low-wage, Black workers with chronic illnesses in physical jobs have challenges at work. What makes this sample of workers even more unique is that they are also essential workers, meaning they are designated as essential to the operations of the university and must report to work when the university is closed, even if due to safety precautions such as adverse weather, or more recently, the COVID-19 outbreak. When asked what makes your job difficult, two custodians noted having to come into work as an essential worker when conditions are deemed too dangerous for others. When asked how they feel about having to show up for work because they are essential during hazardous weather, they responded:

> Custodian Susie: I feel it's unfair. [It is] unsafe outside but if you call out, they don't pay you.
>
> Custodian Nettie: This last time we all called out … all got wrote up and [our supervisors] didn't pay us. I wrote to the manager and I wrote to the manager over him. [I explained] I know you have a right to do this, but it's unfair because we work hard and we need our pay. You going to write us up, fine, but to take our pay. I think that's a bit much.
>
> Custodian Susie: Yeah! We are human and the job is still there. If we cannot do it today, we can do it the next day. I'm staying home. I try to take care of myself. The best I can.
>
> Interviewer: I think you made that decision not to come in as a way of taking care of yourself. And then— [Custodian Nettie: Oh yeah!] and then you got penalized for it. [Custodian Susie simultaneously: we got penalized for it.] Yep.

As these two workers describe, essential workers add another layer to their difficulties. They must figure out the best course of action considering their health, income loss, and the threat of termination if they prioritize their safety.

Resilience, Captured

Adapting to or overcoming adversity was a daily challenge for these workers. Unfortunately, many only consider event-based traumas (e.g., violence, natural disasters, hospitalization) (Rak and Patterson 1996). Resilience, however, is also experienced through adapting to or overcoming daily stressful situations – such as being required to report to seemingly menial work for low pay at the risk of one's safety or health.

Capturing resilience through qualitative methods is subjective since it is not a concrete or measurable concept (Bowling et al., 2021). However, as respondents acknowledged how challenging work could be for older workers, especially older workers with health problems, I could resolve that particular approaches to work and life combined with psychological descriptions of "resilience" as an emergent and important conceptual theme. All interviews had identified resilience in one way or another. Here are examples from four workers:

> "I think a lot of us are having problems with their knees, arthritis, and stuff like that—so it's not just me. It's a lot on us because we ain't young doing this work. We got some age on us. Sometime I might say, "my knees hurting!" … "my leg" …"my hand hurting too." But we keep on working. We keep on going." (Mildred, cashier, 65, 3 chronic conditions)
>
> "I'm the type [of person] that, if I'm given a task to do, I'm gonna get it done. And I'm gonna do it to the best of my ability. It doesn't affect my job for the most part, in a negative way. It affects me, because I push myself harder, to push through it. So that's harder on me." (Valerie, custodian, 57, 2 chronic conditions)
>
> "I don't feel good. But with a lot of people, I just fake it off. I ain't got time to worry about this. I got to keep moving. A lot of things with me, I just try to shake it off." (Henrietta, custodian, 70, 2 chronic conditions)
> "I just go right on, keep on rolling…" (Sophia, custodian, 55, 2 chronic conditions)

Sentiments such as these are not just referencing work ethic, which all of the respondents held in high regard, but rather an unbalanced approach to work and health. Despite the pain, harm, suffering, or psychological distress experienced by living with their chronic conditions, they willed themselves to continue to perform their work duties to a high standard. In some cases, they would detail behaviors such as ignoring pain, working through pain, taking rest breaks, and medicating to finish their job each day. In addition, they prided themselves in not calling in or leaving early because of illness or pain. These individual-level strategies allowed them to clock in and out of work each day and yielded a full paycheck. Still, there were other elements, both structural and organizational, that allowed them more consistency in work and fewer call-in days. I address these other elements in what follows, and I have organized these themes into two sections: 1) managing health (employer selection and scheduling) and 2) managing work (co-worker dynamics, work arrangements). I end with a note on supervisors.

Managing Health

For the workers I interviewed, the successful management of their health included being able to do their jobs without causing further harm to their bodies by aggravating or ignoring their preexisting conditions, being able to make doctor's appointments, working in safe conditions, limiting stress, and being able to afford and take prescribed medicine, therapy, or other treatment. Below, I discuss how they managed their health conditions through a series of institutional-enabling strategies.

