The gender workplace health gap in Europe
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Translated into English by Glenn Robertson and Janet Altman
Preface

When the new Community strategy for health and safety at work was being framed, the TUTB and the ETUC lobbied hard for it to mainstream the gender dimension of occupational health. The document *A new impetus for Community occupational health policy*, published in June 2001, sent a clear message from the European trade union movement. The Commission Communication adopted in March 2002 opens up major new ground on the issue. Trade unions mean to see that it leads on to practical measures.

The TUTB has been working to address the gender dimension in occupational health since the very start. It has collaborated with the ETUC Women’s Committee, and struck up useful contacts in different countries. In 1999, we decided to publish a book edited by Karen Messing, describing a collaborative venture between an academic research centre and Quebec trade unions on the linkage between action for health at work and the fight for gender equality. That book was clearly an idea whose time had come. It found a resonance across the European trade union movement and the broader prevention community. It has been used as a benchmark study for countless discussions as well as practical schemes, and often as training material. Its publication in six languages through cooperation agreements between the TUTB and other organizations is a testimonial to that.

At the same time, other initiatives further underscored the importance of the gender dimension in occupational health. Three World Congresses on “Women, Health and Work” have been staged - in Barcelona in April 1996, in Rio de Janeiro in September 1999 and in Stockholm in June 2002. Each of these drew hundreds of men and women from the world over to point out the political, scientific and practical importance of fusing equality and occupational health demands. Each one was a forum for hugely informative debates between researchers from a wide range of fields, feminist activists and trade unionists. The next World Congress is planned for 2005 in India - clear proof that the developed world has no monopoly on the issues involved. They are central to occupational health throughout the world.
As 2001 drew to a close, it became clear that there was a pressing need to look at the state of play in the European Union countries. In collaboration with two Université Libre de Bruxelles research centres, and with funding assistance from Belgium’s Ministry for Work, we launched a survey on the gender dimension in occupational health policies. The idea was to take a good representative look at initiatives in research, preventive activities, trade union action and national policies. Despite the limited resources at our disposal, the survey unearthed a rich seam of information.

This book reflects some of the outcomes of that survey. It contains a general analysis of the data returned by the survey, a consideration of trade union action and Community policy, and a description of practical experiences through nine case studies that show the potential for “en-gendering” preventive practices.

Hopefully, this book will be a useful aid to trade unions and preventive health and safety institutions in bringing down the countless walls that divide the combat for equality from action for occupational health today.

Marc Sapir,
Director of the TUTB
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The scene was a trade union training course on occupational health in French-speaking Switzerland. One participant threw in what appeared to be a riddle: what is the connection between the work of women clock and watch assemblers, and kidney dialysis? It met with a puzzled silence. At first glance, there is nothing in the scientific literature linking the substances used in clock and watch assembly to renal toxicity. The questioner would not let go. So what about the link between double jobbing by women clock and watch assemblers and kidney dialysis? Or, rather, he added, triple jobbing?

Women working in the clock and watch assembly industry in the Jura have always started work very early to have time for the household chores and, very often, a second job in farming. To help them keep going, employers used to supply them with Kafa powders and Saridon tablets\(^1\). They were painkillers that also had a pick-me-up effect. They were heavily used - to ward off fatigue, improve concentration on tasks that involved dexterity and fine detail work. Even now, ex-clock and watch assembly workers still often talk about Kafa and Saridon. They are familiar, harmless words that no longer have the disquieting overtones of drug names. They were, as it were, the essential aids to maintaining industrial and domestic harmony. They kept the countless “minor women’s ailments” under control, and production flowing.

In the 1970s, hospitals in the Jura began seeing large numbers of women who were kept alive only by dialysis. The connection between the two things is as follows.

Kafa powder was a phenacetin-based pain-reliever. It was pulled off the market some years ago due to fears about phenacetin toxicity to kidneys after a long series of cases of irreversible kidney damage among regular users. The other analgesic, Saridon, contained the same active ingredient. Kafa powder and Saridon are now used as the basis of the less harmful pain-killer, paracetamol.

This example puts a human face to abstract concepts like the linkage between paid and unpaid work (including as part of the

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1. Saridon is a registered trademark of the pharmaceutical company Roche. The substance that produced kidney damage is no longer part of its formulation.
work of producing commercial goods), and employer pressure to speed up the work pace. Even now, medicines are widely used as a means of suppressing the open expression of pain at work. To that extent, Saridon use is part of a continuum of practice that is sadly still common today.

Hundreds of personal stories could be cited, all different and yet all with one feature in common: they show how abstract economic and political concepts have physical effects on the human body. These kind of testimonies are the warp and weft of trade union activity. Homer’s accounts of the rivalries between the Olympian gods unleash the passions, laughter, and mourning of humans. Here, ostensibly highly sophisticated concepts of exploitation, domination and solidarity are erupting into real life. They shape and quicken bodies, light up a smile, move them to anger or extinguish them in death. Each of these testimonies lays bare the simple truth of highly complex processes and, at the same time, shows that nothing is really that simple. *Ibergekumene tsores iz gut tsu dertseyln*, says a Yiddish apophthegm. “Troubles overcome are good to tell”. Good for the teller handing on their experience of life. And good for the listener who all in one go receives an understanding of the world as it is and the desire to change it.

It is these narratives that gave the initial impetus to this book, for they have rarely received proper consideration in the standard approach to occupational health issues. They were irrelevant because their reality went beyond the compartments, concealments and repressions of abstract constructs. Should they be ignored because they do not slot into the one-size-fits-all philosophy? Or could they be used to try and hone our critical faculties? This book sets out to move from abstract concepts to the daily realities of a struggle for health and dignity at work.

***

The starting point was a survey run between September 2001 and June 2002 by the TUTB in collaboration with two Université Libre de Bruxelles research centres. The resulting book falls into two parts. Part one looks at the survey results, and lays out pointers for critical thinking and analysis. Part two sets out nine case studies that address the gender dimension of occupational health.

Although done at a specific point in time, it is less the “final report” of a completed study than a link in a decade-long chain of discussion within the European trade union movement. It is informed by a vast collective body of work contributed to by
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The issues addressed range across countless areas, through which a strictly delineated course had to be mapped. This book is aimed chiefly at trade unionists engaged in the struggle to maintain health at work and, more generally, prevention practitioners. In other words, an audience not necessarily familiar with the input of feminist thought or versed in gender analysis.

In many cases, a mere nod has been given towards lines of further inquiry. So, for example, an analysis of the linkages between working time and health involves examination of a wide range of other things: paid working time and its organization, domestic working time, the respective contents of paid and domestic work and the relations between them, the levels of socialization of reproductive work, the commercialisation of leisure activities, etc. Only a few of the many threads in the tangled skein can be teased out. The individual reader can pick out any of these threads, chart their own course and discover countless connections to their own personal experience.

Another issue to be addressed was differences in the terminology traditionally used in the European countries where this common debate was set rolling. This was not just about the literal meanings of words that might cause translation problems. Behind the words, very different political and theoretical concepts clash against one another. So, the concept of “rapports sociaux de sexe”, which is fairly familiar to French-speakers, is hard to translate into English and not much used in Italy, although fairly easy to translate into Italian. The expression “genre” (gender) has come into widespread use in recent years, but, in Italy, the equivalent of “sexual difference” is more commonly found. Also, its polysemy gives the word “genre” many possible meanings in French. Likewise, in different countries, and also in different contexts (political representation, wealth distribution, training, work, etc.), the words “equality” “diversity” and “parity” will be used differently. A discussion of these terminological differences, the issues of theory and the political issues that they reflect is beyond the scope of this book. Hopefully, its readers will understand the limits of the exercise and take their own thinking further through an exploration of the feminist literature.

Behind these methodological issues lies another more fundamental problem. It is essential that the trade union movement
should independently produce its own knowledge and strategies in occupational health. This is not a self-contained process. It is informed on an ongoing basis through confrontation with other actors, but especially from the rich seam of experience possessed by men and women workers struggling to maintain their health. It tries to collectivize these experiences so as to build up a collective knowledge base that can be put to work for action. It refuses to see women and men workers as the mere object of a scientific approach developed by others which has time and again been used to give more legitimacy or effectiveness to exploitation. The trade union movement is no more exempt from male domination than any other institution in our society. Any discussion, any gain, is only one stage in a larger challenging process. But it does not advance in a straight line: defeats, setbacks and checks happen all the time. If this book can help foster new practices where struggles for occupational health include the demand for a society in which women and men have equality, it will have done its job. And it will then willingly step aside for other more comprehensive, ambitious and systematic contributions.
Part I

The TUTB survey on the gender dimension in health and safety
“Examining occupational health through the prism of gender relations helps inform the role played by the gender division of labour in the differential maintenance of men and women’s health and the productive/reproductive life balance. It also enables a critical analysis of the framing of legislation and regulations, as well as institutional and trade union practices in occupational health.”

Annie Thébaud-Mony
The organization of the survey

The TUTB survey on the gender dimension in health and safety was done between September 2001 and June 2002. The research team was comprised of Laurent Vogel (TUTB), the survey coordinator, Lorenzo Munar of the Centre for the Sociology of Health, Université Libre de Bruxelles, and Marianne De Troyer of the Centre for the Sociology of Work, Employment and Training, Université Libre de Bruxelles.

It received financial support from the Belgian Ministry of Employment and Work.

The main aspects of the survey were:
- developing and sending out two questionnaires and processing the responses;
- trawling through the scientific literature and specialized magazines on occupational health for articles touching on the gender dimension;
- staging a specialized seminar for over 100 participants in Brussels on 16 November 2002.

The questionnaires were e-mailed to about 800 addresses in the TUTB's database of contacts in the countries covered by the survey, mainly:
- individuals/institutions responsible for prevention policies;
- preventive service staff;
- trade unionists with occupational health responsibilities;
- government, employer and trade union representatives on the EU Advisory Committee on Safety, Hygiene and Health Protection at Work (Luxembourg Committee).

Copies of the questionnaires were also e-mailed or posted to a variety of centres/institutions that had relevance to the survey but were not necessarily in the TUTB database.

Supplementary reference material was compiled on the survey topic. More specifically, the scientific magazines listed below were trawled (mostly for the period 1993-2002):
- *Occupational and Environmental Medicine*
- *Ergonomics*
- *Scandinavian Journal of Work, Environment & Health*
- *American Journal of Industrial Medicine* (US)
- *Journal of Occupational and Environmental Medicine* (US)
- *Travail Genre et Société* (magazine published by the MAGE group - France)
- *Les Cahiers du MAGE* (France)
- *Santé et Travail* (France)
- *Pistes* (Quebec)*
Médecine et Travail (France)
Social Science & Medicine
Chronique féministe (Belgium)
New Solutions\textsuperscript{c} (US) (period: 1994-2002)

The specialized trade union press on occupational health and equality issues was also sifted through:

Por Experiencia (Spain)
2087 (Italy)
Risks (United Kingdom)
Trabajadora (Spain) (from 2000 only)

a. Significantly, no responses were received from employer organizations.


c. New Solutions differs in being a trade union-backed scientific journal published by the Oil, Chemical and Atomic Workers International Union. It has an independent editorial committee and upholds the tradition of debate between science and activism in the fields of occupational and environmental health.
Chapter 1
The main outcomes of the TUTB survey

The TUTB survey was a qualitative survey. Several hundred questionnaires were sent out to names in a contact file compiled by the TUTB. The survey’s reach was extended by a number of collaborating websites acting as extenders. The ETUC Women’s Committee also sent the questionnaire out to its network of trade union equality officers. The response rate (150 replies) was quite encouraging, given the complexity of the questionnaire, and returned 240 experiences in all. Some of these recurred more than once, bringing the real sample of experiences down to 227. These structured replies were supplemented by several hundred widely varying types of background documents (scientific literature, training materials, statistics, articles from the trade union or general press, case law, trade union campaign material, etc.). Some were sent in along with the questionnaires, others separately.

Variable interest between countries

From the number of responses, an approximation can be made of the interest different countries have in the gender dimension. The range from no responses in one country (Ireland) to 31 in Italy and Spain shows the very variable between-country degree of interest aroused by the survey (see Table 1). But the impression that might be conveyed by the numbers of responses alone cannot go unqualified. Some countries (mainly the United Kingdom, Finland and Sweden) sent in concerted replies, such that a single response reflected the experience of multiple actors. That can be seen from the relatively high number of experiences recounted (23, 16 and 12 respectively) relative to the number of responses received. Also, the survey was disseminated in several countries by a number of organizations and Internet sites, which resulted in the original questionnaires (drawn up in French, English and German) being translated and sent out in Spanish and Italian by trade unions. While that reflects the interest in gendered occupational health, it also helps to explain the higher number of responses in some countries and where they came from.
A literature review confirmed, and in some cases helped to finesse, the main trends brought out by processing the questionnaire responses.

Arguably, countries where occupational health debates have addressed the gender agenda can be split into three groups.

In the Nordic countries, it reflects a social demand for equality that is also reflected in official policies. The development of en-gendered indicators, specific programmes and cooperation between different actors have yielded a significantly more organized body of knowledge than elsewhere. On the other hand, the number of hands-on experiences reported was not particularly high. There may be two reasons why. Institutionalization of the gender approach may have somewhat stifled feminist activism. In particular, the issue of job segregation - very marked in the Nordic countries - seems not to be high on the occupational health agenda. A more upbeat theory may be that the gender dimension has achieved broad recognition, and so practices seldom refer to it by name. While this may be true in some instances, it is unlikely to be the norm.

In some Latin countries (France, Spain, Italy), there is a real social demand, at present reflected in more localized and often more militant practices. Despite some progress in recent years, the establishment response has been lukewarm. Wide-ranging discussions on time use in Italy in the 1980s and 1990s saw feminist groups and trade unions find common ground (Balbo, 2).

The tables in this chapter were compiled by Lorenzo Munar.

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**Table 1: Response to the TUTB survey by country**

<table>
<thead>
<tr>
<th>Country</th>
<th>Responses</th>
<th>Responses %*</th>
<th>Experiences reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austria</td>
<td>7</td>
<td>5%</td>
<td>9</td>
</tr>
<tr>
<td>Belgium</td>
<td>8</td>
<td>5%</td>
<td>15</td>
</tr>
<tr>
<td>Denmark</td>
<td>7</td>
<td>5%</td>
<td>9</td>
</tr>
<tr>
<td>Finland</td>
<td>4</td>
<td>3%</td>
<td>16</td>
</tr>
<tr>
<td>France</td>
<td>15</td>
<td>10%</td>
<td>23</td>
</tr>
<tr>
<td>Germany</td>
<td>15</td>
<td>10%</td>
<td>10</td>
</tr>
<tr>
<td>Greece</td>
<td>4</td>
<td>3%</td>
<td>7</td>
</tr>
<tr>
<td>Ireland</td>
<td>0</td>
<td>0%</td>
<td>0</td>
</tr>
<tr>
<td>Italy</td>
<td>31</td>
<td>21%</td>
<td>49</td>
</tr>
<tr>
<td>Luxembourg</td>
<td>2</td>
<td>1%</td>
<td>1</td>
</tr>
<tr>
<td>Netherlands</td>
<td>6</td>
<td>4%</td>
<td>9</td>
</tr>
<tr>
<td>Portugal</td>
<td>6</td>
<td>4%</td>
<td>7</td>
</tr>
<tr>
<td>Spain</td>
<td>31</td>
<td>21%</td>
<td>37</td>
</tr>
<tr>
<td>Sweden</td>
<td>6</td>
<td>4%</td>
<td>12</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>8</td>
<td>5%</td>
<td>23</td>
</tr>
<tr>
<td>Total</td>
<td>150</td>
<td>100%</td>
<td>227</td>
</tr>
</tbody>
</table>

(* Percentages rounded off)
The theoretical debates were informed by a large number of surveys. As a result, a new dynamic emerged in trade union demands and legislative initiatives (especially at local government level) for action to make working conditions more gender sensitive. These debates, and especially, the momentum building up for change, have largely fizzled out. In a general climate of “restoration”, relations between the feminist and trade union movements seem to have lost momentum. In local and regional trade union practices, however, recognition of the gender dimension in occupational health is resulting in surveys and demands. Spain is in some ways on the cusp, combining local activism where feminist views are at least partly informing the trade union agenda, with the makings of an en-gendering of institutional activities, currently limited to the production of knowledge. Spain’s long tradition of trade union engagement with societal debates going beyond workplace labour relations was doubtless instrumental in this. Portugal’s situation is less easy to pin down. An overall approach linked to the feminist input was forcefully and cogently argued by the Commission for Equality in Work and Employment (CITE), but in terms of rank-and-file action and changes in workplace practices, the dynamic found in the other Latin countries is missing.

The United Kingdom reports a seemingly more pragmatic approach with no overtly across-the-board agenda on gendered occupational segregation. It is an approach that has resulted both in local, generally trade union-inspired, initiatives and more gender-sensitive research programmes run by official occupational health institutions. There are certain parallels with the situation in Germany and Austria, but the central role played in both countries by the work accident and occupational disease compensation organizations does not make for a clear overall view of gender relations.

The actors

The breakdown of replies to the TUTB survey by type of organization is shown in Table 2 below.

Most responses came from trade unions (31%), partly because of the TUTB’s particularly close trade union links. Also, the main source of demands in local (company or sector) experiences appeared to be trade unions. Obviously, there are wide between-country differences. Most of the trade union initiatives reported were bunched into three countries (Spain, Italy, United Kingdom).
A significant percentage of responses (23%) came from research institutions of widely differing kinds - mostly occupational health institutions, but also a smaller number of public health bodies and sociological research centres. The dividing lines between these research institutions and the institutions responsible for prompting prevention policies are not always clear. A wide range of subject areas were involved, but epidemiological research was under-represented. The other areas of medical research, ergonomics, psychology and sociology supplied the bulk of research studies reported.

Generally, the institutions responsible for prompting prevention policies in most countries replied to our questionnaire (13% of responses). However, analysis of the responses reveals a clear split. In some countries (chiefly the Scandinavian countries) the gender approach seems to be applied to an appreciable range of occupational health issues, in the field of research and statistics at least, while in others, the gender dimension is identified with “women’s issues” (especially those related to maternity protection). This goes to an issue which is arguably central to this survey. Identifying and analysing specific risks alone is not the way to integrate the gender dimension into occupational health. Generally, occupational health institutions are unready to shift from a risk analysis to an overall approach that compasses gender relations as social relations that operate both within workplaces (paid work) and outside (family, school, politics, sexuality, health, etc.). That comes back to the fundamental issue of the relations between prevention policies and social change.

A tentative en-gendering of preventive service activities can be seen locally, but generally only in already female-dominated sectors or for problems regarded as more specifically “women’s issues”. The response rate (9%) is not high enough to comprise a representative sample of these services. It raises questions as to services’ continuing unreceptiveness to workers’ and trade union demands. That obviously raises the issue of how far they are immune to employer pressure. One country alone stands

### Table 2: Replies to the TUTB survey by type of organization

<table>
<thead>
<tr>
<th>Type of Organization</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institution responsible for prompting policies</td>
<td>13%</td>
</tr>
<tr>
<td>Institution in charge of equality policies</td>
<td>3%</td>
</tr>
<tr>
<td>Trade union organization</td>
<td>31%</td>
</tr>
<tr>
<td>Preventive service</td>
<td>9%</td>
</tr>
<tr>
<td>Research centre/institution</td>
<td>21%</td>
</tr>
<tr>
<td>Other</td>
<td>23%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
</tr>
</tbody>
</table>

3. Serious obstacles remain, even in highly female-dominated sectors, as a survey of British trade union safety reps found (Kirby, 1998). Female workers’ problems occupy a minor place in workplace preventive activities (approximately 20% of positive responses for company prevention policy and risk assessments), even though the sample of respondents was taken from highly female-dominated sectors (78% of responses from the public sector, including 42% health, 16% education and 13% local government).
significantly apart - France, with 33% of responses from preventive services (occupational medical services) compared to 7% of responses from trade unions. That may reflect the gender sensitivity of certain occupational health doctors (see box on Eve Semat’s book, p. 26). There are probably two contributory factors: the feminization of the profession, and the fact that occupational health doctors engaged with gender-sensitive prevention practices are part of a critical strand of thought that is challenging professional practices traditionally focused on workers’ individual health (SMT, 1998).

Few institutions with responsibility for prompting or monitoring equality policies replied to the questionnaire (3%). A literature review bears out that occupational health is a secondary concern in workplace gender gaps. This comparatively low profile for occupational health (in the broadest sense of the interaction between working conditions and health) throws into relief one limitation of an equality policy defined in terms of equal opportunities rather than in terms of social equality. This will be considered in more detail in the review of policies.

Particularly surprising was how low working conditions were on the job desegregation agenda. Mostly, there is a special focus on achieving work-life balance, but the evidence seems to suggest that, over and above adaptation of working time in the broad sense (hours of work, part-time work, special leave, etc.), changes to make working conditions compatible with gender balance remained a no-go area.

No responses were received from non-trade union women’s groups. That may be partly because equality bodies do not necessarily have close links with militant feminism. But it may also be down to some dispersion of the organizations that could have contributed to the survey. Our sifting through feminist and “women’s studies” publications produced very mixed results. Only a small body of feminist research in Europe seems to engage with occupational health. While there is copious literature on work issues, and feminist research into health is far from minimal, occupational health goes largely ignored except where labour disputes set it within the broader framework of the gender division of labour (nursing strikes) or highly specific issues (mainly, the different forms of physical and psychological violence at work).

Just over 2/3rds of the survey respondents were women. Women clearly have a keener perception of the gender dimension than men whatever the organization (trade union, preventive

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4. Responses from trade union women’s groups were mainly from women’s committees set up by certain unions. A response was also received from KAD, the Women Workers Union of Denmark.

5. In other parts of the world (Brazil, Quebec), feminist literature appears to address workplace health issues more as a matter of course. But this perception may be coloured by the fact that our contacts with Brazilian and Quebec feminists have been specifically to do with occupational health research.

6. 95 female and 46 male respondents were gender-identifiable. In nearly a dozen cases, no identification was possible because a gender-neutral first name or simply an initial was given. Where a response came from an institution, the named sender was identified even where the response was a collective one.
service, research body, etc.). This is not an isolated finding: most of the articles and books on the gender dimension of occupational health are written by female authors. Arguably, that reflects two entrenched stereotypes: there is no gender dimension for men because they are the human norm; gender is just science-speak for talking about problems specific to women.

**High sectoral specialization**

Many experiences reported to the survey do not specify what industry segment or occupation is concerned. Often, this is deduced from the cross-cutting nature of some research (e.g., into work-life balance issues). Where sectors or occupations are identified, it was found that a large number of experiences relate to a very small number of sectors or occupations.

<table>
<thead>
<tr>
<th>Table 3: Experiences reported to the TUTB survey by sector of activity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Public administration</strong></td>
</tr>
<tr>
<td><strong>Agriculture</strong></td>
</tr>
<tr>
<td><strong>Banking/Insurance</strong></td>
</tr>
<tr>
<td><strong>Construction</strong></td>
</tr>
<tr>
<td><strong>Distribution/Commerce</strong></td>
</tr>
<tr>
<td><strong>Education</strong></td>
</tr>
<tr>
<td><strong>Industry (chemicals)</strong></td>
</tr>
<tr>
<td><strong>Industry (not specified)</strong></td>
</tr>
<tr>
<td><strong>Cleaning</strong></td>
</tr>
<tr>
<td><strong>Health/Social services</strong></td>
</tr>
<tr>
<td><strong>Textiles/Footwear/Clothing</strong></td>
</tr>
<tr>
<td><strong>Domestic work/Work-life balance</strong></td>
</tr>
<tr>
<td><strong>Transport/Telecommunications and other sectors</strong></td>
</tr>
<tr>
<td><strong>Miscellaneous sectors</strong></td>
</tr>
<tr>
<td><strong>Not specified</strong></td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
</tbody>
</table>

36% of reported experiences involved a specific sector. In more than one in four cases, this was health care and social services (mainly hospital nurses), one in ten distribution and retail (chiefly supermarket check-out staff). Relatively few experiences were in industry (under a quarter of identified sectors) and most of these were in the textile, footwear and clothing sectors. Arguably, this breakdown may be the result of two factors. The objective one is clearly linked to gendered occupational segregation. The gender agenda tends to arise only in hugely female-dominated occupations. But there is another factor linked to an awareness specific to certain sectors and/or occupations which does not automatically stem from the make-up of the labour force. This was very clearly seen in the nursing strikes (Kergoat, 1992). Nursing is an occupation where, over
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the last fifteen years, industrial disputes have helped form a collective consciousness in which gender is inextricably bound up with criticism of working conditions. There is evidence that this greater awareness is largely dependent on but not the automatic result of a critical mass (a large female population). Interestingly, education which, at levels like pre-school and primary education, is a highly female-dominated sector, has not seen such a collective consciousness emerge and features in almost none of the responses received\(^7\). Paid domestic work is an extreme case where the gender dimension is strikingly obvious but none of our correspondents reported a single initiative. The literature review bears out this general perception. Prevention policies pay scant regard to the very poor working conditions here. The extreme fragmentation of the sector workforce, the nigh-insuperable problems of developing trade unions and collective actions combine with the widespread but misguided perception of it as not really dangerous work. What makes this particularly disturbing is that in some countries, paid employment in the child and elderly care sectors is being taken towards an organizational model not far-removed from domestic work.

Finally, it is worth pointing out that the approach to male (or predominantly male) working conditions seldom integrates the gender dimension except where there is a feminization-related crisis in the workforce. Feminization may take the form of women’s entry into a historically male occupation, but it may also be connected with non-gender-specific changes in workers’ roles. There is a compelling argument that male work cannot be analysed without bringing in the gender dimension. But that would mean abandoning the implicit “male norm”.

En-gendering can benefit from an inter-occupational approach in very broadly defined sectors. The case of a Spanish trade union federation covering all communication and transport workers shows the potential of an approach that pools the experience of different groups of workers, some female-others male-dominated. For this survey, women’s groups\(^8\) were set up for seven specific groups of workers (actors and actresses; dancers; postal workers; railway clerical, cleaning, electrical and mechanical engineering staff; telephone company and other communication sector staff; car rental agency head office clerical staff; and media personnel). This working method enabled perceptions of what appeared at the outset to be “feminized” working conditions to be compared with others where a degree of job desegregation prevailed\(^9\).

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7. The studies on the gender dimension in education consulted do not come directly from the responses to our questionnaire, but from a trawl of the TUTB’s own documentary database, which turned up studies of Brazil (see, especially, Brito et al., 2001) and Quebec (Messing et al., 1996).

8. Only one of the seven survey groups was mixed - that of actors.

9. A comparable case can be found in the workplace health policy of the COMEDIA trade union federation in Switzerland, which covers all media and communications sectors, and a wide range of occupations.
Some single-issue specialization

The responses also suggest that the gender dimension more often comes into the frame when addressing new risks\textsuperscript{10} (56\% of reported experiences) rather than traditional risks. But these data must be approached with caution, for while risks related to chemical and physical agents were cited in only 17\% of reported experiences, the other categories of more regularly cited risks can exist alongside and interact with traditional risks. 11\% of reported experiences relate to reproductive health hazards. In 15\% of experiences, the risk category was defined as “other risks”. The question arises whether work injuries are underestimated in highly-feminized occupations and sectors. Only very exceptionally was prevention of work injuries mentioned.

<table>
<thead>
<tr>
<th>Risk Category</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risks related to work organization and intensification</td>
<td>14%</td>
</tr>
<tr>
<td>Ergonomic risks</td>
<td>12%</td>
</tr>
<tr>
<td>Musculoskeletal disorders (MSD)</td>
<td>12%</td>
</tr>
<tr>
<td>Psychosocial risks</td>
<td>18%</td>
</tr>
<tr>
<td>Chemical hazards</td>
<td>9%</td>
</tr>
<tr>
<td>Risks related to physical agents</td>
<td>8%</td>
</tr>
<tr>
<td>Reproductive health hazards, health of pregnant workers</td>
<td>11%</td>
</tr>
<tr>
<td>Other</td>
<td>15%</td>
</tr>
<tr>
<td>Total</td>
<td>99%</td>
</tr>
</tbody>
</table>

The interplay of waged employment and unwaged reproduction work is only very rarely addressed (except within the fairly limited “work-life balance” issue). The most systematic attempts encountered were in Spain, both as regards surveys and theoretical discussion. Likewise, broader approaches to reproductive health outside the confines of maternity protection were few and far between\textsuperscript{11}. The question of working time as a collective occupational health issue was notable by its near-absence. There is an extensive body of general research into gender-differential time use, but when it comes to workplace occupational health practices, working time goes largely ignored outside of individual time management systems that claim to help achieve a better work-life balance. Relevant exceptions to this general trend include the Spanish trade union initiatives to get working time negotiators to share experiences with rank and file equality and occupational health activists.

10. For these purposes, “new risks” fall into one of the following four categories: risks related to work organization and intensification, ergonomic risks, musculoskeletal disorders, psychosocial risks.

11. Of experiences brought to our attention, only one survey in Tuscany addresses the relationship between working conditions and sexual life.
More knowledge than action

Of the 227 reported experiences, 70% can be classed as research. This is likely to be an accurate reflection of the overall state of play. Research is starting to be done at different levels, but obstacles still remain to its being applied in prevention practices. Significantly, the compilation of studies published by a group of occupational health doctors in France on violence against women (Semat, 2000) asks the compelling question of how to go beyond the anecdotal evidence? One reason these doctors decided to carry out this work in their own time was the gap they found between the wealth of personal testimony collected through face-to-face encounters and the pressing issues involved, and the difficulty of delivering satisfactory preventive solutions without throwing the traditional practices of the profession open to question.12

Most preventive measures seem to be chiefly one-off activities (e.g., an information campaign on a specific risk, a training course, etc.). Arguably, there are two main issues. One cuts across all occupational health. It is that collective actions, and especially grievance disputes, abound but tend to be sporadic. They cannot easily be fitted into an overall strategy of long-term mobilization. The other is to do with the traditional separation of equality and occupational health issues.

There is an added difficulty with rank-and-file actions. They are poorly documented and even trade unions have only very piecemeal written materials on actual instances of workplace grievance disputes. Some coverage was found in the trade union press and even fewer sociological studies of particularly significant rank-and-file action like the nurses’ strikes in France. Also, grievance disputes over equality rarely seem to be single-issue actions. Occupational health, working conditions, recognition of qualifications, pay rises, opposing affronts to dignity, etc. are most often combined when workers find their voice. This also emerged from the historical literature review.

The obstacles that seem to account for the difficulty in moving from knowledge to preventive action will be considered in the conclusions.
Women, work, violence

*Femmes au travail, violences vécues* was written under the name of Eve Semat, a pseudonym for a group of 32 occupational health doctors, all members of the Santé et médecine du travail (occupational health and medicine - SMT) association. It is a harrowing compilation of personal accounts of the working conditions women put up with, and shows the need to explore the biological, economic, social and cultural determinants of the growing burden of insecurity on women.

In a first set of studies, *Souffrance et précarité au travail. Paroles de médecins du travail* (1994), SMT showed how the wholesale decline in women’s working conditions matched up with the existing data on unemployment and insecurity: female unemployment is running at 14% compared to 10% for men, 10% of women are in insecure jobs compared to 7% of men. Despite steadily rising female qualification levels, they are working in increasingly contingent jobs. Involuntary part-time is spreading and job mismatch rates (overqualification) are very high. Also, a growing number of women are now not earning enough to provide for their and their family’s needs. They account for 46% of the labour force, but 80% of the low-paid. Surveys have revealed a gender unequal allocation of job stressors, including within categories of workers. The most rigid pace of work constraints mainly affect women (...).

What is even more striking than the sufferings exposed is that they are suffered in silence. But should the violence of their lives remain shrouded in invisibility? Must the sufferings told in secret under the cloak of doctor-patient confidentiality be kept quiet? For a time, we were paralysed by being pulled in different directions: we wanted to provide more than individual support by acting in the workplace; but the only way not to harm these women was to respect their silence. But while suffering at work marginalizes women in the firm, the idea of putting their suffering into print struck a chord and they jumped at the chance. That is what prompted the SMT occupational health doctors to collect a fresh set of narratives.

Our aim is to bear witness to the violence experienced by women at work: verbal assaults, harassment, affronts to dignity, talking bans, bullying, etc. We took it that “violence” was present in work situations where women were suffering, even if not from actual physical force, and had no way of overcoming it or escaping it by getting another job. In women’s work, “violence” starts with lack of concern, the negation of others and oneself, which is not violence per se, but contains the seeds of it. This compilation of personal accounts compels us to address the question of how to bring this violence to an end. This made us look back at our own jobs, forcing us to move from the ethical issues of the personal accounts to analysing what we do. Being able to hear, trying to understand and reporting what was said was not enough to reflect the reality of our work.
Is the violence suffered by women potentially destructive? Is silence a form of resistance? Do they maintain their dignity by seething in silence? Or is it an anger kept bottled up and in check, an anger of indignation, confrontation, mutiny? Do the consequences go beyond fear as far as decompensation and sickness? Work activity is not just about what gets done. Activities that are prevented, suspended, postponed, thwarted or dreamed up may not be carried out but they are real for the workers. It is an established fact that passivity, to which there is no alternative in some situations, takes more out of one than activity actually performed. These new angles compel us, as occupational health doctors, to read into health both the work activity and the unique characteristics of each employee.

Some women find the doctor’s surgery a space for free expression, time out and closeness. The need to break the silence and the intensity of what they have to say leads them to tell who they are, to reveal their aspirations, to disclose their vulnerability but also their strength at work. These moments then become anchor points, points of resistance like boundaries set to the inflicting of violence. In this relationship, the women become different, rediscover their empowerment. They tell us of their outrage at having been short-changed, dispossessed of the abilities they have won and quickly lost. They tell us of their shame when sickness, disability, ageism thrusts them into exclusion and unfitness for work. But they also speak of their demands to have or preserve their dignity, in silence, their ability to hold out, to withstand. This finding forces us to overcome our own inaction, rethink the profession and reinvent new professional practices.

We therefore need to give profile to our practices, call on our creative imagination. Help, not take over. To get back to basics, however basic they be, where the employees are in control, to the activity where they express their concern and responsibility towards the common world. At this level, an area of resistance can be carved out wherein new rights can be framed and founded.

*Femmes au travail, violences vécues* aims to go beyond personal narratives to write that work which is invisible in work, which is to defuse violence and initiate intersubjectivity, taking our real-life experience as the support base. The idea is not just to report the damage to health, workplace inequalities, but also to make visible that “political domain of health” that employees can re-own through their own personal history, thereby reclaiming their power to act on organizational constraints.

Eve Semat
(Odile Riquet and Denise Parent-Renou)
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Part II

The state of knowledge
A recent article by F. Carnevale (2002) on the health of women workers bears the title *Three centuries of struggle*. And it is true that much evidence can be found of strategies deployed by women to change working conditions that were making them ill. Where they could not be changed, other strategies were used to minimize the damage to their health: changing jobs, temporary or permanent withdrawal from the labour market, sickness absenteeism, sabotaging production by causing breakdowns and technical faults, bringing poor working conditions to public notice, etc.

Where occupational health is concerned, collective action has usually gone before scholarly knowledge. It has been developed through a complex relationship with the strategies deployed by men and women workers to protect their health - sometimes receiving a decisive impetus from and often being informed by them. It has generally mediated labour action by workers and that of other bodies, in particular the State. It has assumed a wide range of forms: from conveying to concealing needs, from legitimizing action to victim-blaming. Its own legitimacy has generally been drawn from the idea of objective neutrality. That has had two consequences. Specialists have as it were voluntarily restricted their own ability to get to grips with the deep-rooted social issues of what is before them: they have learned to tackle the work-related factors of some medical conditions instead of the employment relationships that make it possible to foist poor conditions on workers. They have erected a barrier between scientific objectivity and the subjective experience of workers, as if the latter were not an essential means for understanding the complexity of the relationship between work and health. In so doing, they have moved from the person to their body perceived as a piecemeal jumble of its component organs. Health has been chiefly addressed through a long series of problems reduced to specific causes that have tended to be treated in isolation from labour relations as a whole.

This section sets out to review the state of knowledge. It considers the production of indicators which are often key contributors to policy-making and the research input. It aims less to be a comprehensive literature review than to identify the obstacles
to full integration of the gender dimension in occupational health, and to demonstrate the potential offered by some of the projects that the survey brought to light. It first offers a few thoughts on the development of workers’ knowledge in occupational health from a gender perspective, followed by an examination of the main sources of indicators available today in the European Union, and concluding with remarks on selected aspects of the research.
Chapter 2
Gender and the social construction of knowledge in occupational health

There is a vicious circle in occupational health. Prevention policies are framed on the basis of indicators and knowledge. The development of these indicators and knowledge depends on a set of factors that focus attention on a number of risks while others go disregarded or ignored. The social history of knowledge in occupational health is illuminating. The immediate reaction to a health problem has often been to play down its links to working conditions. Many examples spring to mind: silicosis, radium poisoning, asbestosis, carpal tunnel syndrome, etc. In the literature on diseases whose links to working conditions have long been denied, two more specifically relate to women: radium poisoning among the women workers mobilized for the war effort during World War One (Clark, 1997) and musculoskeletal disorders in recent decades (Dembe, 1996 and 1997; Kome, 1998).

What is a work-related illness? The answer lies at the intersection of two takes on reality. One is social, political and legal. In a particular combination of conditions, a particular illness may be seen to have links with working conditions. Some may even be recognized as an occupational disease. This concept is a specific legal category which is tied to criteria for recognition that allow compensation to be paid and often dictate particular preventive measures. It is an adversarial process, which largely reflects a clash of values and power relationships. The other take on reality is biomedical. This obeys a scientific rationale. This division into two discrete orders - socio-political developments and scientific progress - is not wholly accurate since it makes no allowance for social determinants in the development of scientific expertise. These determinants have been highlighted in a series of often fascinating studies published in the United States in recent years pointing up the variations in medical pronouncements on work-related diseases.

Research into the social history of work-related illnesses in Europe is less well-developed. Cottereau’s seminal work (1978) on tuberculosis in Paris is noteworthy for the extreme clarity with which it addresses the issue of social rationales in the means of production of medical knowledge. The author observes that: “The shift in the epidemiology of tuberculosis was influenced
by the following constraining factors. Because rest was not a feasible treatment under social relationships as they were, diagnosing workers as worn down by work became in turn a major threat. Giving recognition to the effects of wear and tear would have given added legitimacy to rest as a preventive or remedial treatment. As a result, diagnoses took an entirely different tack. Tuberculosis was blamed on unhealthy conditions in housing, workshops and the urban environment”.

The wide variations found in the recognition of work hazards cannot be explained away by political and economic factors alone. Not everything can be put down to the employer’s keenness to deny the real scale of workplace risks and pass the costs onto the victims or society (Bennett, 1993). This unrelenting pressure from employers joins up with socially-constructed medical knowledge. This applies equally to the other sciences and disciplines concerned with workplace risk prevention15. That is compounded by the complexity of defensive strategies adopted by the workers themselves. It is not easy to live with the idea of risk permanently present and a clear perception of the health damage that one is forced to accept (Cru & Volkoff, 1996). Waged employment is always a trade-off between different imperatives. The cheapening of risks, the denial of a link between work and some kinds of health damage can be other ways of dealing with health. There may be a prevalent feeling that risks cannot be eliminated in prevailing conditions, but it is not uncommon for them to be denied. Studies in the psychodynamics of work have produced the concept of a defensive ideology towards work to explain the cognitive dissonance whereby concern for health coexists with a denial or belittling of some risks of the job. The gender dimension of this is very marked, with selective perception of risks differing between male and female workers.