Preferred Employer. The first strategy older low-wage workers used to manage their health was to find a good job. These workers benefited from employment with a 'preferred employer,' which was a large state university in this study. A preferred employer has greater employee satisfaction, a great referral rate, a higher retention rate, lower turnover rates, and organizational competitiveness (Baker 2014). When talking about her reasons for staying with this preferred employer, Custodian Rosena claimed, "You can advance anytime. You can promote all the way up to Director. [You can go] even higher than that." At this workplace, the workers in this sample really enjoyed the work they did. Mildred, a cashier, described her daily experience as, "We just have fun." Custodian Mary said, "I like my job, my work. I'm not being hassled or anything." Many of these workers have done similar work their whole lives, but it was not enjoyable.

This workplace allowed them to do familiar work in an environment not as stressful as their previous jobs. The workers claimed that they experienced less stress by working with friendly clients (students, staff, and faculty), having "compassionate" supervisors, enjoying camaraderie with peers, and working familiar jobs. For example, Henrietta, a 70-year-old custodian, noted, "I like it here so much because it's better than any other job I have had. And I can say, I love the money and I love the benefits." As this statement illustrates, respondents' employment at a preferred employer could arguably be the most important factor when managing their health. In addition to the qualities listed above, their workplace paid higher wages for low-skilled work and offered full benefits at a lower out of pocket cost than (mostly) all their previous low-skill, low-wage workplaces. This was noteworthy as many workers aged in these jobs. For example, a 52-year-old custodian, Nettie, told her story:

> I have bad health. When I started work here, I was healthy. I fell down sick in 2010. I got seizures from my thyroid. And I really needed my insurance.
>
> She then explained the importance of having extended health care:
> I have to go see my daughter many times [due to her illness]. And I be on family medical leave some time. So, I really need my job. I can support my life.

She continued:

> My mom passed away six years ago and they give me my time. My dad he passed away one year ago. You know, and they work with me. They got good benefits for me. (Nettie, custodian, 52, 3 chronic conditions)

Having time off to care for others through the Family Medical Leave Act (FMLA) was just as important as having health insurance in some cases. This workplace was also ideal as it was located on a public bus line and light rail transport system, allowing them to make it to work without having personal transportation, which many did not have.

The workers did not earn high wages, but they were offered and able to afford their employer's healthcare. This is distinct from the typical low-wage worker in a "bad job" characterized by low pay, few or no benefits, heavy workloads, and high turnover (Kalleberg, Reskin, and Hudson 2000). This is also distinct from many of their peer-workers employed through a third-party temporary employment agency

that paid minimum wage and did not offer healthcare for the same jobs within the same workplace. Many of these workers worked at this site between 10-15 years, some having the interesting story of working for the organization when they were younger and returning years later seeking employment stability.

Scheduling. The second strategy that workers took advantage of was the consistent scheduling of their jobs. Again, having standard schedules in low-wage work is rare, causing problems securing steady transportation and childcare. Inconsistent scheduling contributes to work-family challenges, inconsistent income, high turnover, and low employee engagement (Swanberg, Watson, and Eastman 2014; Lambert and Henly 2009). It has also been found to contribute to poor mental health (Lambert and Henly 2009). This study highlights the rarity of low-wage workers with fixed work hours. This group typically worked Tuesday-Saturday from 5 am to 2 pm. This allowed for easy medical appointment scheduling, which was the main area of concern when they discussed their obligations for maintaining their health. The consistent scheduling also aligned with the public transportation system. Third shift workers did not have problems with medical scheduling either as they worked from 11 pm-5 am.

The participants all expressed relief when we discussed their ability to make appointments outside of their scheduled hours. The most significant relief they expressed was not asking for permission to have time off or to turn in doctor's notes to account for time missed at work. All participants noted that Human Resources and their supervisors were receptive to them taking work off for doctor's appointments, if necessary. Still, nearly all said they avoided asking for time off for two main reasons: they did not want to build a "paper trail" under their name, even if for a legitimate excuse, and they did not want their supervisors to know about their health concerns. This is very telling and possibly speaks to the vulnerability older, low-wage workers may have felt in disclosing their health conditions to their employer. Avoiding this through standardized work hours was a psychological burden they could avoid, reducing possible stress and anxiety.

Although this preferred employer had standardized hours that worked to the advantage of the older workers, the employer did not provide flexible scheduling. A housekeeper explained why she felt this was an injustice:

> One of my co-workers has cataracts [and] on Mondays she works from 8 [am] 'til 5[pm]. And it's dark. So, she asked the managers if she could up her time to 7 to 4 [pm] so she could get off before dark because the lights bother her. And they just flat out refused for that one hour." (Valerie, custodian, 57, 2 chronic conditions)

This employer did not allow for flexible work arrangements identified as one of the most effective methods to decrease work-family conflict, increase job satisfaction, and reduce turnover (McNall, Masuda, and Nicklin 2009). In this case, the allowance for flexible work arrangements could have also helped an employee manage her health condition. Unfortunately, even in the case of a preferred employer, good jobs still have institutional barriers that constrain workers from optimal health management. Fortunately, there seemed to be more institutional enablers in this case.

Managing Work

There were several strategies the participants engaged in to complete the physical and hard work they were responsible for, including moping college cafeteria floors, lifting and transporting heavy boxes, dumping trashcans, cleaning classrooms, and handling heavy equipment and dangerous chemicals. These were daily duties with tight time constraints for completion. Here, I discuss how they completed their jobs through a series of institutional-enabling strategies.

Work Arrangements. This workplace organized work using a teaming system where workers were assigned to work in the same building or area during their shift. Participants often relied on teamwork with other older workers to complete job tasks while working while sick. These workers reported arthritis stiffness, especially in their hands and knees, muscle soreness, dizziness from medication, and feeling lethargic at times. At the same time, this sample of respondents prided themselves in their dedication to come to work despite their illness. The teaming system allowed them to depend on co-workers and manage their tasks while feeling unwell.

In some cases, they would tag-team tasks — one would take a break, while another did the job for both, then switch. In other cases, one would take on the heavier, more strenuous workload, while another would handle lighter tasks. For instance, when asked what people do to help her physically or emotionally on the job, Sandra, a dining room attendant, described her team as "all one family," saying they "have a good time." She noted an older male co-worker, a stock room attendant, "does everything," and she "does not do a bunch of lifting" because "he does that." She said they are "a team on the floor."

Teaming was not always successful institutional support as younger workers were often deemed not

helpful in sharing tasks or alleviating physical workloads. For example, Charlie, a 56-year-old stock room attendant with three chronic conditions, described how he would approach work if he were younger, and he worked along with an older worker:

> [I would say] I'm not gonna let that old man work hard. You chill out. I got you because I'm young enough. My back's strong enough. I can do that.

Then he lamented:

> I work harder than y'all [young workers] and I shouldn't be." (Charlie, stock person, 56, 3 chronic conditions)

In this quote, Charlie expressed frustration with his younger male co-workers. An older worker is rarely employed in such a physically demanding job, so he was the only older worker stock attendant. He had done stock work his entire life, so he had gained expertise in lifting and transporting heavy items with the least amount of physical wear on his body. However, while earning menial wages, doing this work for nearly 30 years has taken a toll on his body. His expectation was not to relax or assume others would do the work for him, but rather that these younger colleagues consider his age and seniority and do not sit back and allow him to do the most strenuous of the workload.

Just as with managing their health, these older workers were very resourceful in figuring out ways to manage their workload. However, there is only so much they could control within the organizational constraints they worked. Along with the inflexible work schedules, another complaint was that "there is no light duty." Mary, a 50-year-old female housekeeper with three chronic conditions, shared that work is allocated equally amongst all workers, regardless of age. Of course, they understood this to be a standard requirement. They were hired to do a particular job, with a well-defined job description laying out physical needs and abilities (e.g., ability to lift 40lb+ or stand on your feet for six hours+), but many of these workers took these jobs when their bodies were younger, stronger, and more physically resilient.

They aged in these jobs and did not have the skill or educational background to switch to the office or administrative jobs that did not require physical labor. They could not quit their jobs, as most have been in low-wage work their entire lives and had little to no financial safety nets. They were, in essence, trapped in their physical and low-paying jobs as the work is familiar and consistent. Resiliently, they have created ways to manage their hard work while their bodies and physical ability declined with age and illness.