How does medical knowledge distort perceptions of work-health linkages? Arguably, in two key ways.
• Medical knowledge is mainly validated through expert knowledge derived chiefly from biological parameters independent of sufferers’ own perceptions (Lax, 2002). But no one technique by itself does anything to address a health problem. The contribution of technical analyses has to be set within a framework for interpretation which gives meaning to measured parameters from which a specific judgment (a diagnosis) is derived.
• Western medicine has developed explanatory models by which to forge a causal link between particular situations and health damage. These models are derived from the

experience of mass epidemics caused by infectious agents. Admittedly, they became so informed as to be able to address multi- causality. But big obstacles remain to the development of a holistic approach to health, in particular full integration of all social determinants (Williams, 2003). More specifically, the search for a causal link between pathogens and diseases does not fully account for more complex relationships in which health is maintained by restoring balance between priorities and an environment which cannot be considered as just a source of risks.

While these characteristics are not specific to workplace health, the peculiar social status of occupational health accentuates the biases recorded above. Broadly speaking, occupational health has developed out of a set of highly fragmented disciplines with few ties to public health. This tenuous connection with public health is a further obstacle to forging the linkage between the knowledge produced on occupational health and policy action on the broader social determinants of working conditions-related health gaps. This is what surfaced from the late 19th century debate on tuberculosis as analysed by Cottereau (1978). Koch’s bacillus is not directly produced by working conditions, and so is not an “occupational risk” except in certain specific occupations involving a particular risk of contagion (hospital work, for example). On the other hand, tuberculosis does develop among people with exhausting jobs who are worn down by over-long working days, inadequate recovery periods, pay too low to afford a proper diet, substandard housing, etc. Effective prevention against tuberculosis involved action on all these factors and a radical overhaul of working conditions. Most occupational health professionals chose to voluntarily restrain their activities to provision of limited effectiveness (improved workplace ventilation, state control of people with health problems as part of the fight against “social evils”…).

The advent of occupational health specialists into the workplace came about more often as a result of a State- if not employer-initiated compromise than in response to labour demand. The circumstances in which occupational health specialists began to act in workplaces differ by country and field of prevention, but as a general rule, it was less as a result of workers’ demands than a “top-down” initiative. In some cases, the State meant to regulate the conditions of exploitation in line with its own objectives (preserving industrial harmony, pro-natalist policies, the need for healthy cannon-fodder, etc.). In other cases, it was from employers looking to optimize productivity while accommodating other goals like keeping staff, preserving industrial
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The aim was to reconcile their action with company profitability and preserve the employer’s dominion over work organization. And, in practice, the balance tended to tip towards outright subordination. A subordination made possible by the definition of methodologies that concealed some work-related health problems. A reasonable inference might be that so as not to have to massage or conceal data, thereby breaching the most fundamental rules of professional ethics, the methods for collecting and analysing these data had to include blind spots which could be used to deny the materiality of the most inconvenient issues. This made a worker’s complaint more readily suspect than that of a person presenting with health problems in a non-adversarial context. The reality-checking of expert knowledge of working conditions with workers’ knowledge tends to be distorted by this suspicion (Lax, 2002). Workers’ responses, too, often display an extreme lack of confidence in research whose preventive purposes are not always clear to see.

The gender dimension of expert knowledge in occupational health

How gendered is this social construction of expertise in occupational health? Research has only quite recently begun to address this issue (see in particular, Messing, 1998-b). And yet it is crucial. While there is a clear economic point to denying the risks of women’s work (it helps to justify pay gaps), there is more to it than this. Gendered analyses give a better understanding of the linkage between the general approach to women’s health and the gender division of waged labour.

The industrial revolution came about in a context where women had been almost wholly excluded from the health sphere or, to be specific, the spheres of decision-making on the production of knowledge and organization of care (see in particular, Peter, 1980; Knibielher, 1991; Coenen, 2002). Denied access to the medical profession throughout almost the entire 19th century, women were an oddity for male-oriented medicine, brought to an awakening of their many divergences from ordinary male humankind. The biological difference with specific organs and singular processes (pregnancy, menstruation, menopause, etc.) appeared to give rise to often barely-comprehensible psychological differences (hysteria, involutional psychotic reaction, etc.). Still today, the scientific literature that attributes health complaints to outbreaks of collective hysteria refers essentially to female populations. Messing (2000, pp. 154-155) cites a list of epidemics of “collective hysteria” ( rollout, 2000), for Italy, Germany and Britain, see Weindling (1985).

17. For France, see Billiard (2001), for Italy, Germany and Britain, see Weindling (1985).

18. The subordination of a large number of occupational health doctors and other prevention operators to the employer is revealed strikingly by the cases of silicosis and asbestosis. The limitations of epidemiological models and the systematic doubting of the toxicity of certain fibres to a large extent acted to cloak realities. In many other cases, a more complex linkage was produced between external and internal conditionings. The refusal rate was higher among manual workers than managerial staff.

19. Finnish research on absenteeism (Vaananen et al., 2003) reveals the extent of this mistrust. 44% of workers asked by the researchers for consent to access their personal data on sickness absences refused despite the assurances of confidentiality given to them. The refusal rate was higher among manual workers than managerial staff.

20. This goes some way to explaining - although it is not necessarily the main explanation - the savagery of the witch hunts from the Renaissance to the Enlightenment periods.

21. In France, the first women were accepted into the faculty of medicine in Paris in 1868 (Christen-Lécuyer, 2000). In Russia, this had occurred fifteen years previously, but with female students flocking to join the revolutionary movement in droves, a sharp backlash occurred against the admission of women to universities. The doors of Russian faculties of medicine began to close on them in the 1860s just
of articles attributing complaints about chemical poisonings to mass hysteria or mass psychogenic diseases. Of 1403 workers involved in 30 events described as mass hysteria, 1272 were female.

Women are therefore seen as abnormal and a frail sex that cannot do without the governing hand of a man in family life. Extended to wage labour, this perception would be used to undervalue women’s compared to men’s work, or exclude women from certain segments of the labour market, as the case may be.

But a purely economic interpretation of the gender division of labour in terms of competition, segmentation or exclusion on the labour market would not account for the involved nature of social relationships. Green (1998) demonstrates the complex social, cultural and economic determinants of the division of labour in the garment industry in Paris and New York between 1880 and 1980 in a study which analyses the dialectics of gender and immigration/ethnicity. Many transitions from male to female work and vice versa are to be seen at different periods and in different towns. At times, the division of labour may seem very straightforward. Women make women’s and men men’s ready-made clothing. But that is the exception. Nor is pressure on wages alone a sufficient explanation. The changes in evidence are also linked to an ethnic structuring of work which to some extent links the division of labour and capital accumulation processes through ethnic networks. Finally, the only constant which arguably emerges is that immigrant workers occupy the lowest rungs on the pay ladder. Green particularly stresses how flexibility has permanently redrawn job segmentation.

Whether employed or excluded, women are more than just “labour force units”, interchangeable on the market\(^\text{23}\). Both their employment and their exclusion will shape both their own and men’s work organization. Downs (2002) gives a very lucid analysis of this process in relation to work in the metalworking industry in France and England between 1914 and 1939. Wage labour creates an interdependence between the job market, the domestic economy (in the broad sense of reproduction and the production of tradeable goods) and work organization. The development of capitalism involves an across-the-board reorganization of human work, including unpaid domestic work, because the very whys and wherefores of work change radically compared to previous patterns of production. It is a dynamic that changes all aspects of human existence. As human work is reorganized by reference to the imperatives of capital accumulation, other activities - from

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22. See Aiach et al. (2001).

23. One major blind alley of the 19th century male labour movement was its mainly economic take on women’s employment from the angle of competition for jobs. While standpoints were at opposite extremes of the spectrum (Proudhonists thought women should be “returned” to hearth and home, while Marxists argued that their labour force participation would be the vehicle of their emancipation), attempts to introduce a feminist take within the labour movement (and there were many, from Flora Tristan to Alexandra Kollonta) all failed until an independent feminist movement challenged it from the outside.
sexuality to leisure, from sports to artistic creation, from fashion to self-care, etc. - are changed by becoming commercialized. It is not just an issue of economic change, restricted to borrowing principles of the division of labour from the domestic model. It is also an anthropological and cultural upheaval that is bringing in an ongoing dynamic of change.

**Naturalization of differences**

The separation of humankind into two groups - male and female - is the oldest and most commonplace division in society. It is found in all known human societies. It is a cross-cutting division, i.e., it is a recurring essential element of other divisions - between classes, ethnic groups, free persons and slaves, caste or religious, clan, national, and other group memberships. The division is between men and women workers, men and women slaves rather than “worker” and woman, “slave” and man, etc. There is no simple aggregation of situations between gender and other socially-defined membership groups. Gender is involved in the formation of them all. In all known societies, the gender division is inseparable from an unequal segregation of duties and social norms regarding sexuality.

Naturalistic explanations for this linkage are unpersuasive. To attribute labour segregation to the mere fact that women may fall pregnant and give birth is to disregard the fact that some women in any society do not reproduce. In societies with comparatively long birth spacings, aggregated periods of gestation now occupy only a small part of life. In the same way, sexual norms cannot be looked at chiefly from the angle of reproduction of the species. Only a very few of all the sexual activities engaged in by an individual between birth and death may contribute to the reproduction of the species.

Sex remains the central biological marker for the division of humankind into males and females. But what defines sex? The most visible criterion is the external reproductive organs, by which an individual can be gender-assigned at birth. Now, ultrasound scans enable this to be done during embryo formation. This first visible difference is usually accompanied by other biological differences. Genetic science has identified sex marker chromosomes to which a number of other biological differences are regularly attached (e.g., hormone production). Most other biological differences relate to abstract means based on a preliminary division of a study population into two groups - male and female.

24. For a comprehensive critique of naturalistic interpretations of the gender division, including its differentialist feminism variants, see Delphy (2001).

25. This obviously relates to contemporary Europe, but in other contexts, contraception techniques produced very low birth rates, particularly among the black slaves in Brazil (Queiros Mattoso, 1979).

26. Which is not to say that individuals classed as male or female by certain biological criteria necessarily possess all the relevant markers. The ancient Greeks and Romans, like many other cultures, displayed a fascination for hermaphrodites as representing an essential flaw in the conception of a perfect binary division between male and female.
Using criteria like size, weight and muscle strength, classifications can be made in which each subgroup includes a certain number of men and women. The proportions of men and women in these different subgroups vary, as do the proportions of persons based on other socially defined criteria (nationality, race, etc.). So, while the average female in a given population is generally shorter than the same-cohort male, most males and females lie within “mixed zones”, and there is no reason why, in a representative sample, the tallest individual should not be female and the shortest, male. Also, most anthropometric and biomechanical factors like size or muscle strength are not purely biological but the result of both genetic factors and social determinants. At no point in life can the body be reduced to just a biological “datum”.

Work and sexuality are not two discrete spheres. There is a link between the division of labour between individuals classed as male and female on the one hand, and the way in which sexual norms differentiate individuals. This linkage is chiefly found in power relationships, from which stem all property relationships regardless of legal form27. The expression of the link between work and sexuality is distilled in societies where the basic production unit and sphere of sexual domination are combined in the family. But the link between work and sexuality is not purely collective. Its social dimension can also be seen in the way in which work contributes to the individual’s psychological makeup. For psychoanalysis, work is a key sphere of sublimation. Its pleasure/pain dynamics have a sexual content (Dejours, 1988-b and 1993).

Industrial work - and, subsequently, non-industrial wage labour - imposes a discipline on human bodies that goes well beyond the strict physical needs of productive rationality. This physical dominion also involves sexuality and is not exercised in the same way over men and women28. The extent to which sexuality is controlled by work organization is connected to the ability to “naturalize” gender differences in the workplace, although it is not the sole issue. Control of sexuality is also about imposing a discipline that increases human productivity within a chain of command work organization and enables the individual to adapt to (including by drawing pleasure from) its constraints.

The means of this control vary widely between era, occupational group, age groups, cultural environment of origin and sector of activity. They include:

- The near-universal use of sexual symbolism by men to characterize activities, things and machinery29.
• The more extensive reference to family roles (mothers, homemakers, wives, etc.) in connection with women’s work.\(^{30}\)
• Gender-differentiated rules of decorum, moral standards and propriety.\(^{31}\) Perrot (1998) shows the extent to which oversight of women workers in the 19th century betrays obsessive moralising. Bans on laughing, singing, chatting, very strict rules on body postures made the 19th century factory a place of learning for working class women on two counts - to make them productive and repress their sexuality.
• Sexual harassment (Pernas et al., 2000) which is linked both to working conditions and a devaluation of women in special circumstances where they are seen as more “ownable” by men (unattached and divorced women, ethnic women from groups regarded as “pools” for dominant ethnic male groups).
• Crudely overt or latent homophobia in a work organization where heterosexuality is the norm (see Kempe, 2001; Falcoz, 2003).
• Virtual initiation rites for young people seeking to access some occupations.
• Strictly male-female differentiated coded use of emotions (Soarès, 2002).
• The importance of dress, gesture and body language codes in work, and the very strong links between these codes and sexual identities.\(^{32}\)

All these things leave work’s mark on human sexuality. In a sense, wage labour foists a “masculinization” on men and a “feminization” on women.\(^{33}\) This dual process combines compulsion and agreement. It develops gendered social identities. It makes an inconsistent contribution to the acceptance of work constraints by legitimizing them, but contributing to their on-going renegotiation. An examination of women workers’ strategies for resistance also reveals how they manage to turn the genderized division of labour to account. Faced with particularly gruelling working conditions, they can argue that “it is not women’s work”. The account of a striker at Belgium’s national ordnance manufacturer Fabrique Nationale d’armes in 1966 is informative. She attacked the working conditions, highlighting the conflict between the filthy state of the factory and what is expected of women once they pass through the factory gate back into town: “We were saturated in oil. You’d put a big blue cloth, a moisture-absorbent duster, on your apron to soak up the oil so as not to have it everywhere. You had to wash under cold water pumps. There were no showers. You couldn’t get rid of the smell of oil. When the special trams came to pick up the FN workers at finishing time, the drivers used to say to each other in

30. Downs (2002, p. 407) cites an English employer’s appraisal of the work done by women in a metalworking factory, assembling textile machinery. The original dates from 1934: “The knowledge needed for all this assembly work is no more than that used by most housewives when they assemble the mincing machine in their kitchens on Tuesday morning to use up the last scraps of the Sunday joint to make a tasty family meal” (unofficial translation).

31. Macedo (1993, pp. 177-195) gives a fascinating analysis of the relationship between the sexuality of young girls and boys and factory-exercised controls. She describes the dominion exercised by a textile factory employer in Brazil in the 1940s on the sexuality of the young (male) workers. Young male workers who took up with female workers were sometimes forced to marry them, while fierce social pressures on single pregnant women were not unknown to lead to suicide.

32. Macedo (1993) studied the gesture language of women textile workers in a Brazilian factory. It is a complex language embracing production, emotions, moods and sexuality.

33. The celebration of manliness has been specifically addressed by Dejours (1988-a, 1998). His reference frame of psychoanalysis led him to distinguish the manliness on which work organization is based from “masculinity”, which is an empowering completion leading to an adult sexual identity that Dejours links to its conception of heterosexual normality.
While empirical data from work analysis bear out his analysis of manliness, whether they do the same for his conception of masculinity is more of a moot point.

34. Macedo (1993) cites an informative example of this dual process in a Brazilian textile factory some fifty years ago: young male workers were taken by workshop teachers to prostitutes in order to prove themselves virile, while young female workers were subjected to a virginity test. Both operations were organized by the company - through the workshop teachers for the apprentices, through its own doctor for the girls. The factory organized the prostitution for the apprentice boys separately from that for married men.

35. Downs (2002) argues that the industrial action by women metalworkers in France during the First World War challenged the “union sacrée” popular front policy followed by most of the trade union leadership. Likewise, the Russian revolution of February-March 1917 was triggered by the Petrograd workers’ demonstrations on the day of protest traditionally called by the international socialist movement (the origin of the 8 March Women’s Day celebrations).

36. Downs (2002, pp. 95-96) remarks on the very marked split in France’s metallurgical factories during the First World War between French and colonial male workers who were on near-female pay levels and subjected to military discipline. The present day cleaning industry is largely staffed by young male and female immigrants (or of immigrant origin).

Walloon “I’m on the muck run”. They looked down us because we smelled oily, rank, dirty. Smelling of oil is degrading for a woman, you know” (J. Magnée, cited by Coenen, 1991, p. 98).

In other circumstances, the hard graft of their work enables them to reject the traditional submissive or passive roles. The experience of the generations of women workers who - in wartime or periods of peak labour demand - replaced men wholesale in traditional male sectors gave momentum to many actions in the fight for equality.

In yet other circumstances, it is the experience of struggle that has reversed the traditional gender allocation of roles. The central role played by women workers in the pre-1914 New York garment industry strikes was behind the development of a distinct women workers’ identity which marked the history of US garment industry trade unionism. The “uprising of the 20,000” rocked New York in 1909-1910 (Weinstock 2001, pp. 67-70). It was a strike by women shirtwaist makers which lasted from 22 November 1909 to 15 February 1910. Some years later, a trade union leader wrote: “Take the male workers first. I have to say that this will come as a surprise to many old trade unionists who know little about our job. What do you mean, the problem of male workers?, they will ask. Very few men at all work in the garment industry (...). Their job prospects are fairly limited (...). But in many cases, the men are weak and half-hearted. ... They try to show that they won’t go on strike. They creep to the boss and the foreman; in other words, they act like scabs” (Abraham Baroff, 1914, cited by Green, 1998, p. 229).

En-gendering preserves spheres within work that are not ruled by production demands and leaves room for the expression of a range of desires and pleasures. This may be square with, be equivocally against, or an outright challenge to dominant models. As Molinier observes “Work creates gender. But, paradoxically, it is also the place where opportunities to undermine gender most abound. When a woman engineer builds a bridge, she changes the accepted perception of women” (interview in Libération, 10 March 2003).

These processes are riven by countless tensions which do not stem simply from a male/female paradigm, but from multiple issues between individuals and groups, between generations/cohorts, between management and male or female workers etc. There is an ongoing interaction between work organization and society at large. The use of the body, the expectations of it, the experience of pleasure and pain bear the clear imprint of
genderized work and alter the perception of risks and health damage37.

Paradoxically, while the link with sexuality imbues all attempts to naturalize the gender division of labour, it tends to be played down thereafter because it is rarely overt in official management rhetoric and makes little showing in trade union lines or scientific disciplines that study work. The body as controlled by work organization thus gives the misleading appearance of sexlessness (Hearn and Parkin, 1987; Pernas et al., 2000). Work usurps (repressing and controlling it, but also in the pleasures that it procures) then seems to deflect sexuality. At work, gender obliterates sex as it were or, more accurately, seems to reduce it to a biological indicator. Leaving aside those activities where sexuality is of the essence (prostitution, phonesex lines, pornography, etc.) and - to a lesser extent - those that exploit physical sexuality, like fashion, sport and advertising, the express link between sexuality and work is rarely given recognition. It is interstitial, pervasive in language in particular, or in violence that tends to be singled out as individual misconduct.

It is indicative that where the normal mechanisms of naturalization do not operate, a sort of explicitly genderized division of labour is found. So, in a Swedish survey (Björklöf, 2000), male hospital nurses were asked how they were regarded by doctors. How far could they invoke the “Florence Nightingale” model of patient, submissive devotion to justify a work organization that also applied to men? The reply is disarmingly straightforward: doctors believe that men who choose to go into nursing must be gay. Likewise, colonial (read, racist) literature commonly ascribed female identity to dominated peoples. For Kipling, the white man’s burden was as much male as white.

Pernas et al. (2000) argue that a wide gender gap exists in the way sexuality is controlled by work organization. For men, self-control of the body at work does not completely rule out sexuality, which is given recognition provided it conforms to the norms of manliness. Women’s sexuality tends to be more radically excluded if it is self-willed and empowered.

This prompts the question whether the debates on sexual harassment do not contain an undertone of conflict between two opposing approaches. Victims - overwhelmingly women - want their dignity and the right to possess their sexuality without constrictions from any source (superiors, colleagues, public). From that angle, the fight against sexual harassment contains a strong anti-hierarchical element in confronting the levers of

37. Johansson et al. (1999) analyse the significance of pain in respect to musculoskeletal disorders. This Swedish study shows the impossibility of accounting for the subjective experience of illness on the basis of purely bio-medical criteria.
pressure used at will for a wide range of ends. The power relationships based on freedom to hire and fire, promote, allocate an easier or better paid job, make pay dependent on individualized bonuses, are all contributory factors in sexual harassment. Challenging them gives men and women workers more control over the organization of their work. Employers and some state bodies, on the other hand, pursue two main aims: to sideline the debate on how work organization is tied into male domination in the workplace and broader society and so fosters sexual harassment, and to set the fight against sexual harassment within a framework by disciplinary procedures which essentially reduce it to issues of individual conduct.

Women workers, like their male colleagues, face an often dismissive repudiation of their own experience of the relations between health and work. But, as women, their experience is queried on two counts. One is because their bodies are not those studied by hygienists who tended to focus on biological and social reproduction functions. Hygienists had two main concerns about women’s bodies: their ability to produce healthy children, and encouraging the development of a model working family by opposing the lax moral standards and promiscuity in which women workers were thought to indulge. Now, valued as a commodity, women’s bodies are devalued by suffering. Working women must set themselves challenges, be fighters, suffer their varied forms of “ill-being” in silence to show that they have achieved the ideal of employability. At a push, unlike the pre-mass contraception situation, even maternity could be suspect on the grounds of evidencing a lack of commitment to the firm. Many women workers mention this suspicion of betrayal which greeted their pregnancy.

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**Sex and work: machines and bodies**

The sewing machine revolutionized the 19th clothing industry. From factory production via home work to production for family use, its advent changed all the conditions of women’s work. Perrot (1998, pp. 177-189) described at length the many ramifications of the introduction of the sewing machine, especially its contribution to the persistent and increasing burden of poverty on women at the turn of the century. She reports the reaction of the French Academy of Medicine in 1868: (A report presented to the Academy) “condemns the havoc wrought to women’s bodies: leucorrhoea, amenorrhoea, perhaps infertility”. The main culprit was the leg movements working the pedals; “The continuous movement of this kind of device excites hysterical delirium”. In some workshops, the sewing machine “produces such intense genital stimulation that women workers have concerned with uteruses than sight, with pedals more than working hours, paces, and conditions themselves”.

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38. Hygienists were often supported by the attempts of well-meaning middle-class women to tend to working women through charitable activities. Social workers subsequently played a similar role. Downs (1993 and 2002) gives a forensic analysis of the role of ordnance factory female “superintendents” in France during the First World War.
It would be wrong to play down this example as a mere anecdotal curio. Beyond the mistaken scientific beliefs it betrays, it is informative in several respects.

- The experience of women workers was flatly challenged. Far from being a multiple orgasm machine, the sewing machine, in the working conditions they worked in was the source of many physical health problems.
- Avoiding unbridled enjoyment and preserving motherhood are two indissociable concerns.
- In a comparatively solitary place like the home or an enclosed nearly all-female community like the sewing workshop, machinery excites surprising fantasies. Might it enable women to dispense with men both at work and in sexual life?

How this report was communicated is also interesting. Perrot found it because it was used as the basis for a delegate's speech at the 1879 Marseilles Congress which was a key moment in the rebuilding of the labour movement in France after the fall of the Paris Commune.

Does this report speak to us only of a bygone age? Probably not. Both the denial of women workers’ experiences and the obstacles to their ownership of certain technical activities remain central to the social relationships that shape work today. Obviously, the language is old-fashioned, and hysteria is an outdated concept. But a French survey on the use of new technologies (MES, 2001) found that using robots and numerically controlled machine tools is still a male preserve (with usage rates in 1998 of 0.6% women and 2.4% men for robots and 1.7% women against 6.2% men for numerically controlled machine tools, respectively).

Whence the paradox that the denial mechanisms which came with the industrial revolution are still at work, but in a new way where the (now) politically correct language of gender neutrality has become a substitute for equality.

Several things play a particular role:

- Women’s exclusion from a number of high-risk jobs remains a main factor of the gender division of labour. This exclusion quickly leads to the misperception that female jobs are by definition low risk. In reality, the risks may simply be different and, in particular, longer-term. Male domination imbues this difference with a hierarchical principle. Women’s risks are regarded as lesser not because they are not harmful to health or give rise to fewer health problems, but simply because they are detrimental to aspects of health regarded as less important. This hierarchical ordering of health damage is implicit in much occupational health research.

- The fact that women do most of the domestic work means that the health effects of this can be treated as a simple confounding variable. The refusal to give recognition to the musculoskeletal disorders of a large number of women workers is excused by the suspicion that their domestic activities may be the main cause of their condition. The countless daily gestures involved in cleaning and ironing become suspect even
though they have been used to legitimate low pay and confining women workers to repetitive tasks.

- Illnesses which are specifically female (breast cancer, for example) or have a higher incidence among women for biological or division of labour reasons seldom receive priority. For example, there are few studies on the role of work-related factors in breast cancer (the most prevalent form of cancer among women), and much conjecture needs to be verified. Even though a correlation between night work and breast cancer was hypothesized in 1987, the first epidemiological study was not published until 1996. To date, there are only 4 studies on this issue (Swedlow, 2003).

- Health is not just a matter of avoiding sickness. It is an ongoing process within which the individual strives to balance individual environment-related demands. This ongoing process itself involves collective strategies. Both the demands and the strategies differ by social class, gender and other factors. The paradoxes usually found in health surveys (female mortality leads, but lags in self-assessed health) show the difficulty of laying down an approach to health that goes beyond the male norm by which women are judged. Both the approach to suffering and how male workers’ perceptions are addressed reveal particular biases against women.

A study of the scientific research on occupational health leads Messing (1998-b, p. 208) to the firm conclusion that: “The occupational health and safety system is a male world in which women’s biology, social situation and jobs are alien to those that judge them. The conditions that cause their suffering are not deemed dangerous, their word is doubted and they find it hard to talk about the affected body parts (...) The lack of relevant scientific evidence exacerbates this situation”.

39. A summary will be found in Weiderpass (1999) and Pollán (2001). Weiderpass cites nine studies on the links between breast cancer and work-related factors, the earliest of which dates back to 1980. Pollán cites 50 studies published between 1993 and 2000 and 15 regularly cited previous studies in the bibliography. His wider selection criteria include any study which mentions occupational activity even where the occupational exposure factors are not the main focus of study or where it is a more general study on cancers.

40. So, from a historical standpoint, Cottereau (1983) observes that the strategies deployed by women workers in 19th century France to resist health damage more often than men’s strategies involved withdrawal from the labour market. This points up the interplay between strategies of resistance and the gender division of labour. A low paid job seen as “pin money” is easier to leave when it becomes unbearable. In the Netherlands today, the sharper rise in the number of women forced out of the labour market by invalidity may reflect both women’s poor working conditions and the strategies of resistance enabled by a labour market highly gender-segregated by part-time work.
Chapter 3
The statistics and main indicators available

The survey findings combined with a trawl of the data available from different national institutions reveal wide discrepancies in the statistics and indicators available. This study considers only the most significant data that could be found. The compartmentalisation of occupational health, public health and equality data must be stressed. Very few attempts have been made to join these three aspects up. Most information systems are run by different institutions and the scope for establishing linkages between systems is extremely limited.

Women's work in occupational health indicators

Occupational health indicators may be developed from a wide range of data, which may be classified as:

- data on working conditions broadly defined (sectors, occupations, working time, length of service, etc.), characteristics of the work done (personal interaction, repetitiveness, autonomy, etc.) and characteristics of the employment (type of contract, etc.);
- data on exposure to risk factors;  
- health data (work accidents, occupational diseases, other diseases, absenteeism, etc.) which may be extended to the broader concept of quality of working life;  
- data on the organization of prevention (access to health surveillance, coverage by preventive services, employee representatives in health and safety, specific training in health and safety, etc.);
- data on the population concerned (age, sex, nationality, educational level, pay level, pre-employment status, length of service in the job or with the firm, family status, etc.).

These data may also come from widely varying sources: workers’ self-assessment, employer’s reports, data collected by preventive services or the labour inspectorate, measurements taken by experts, statistics covering an entire study population, survey of representative samples, etc.

A survey done in 1995 by the Dublin Foundation listed 212 different database systems on the working environment in 17

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41. Working conditions and risk factors are partially overlapping concepts, as is easily exemplified by night work, work to tight deadlines, etc.

42. Including the major French study on happiness and work (Baudelot & Gollac, 2003) and the Quality of Working Life Survey done annually in Spain since 1999 by the Ministry for Work (URL: http://www.mtas.es/estadisticas/ECVT/Welcome.htm). The latter survey also covers work-life balance issues.
European countries. If the many local and sectoral sources are included, the EU countries have very many more sources of available data. An examination of all these sources went beyond the scope of this survey. As a result, it focuses on a sample that gave an overview of the situation.

Working from the data collected, a comprehensive assessment can be attempted of the available data and their application for a gendered preventive approach. Between-country comparability of data is not considered in this study.

There is copious raw data for most indicators, but the between-country distribution is very uneven.

Comprehensive surveys of working conditions are found in about half of EU States. They are usually repeated at regular intervals to track long-term trends in working conditions. One big failing of these surveys is their tendency not to see work holistically, but to look only at paid work. Total workload is very rarely assessed. Occasional data are found on the work-life balance. Consideration of total time use is exceptional. While detailed data are generally to be found on annual and weekly working times, and the breakdown between day and night, Saturday and Sunday work, almost no information is given on the doubling up of unpaid and paid working time and scant information on other times (travelling, rest, leisure, social and political activities, training, etc.).

Data on health damage are partly based on the traditional indicators of work accidents and occupational diseases. These are found in all EU States, but their use for prevention purposes remains limited. Between-country comparison of data is very difficult due to reporting system differences. These indicators also introduce significant biases which systematically under-estimate the risks of women’s work. Other indicators (absenteeism) are less clearly relevant to prevention. Data on working condition-related injuries and disorders is unevenly distributed whatever methodology is used (worker self-assessment, doctor or public health service surveys, epidemiological studies, registers of specific diseases or disease-related deaths, hospital admission records, etc.). Where they exist, these data tend to be far more reliable than those from systems for the recognition of occupational diseases (HSE, 2001 for Britain; Dupré, 2002 for the European Union). The conclusion in all cases is the same: the low levels of recognition of occupational diseases for women do not reflect the reality of work-related illnesses.

43. EUROFOUND (1995). The survey covered the fifteen European Union countries, Norway, the Czech Republic as well as the European Union and the World Health Organization. A total of 159 systems were described for the European Union countries.

44. There is extensive research into absenteeism in the Netherlands, and the gender dimension is addressed occasionally.
Risk factor exposure data are sometimes subsumed under data on working conditions, as with the European survey done by the Dublin Foundation. More infrequently, they are kept separate (exposure registers in Germany and Finland, in particular). The general trend is that worker self-assessed risk factor exposure data, when collected, tends to be subsumed into a more general survey of working conditions, whereas when the same data are collected based on measurements taken by experts, they tend to be kept in specific databases. But few States provide means for the systematic collection and processing of data produced by the normal activities of preventive services in workplaces. This under-use of a valuable body of information is largely due to preventive services being privately-run and the lack of effective measures for collectivizing their activities. By contrast, some large-scale surveys (like ESTEV and SUMER in France) that are based on the activity of preventive services reveal the vast potential that is going untapped (Vogel, 2003).

While detailed data on exposure to risk factors are scarce at national level, they are much more abundant in local and sectoral surveys. But there is a striking under-use of data from workplace risk assessments, which are almost never systematized at sectoral and/or local level. Barring the German research, summarized in the case studies (page 207), there is a paucity of data on exposure to chemical risks in women’s work. The lack of access by many female-dominated occupations to appropriate occupational health services is a factor in this. The consequences of this failing are worsened by powerful chemical industry lobbying aimed at limiting risk assessments of substances placed on the market to a handful of high-profile risks (flammable substances, acute poisoning risks or proven lethality of certain carcinogens) while most of the less visible risks are underestimated, sometimes significantly. There is a dual gender dimension to this underestimation. Women are clustered in occupations where there are looser controls on exposure (cleaning, textiles, home work, etc.). Some studies have suggested that they are more affected than men by multiple low-dose exposures. Because there are fewer women than men in the basic chemicals industry, they are more apt to be disregarded in epidemiological studies. But, where chemical risks are concerned, there is plentiful data pointing to gender-differential biomedical effects of exposures.

Data on access to and the workings of preventive provision are scant. The literature trawl turned up barely any attempts at a gender analysis of these data. Coverage of firms by preventive services in the European Union is patchy (Vogel, 2003).

45. See the chapter on regulation of the chemicals market in the discussion of Community policies, infra.

46. In particular the studies reported by Messing and Kilborn in Kilborn et al. (1998), pp. 109-111. Blair et al. (1999) reviews the justifications for specific studies on occupational cancers and women. They suggest that aside from female-specific cancers, on which there is scant occupational health research, the carcinogenic potential of some exposures may be gender-variable and male/female-specificities in the development of some cancers cannot be ruled out.
Hämäläinen (2001) estimates that nearly 50% of workers have no access to such services, and there are wide between-country variations. The United Kingdom records a sharp drop in the coverage of workers by such services (Ponting, 2002). It would be interesting to look at the gender differentials within this. Likewise, workers’ ability to get collective representation on workplace health and safety issues may depend on a range of factors like company size, trade union presence, sectors, employment status, and so on. Employers in EU countries have a legal duty to draw up a risk assessment and prevention plan on this basis. In practice, there are wide differences between firms (especially by size), sectors and countries (Karagiorgeou et al., 2000). It is often hard to include the issues raised by women in risk assessments (see Kirby, 1998 for the UK situation). National prevention policy and labour inspectorate priorities can also add to the inequalities in access to preventive resources. In many countries, reported work accident rates remain a benchmark in setting priorities for prevention resource allocation. Generally, there is good evidence for the claim that women workers have less access to preventive provision. But this is only a reasonable assumption. The different EU countries have plentiful data on preventive provision, but lack any systematic information on gender discrimination.

Spain is a case apart here. There is a body of evidence to show that women as a whole have less access to preventive provision than men. The survey on women’s working conditions in Navarre carried out in 1997 (INM-INSL, 1999) contains much information on access to preventive provision. Some of the figures are telling. While 6.9% of the women worker respondents reported knowing that their firm carried out a risk analysis, the figure was 12% for their male colleagues. 8.6% of women workers - but 28% of men - had been given training in workplace risk prevention. This contrasts sharply with access to general training (i.e., not specifically occupational health training), accessed more frequently by women workers (34.4% against 24.5% in the twelve months preceding the survey). The fourth national survey on working conditions (1999) produces comparable findings. 48.1% of female compared to 57.1% of male workers are in firms that have prevention reps. The gap widens where health and safety committees are concerned: 73.5% of male versus 69.5% of female workers covered by prevention reps have a workplace health and safety committee. The table below illustrates the inequality of access to preventive services. For all possible options, the percentage of female workers is below that of male workers. Only for negative and “don’t know” responses are the percentages of women significantly higher.
Similar gaps are found in the different forms of workplace preventive health provision. 49% of women against 61.6% of men had been examined by an occupational health doctor in the 12 months preceding the survey. The types of health check administered are not necessarily the same. 42.4% of women workers - but only 33.3% of men - with access to a medical examination had a non work hazard-related general check-up. For 15.3% of women, a risk assessment had been done of their job within the 12 months preceding the survey. The same applied to 21.4% of the men. Where such a study was done, 42.6% of women were not informed of the outcome, compared to 32.2% of men. The consequences in terms of preventive action are more unequal still. Where a risk assessment was done, preventive measures were taken for 65.3% of men against 49.3% of women. Women have a slight edge over men in access to training provision (43.4% against 41.0% had some form of training in the twelve months preceding the survey). On the other hand, of workers who did have access to training, only 26.5% of women compared to 45.1% of men received training in risk prevention.

**No trace of unpaid work**

As mentioned earlier, occupational health data rarely include figures on unpaid work. Some data can be “deduced” from demographic descriptors or family status data, but do not take the analysis very much forward.

So, age-, family status- and sex-specific data on populations studied for occupational health statistics often show a higher proportion of married men than married women. They evidence the difficulty for parity-2-plus mothers (evidently, differing by child’s age) of combining paid work with unpaid work.
But these data are generally sparse.

The evidence is, however, that women who work only as home-makers suffer far worse health than women who combine work in the professional and domestic spheres. The “healthy worker effect” alone cannot explain such wide differentials, including in high female labour force participation rate countries (which probably restricts the scope of this selection effect). The reason for this phenomenon is tied to the beneficial health impacts of paid work. The factors most often cited are:

• socialization;
• substantial financial independence, enabling them to have a life which is not dependent on a family head (spouse, parents, etc.);
• a major contributor to self-esteem;
• a diversification of activities which, when carried out in a setting which the woman worker can control, enhances her abilities to deal with the outside world.

The evidence is that, as regards each of these factors that can have a positive impact on the development of healthier working, the conditions in which both paid work and unpaid work are done can have a decisive impact. This can be concluded from these few examples:

• home work and paid domestic work tend to offer many fewer socialization opportunities than other forms of work;
• diversification of activities may be very limited for some occupations where female activities are an extension of their unpaid domestic activities;
• unpaid domestic work can be done in a wide variety of conditions depending on whether other family members help, the material and emotional support the woman worker has, the social recognition attributed to it, etc.

The “double workload” clearly seems to have differential effects according to the characteristics of unpaid work, paid work and how they are connected.

A Swedish research study posits a general explanatory framework for the health impact of different ways of combining work life and unpaid work. While all the scenarios hypothesized by this framework are deserving of more in-depth study, a rapid overview of the main ways in which the “double workdays” combine and their health impact is no less useful.
This model assumes that the health impact of the situations depicted is gender-neutral\textsuperscript{49}. Some situations are far more typical for women (particularly major risk situation 1 and situation 4). Others mainly concern men (3 and 6).

There is very little data being produced on this combination at present.