A Note on Supervisors. Participants typically spoke very highly of their supervisors, describing most of them as friendly, compassionate, and understanding. They also noted that supervisors were helpful in scheduling time off for medical reasons and appointments. On the other hand, supervisors did not offer to adjust physical work responsibilities. Thus, supervisors were not considered by workers as a part of the management of their workload. Supervisors were not considered a part of the work arrangements the workers engaged in either. This mainly was because participants admitted that they did not want to disclose that they had health issues. A 60-year-old custodian, Saundra, explained:

> We might say something every now and again like, "Oh man! I'm getting too old for this". I have some co-workers call out like all the time [saying] they [are] sick or I'm not coming in today. I'm not that one. I mostly deal with it come to work. They would never know if I'm dealing with anything or not because I just keep the same. (Saundra, custodian, 60, 3 chronic conditions)

Most of the participants echoed Saundra's lack of disclosure with her supervisor concerning her health. Some, like Valerie, a 57-year-old custodian with two chronic illnesses, said she did not share with her co-workers either about aches and pains. When I asked why, she exclaimed, "what good would it do?" Either way, these workers preferred to fly under the radar and did not want to be seen as a problem. Moreover, they did not want their supervisors concerned with their physical well-being as they felt it put them at risk for surveillance.

Racism and Ageism at Work. Historically in the South, physical low-wage work has been carried out by Black men and women. These jobs, deemed undesirable by white workers, were few avenues. As a result, black workers could gain viable employment without competition from their white counterparts. However, once these jobs became more desirable, through increases in pay, status, and mobility, those in power begin to build boundaries around those jobs, monopolize those opportunities, and exclude minority members who compete for those jobs (Tilly, 1998; Tomaskovic-Devey and Avent Holt, 2019). This process is called "social closure," It is a form of discrimination based on any social category that helps gatekeepers justify exclusion, expulsion, and harassment on the job (Roscigno, Mong, Byron, and

Tester, 2007; Roscigno, Garcia, and Bobbitt-Zeher 2007). The current study exemplifies how the intersection of race, class, and age were status markers used to perpetuate workplace discrimination and social closure.

In this example, a male floor technician (a skilled yet lower-wage job dealing with specialized equipment and chemicals) named Will told how this dynamic has changed over time and how he perceived the organization opened jobs up to white workers while blocking Black employment opportunities. He previously worked at the site in the mid-1980s and explains how the workplace is different now and why:

> It was pretty much different actually… '85… when you go to the dorms, that's where the Black folks did housekeeping. Then you get on my side [floor technician area] —which the white folks was runnin' it. [White workers] don't care nothin' bout this job until they raised the salary. See, when I was here in '84, you couldn't get them here — wasn't one white person on campus in housekeepin'. Now, they in there and they done set up these little blocks to secure they [sic] job, which most of 'em could [because it was based on] book knowledge, which [that job will] never be. [That job is based on experience] which [hiring managers] don't seem to accept that. They into these tests and all that, which, I'm good at that too [because] I [have] been to a floor tech class. [Previously, I] never seen nothin' like it. Ain't never took a test like this before. As far as bein' fair and all this kinda stuff? I never experienced nothin' like this in a test in my life. (Will, floor tech, 62, 2 chronic conditions)

Will gives us a glimpse into the institutional history of this organization. He explained that housekeeping used to be a poorly paid job in which only Black workers were employed. It wasn't until the base salary was raised that white workers became interested in the job. The floor technician job was similar. Black people worked the job, while white people managed it. Then, once the salary was raised, the job required a written test for eligibility, when it was previously based on experience only. Will explained (maybe unlike other Black workers) that this change did not exempt him from employment because he took a floor technician class to learn the "book knowledge" required for the job. Even with this advantage, he questioned the fairness and absurdity (i.e., "I never experienced nothin' like this in a test in my life) of the process.

The shift to preferring education over experience was met with the shift to computers and technology, which disproportionally eliminated or disadvantaged Black workers from employment or being fully engaged in their work process. The workers in this study regularly talked about how lack of finances limited their access to a computer and opportunities for education, which negatively impacted their chances for employment and advancement. Their contention with the computer also seemed to come at the intersection of their age and economic status. One custodian, Brenda, said, "We ain't that good on the computers [which are required] to check on our pay and all that kind of stuff." A 70-year-old Henrietta lamented, "I got to focus on all this computer stuff and it's new to me, and I'm like "Oh my God," and that's kind of overwhelming." Sophia, younger 55-year-old custodian stated, "I should know [the computer]. I don't ever have the time or just don't have the interest."

One cannot simply tie the apprehension to computer training as explained by age and income alone. Race played a central role. Most of these workers have been in these jobs their entire life because they were not afforded education and employment opportunities. After all, they were Black. The availability of a job that preferred experience over education was vital as they could learn domestic and technical skills from a young age independent of the educational system, then take those skills into a paying job as an adult. Floor technician, Will, reminded us that he came of age during a time that "didn't have computers." They had "typewriters, so computers don't make any sense to [him]." For many, the reliance on computers represented a changing time that they were not equipped to keep up with.

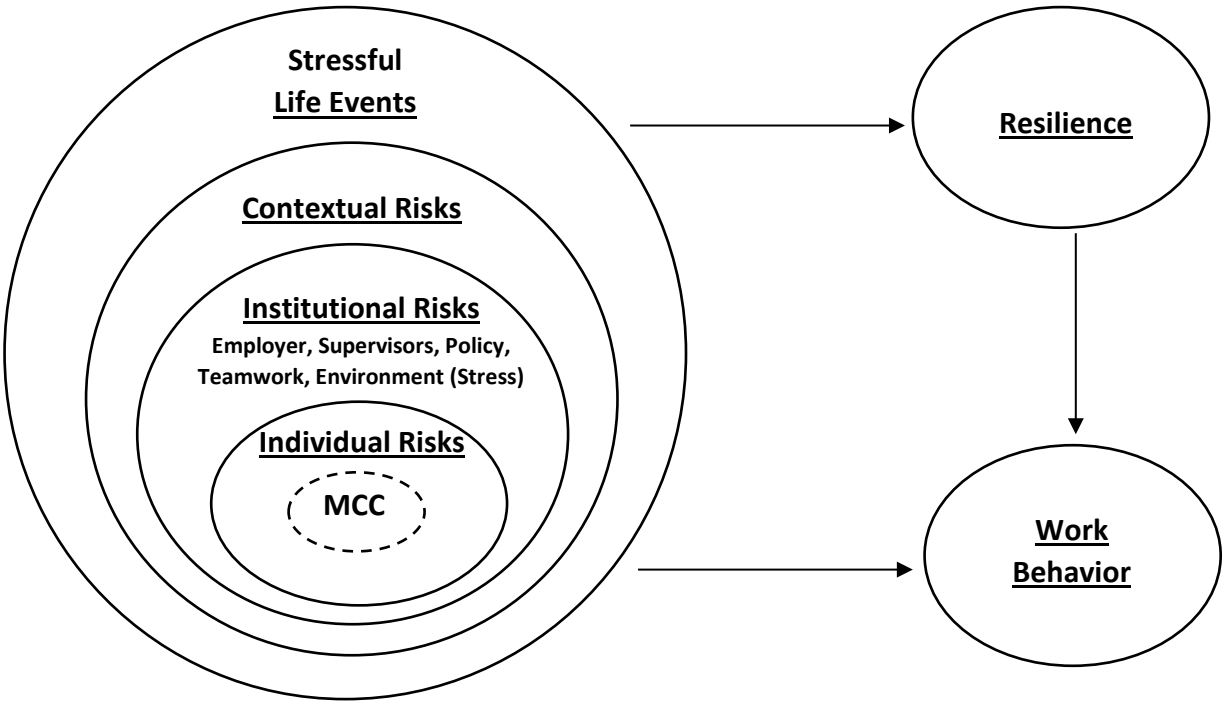
The shift to computers was also perceived as hiring managers could deter or eliminate Black and other minority workers from jobs. When I asked Will why he thought it took six months for him to get hired when he had certifications and experience, he explained:

> The computer picks everybody. [At least] that's what they say. Which I don't believe. They say the computer pulls [your job application] and then they decide to interview you. They throwed [sic] in that computer as a process — a way of eliminatin' ya — you don't have nobody to point a finger at — it's a computer. You can't sue a computer. They take the fight out of the lower man or woman. (Will, floor tech, 62, 2 chronic conditions)

This worker's response captured his race-based distrust in the hiring process and his perception of how organizations could justify the exclusion of qualified Black workers to make room for white workers. This is an example of institutional discrimination, which

occurs without the direct action of racist white people (Bonilla-Silva 2006). The shift and dependence on technology and the present-day requirement of testing into low-skilled jobs in which the finances for education and training are not equally accessible to low-income, less educated Black people,

Figure 2: Adapted Socio-Ecological Risk and Resilience Model with Institutional Risks



are examples of how racism is built into the policies and practices of a modern-day worksite which previously did not present these same challenges for Black low-income workers.