A survey on the health of men and women workers in Terrassa (Catalonia) offers interesting insights (Artazcoz et al., 2001-a). All the respondents were working couples. The domestic workload was estimated from four indicators: household size (divided in two groups - over 4 and between 2 and 4), one or more present-in-household dependent children under 12, a present-in-household person aged over 65, and the use of another person’s paid domestic services. For men, there was no significant variation by which to link their health with three of these factors (the only factor producing a significant - and favourable - variation was the presence of a person over 65). This bears out the findings of many time-budget surveys that men’s contributions to domestic duties remain fairly constant regardless of their total volume. Occupational status, on the other hand, does seem to be a decisive predictor (the number of men reporting poor health is 2.69 times higher in the two lowest social status categories than the highest one). The reverse holds true for women, where there is a very close correlation between all the domestic variables and health. Women in households of over 4 people are 3.65 times more likely to report poor general health than those in households of 4 and less. Those who do not buy in domestic help are 4.43 times more likely to report ill-health than women who do. A present-in-household child under 12 is a favourable factor, and a person over 65 a very favourable factor (the only domestic variable that was a predictor - albeit a lesser one - for men). The authors of the study report inconsistent estimates in

\begin{table}[h]
\centering
\begin{tabular}{|c|c|c|}
\hline
Paid job & Unpaid work in the private sphere & \\
\hline
\multicolumn{3}{|c|}{Primary responsibility} \tabularnewline
Stressful & Shared responsibility & Little responsibility \tabularnewline
\hline
1. Major risk to health & 2. & 3. Risk to health \\
Good & 4. & 5. Best health \\
None & 7. Risk to health & 8. \\
\hline
\end{tabular}
\caption{Potential links between the “double workdays” and health}
\end{table}

\textsuperscript{49}. This point needs to be qualified. It depends on many other factors: the division of labour in shared domestic duties is rarely equal. The value attached to male domestic work varies widely with social and cultural factors and tasks. The view long held by fathers that changing a nappy was beneath them is now changing.
the literature of the correlation between health and a present-in-household person over 65. The health benefits could result from the practical and emotional assistance offered by an elderly person.

From gender-disaggregated data to gender analysis:
A transition rarely made

Treatment of data is very patchy, largely reflecting the public policy priority given to occupational health.

Some countries have put comparatively extensive occupational health information systems in place. These are long-established in the Nordic tradition. Elsewhere, major efforts have been made to get a regular overall view based on a battery of indicators. But how far have these attempts integrated the gender dimension?

Gender-disaggregated data are apt to be found in most existing information systems, although still with serious gaps. But gender-disaggregated data alone will not support a gender analysis of situations. In many cases, they serve only as a demographic variable of the reference population (a sort of “vital registration record”: age, sex, possibly nationality), enabling no sufficient linkages to be made with job segregation and gender-specific working conditions. Severe underuse of the gender variable in analysis creates a real problem in knowledge production. The shares of women in part-time employment, or aged 50-55 in employment, are broadly known, and gender-disaggregated data are usually available on work accidents and registered occupational diseases, as well as absenteeism and invalidity rates. Fairly detailed data are also available on gendered occupational segregation. But there are few analyses to link them up. The main failing lies with the paucity of the underlying explanatory models. As an independent variable, gender is not particularly explanatory in occupational health. It needs to be integrated into a more overall matrix which includes the forms of employment, working time issues, sectors of activity, tasks/duties, etc.

Some sources provide information on family circumstances (married, divorced or single living alone, divorced or single living in a union, etc.). Information can also be found on parental status (number of children, ages, presence-in-household, etc.). But rarely are they used as explanatory variables of working conditions (except, quite frequently, to explain women’s segregation in part-time jobs). A French survey on the different forms

50. These include the annual reports on working conditions and the substantial body of DARES research on this in France. In the Netherlands, the Ministry for Work publishes an annual review entitled “Arbo-balans”. Other countries - like Italy, Belgium, Luxembourg, Portugal and Ireland - produce no overall reviews, but dispersed data on occupational diseases, work accidents and special surveys on specific topics.
of violence towards women (Brown et al., 2002) makes a link between the different forms of violence in the workplace and women’s conjugal status (married, widowed, divorced, single, in a union, not in a union).

Table 7: Women reporting violence at work by family circumstances (%)

<table>
<thead>
<tr>
<th>Type of violence</th>
<th>Married or widowed</th>
<th>Single in a union</th>
<th>Divorced or separated in a union</th>
<th>Divorced or separated Not in a union</th>
<th>Single Not in a union</th>
</tr>
</thead>
<tbody>
<tr>
<td>N =</td>
<td>2883</td>
<td>768</td>
<td>66</td>
<td>335</td>
<td>471</td>
</tr>
<tr>
<td>Verbal abuse and threats</td>
<td>6.7</td>
<td>7.9</td>
<td>14.7</td>
<td>10.1</td>
<td>12.5</td>
</tr>
<tr>
<td>Psychological abuse - of which bullying</td>
<td>13.6</td>
<td>19.9</td>
<td>26.2</td>
<td>22.9</td>
<td>18.9</td>
</tr>
<tr>
<td>Destruction of work</td>
<td>1.5</td>
<td>2.4</td>
<td>5.6</td>
<td>3.5</td>
<td>3.8</td>
</tr>
<tr>
<td>Physical violence</td>
<td>0.6</td>
<td>1.2</td>
<td>0.0</td>
<td>1.1</td>
<td>0.4</td>
</tr>
<tr>
<td>Sexual harassment or assault</td>
<td>0.9</td>
<td>3.3</td>
<td>2.9</td>
<td>4.0</td>
<td>3.6</td>
</tr>
</tbody>
</table>

Scope: all women having worked within the preceding twelve months.

Genderized national and regional surveys

The survey collected a range of national and regional experiences where significant efforts had been made to make the gender dimension of occupational health visible. Although in the minority among all surveys on the health impacts of working conditions, they deliver a creditably practical response to the excuse pleaded by many institutions that full genderizing is not possible due to insurmountable methodological obstacles.

In Navarre, two institutions - the Navarre Institute of Occupational Health and the Institute of Women in Navarre - formed a partnership to survey the health and working conditions of women in Navarre (INM-INSL, 1999). The survey was done in 1997. The basic survey questionnaire on working conditions was revised to include a handful of new variables that were not normally found in occupational health (designed to measure the scale and conditions of unpaid work) but would clarify gender differentials. It is tempting to say that this involved asking just a few simple little questions that are always overlooked. The Navarre project suggests that political will and listening to women workers’ first-hand experiences are the two keys to clarifying gender relations in occupational health. A comparison of the work done
The gender workplace health gap in Europe in Navarre with the independently produced national data of the Institute of Women\(^1\) (Instituto de la Mujer) and the Spanish Ministry for Work shows the vast differences that stem from political conditioning. It only takes a small number of methodological changes to give a far more accurate view of the situation.

A German report on women’s health includes a major focus on women’s occupational health (Ducki, 2001). As well as looking at the work-life balance, the report includes:

- health indicators for women in work, in particular data on incapacity, unfitness for work, work accidents, occupational diseases and enforced early retirement on the grounds of illness;
- information on the work-related constraints and resources of workers in female-dominated occupations and sectors (office work, cleaning industry, retail sales, social professions: social workers and home helps, health care sector: especially nursing);
- data on home work, women’s family work, unemployed women and the health impacts of these situations.

Finland’s Quality of Working Life Survey looks at both the physical and psychosocial aspects of the working environment. The data are collected from interviews with a sample of between 7,500 (first survey, 1977) and 3,500 people (fourth survey, 1997). Statistics Finland conducted four of these surveys. The most recent, dating from 1997, was complementary to the European Labour Force Survey (LFS). The questionnaire addressed the physical, mental and social aspects of the working environment. It includes ten questions on unpaid work, its intra-family allocation and its relations with paid work.

Secondary analyses of the survey data have generally been highly gender-sensitive (Lehto & Sutela, 1999-a and b). Points they make include:

- time pressure has steadily increased in recent years. While this mainly affected men in the past, it is now affecting women in growing numbers;
- there are systematic differences between men and women’s opportunities for influence or control over work. Women have less influence over their work than men as regards: job content, pace of work, working method, work allocation and equipment purchases;
- generally, women are more discriminated against than men. The areas of greatest discrimination are access to in-service training, work-related information and the attitudes of colleagues and superiors in general.
A more general review is given in the case study *The worklife of Finnish women* (page 290).

Sweden’s National Institute for Working Life and Working Environment Authority (which is in charge of the labour inspectorate) have published an exhaustive report on working life and health in Sweden in 2000 (Marklund, 2001). The gender analysis shaped this book in three ways. It informed the choice of issues examined, which do not focus on traditional male risks. It cuts across most of the topics, providing gender-disaggregated data and surmised explanations. It is the main thrust of a chapter giving a gendered analysis of health damage. Unlike the experiences described for other countries, the Swedish report consolidates data from many different sources. It shows that the technical problems of linking up data are not an insurmountable obstacle to drawing up a summary based on a set of qualitative evaluations done from common questions. On the other hand, it treats the linkage between paid work and unpaid work very much as a side issue. Here, it still reflects a fairly traditional approach to occupational health. This is particularly surprising given the more important ground it opens up in other areas (e.g., the relations between health, unemployment and insecurity).

France has a fairly wide array of statistical instruments addressing occupational health and working conditions. Aside from the traditional indicators on work accidents and occupational diseases collected by the occupational risk compensation systems, there are data on medical surveillance (the SUMER survey, covering over 48,000 workers) and a large body of data on working conditions collected and analysed by the DARES. The surveys of working conditions done in 1984, 1987, 1991 and 1998, in particular, help plot changing situations. The survey covers a sample of some 20,000 workers. For long, there was no systematic gender analysis of these data. Male and female data were generally disaggregated in tables, but there was little secondary analysis to interpret the differences observed. One correspondent reports that a research project was launched by the Ministry for Scientific Research in 2002 to improve the gender analysis of working conditions.

Gollac and Volkoff (2002) analysed the data on male and female manual workers’ working conditions, covering approximately 30% of the population in a job included in the 1998 survey. They also did a more forensic analysis of the working conditions survey data using data from other surveys (on work and lifestyle, and on technology and work organization). The value
of a specific analysis of the manual working population is to avoid that smoothing of the data that occurs in studies of the total employed population. Often, gender differentials are not very clearly evidenced because the statistics provide aggregated data that group together very different groups of workers. By focusing exclusively on the manual working population, the authors brought out the importance of the gender division of labour in work organization. They stress the extent to which traditional stereotypes have found a new lease of life in recent changes in work organization that combine work intensification with forms of controlled autonomy. They note in particular that: “Manual labour (...) seems like a caricatural embodiment of certain gender stereotypes. The (professional) role of women workers is to be submissive, work hard at routine tasks, and work in comparative isolation (isolation is often the lot of domestic work). On the other hand, they are comparatively sheltered, not necessarily from constraints, but from the most violent forms of physical injury: they have to run fewer immediate risks to do their job, in the same way that, outside work, women are not expected to take part in violent activities. Finally, their hours of work are compatible with intensive out-of-workplace activity”.

The table below illustrates a disciplinarian form of work organization that affects women workers in much greater numbers.

<table>
<thead>
<tr>
<th>% reporting that:</th>
<th>F</th>
<th>M</th>
</tr>
</thead>
<tbody>
<tr>
<td>They work on a production line</td>
<td>24%</td>
<td>7%</td>
</tr>
<tr>
<td>They do repetitive work with cycle times of under a minute</td>
<td>27%</td>
<td>10%</td>
</tr>
<tr>
<td>Their superior dictates how to do the work</td>
<td>29%</td>
<td>21%</td>
</tr>
<tr>
<td>Their work pace is under at least daily surveillance control by their superior</td>
<td>43%</td>
<td>37%</td>
</tr>
<tr>
<td>Their work pace is set by standards or times of one hour or less to be met</td>
<td>41%</td>
<td>34%</td>
</tr>
<tr>
<td>Their work schedules are set by the firm and they cannot change them</td>
<td>84%</td>
<td>87%</td>
</tr>
<tr>
<td>They cannot choose when to take their breaks</td>
<td>22%</td>
<td>13%</td>
</tr>
<tr>
<td>They are not allowed to talk when working</td>
<td>10%</td>
<td>2%</td>
</tr>
<tr>
<td>They have no opportunity for group discussions of organizational problems or how the department is run</td>
<td>54%</td>
<td>38%</td>
</tr>
<tr>
<td>Their relationships with their superior are sometimes strained</td>
<td>25%</td>
<td>31%</td>
</tr>
</tbody>
</table>

Source: DARES survey 1998 in Gollac & Volkoff, 2000, p. 65
A slightly different presentation of the same data, expanded to include a disaggregation between skilled and unskilled male and female workers can be found in Gollac & Volkoff, 2002, p. 28.

Gollac and Volkoff also stress that the rise in female unskilled employment has been concentrated in “pink-collar” jobs. Between 1984 and 1998, the number of unskilled female manual workers fell from 850,000 to 650,000 while the number of unskilled female office workers rose from 1,800,000 to 2,400,000. But a range of parameters point to a faster decline in the working
conditions of unskilled female office workers than unskilled female manual workers. Of the thirteen factors considered by the authors, only one showed an improvement (regular exposure to loud noise). Physical constraints (in particular, painful and tiring postures and manual handling of heavy loads) and work pace constraints rose sharply between 1984 and 1998.

Surveys on ageing and occupational health are another important source of information on working conditions. They include sex-disaggregated data, but the application of that data to a gender analysis remains patchy. Studies based on ESTEV\textsuperscript{52} survey data on the self-assessed health of a population of more than 21,000 workers have attempted to include a gender dimension. Amongst the findings are that while women are generally less exposed to physically painful factors, they are more exposed to clock-bound repetitive work regardless of age. The survey highlighted stationary-selective constraints, meaning constraints that are present at the same level in work, but do not affect the same individuals continuously, and which are so strenuous that those affected to get away from them as soon they can. For women, this type of constraint essentially concerns shift work and repetitive work.

\begin{table}[h]
\centering
\begin{tabular}{|c|c|}
\hline
\textbf{Swedish working conditions survey highlights widening equality gap} & \\
\hline
The Moa project multi-disciplinary survey on modern working and living conditions run from 1995 to late 1997 studied organizational, psychological and ergonomic conditions, as well as physical and chemical factors, in 80 public and private workplaces. Investigators talked to employers and management, and sifted through written material on work organization. Equal numbers of two hundred men and women workers were selected for in-depth personal interviews and questionnaire surveys. The aim was to look closely into the tie-in between changes in work organization and working life at both organization and individual levels. The gender perspective was recognized as key from the outset, both for its impact on recruitment practices and work situations. From the information collected, job clusters were identified which reflected similarities in changing work organization and working conditions of groups of workers. All the evidence pointed to growing differences between working conditions. In other words, social divides - as expressed by working conditions - were widening. No-one should be surprised at this, given the visible spread of inequalities in other areas (income, wealth, access to health care, life expectancy, operation of justice and prison systems, etc.). This Swedish research gives the lie to the upbeat official spin on the “information society” in showing that the new work patterns do not strike a balanced compromise between the different interests in the workplace. Anything but - it is abundantly clear that there are winners and losers.
\end{tabular}
\end{table}

\textsuperscript{52} See Bardot et al. (1996) and Bertin, Dubré & Meritet (1997).
The research is too detailed for a full treatment, so just the six main clusters identified by the researchers are described here.

1. “Decent jobs”. Men and women workers who have a good balance between work and private life. They enjoy good management and sufficient resources to do their job properly. They tend to work fixed hours, often in the private sector, and are generally office workers.

2. “Boundaryless jobs”. Work and leisure time merge. Work deadlines are tight. Jobs are gender-segregated. Individuals have a great deal of influence over their own work. This group includes project managers, consultants and media workers.

3. “Locked jobs”. Work is bound by the clock, and very stressful. Usually in sectors exposed to fierce competition. Workers may have many superficial customer contacts and little influence over their work. It includes check-out staff, call centre staff and bus drivers.

4. “Exposed jobs”. These are physically demanding jobs in a poor physical work environment (where the chemical and physical risks are greatest). Many people in these jobs suffer poor health despite being young.

5. “Heavy, monotonous jobs”. These are usually physically demanding jobs, often insecure and with monotonous duties. Workers are often passive in their leisure time and completely exhausted at the end of the working day. Job insecurity is often linked to privatisation and tender-based outsourcing. Heavy goods drivers and cleaners are in this group.

6. “Restrained jobs”. Workers who consider they are prevented from doing their actual job. These are usually found in the public sector. They have undergone restructuring and are increasingly paper-bound. Workers tend to be highly educated and in highly socially regarded professions. This group includes policemen, public prosecutors and care staff.

Researchers also looked at the increasing time pressure of work and individual control over work. Workload had increased in all the firms looked at, but especially so in women-dominated, sectors catering to the public (users, customers, etc.). The group where most changes related to “flexible working” included a hospital, schools, a supermarket, a large industrial firm and an IT firm.

The research took a hard look at the gender dimension of changing working conditions, and came to a series of conclusions:

- who work in gender-mixed workplaces tend to share more of the unpaid domestic work with their partners than men in segregated jobs;
- the worst working conditions are often in women-dominated workplaces. The worsening quality of public service jobs is a key contributor here;
- men benefit more than women from a gender-mixed workplace;
- changes in work organization seem to have widened the gap between groups. Class differences have become more entrenched. Men’s and women’s situations are broadly alike where work and living conditions are the same - which is about once in a blue moon!

Source: Lena Skiöld’s report in Working Life. Research and Development News, No 3-2000. Other information supplied by Annika Härenstam, Project Director (contact: annika.harenstam@niwl.se).
The gender dimension in occupational health data produced by EU institutions

This section considers only research with a direct bearing on the health impacts of working conditions. The integration of the gender dimension in other research programmes on public health or equality was outside the scope of the survey.

Three Community institutions play a key role in occupational health matters.

The Dublin Foundation

The European Foundation for the Improvement of Living and Working Conditions, usually referred to as the Dublin Foundation, carries out research across a range of areas including working conditions. Arguably, it is the one Community institution whose work is most systematically en-gendered. Three surveys on working conditions have been done (1990, 1995 and 2000) based on a questionnaire disseminated in all Community countries. The last survey was also extended to the twelve countries applying for membership of the European Union\(^3\). The questionnaire included a gender dimension inasmuch as the indicators chosen accommodated a series of crucial issues: non traditional risks, gender system in management, etc. A first report specifically on the gender dimension was produced out of a more in-depth analysis of the 1995 survey findings (Kauppinen, 1998).

Analyses were also done of the 2000 survey that gave more than a basic comparative study of the raw data for men and women by reference to the survey parameters.

Véronique Daubas-Letourneux and Annie Thébaud-Mony's (2002) analysis of work organization and occupational health in the European Union takes a secondary analysis of the 2000 survey findings as the basis for comparisons with data from the previous surveys. Rather than an overall comparison of the two data sets for men and women, the aim is to analyse different forms of work organization to identify the links between them and health damage. This goes beyond an overly narrow, epidemiology-inspired causalist approach to determine the health impact of specific risks. It also shifts the focus from legal relationships (defined through a typology of forms of employment\(^4\)) to relationships of domination in the workplace as reflected in a variety of ways in different types of paid-work

\(^3\) A summary of the data on each of these twelve countries can be found at: http://www.europfound.eu.int/working/cc/factsheets.htm.

\(^4\) The types of employment contract are a frequent benchmark in studies on job insecurity. On the plus side, they are a recurring variable in a very large number of surveys. But they have two limitations. There is a "filter through" effect where the insecure working conditions of non-standard employment relationships change the working conditions of "standard" workers (full-time permanent contracts). But also, the mere legal form of the contract does not determine all the working conditions. A high-level information systems specialist able to negotiate part-time employment contracts on good terms is not similarly placed to a hypermarket check-out worker.
The gender workplace health gap in Europe

The authors identify four groups of women and four groups of men. The groups are identically named and share broad defining characteristics. On the other hand, they differ significantly in their respective importance in terms of the population concerned and how they cause health damage.

Group 1 - constrained work (characterized, among other things, by low autonomy, high management constraints, no possibility of choice). This accounted for 18% of female and 17% of male employees.

Group 2 - flexible work (high flexibility of working time and commercial demand-driven work pace constraints). This accounted for 7% of female and 16% of male employees.

Group 3 - autonomous work (comparatively high autonomy, commercial demand-driven constraints). This accounted for 53% of female and 49% of male employees.