The findings in this study extend the theoretical model offered by Jason et al. (2017) and reveal how organizational risk factors (e.g., type of employer, supervisor support, policy, teamwork, working environment) create barriers to older adults' continued engagement in the workforce (see Figure 2). In addition, I have demonstrated that the way a workplace is structured may buffer the negative impacts of MCC and enable more vulnerable workers to bolster resilience, independent of individual-level factors.

Further, through the voices of older Black workers, I have provided empirical support for how racialized structural and organizational processes shape daily work experiences and decisions. Even as the workers in this sample are employed with a "preferred employer" and benefit from decent pay and access to healthcare, they are trapped in organizational systems that perpetuate racism, ageism, and classism. This study also demonstrates how discrimination is experienced at work. Marginalized people, like these older Black low-wage workers, disproportionally experience interpersonal, institutional, and structural discrimination throughout their life. The Adapted Socio-Ecological Risk and Resilience Model with Institutional Risks captures not only resilience and work behavior as an outcome of discrimination experienced through daily life events but also how institutional risks are embedded within work-related organizational processes.

Discussion and Conclusions

In the current study, I have identified key organizational factors that enabled older workers to navigate work and health risk factors better and remain engaged in the workforce despite their health challenges. The participants of this study were interviewed on their work history, health status, and their ability to remain engaged in work despite being diagnosed with multiple chronic conditions to capture individualized strategies of adaptive resilience to working in physical, laborious work conditions. The narratives that emerged, however, challenged the current understanding of resilience since their strategies did not only simply fit in more internalized

feelings of resilience but rather, they detailed the ways their work was organized which allowed them to enhance their feelings of resilience and buffered the negative impacts of working hard while sick. Previous research on resilience and aging workers found that having higher levels of resilience may provide the psychological resources needed to sustain work engagement in the face of challenges, such as chronic illness (Jason, Carr, Washington, Hilliard, and Mingo, 2017). This research is an empirical illustration of such findings.

Findings

These workers were diagnosed with an average of three chronic illnesses. They managed their health risks by seeking better pay and affordable complete coverage healthcare with a preferred employer. They benefited from standard work hours and supervisors and Human Resource offices that encouraged policies that support time off for doctor's appointments and illness. By benefiting from these institutional supports, they were better able to decrease work-related stress and bolster feelings of resilience. However, working for a preferred employer did not eliminate the challenges they faced as an older, low-wage worker with chronic illness. With no light-duty and inflexible work schedules, they lacked control over their workload. They responded by working on teams and creating informal work arrangements sharing the workload with older co-workers.

I have extended the literature on resiliency by examining structural explanations to psychological resilience. Identifying positive and negative influences on resilience that diminish or bolster feelings can inform organizational policy and structural practices to allow older workers to remain at work and improve their work and health experience. This model is particularly relevant to vulnerable populations such as low-wage Black workers because it considers discrimination as a part of the lived experience over the life course that influences decision-making and outcomes in later life. It is essential to recognize that in addition to cumulative health issues, Black and older workers have faced discrimination over the life course, and this consideration should be central to examining later life processes. This study's results extend theoretical innovation to risk and resilience models (Jason et al., 2017, Fraser and Terzian 2005; Bronfrenbrenner 1979). Here I not only extend the theoretical argument presented in 2015 by adding institutional level factors, but I provide empirical evidence to support the theoretical argument.

These findings support the extension of the adapted socio-ecological risk and resilience conceptual model by introducing institutional risks (See figure 2). Contextual risks in the SERRM model included financial strain, health insurance, and social support— all individual-level factors that have been associated with health status and working longer (US Department of Health and Human Services 2014). By introducing institutional risks (e.g., employer type, work policy, teamwork, and supervisors and co-worker support, we have a more comprehensive understanding of the institutional constraints and enablers that determine whether workers with chronic illness can remain engaged in work for as long they choose.

Workplace Policy and Practice Implications

As a result of the current study, I recommend the following workplace policy and practices to help alleviate challenges older workers with chronic illness face for adaptation in workplaces. First, more workplaces should increase their capacity to offer low-wage and older workers standard work hours and flexible work arrangements. This includes phased and staged retirement options and investing in work equipment and practices that ergonomically support workers, decreasing the risk of injury. Second, workplaces should invest in external professional consultation to address how racism, sexism, and ageism are built into policy and practice and design effective policy changes to minimize interpersonal and institutional discrimination. Third, workplaces need more support and understanding of the Americans with Disabilities Act (ADA) and should invest in the education and training of managers, supervisors, and workers regarding what protections workers with cognitive and physical disabilities have from discrimination at work. Also, consider that older workers are more likely to face job discrimination due to age-related stereotypes (Webster, Thoroughgood, and Sawyer 2019), including assumptions about ability, cognition, and retirement plans. Finally, I recommend encouraging and helping workers file grievances should they experience real or perceived discrimination. This practice should be complemented with stronger enforcement of discrimination-related sanctions.

Fourth, workplaces should invest in practices that enable adaptive resilience for their workers. These include management sensitivity training encompassing mindfulness and organizational awareness, building socially diverse collaborative work teams including older and low-wage workers, and investment in health and wellness programs that acknowledge the adverse health effects of discrimination. Fifth, workplaces should pay a living wage and offer affordable healthcare regardless of the type of job. Finally, for those older workers who

cannot work longer due to their failing health or care work, following the recommendations of Gatta (2018) and Makris and Gatta (2020), workplaces should work with the local legislature and collaborate on policies to support economic security and safety through Social Security, retirement, or public assistance, such that older workers can retire or exit under less financially precarious conditions.

COVID-19 Related Policy Recommendations

The Economic Policy Institute (2020) reports that older workers have been hit the hardest by the effects of COVID-19, including spikes in unemployment. However, many older workers continue to work, even as essential workers, who are even more constrained by workplace policy. Black workers are more likely than other workers to be in frontline jobs and essential work (Rho, Brown, and Fremstad 2020), putting them at higher risk for exposure to COVID-19. The effects of COVID-19 have drastically widened the inequity gap Black workers face at work, exposed them to devastating and long-lasting health effects, and left an uncertain and even more precarious future. COVID-19 has disproportionately affected Black workers, women caregivers, and low-wage workers (CDC 2020; Spurk and Straub 2020).

My final set of recommendations is designed to lessen the effects of COVID-19 on older Black workers, especially those with health concerns: (1) Limit exposure to COVID-19. Workplaces should reconsider the rigid expectations of essential workers and may need to recategorize which job duties are genuinely essential to the operation of the workplace; (2) Promote worker legal protection and support through unionization and collective bargaining; (3) Provide Personal Protection Equipment to workers daily; (4) Offer flexible and reasonable scheduling as essential workers are also thrust into remote learning for (grand)children, extended caregiving, and limited social services for their families; and (5) Give older Black workers a place at the table as many have institutional history, shop floor knowledge, and lived experiences to inform solution-driven policy

Limitations and Future Research

This study has some limitations that must be considered. First, study participants were self-selected. As stated previously, random sampling was not used as there is no accessible list of potential participants within this wage category, nor one that lists employees by race, age, and health status. The respondents here may have been more likely to volunteer because their health issues did not impact their absenteeism or workability. They may have had additional buffers and supports external to the workplace that enabled them to report to work. It is likely their counterparts, who did call into work when ill, did not have such support. Finally, even as social supports were asked in the interviews, no patterns emerged as explanatory in this study. Even so, future research should examine social supports more extensively.

Second, the cross-sectional design of this study does not detail how these findings could change over time, significantly as health status and work conditions change. A longitudinal design would allow a more robust assessment of the extent to which health problems impact work experiences and how work conditions impact health. This research calls for social scientists to design studies to disentangle the bi-directional association between health and work. Third, although this study centered on physical illness, mental illness has been found to have similar negative impacts on work engagement (Wang et al. 2004; Greenberg et al. 2003; Stewart et al. 2003). This study considered workplace characteristics that may increase and decrease stress, but conditions such as depression and mental illness often co-exist with physical illness (Wilson-Genderson, Heid, and Pruchno 2017). Fourth, attitudes towards mental illness are gendered and racialized, and these intersections should be examined more deeply.

Finally, this study does not account for workers who have already left the workforce because of health problems or death. Adversity and stressors in early life affect later-life health, thus influencing work outcomes, including those with the most severe health problems, which face a higher risk for early mortality (Arias and Xu 2019; Ferraro, Markus, and Wilkerson 2016; Turner, Thomas, and Brown 2016). Future research should consider the intersectional considerations of this group and examine how cumulative (dis)advantages influence work-related decision-making in later life. Despite these limitations, this study provides insight into the relationship between health, race, resilience, and workforce engagement and can inform policy and practice enabling workers to work as long as they desire despite their age or health status.

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