Group 4 - automated work (low autonomy, industrial type pace constraints). This accounted for 22% of female and 18% of male employees.

A more forensic analysis reveals for each group work characteristics which are not identical for men and women. So, cross-cutting phenomena are found that affect:

- all groups of women with a high prevalence of commercial demand-driven constraints on work paces. “The customer is always right” for at least two-thirds of women workers in each group; or
- all groups of men: work controlled by respect of quality standards and personal evaluation of the quality of their work.

Significantly, these gender characteristics of work organization transcend the mere sectoral division between industry and services. Furthermore, for male and female groups alike, the types of work organization are found across all sectors, though variably distributed.

The country breakdown of these four groups can show wide variations. So, constrained work represents 42% of female jobs
The gender workplace health gap in Europe

in Portugal against 4.9% in Denmark, while the breakdown by age brackets, sectors and occupations also differs substantially.

A health damage analysis reveals different typologies for men and women in each of these groups.

Colette Fagan and Brendan Burchell (2002) analysed the relationships between gender, job and working conditions. The report found a quite stable pattern of the gender dimension in working conditions throughout the decade observed, except in two areas. Work intensification affected all workers, but women more so. Likewise, there was a considerable rise in Sunday work among women. On these indicators, the overall situation of men and women is moving closer together. The second finding of the analysis was that a gender relations-based model rather than one limited to job segregation was the most relevant model for analysing working conditions. There is a strong interaction between the unequal division of paid and unpaid work, for one thing, and all other working conditions, on the other. As regards the health impact of working conditions, the report looks at men’s and women’s situations in the light of within-group differences in part-time and full-time work. While part-time women workers generally report fewer specific health problems than full-time women, there are significant differences in absenteeism rates. Fewer part-time women workers had time off for work accidents, work-related illnesses or other health problems. But sickness absences were markedly longer when the health problem was work-related. So, the average length of work-related sickness absences was 25 days a year for part-time women workers, but 17 days a year for full-timers. One explanation for this may be conditions that make daily management of health at work harder and end up with a build-up of health damage producing more serious illnesses.

Other research done by the Foundation has highlighted particular aspects which can be usefully taken into account. They include studies on:

- working time preferences (Fagan, 2003);
- precarious employment and health-related outcomes (Benavides, Benach, 1999; Benach et al., 2002);
- sectoral profiles of working conditions (Houtman et al., 2002);
- specific sectors, e.g., services to households.
The Bilbao Agency

The European Agency for Safety and Health at Work - known as the Bilbao Agency - is a more recent creation and works in quite a different way to the Dublin Foundation. Its work largely depends on the quality of the input into its information system from the national focal points. Until recently, the reports published by the Agency had largely skated over the gender dimension.

The biggest report - that on the state of occupational health in the European Union (European Agency, 2000) - contains no gender analysis as such. This is largely due to the method followed. The report is cobbled together from a mixed bag of baseline data taken from previous research (Dublin Foundation's 1996 survey, Eurostat data on work accidents, etc.). The focal points were asked for replies to a series of questions which would enable the national data for their country to be consistency-checked with the Community data. They were also asked for remarks to help identify the biggest risks. This approach fell foul of two big methodological difficulties. National data may be very dissimilar or nonexistent, as becomes quite rapidly clear from an analysis of the responses. The main risks were identified simply by aggregating discrete data, disregarding weighting factors (e.g., the respective importance of the chemical industry in Germany and Ireland should have cautioned against awarding the value “1” to every reported existence of a risk to which chemical industry workers in the two countries are exposed). Also, such an approach completely disregards the interplay of risks and work situations.

The only attempt to address the gender dimension comes through the question “Which gender is most exposed to the risk concerned...”. But it was a confusing question: was it about overexposure based on the total absolute numbers of men and women exposed in the population, the gender-specific intensity of exposure, etc? As might be expected, the non-response rates are huge. Of the eleven broad risk categories examined, an average of 10 out of 15 focal points failed to reply to such an ill-phrased question (European Agency, 2000, p. 338). The smattering of replies received show a stereotyped view of the gender-distribution of risks without the slightest attempt at analysis. On a minor note, 2 national focal points estimated a higher female rate, and one a higher male rate, of work-related illness absenteeism. The other 12 had the decency not to attempt any evaluation. The high levels of refusal to recognize women workers’ occupational diseases in EU countries cast some doubt on this 2/1 ratio.
On the other hand, the Agency’s work programme offers some encouragement. It plans to publish a report on the gender dimension in occupational health\textsuperscript{55}, and integrate the gender dimension in other ongoing projects.

\textbf{Eurostat}

Eurostat has for a number of years been studying work accidents and occupational diseases with a view to framing a common statistical approach. But it has not been gendered research. This omission is particularly glaring in the various studies on occupational diseases, which are a key source for assessing failings in the systems for recognition of occupational diseases and the failed attempts at Community-wide harmonization over the past forty years. In 1999, the European Labour Force Survey included a specific module on work accidents and work-related illnesses\textsuperscript{56}, which was a helpful in comparing the data on officially recognized accidents and the accidents reported by workers to the survey.

A statistical gender analysis was done on the 1999 survey work accident and occupational health data, on the basis of which Eurostat published a highly informative summary analysis (Dupré, 2002). This showed that while the incidence rate of recognized work injuries was markedly higher among men when calculated relative to the total numbers of workers covered, the gap narrows when working time is factored in. Calculated on those in full-time equivalent (FTE) employment, there was a persistent gap attributable chiefly to sectoral and job segregation. On trends, Dupré (2002) notes that in most Community States, the incidence rate gender gap in work accidents narrowed between 1994 and 1998. This is probably attributable to the general shift in employment away from manufacturing and agriculture and into the service industries. In all save four Member States, the male incidence rate fell more sharply or rose more slowly than the female rate. In Germany, the female rate even rose while the male rate fell. A comparison of recognized accident data with the labour force survey findings reveals a narrower gap between the male and female rates for self-reported figures than in the statistics generally produced by compensation systems or employer reporting systems. The survey covers all sectors of the economy, while the national statistics in the ESAW (European Statistics on Accidents at Work) system differ from one country to the next in the population covered. On the other hand, the survey covers only 11 of 15 countries.

\textsuperscript{55} Not yet published at the time of writing. The Agency kindly supplied a copy of the most recent draft version.

\textsuperscript{56} The module was not used in Austria, Belgium and France, and only partially in Germany.
As regards occupational diseases and other work-related health problems, the data calculated on FTE jobs point to a higher prevalence among women than men. This is observable in all the survey countries except Greece. The analysis by type of health problems also shows some significant gender differentials. There is a higher prevalence of musculoskeletal disorders, stress, depression and anxiety among women than men (with 54.4% against 51.4% for the first group of diseases and 20.2% against 16.5% for the second group, respectively). The reverse is true for respiratory and pulmonary problems, heart disease, cerebral strokes and other cardiovascular problems as well as hearing problems, where male prevalence rates are higher.

**Public health indicators**

Public health is where most failings were identified. Social inequalities in health tend not to be a key focus of the data collected. Also, working conditions play a very minor part in the analysis of health inequalities, and gender-differentiated overall conditions (paid work and unpaid work) virtually none.

Most public health data offer no way of measuring the health impact of working conditions. Even where social health inequalities are specifically addressed, the link with working conditions is rarely followed up. Public health information systems are suffering from the under-socialization of the preventive services that is to be seen in all European Union countries (Vogel, 2003).

A number of studies have nevertheless tried to include working condition-related variables. The study by Costa et al. (1998) on health in Turin is interesting for its inclusion of factors directly related to working conditions (following the Karasek model, combining job demands and control, factoring in other parameters like shift work and exposure to sources of injury). Borg and Kristensen (2000) study the relationships between self-assessed health, social class (broken down into five groups based on occupation and education), working conditions and selected lifestyle factors in Denmark. It is based on a five-year cohort study of 5,001 workers. The findings point to a close correlation between the four series of factors studied. Working conditions and lifestyle factors are significant explanatory factors in health decline over time. Incorporating other factors is easier when the base population for cohort studies is the workers in a specific undertaking or sector. Highly informative exploitations of epidemiological surveys that deserve attention include:
• The GAZEL survey in France based on a follow-up of 20,000 workers EDF-GDF workers since 1989. The cohort comprises approximately 75% men and 25% women. The survey has given rise to annual reports and 46 articles addressing a wide range of health issues. Gender differentials are a standard consideration.57.

• The Whitehall II survey first done in 1985, covering just over 10,000 civil servants in different departments of British government.58.

The picture as regards production of macrodata on the health of national or regional populations is not encouraging. For instance, the importance of factoring in working conditions is recognized in a recent French report on health in France (HCSP, 2002), which addresses inequalities of health at length. But the available data are very piecemeal. They mainly show that occupational disease statistics offer no guidance as to how working conditions contribute to health inequalities. On this point, there is a striking unanimity of findings and extreme passivity by public health institutions in taking practical steps to remedy this situation.

A working group was set up under a Community action programme on health monitoring to take stock of systems for routine data collection (Lagasse, 2001). The report describes a general situation where no occupational health data is fed into systems established under public health programmes. Of twelve systems whose heads responded to the survey questionnaire, only 5 recorded the patient’s employment status. Working conditions - be it exposure to physical hazards (chemicals, noise, dangerous equipment, etc.) or psychosocial factors (degree of control over work, time pressures, etc.) - went unmentioned. The report also examined the data collected routinely by occupational health systems, and showed that by and large, they were not systematically followed-up. Each country had laid down its own means of health surveillance and exposure monitoring, and in most cases the information stayed within the firm or the preventive service.

More recently, efforts have been made to collect data that are more informative about gender health differentials. Examinations of gender differentials usually relate to most of the outcome measures (mortality, disease incidence, disabilities, etc.), and descriptive indicators of access to the health care system (medical examinations, hospitalization, dental treatment, consumption of medicines, etc.). But almost all the research found and consulted disregards or fails to address women’s working conditions.
conditions, focusing instead on family circumstances (single / in a union / number of dependent children, etc.) and individual behaviours (drinking, smoking, sexual behaviour, diet, physical exercise taken, etc.). Some countries also include ethnic origin. But this is still a blinkered approach. More appropriate would be to take account of the combined impact of paid and unpaid work, and, especially, not to restrict the analysis of women’s economic conditions to family life-related indicators.

From a sweeping analysis of the different health surveys done in Spain since 1983, Rohlfs et al. (2000) summarize the relevant variables for the gender dimension. Above all, the summary shows the importance of an analytic framework and a political will. Only a handful of variables ought really to be added

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* Only care given to children and sick adults was recorded, and it is not recorded whether the respondent was the caregiver.
** The caregiver’s gender is not specified.


The number of surveys was reduced from eight to five for practical considerations. Greyed-in boxes represent variables for which data exist in all the eight surveys analysed by the authors.
to those routinely included in most health surveys, and there would not seem to be any significant technical reason why they should not be. Table 9 (see previous page) considers the sociodemographic and work-related variables covered by a number of health surveys in Spain. From an examination of the surveys to which the present study had access in other countries, the Spanish situation is far from the worst. In fact, in recent years, Spain has been one of the EU countries to mount the most systematic study of the gender dimension in health inequalities59.

Improving data collection also means redefining the theoretical frameworks by which to measure gender-differential social health gaps (Rohlfs et al., 2000; Härenstam et al., 2001). Some studies on social inequalities in health argue that socioeconomic status categories are less relevant explanatory factors for health differentials among women. While socioeconomic status classification-based gradients and key health outcome measures (chiefly mortality and morbidity) are almost invariably clearly correlated for men, they are less so for women.

So, in France, the life expectancy differential at age 35 between a manual worker and a managerial employee or professional is 6.5 years for men, while the inter-group differential is 3.5 years for women (HCSP, 2002, p. 169). A Finnish study (Koskinen and Martelin, 1994) finesses this general picture: any narrower social differences in female mortality relate only to married women. Social differences in mortality between other women are far wider than among men.

Does this mean that health inequalities among women are narrower or that women’s health is less shaped by their paid work or by the combined impact of their paid and unpaid work? It would be foolhardy to beg the question by looking for the main causes of intra-female health differentials in individual (or putatively individual) determinants. Likewise, it is questionable whether a shared experience of mechanisms of patriarchal domination reduces social differences among women to the point of having marginal health impacts60.

Recent British research on social inequalities in mortality (Sacker et al., 2000) usefully informs the debate. It argues that a socioeconomic status classification based on a typology of broad groups is much more workable for men than women. The authors do not conclude from this that social differences have no bearing on social inequalities in mortality among women, simply that the research used a different classification of a social group for which there is a pair-wise connection with the

59. See in particular the copious documentation held on the Andalusian School of Health’s Gender and Public Health Group: htp://www.easp.es/sespas.genero.htm.

60. Such an approach could explain the almost total absence of any analysis of working conditions and social inequalities among women in the pages of the Women’s Health Issues journal.
occupations of other persons with whom they are socially closer (partners, friends). The underlying rationale of this schema is that the network of social relations fairly accurately reflects self-assessed social status. Based on this classification, social inequalities of health among women appear far more marked. A fairly regular linear progression associates each social group thus defined with mortality levels. It is hard to say whether these conclusions can be generalized. Their main value lies in sparking a debate on the methods of inquiry into social health differentials. A big focus on the gender dimension could stimulate the search for more precise batteries of indicators for defining social groups. This squares with what is already known about women’s “double workday”.

Genderizing public health surveys, and especially analyses of social inequalities in health, requires a more searching methodology. Aspects that call for discussion include:

• Distribution between broad socioeconomic groups is not necessarily the best predictor of health for men or women. It is a fairly invariable predictor of male, but less so female, mortality. Actual working conditions may be an important factor. So, various research studies into cardiovascular disorders and stress argue the relevance of a description of working conditions that includes individual job demands and control, etc. (Griffin et al., 2002).

• The description of social status should include the time factor, because social status may vary over time. Some cohort studies that factor in the social and economic situation at different life stages appear to produce a more coherent analysis of the relationship between social status and health. A Scottish study argued that it was essential to understanding social inequalities of health among women workers (Heslop et al., 2001). The study looked at social and economic circumstances throughout the life cycle based on five variants: father’s social class, female worker’s social class at the survey date, social class throughout life (based on a description of the father’s socioeconomic group, and the worker’s own group previously and at the survey date), the Carstairs index of deprivation, and the worker’s age at school-leaving). The study argues that this method of describing social status provides a much more powerful predictor than other measures of socioeconomic situation for overall mortality and cardiovascular mortality.

• Social integration appears quintessentially important to understanding social inequalities of health. The report on health in France (HCSP, 2002) stresses the role played by insecurity. There is an interplay between job insecurity
(which more frequently affects women than men), unemployment and a sort of disengagement from society, involving a section of the population affected by a combination of a growing burden of poverty, isolation and health problems (mental health, in particular). This interaction is much more complex than a simple combination of exposures on individuals. A Swedish research study (Novo, Hammarström, Janlert, 2001) on the health effects of unemployment among young people suggests that mass unemployment is far from just affecting the health of the unemployed, and affects all young people who live in circumstances of great insecurity. The main effect for young males appears to be connected to uncertainty about the future, while for young females, this factor is compounded by a marked decline in their own working conditions. This latter factor is clearly identifiable in the Swedish context due to very marked labour market segregation. The feminized sectors (mainly the public services) are those that were most affected by redistribution of wealth in favour of the propertied classes and their powerful lobbying for public spending cuts. A survey on social inequalities in mortality in Barcelona (Pasarín, Borrel, Plasència, 1999) argued the case for a sort of “double model”. For certain mortality causes, a fairly regular linear progression was observable which enabled a correlation to be made between the social situation of a basic health district and a mortality level. Other mortality causes displayed not a linear progression but sharp surges, indicating high social marginalization of the district’s population. On the face of it, this suggests that, at a certain level of social inequality, a sudden disengagement from society occurred with disastrous consequences for certain mortality causes, through the combined effect of poverty with a disintegration of community life resulting in high levels of mortality from tuberculosis, AIDS and drug overdosing.

- Mortality indicators (life expectancy, causes of death, etc.) need to be supplemented by indicators for high-prevalence diseases, self-assessed health, disabilities, disability-free life expectancy, etc. A more diverse range of indicators would better reflect women’s more specific health damage (Rohlf et al., 2000; Moss, 2002). A review study on social inequalities of health in Catalonia (Artazcoz et al., 2003) suggested that these were less significant for female than male mortality. But the converse was true for mental health, where social differences were non-significant for men, but showed a very significant linear progression among women.

61. On disengagement from society, see Castel (1995), Bourdieu (1993) supplies a set of personal narratives that inform an understanding of contemporary forms of working poverty in an affluent society. Other researchers talk of alienation from work and society. The SIRS international research project on the populations of large metropolitan areas like Abidjan, Antananarivo, New York, Sao Paulo, Paris and Warsaw is a case in point (see: http://www.b3e.jussieu.fr/sirs/cadreinternational.htm).

62. Basic health districts are small, homogeneous territorial units in geographical, demographic, social, epidemiological and communication terms. There are 66 in the city of Barcelona. The social situation was described on the basis of unemployment levels. The study covered all deaths for the period 1989-1993 (43,199 males and 41,972 females).

63. There is both male and female - but significantly more male than female - excess mortality. Between the two ends of the spectrum of the basic health districts, there is a difference of 13.7 years for male life expectancy and 7.2 for female life expectancy.
Equality indicators

Equality data are much more varied. In the spheres of concern here, they relate mainly to job segregation, pay gaps, the job ladder, employment/unemployment and time use. Only very exceptionally do these data give a purchase on the potential health impacts of gender inequality in working conditions (taken in the broad sense as comprising both paid and unpaid work). Most time use studies fail to address health. Likewise, there is only very piecemeal information on the relationships between female unemployment and health damage caused by prior working conditions (Frigul et al., 1993, is one of the very few studies). While the ostensible paradox between women’s longer life expectancy and their worse health has been widely discussed in public health, the impact of working conditions and - especially - work-related wear and tear is seldom addressed.

Some countries have made the gender dimension a major focus of all social statistics. Steps have been taken to improve the methodologies used and join up broad data sets so as to frame more accurate indicators on the respective situations of men and women across many areas. The Nordic countries pioneered in this field, having begun working together in the mid-80s to produce comparable statistics on gender equality indicators. Internationally, the process was stepped up after the 1995 Beijing international conference. One aim laid down at the conference was to establish statistical systems by which to track progress on achieving equality and to disseminate statistics more widely, in particular via an international site.

After the Beijing Conference, the UNECE (United Nations Economic Commission for Europe) hosted a seminar on gender statistics in 1998, at which over half the national reports presented related to EU countries (Austria, Finland, France, Italy, Netherlands, Sweden). Issues relating to paid work were addressed in many reports. While occupational health was not addressed as such, more specific methodologies regarding gendered time use were. A second seminar was held in October 2000.

Most EU countries now produce statistics that should enable key equality indicators in different areas (work, time use, political representation, health, etc.) to be globally tracked.

It is clear from the United Nations’ gender statistics site that no specific focus has so far been put on occupational health.
All-too conventionally, the recommendations on collection of statistics put health, work and “households and families” into separate boxes. Neither paid work nor domestic work feature among the things explicitly mentioned in the analysis of health factors.

The following review is confined to a small number of EU countries.

Spain’s Instituto de la Mujer has a website database on “figures on women”68, but in the areas of concern to this study, the information it holds is all-but unusable. None of the health data include information on working conditions or social differences. Most of it relates to “lifestyle choices” - smoking, drug overdose deaths, teenage abortions, etc. - presented as not work-related in any way. There is nothing on social inequalities among women and men. Paid work falls under the heading “employment” with the usual statistics on labour force participation, employment and unemployment rates, data on pay, and a few figures on job segregation. But there is nothing about working conditions and their health impacts. Finally, no linkage is made between indicators on unpaid work (dealt with under the heading “family”) and paid work, or between unpaid work and health.

Belgium has made big efforts to systematize the development of gendered statistics. The first report published (MET, 2001) contains much data on both paid and unpaid work. Job segregation is consistently addressed. The health data, by contrast, are piecemeal and unusable to analyse social differences among men and women. The key indicators used (mortality, infant mortality, cancer, cardiovascular disease, suicide, road traffic accidents) are treated as independent variables unconnected with either gender-specific social inequalities or working conditions.

The scarcity of data is understandable in countries whose occupational health statistics largely disregard the gender dimension, but it is surprising to find it also in countries that do compile such data. It is as if they were seen as secondary to the development of synoptic data that are assumed to provide the key health equality indicators. Finland - an EU country whose occupational health statistics incorporate the gender dimension across the board - is a good case in point. The book Women and Men in Finland - 2001 contains more than 100 statistical tables split into 10 categories. None of them relates to the allocation of unpaid work or its potential connections with occupational health or other conditions of paid work. Fairly extensive statistics on paid work

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(31 tables) cover gendered job segregation by sector and occupation, the distribution of non-standard forms of work (part-time, fixed contract), labour force participation rates for paid work by family size, and three occupational health indicators (work accidents, violence at work, physical workload). By contrast, the “health” category focuses on individual lifestyles as determinants, considering four indicators - diet, drinking, smoking and physical exercise. There are no data on social health gaps among men and women, nor the relationships between paid work, unpaid work and health.

A much more systematic mainstreaming of health inequality issues across equality indicators could be informative in various ways:

• By helping to show how far health undermined by the dual constraints of paid and unpaid work itself becomes an obstacle to equality. For example, female employment rates above age 50 or 55 are commonly low, but little is known about why. How compatible are workloads with poor health?
• It would make patriarchal violence more visible across all spheres of life (in the family, at work, in towns, etc.).
• It would give a better purchase on the production of intra-gender social inequalities.
Data collection requires a theoretical framework, which depends partly on research and partly on the scientific community’s receptiveness to issues put on the agenda by social movements. The dynamic of women’s studies exemplifies this interaction between the input of militant feminism through a vast number of wide-ranging demand-based claims, and the challenges to traditional methods of knowledge production by a segment of the scientific community. Likewise, the sociology of work involves a commitment by researchers to ally with the labour movement, actively listen and learn in the school of labour struggles.

An examination of occupational health research rapidly brings one to a surprising conclusion. Few researchers, whatever their field of work, deny that significant gender differentials exist in working conditions and their health impacts. Some may focus on inescapable specific biological differences. Most will rightly stress that social differences play a more fundamental role. But this recognition of the gender division of labour as a fact is seldom taken forward into the development of an analytic model and methodologies.

Occupational health research extends across many different fields - toxicology, epidemiology, other areas of medical research, ergonomics, psychology, sociology, etc. The studies in most of these fields tend to focus on populations of male or predominantly male workers. Even now, female workers are still apt to be marginalized.

But this quantitative aspect is certainly far from the only issue. While recent years have seen a rise in the number of female workforces studied by occupational health research, that has not *per se* en-gendered the research base. This can easily be seen from male workforces which, while dominating research in total numbers, are very rarely analysed through the gender prism.

This issue ties into the way in which workers are considered by research. As a set of bodies subject to the effects of work? As socially positioned and developed bodies that talk, think, have
feelings and lead an existence which goes beyond the bounds of work production activity even when at work?

The following notes aim to inquire more closely into some aspects of this assessment, but represent only preliminary jottings, as it were, for the more extensive debate that is needed.

**Largely peripheral research**

Most responses received to the questionnaire dealt far more with research than practical actions. There is a lag in all areas between the development of knowledge and action to bring about practical changes. The lag in occupational health is even longer if prevention is likely to challenge the employer’s authority in the firm or affect profits.

The difficult transition to practice is arguably made worse here by an additional factor. Research into the gender dimension in occupational health is apt to be “peripheral” to the institutions that are traditionally most active. Broadly, different trends can be identified:

- Attempts to integrate the gender dimension into the general research programme of public occupational health institutions. So far, only the Nordic countries seem to have progressed in that direction.
- A bigger focus on women in research into specific risks. This is being done by the British HSE, and is starting to be done in other institutions (especially on issues related to stress and musculoskeletal disorders). Commendable development though this be, there is a risk of creating new stereotypes. Some so-called emergent risks may be specific to female work; most of the so-called traditional risks are not.
- A bigger focus on some highly female-dominated sectors. Nursing is a significant case in point. The industrial strife that has riven the sector, real recruitment problems in different countries, and high early exit levels have put an unaccustomed focus on this female workforce. Other sectors, by contrast, remain broadly overlooked. There is only limited European research on teachers’ occupational health, little on women textile industry and motor vehicle subcontracting workers, and virtually nil on domestic cleaners.
- Most research comes out of institutions that are less “mainstream” than occupational health research bodies (sociology of work or sociology of health research bodies) or from collective initiatives of organizations and individuals that engage with prevention policies but do not necessarily have
substantial institutional backing (trade unions, groupings of occupational health doctors or ergonomists).

The premise that much research comes from outside the main occupational health research institutions is largely borne out by the work of the three world congresses on “Women, Health, and Work” held in Barcelona in April 1996, in Rio-de-Janeiro in September 1999 and Stockholm in June 2002. The input of specialized occupational health research institutions to all these was marginal and originated in a handful of countries.

The limited integration of the gender dimension by the main occupational health institutions has different consequences, most immediately apparent of which is the distribution of fields of study.

Gendered research into occupational safety is exceptional, and little of it includes women. A keyword search (women, gender, female, male) on the “Safety Science” magazine’s website covering a period of 13 years from 1991 to 2003 turned up two articles analysing the gender dimension as such, 3 on exclusively female populations, and a further 23 that included gender among other variables like age or occupation. In most cases, it was a fairly secondary descriptive variable included in the statistical tables but serving no real analytical purpose. Significantly, the only articles to address the gender dimension or exclusively female populations came from two countries/regions: Sweden and Quebec.

Likewise the literature on chemical hazards, except in one area, that of reproductive risks (which results in a distortion with serious consequences in terms of prevention policies). Biomedical epidemiology of workplace risks also glosses over female workforces, partly reinforcing the stereotype that chemical hazards mainly affect men. Here, the tendency to extreme specialization by including women in only a handful of reserved areas (studies on stress, biological risks in hospitals, violence, etc.) does nothing to break with the dominant stereotypes. Ergonomics comes at the situation from a different angle. A growing number of ergonomic studies are focusing on female-dominated workforces, helped on by the big focus put on musculoskeletal disorders. By and large, however, women remain treated as a demographic variable supplemented by the odd anthropometric and biomechanical consideration (for a review of ergonomic interventions, see Messing, 1999).

Granted, these are just broad trends, and exceptions abound in all fields. So the question is - where do they come from, and what do they add?
The exceptions available for analysis came from four main sources:

- The sociology of work. Workplace health issues have been gradually brought into ongoing research on the gender division of labour.
- The sociology of health and social epidemiology. The starting point was the analysis of gender differentials in health, and a bigger focus was gradually put on work. To begin with, this was mainly employment as such. Later, working conditions became seen as an explanatory factor enabling a more forensic analysis of the health impact of paid work.
- Ergonomics, addressing a social demand by female workforces pursuing a gender agenda. These exceptions must not conceal the fact that, taken as a whole, ergonomics remains fairly un-engendered.
- Trade union surveys, mostly done among highly female-dominated workforces. Some surveys on broader population groups also address the gender dimension, but these are exceptions. This latter source will be analysed separately.

This breakdown between fields of study correlates in part to a breakdown between institutions. It is this aspect that is meant by the phrase “peripheral research”. Much of the most interesting research comes not from institutions involved with workplace health policies, but is either a response to grassroots demand, or forms part of a more general trend in gender studies or women’s studies in academic circles.

This situation is problematic in several respects:

- It restricts the scope for putting a multi-disciplinary approach into practice. The “hard core” of health and safety at work remains relatively impervious to an external input that would force it to question its own “work-related hazards”-centred approach.
- It restricts the impact on workplace health policies, which often look for tangible outcomes on simple indicators: a drop in fatal accidents or work accidents generally, tackling absenteeism or staffing problems in sectors with particularly onerous working conditions, steadily rising average age of withdrawal from employment, etc. Genderizing upsets the certainties about the policy options of the aims and the effectiveness of the measures taken.
- It restricts interaction between the different prevention practitioners operating in workplaces and the minority in the research community trying to introduce a gender perspective. This is compounded by under-socialization of the preventive
services and the many policy uncertainties surrounding their activities (Vogel, 2003).

- It deprives women workers of a place where their real experience will be addressed when they raise traditionally disregarded occupational health issues. The situation with sexual harassment is informative. In most cases, occupational health services as they have developed in EU countries have sidestepped the issue, often by creating new bodies like “complaint resolution officers”, and specific mediation procedures, thereby reducing a working conditions problem to an interpersonal conflict level (Vogel, 2002). The immediate response to a Barcelona hospital staff’s complaints about multiple symptoms of pesticide exposure was to brand them as “mass hysteria”. It took three years of relentless pushing from the trade union to get the problem looked at (Torada, 2001).

What keeps the research peripheral?
- The decision to conduct occupational health research has always been largely driven by social demand which, in most cases, is “filtered” through occupational health institutions. Where these institutions depend on the established compensation systems (e.g., the INRS in France and BIA in Germany), their priorities tend to be set by reference to the visible cost of health damage to these systems. The occupational health institutions have generally been relatively impervious to the gender dimension, the only exception for the past ten-odd years being those in the Nordic countries.
- The research itself is marked by a lack of cross-over between policies. So, while there is a large body of research into job segregation, there are very few studies linking it to workplace health issues. There is copious literature on the obstacles to women breaking into certain occupations in the new information technologies sector. But often, these do not address the working conditions, which may be more exclusionary for women than for men (in particular, extreme deregulation of working time organization). Detailed “time budget” surveys have been done in many countries, describing the allocation of time to different activities from a gender perspective. But most do not forge the link with working conditions to analyse how they can be exclusionary and/or damaging to health by standing in the way of work/life balance strategies.
- Arguably, there are relatively few practical outlets for gendered occupational health research, largely because it raises issues outside the traditional limits of preventive occupational health policies. But this situation is not impervious to change, as the CINBIOSE experience in Quebec shows.
There is a sort of inhibition about research which it is felt will clearly force prevention operators to “think outside the box”.

**The many dimensions of gender**

The responses to the questionnaires reveal a very wide range of interpretations of what the gender dimension means for occupational health research.

For some, the gender dimension was addressed simply where the research population included a significant proportion of women, so any research into nurses or women textile industry workers was regarded as exploring the gender dimension. Others thought it required at least a consideration and comparison of two groups - male and female - in analysing the problem. What both approaches have in common is that neither puts the question of exactly why it is women who are mostly nurses or supermarket check-out staff, and building sites and police stations are mainly male bastions. It is as if the gender division of labour were a mildly regrettable but inescapable fact with no health impact in and of itself. In such an approach, the health impact of work is mainly seen in terms of specific risks. Nurses lift patients, are exposed to chemical agents and contagious diseases, risk slipping in buildings that are inappropriate to their work, etc. while building workers may fall off scaffolding, are exposed to other chemical agents, lift bags of cement, etc. But health development is not just a simple response to different attacks. It comes out of a dynamic clash between factors of harm and defence mechanisms that are developed as much out of the factors of harm as the individual’s expectations, which are themselves social constructs. Injuries and disorders arise when a sudden or major upset occurs in the balance, when the individual is unable to marshal the resources needed to restore the dynamic balance of health maintenance. From that point of view, the fact that women are more often check-out staff than building workers has a relevance that goes beyond simply establishing that they are differently exposed to occupation-specific risks.

At another level, there is an added requirement that the problem should encompass issues that concern women only or mostly. So, many responses reported research into reproductive health, sexual harassment or bullying, or work-life balance. That female workforces are given more central consideration than in the past is certainly positive, but the regeneration of
new stereotypes prompts fresh misgivings. The word “gender” is polysemous. It is a polysemy that goes far beyond the dictionary meanings, and also reflects a political ambiguity. The word “gender” nowadays can be coded language for women’s issues, signifying that some of the feminist analysis (on the invisibility of women) has been taken on board, but no consequences have been drawn from it.

Other research goes much further, focussing on the linkages between the organization of paid work and more overall social determinants. In particular, they look at how paid work interfaces with (and in the case of women, is often shaped by) unpaid work. They also focus on the social construction of maleness (or manliness) and femaleness both in and out of the workplace. In this respect, a research study can perfectly well include the gender dimension in the study of an exclusively male population (See Molinier, 1997 and Kjellberg, Men are also gendered, in Kilborn et al. 1998, pp. 279-307).

The semantic field used to describe the research evidences certain tensions. In most of the responses received, “the gender dimension” was virtually equated with “women’s place”. By contrast, the phrase “feminist research” was almost entirely absent. The only exceptions were Spain and Italy, but, even there, it was exceptional (Carrasco, 2001; Tempia, 1993). There is a potential upside to equating the gender dimension with “women’s issues”. By designating the gender that is subjected to a relationship of domination, it can lead to a recognition of that gender’s demands. It can be developed out of the input of women’s experience as the basis for a critique of the existing situation. But these are only possibilities. Identifying gender with women’s issues can, from another standpoint, mutate into a conservative agenda where the essence of gender relations is seen as a more or less unchangeable given, and occupational health is addressed within the confines of that constraint. It is, for example, an ambiguity that characterizes much research into work-life balance.

Conversely, the systematic use of the word “gender” can also reflect two opposing dynamics. “Gender” can just become a way of differentiating two groups of human beings without designating a specific relationship of domination. For example, studies on job segregation may contain a false symmetry in the concept of “under-represented gender”. The meaning of this concept is profoundly equivocal. The real experience of men in a male job is profoundly different from that of women in a female job. Also, the pressure for gender balance comes mainly from women (Fortino, 2002).
In most areas, a cycle can be seen going from feminist studies to women’s studies, and occasionally leading to “gender studies”. This cycle reflects at once a closer inquiry into, and to some degree a neutralization of, issues raised by feminist movements, a fracture in the unity between research, struggles and blueprints for societal change.

The problem in occupational health is that the basic corpus of feminist studies is not very large. As a result, occupational health has often been only a peripheral or tangential consideration in women’s studies (see box below). This can influence the way in which contemporary gender analyses are undertaken. This is not a purely academic question, as can be illustrated by the issue of part-time work, for example. For a section of the research community, “the scale of unpaid work among women means that part-time work can be an appropriate response to the problems of work-life balance”. Another section, more firmly-rooted in the feminist tradition of attacking inequalities, stresses how part-time work introduces one of the key methods of segregation in paid work.

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**Occupational health, women’s studies and feminist publications**

In the 1970s, a wave of labour disputes by women workers regularly put working conditions and their health impacts on the pages of the feminist press. The *Cahiers du GRIF* (a French language feminist magazine published in Belgium from 1974), for example, regularly covered these issues, giving prominence to workers' personal stories and analyses of industrial actions. In 1976, the magazine published a special issue on work and health *Le travail, c'est la santé*, following on from two other special issues on domestic work (*Faire le ménage, c'est travailler*) and the extraordinary empowerment represented by the strikes of women challenging their working conditions (*Faire la grève, faire la fête*). More than the editors’ own agendas, this can probably be put down to the shockwaves that the strikes of women workers in Belgium’s national ordnance manufacturer, the Herstal-based Fabrique Nationale d’Armes, in 1966 and 1974 (Coenen, 1991; Denis, Van Rokeghem, 1992) sent throughout Belgium (and, to a lesser extent, neighbouring countries). The first strike was mainly about equal pay, but also against the repetitive work done by “robot women”, and the very poor working conditions (noise, dirt, work accidents). The second strike was more directly against working conditions, and for women’s access to traditionally male jobs.

Keyword research among the issues of the *Women’s Studies International Forum* magazine for the period 1982-2003 held on the Elsevier publisher’s website - approximately 120 issues in all - returned:

- 43 articles with links to the word “health”, 3 of which mainly addressed the relationships between paid work and health.
- 51 articles with links to the word “workers”, 2 of which mainly addressed the relationships between paid work and health. Both articles had already been referenced in the previous selection.
Keywords for specific health problems returned little additional material. Of three articles returned with the word “hazards”, two were about paid work, and one had already been returned under the “health” search. The word “cancer” returned 7 articles, none of which dealt with paid work. The word “reproductive” returned 39 articles none of which concerned paid work. The word “stress” returned 23 articles, 6 of which directly concerned paid work (3 new articles, 1 book review and 2 articles already returned for “health” and “workers”). The various keyword searches done for musculoskeletal disorders (“repetitive”, “musculoskeletal”, “strain injuries”) returned no results, any more than did “chemicals” and “chemical hazard”. The word “harassment” returned 10 articles, 5 of which concerned paid work: 2 new articles, 1 book review and 2 previously returned articles.

Keyword searches by occupation or industry segment (“textile”, “nurses”, “maquiladoras”, “migrant”, “agriculture”, “supermarket”, “teachers”) returned no new data.

That adds up to a total of 8 articles and 2 book reviews in a period of nearly 22 years.

A trawl through the issues of the magazine *Women's Health Issues* published between 1995 and 2002 returned only one general article of relevance to this research study (Mead, 2001). Keyword searches by occupation and risk returned few results: no occupations in industry or agriculture, five articles on women soldiers, one article on nurses, no articles on black or migrant women workers.

The “Mujeres y Salud” (women and health) website is an innovative venture. It is an electronic journal containing leading articles, practical advice and a discussion forum covering all health-related topics: paid work, domestic work, sexual life, reproduction. The site was set up in 1997 by the Barcelona-based CAPS (Centro de Análisis y Programas Sanitarios) after the international Congress on “Women, Work and Health” and forms a continuum with what the feminist movement in Catalonia has been doing. Health issues have been on its agenda since the 1970s. Activism (focused at the time on the fight for the legalization of abortion) has always been combined with discussions on women’s own experiences as basis of for a critique of conventional ideas about health (Cervera, 2003).

Scrutiny of the synopses of the magazine *Nouvelles questions féministes* (issues published between 1981 and 2003) returned a smattering of articles, mostly dealing with physical or psychological violence and maternity.

The magazine *Chronique Féministe* (published by the Women’s University in Belgium) has published a number of more substantial articles on paid work and taken a more systematic approach to workplace health issues (especially in special issues on nursing, night work and occupational health).

The French magazine *Les Cahiers du MAGE* which changed title in 1999 to *Travail, genre et sociétés* (work, gender and societies) has regularly addressed workplace health issues and has been an invaluable source for this study.

The Spanish newspaper *Trabajadora* stands apart as being a feminist trade union publication. Every issue consulted contained articles dealing with workplace health issues.
The issue of time use was very high on the Italian feminist research agenda throughout the 1990s (see, in particular, Tempia, 1993). There have been some systematic studies of associated work-related health issues (see, in particular, Corradi, 1991). Other Latin countries have also helped inform the debate (for Portugal, see Perista, 1999). In Spain, Carrasco (2001) considerably widened the debate, raising fundamental issues about the linkages between different human activities. This thinking met with a response in feminist trade unionism.


b. Although the word “feminist” only rarely appears in its columns, reflecting the uneasy and often adversarial relationship between trade unionism and feminism. As far as could be ascertained, there is no feminist trade union press (or even specifically women's trade union journals) in most other European countries. The journal Antoinette published by the CGT in France in the 1970s early '80s is a notable exception.

The example of epidemiology

“If the biological finality of death can only be explained in a wider social context then the complex realities of women’s sickness and health must be explored in similar ways. In order to do this, traditional epidemiological methods have to be turned on their head. Instead of identifying diseases and then searching for a cause, we need to begin by identifying the major areas of activity that constitute women’s lives. We can then go on to analyse the impact of these activities on their health and well-being.”

Leslie Doyal (1995, p. 21)

Epidemiology plays a key role in occupational health research as an essential basis for preventive activities and policy-making alike. It is therefore relevant to consider how the gender dimension is addressed in epidemiology.

A quantitative conclusion first. Few replies to the questionnaires mentioned epidemiological research, with a few notable exceptions that reveal major new ground being opened-up by some epidemiological research. These include:

- a series of studies on the nursing profession reported by a nursing union in Denmark;
- a highly detailed reply from the Health and Safety Executive in the United Kingdom referencing various epidemiological research studies that include the gender dimension;
- a Portuguese reply referring to a major study on reproductive health;
- a detailed bibliographical overview supplied by the institutes of occupational health in Finland and Sweden.
The limited epidemiological resources available for gender analysis call forth two questions. How does epidemiology need to develop in order to more precisely address the issues raised by the gender health gap? What contribution can epidemiology make to an overall analysis of the gender dimension in occupational health? Put in different and more challenging terms, the question is about the inherent limits there may be to the knowledge produced by epidemiology and the need to supplement it by contributions from other fields of study.

The debate on epidemiology and occupational health has been rumbling on for at least twenty years (Goldberg, 1982 and 2002; Williams, 2003). What conditions are needed for the development of a social epidemiology that accommodates the maintaining of health within the complex framework of social relations? The conditions may be internal (definition of a methodology, analytical frameworks, coherent definition of confounding variables, etc.) or external (related in particular to research funding, the independence of researchers and their agendas, the evaluation criteria of research committees and refereed journals, etc.). Only more recently have issues directly related to gender inequalities begun to be aired (Messing, 1998-a; Inhorn and Whittle, 2001).

A detailed review of the epidemiological research was far beyond the scope of this research and the author’s abilities. The starting premise was a counterintuitive finding:

- Most of the epidemiological research originating with occupational health institutions has no gender dimension or at best deals with it as a simple objective demographic variable (Messing, 1998-a, gives the most comprehensive summary on this). The obstacle that the institutional framework may create explains only part of the problem.
- Research developed within the wider framework of social epidemiology places much more focus on the gender dimension (as the bibliography of this book shows), but is arguably an insufficient basis for an overall analysis of the gender perspective in the workplace and occupational health (Inhorn and Whittle, 2001).

The results of a Finnish survey provide a useful preface to the discussion.

A Finnish survey

Nurminen and Karjalainen (2001) estimated the proportion of adult deaths related to occupational factors in Finland. They reviewed 340 epidemiological studies published in English-
speaking refereed journals dealing with industrial countries, in order to extrapolate the data obtained to the Finnish population. 50 cause-of-death diseases were examined and, for each disease, the authors examined different work-related factors for which epidemiological data were available. These data were used to calculate the share of deaths related to the occupational factor studied. The authors calculated the distribution of workers between branches of industry, and used a job-exposure matrix\(^{70}\) to calculate the attributable fraction of work-related mortality in total deaths in the adult population\(^{71}\). To its very great credit, this work adds to the sum of knowledge about the impact of working conditions on social mortality inequalities. It bears out the general trend observed in all industrial countries: that mortality from work-related diseases (especially cancers) is very much higher than work accident fatalities, as reported in studies on the United States (Leigh \textit{et al.}, 1997; Steenland, 2003), Canada (Kraut, 1994), Australia (Kerr, 1993) and Switzerland (Conne-Perréard, 2001).

The aggregate data are as follows. From available epidemiological studies, the attributable fraction of work-related mortality can be estimated at 6.7\% of deaths for the diseases and age categories covered by the adult survey. Disaggregated by gender, the gap is vast: 10.2\% for males and 2.1\% for females. Compared to general mortality (all cause-of-death and age categories together) the estimated percentage was 4\%. That amounts to an estimated total of 1,800 deaths attributable to working conditions in 1996 for a working population of 2.1 million people. 86\% of these were male deaths.

A gap of this order raises various questions. The authors did not set out to assess the quality of the epidemiological research from a gender perspective. They conducted a forensic analysis of what had been published in refereed journals. For almost all diseases, they strove to differentiate between male and female attributable work-related mortality\(^{72}\). The only diseases for which such a distinction was clearly meaningless were gender-specific diseases (e.g., prostate cancer for men, cervical cancer for women). It is clear from the aggregate data by category of disease that in the overwhelming majority of cases, existing studies produce significantly higher estimates of male mortality. Only three “non-specific” diseases stand apart from this trend: asthma, with a very slightly higher percentage of work-related mortality among women (18.4\% against 17.8\%), liver cancer, where the difference is more pronounced (5.3\% against 3.5\%), and infectious diseases, where the gap is highly significant (32.5\% against 4.8\%). There is a very simple explanation

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70. Finland is one of the few countries to collect systematic data on occupational exposure, which is kept in centralized job exposure registers. For an inter-country comparison, see NOHSC (2002).

71. In most cases, the authors chose to calculate mortality among adults aged 25 to 75.

72. This displays a commendable concern for transparency. Other similar studies take a much less explicit approach to disaggregating male and female mortality. This is a failing discernible in Steenland (2003) for the United States, where the summary table shows only male deaths from cancer of the skin, larynx, kidney or liver attributable to an occupational exposure. In each case, there is an explanatory sentence: “Exposures were assumed to occur primarily among men”. The study does not consider breast cancer.
for this latter category: an overwhelming majority of health sector and social services workers are women, and these are the sectors with the highest incidences of occupational exposure to such diseases.

Applying a gender analysis to these data involves looking at different limits, including:

• The differential fractions of mortality attributable to work-related causes derive from just a handful of specific case studies that evaluated men and women separately (or separate studies on males and females). Two studies on the relationship between shift work and the risk of cardiac problems are a case in point. By far most studies are on “ungendered” workers. In a short dozen of cases, they are expressly stated to cover males only, and no females-only study seems locatable. In all these cases, gender-differential estimates can only derive from the difference between the number of men and women working in occupations or sectors for which the exposure is known. Any gender-differential effects of the exposures cannot be included in the calculation.

• Estimates are heavily reliant on what is known about occupational exposures in different branches of industry. Very patchy health surveillance and inappropriate methodologies for “en-gendering” it probably result in an under-estimation of occupational exposures in many female jobs.

• Overall estimates clearly depend on which possible causes of death are sought in epidemiological research. For example, only very recently has a possible correlation been looked for between breast cancer and night work (Swerdlow, 2003). Based on the literature review in the Finnish study, night work is not included in the estimate of deaths from breast cancer. Likewise, a correlation between breast cancer and agricultural pesticide use (Brophy et al., 2002) is not in the frame.

The existing studies did not permit of a more forensic estimate of gender differentials. Arguably, Nurminen and Karjalainen’s study (2001) also has the merit of enabling a critical approach to the way in which epidemiology addresses the social determinants of health. All the research used as the basis of the study identifies risk factors and specific diseases. This is not a method that can allow for mortality causes in terms of combinations of diseases or factors, nor the total share of work-related physical and mental wear and tear in male and female mortality, still less calculating the impact of median effect exposures on deaths from non-specific diseases. Many work-related factors result in health damage which is not itself fatal. In some cases, these may not be diseases proper (e.g., immunodeficiency, tranquiliser use...
or smoking). As a result, the causality model by which to work from a work-related factor (or combination of factors) to a cause of death only very partially accounts for the overall dynamic of health maintenance. For example, a research study on shift work by women workers in the food industry (cited by Weddeburn, 2000, p. 30), reports that over a third of women workers covered by the study took tranquillisers. This very high level of consumption was associated with chronic anxiety and depression. Another study on hospital nursing staff (cited by Weddeburn, 2000, p. 30) makes the same finding on tranquiliser use, but with a gender-differential: 10.2% of female nurses against 6.1% of male nurses. Tranquiliser use is an infrequent immediate cause of death, and deaths in which anxiety and depression are the immediate cause are certainly few and far between. On the other hand, thought should be given to the possibility that heavy tranquiliser use may contribute to undermine an individual’s general health, and thereby be a probable explanatory factor in some of the social inequalities in health caused by poor working conditions. Where smoking is concerned, the situation is often worse: many studies adjust data so as accommodate “hard data” on the survey population. Adjustment for what are regarded as variables extraneous to the issue obviously depends on the researcher’s conception of occupational health. “Lifestyle factors” like smoking may also often be involved with working conditions. So, night workers and those in highly stressful jobs smoke more than average. To that extent, smoking may be a defensive strategy for the maintenance of health, although probably a risky one. But there is a valid point in showing that scientific objectivity in comparing a specific group to an average ideal population is itself shaped by moral values and social stereotypes. An evaluation of the links between musculoskeletal disorders and manual handling would be unlikely to treat the use of anti-inflammatories as a “lifestyle factor”. Adjusting percentages to an abstract average population often means disregarding a significant number of the ways in which working conditions can shape health.

What knowledge for what public health policy? Considerations for a debate

The Finnish review examined above shows the current limits to epidemiological production when seen through a gender prism.

Some of these limitations could be overcome by a set of changes that would not affect the general framework of that research.
They include:
• improving knowledge of men and women’s respective exposures to work-related risk factors;
• separate studies of groups of men and women;
• more comprehensive coverage of a range of workforces so as to take account of highly female-dominated sectors;
• widening the scope of the ailments examined and hypothesized causal factors.

While these are methodological changes, the conditions for achieving them in all cases probably go beyond that. The independence of researchers, their relationships with the workers of both genders, their ability to go beyond social conditioning, etc., are all key elements in achieving change.

This would result in a gender-sensitive epidemiology of work-related risks, which would be a net gain by giving a more closely detailed scientific basis to prevention policies.

That said, it is open to discussion whether such changes are enough for a gender analysis of occupational health. This is a long-standing debate which in different guises has punctuated the history of epidemiology (see, in particular, Frohlich, 2001 on John Snow and the 1854 cholera epidemic in London; Popay and Williams, 1996; Inhorn and Whittle, 2001 for a more specifically feminist critique; Goldberg, 1982 and 2002). The birth of epidemiology accompanied a groundswell of action for social reforms, and this initial prompting has never completely gone from what drives some in the epidemiological research community. More than a matter of personal beliefs, it has formed the basis of some professional practices. It has remained a dynamic factor for challenging other practices seen as at variance with the aims of health protection. The contributions of Alice Hamilton in the United States (Hepler, 2000) and Alice Stewart in Britain (Greene and Caldicott, 1999), are cases in point. A commitment to improving society and responsive listening to women workers’ experiences gave them the ability to challenge the certainties of their “peers”. But step changes towards three distinct disciplinary fields were clear to see:
• Biomedical risk epidemiology. This is the predominant discipline in the occupational health field, to the extent that it is normally referred to just as “epidemiology” without a qualifying adjective. And for many, it is simply epidemiology. Through it, the causal links between some diseases and exposure factors can be highlighted. Its main focus is on quantitative analysis techniques. By contrast, the assumptions underlying distribution of the facts (between risks,
confounding variables, demographic data, health impacts) are less systematically discussed.

- Social epidemiology, which argues that aggregation of exposures to different risks alone cannot account for social inequalities in health. Its favoured territory is less specific risks than batteries of indicators by which to study the general health of a specific population in terms of social inequalities. Here, self-assessment of health and living conditions can be a recognized source of knowledge no less legitimate or relevant than measurements made by experts.

- Health sociology which aims to provide more systematized explanations of the links between social relations and health. The focus of research for long centred almost exclusively on class relations, shifting slightly later to include gender relations and ethnicity, the latter especially in countries like the United States and Brazil. Ethnicity research here was into methods of organizing society in which slavery played a fundamental role. The divisions that are the legacy of the slavery era continue to mark society in significant ways. In western Europe, the presence of an immigrant population whose origins often lie in the old colonial territories is what has brought ethnic relations into the equation.

The dividing lines between the three disciplines are not fixed. Some social epidemiology research also overlaps into risk epidemiology, and has significantly informed health sociology. Even so, a critical look at the attempted generalizations by which biomedical risk epidemiology can analyse social inequalities in health reveals how different the issues involved can be.

Efforts made by researchers like Nurminen and Karjalainen (2001), Conne-Perréard (2001) or Steenland (2003) have a real political value, and cannot but give an impetus to attempts to forge the link between occupational and public health. They show that actual mortality attributable to working conditions is very significantly higher than might be inferred from fatal accident statistics alone. They also have a use in relation to current methods of policy legitimation, where values, blueprints for society, criticism of how things are, are dismissed as ideology. Statistics, economic calculation and risk assessments are claimed as guarantees of sound “governance” (to use today’s euphemistic buzzword for the machinery of the exercise of power). Above all, they reflect a glaring omission: no proper multi-disciplinary science of the social inequalities of health has yet been developed (see Graham 2002). This omission creates discontinuity and often inconsistencies in public health policies (Whitehead, 1998, demonstrates these discontinuities.
in three countries: the United Kingdom, Sweden and the Netherlands).

R. Chauvin puts the situation thus: “Inequalities of health are today known and analysed in France just as in most industrial countries. However, whether the focus of study be mortality, morbidity, individuals’ lifestyles, the way they treat their health, or their consumption of care, the available social indicators used for comparison - social status category, income bracket, educational level, membership of a welfare category (minimum income guarantee claimant, unemployed on benefit, etc.) - only give a rough-and-ready account of the individual’s social and economic position, and an even poorer one of their living conditions. The limitation of these approaches is that they remain essentially descriptive. They tell us little about the causes that lead people to these adverse health situations or, at a collective level, the “new” social determinants and risks, i.e., the new forms of vulnerability and social and health insecurity”. Shim (2002) conceptualizes the routinized inclusion of race, socioeconomic status and gender in epidemiological studies on chronic diseases as a “black box”. She argues that the general recognition of a link between disease and social and economic, racial or gender factors adds nothing to an understanding of the real mechanisms. How do these factors worsen inequalities?

Arguably, two things are particularly important to a better understanding of social inequalities in health which incorporates gender relations and working conditions.

Working across boundaries

The unity of the subject - how work affects people’s health - is fragmented between the different fields of study, each with its own individual take on the matter, but also between the different issues addressed (working time, mental health and work, work-related illnesses, linkage between paid work and unpaid work, etc.). Genderizing the analysis requires both interdisciplinarity and cross-fertilization between the issues addressed. This is what prompted Eleonora Menicucci (1997) to write of the need for a “cross-cutting approach” that goes beyond an analysis of work risks to focus in particular on the interplay of the domestic and work spheres.

Interdisciplinarity is particularly important to forging the link between non-standardized data. Because they derive from different disciplines, the various concepts involved in occupational
health are not immediately usable for a decontextualized overall analysis. Groundwork needs to be done to infuse these concepts with meaning. Type of job, occupational category, industry segment are all fairly abstract classifications, useful for statistical purposes, but not enough to analyse a continuum in working and living conditions. Likewise the concepts of control, autonomy, authority, job segregation. An economist may reasonably argue that the cleaning of offices and factories is a gender-mixed activity if the workforce is observed to comprise approximately equal numbers of males and females. He can also compare pay levels and devise level-of-equality indicators. A lawyer will look at the employment contracts. A sociologist will doubtless add that the ethnic/immigrant origin of the individuals is an important consideration for understanding the real import of this gender balance. An ergonomist will show that men’s and women’s activities are far from being identical. Even where educational qualifications are identical, the real job content may be very different. A psychologist will argue that the meaning of cleaning work may vary with a number of factors, especially whether or not it perpetuates traditional family roles. A doctor will probably note health differentials. This very cursory example shows that a coherent analysis involves looking again at the same reality from its different angles. The prerequisite for such cooperation probably lies in a recognition of the unity of the subjects. That means that men and women workers stopping being simply the object of study, and their perceptions and viewpoints being recognized as sources of knowledge on an equal footing with expert knowledge.

Who asks the questions? Who answers them?

It is important to any review of occupational health research to know who is asking the questions. Karen Messing (1998-a) stresses how science may see only half the picture (in her book entitled One-Eyed Science). She point to researchers’ lack of interest in how working conditions may affect menstruation, when various surveys of female union reps in highly female-dominated sectors reveal this as a pressing concern among workers (interviews with activists from Spain’s labour committees in the ceramics industry, survey of female safety reps in Britain, etc.). Subjective experience - i.e. the individual and collective experiences of men and women workers - is largely ignored when framing the questions for occupational health research. Herein lies a real problem with defining social demand which is partly connected with the way the “big institutional commissioning agencies” operate. Employers are constantly
looking to dictate their activities through joint or tripartite mechanisms that allow them to wield a sort of veto. This leads to a blurring of lines between those who evaluate the risks and those who manage them and, most often, create them\textsuperscript{80}. The debate on the connection between the relevance of the questions asked and workers’ direct experiences is very persuasively addressed by Laura Corradi’s (1991) remarkable book on night work in the Barilla group’s factories in Italy.

80. On this, see in particular INRS (2003).
Chapter 5
Lay knowledge challenging lofty science: trade union surveys

One of the key sources of knowledge for this survey was trade union surveys on working conditions. “Trade union surveys” here refers to a wide set of investigations that include surveys done by trade unions themselves plus what might be described as “trade union-related” surveys commissioned by trade unions or done collaboratively with them by research centres within or with close links to the trade union movement. In some cases, institutional bodies (universities, occupational health institutes, etc.) work under a cooperation programme with trade unions, but this is not common practice.

Trade union activity is not a scientific discipline. It produces knowledge for action. The validity of that knowledge depends not on scientific criteria of legitimation, but upon its ability to provide the foundations of a collective consciousness, to get concerted action going and bring about changes in working conditions. And the status of that knowledge is itself the focus of a conflict. Its mere existence challenges the traditional division of labour. It deconstructs the myth of a manual work/brain work antinomy to justify inequalities. It shows that direct experience of working conditions can give rise to radical criticism of them.

The scientific literature uses varied terminology which reflects what may be a wide range of attitudes to this type of knowledge, from mistrust of its subjective and activist dimensions to a real like-mindedness, from attempts to use it as raw data to an acceptance of its equal comparability with expert knowledge. Keith et al. (2002) present an interesting review of examples of “barefoot research”, alluding to the health auxiliaries sent out into the Chinese countryside during the 1960s known as “barefoot doctors” (the name was later revoked in the general restoration of privilege during the 1980s). Michel Callon (INRS, 2003, pp. 77 et seq.) commends “open-air research” and examines the links between it and “indoor research”. The reference here is more artistic than activist: it is drawn from Constable and the French Impressionists, who took their easels from their painting workshops into the outside world. Mostly, however, the references are to the supernal: lay knowledge is antithetic to the Science of professional experts (Popay, Williams, 1996).
Some of this antithesis stems from power relationships: much prevention practice and research is dictated by the employer’s interests (Lax, 1998). It is also due to the disparateness of collective activist knowledge compared to scientific disciplines. This is evidenced by a survey on collective perception of risks among men and women ceramics industry workers in Spain: “Unlike the usual terminological distinctions specific to the jargon of prevention techniques, workers’ spontaneous, collective assessment of work risks is generally expressed as a composite whole in which, for example, safety or health hazards are connected with specific forms of organization and are perceived as their physical expression in the form of health damage (...) In discussion groups where a less mediated collective perception of risks emerges, the workers talk about different problems and priorities to those identified by the technical experts. In particular, it is clear that workers attach importance to work organization-related health problems compared to the almost exclusive technical focus on safety issues and work accidents” (Boix et al., 2002, pp. 36-37). Antonio Grieco, who long headed the Milan occupational health institute, characterized the approaches of prevention technicians and workers as two different cultures: “There is a sort of dialectical relationship between these two cultures - which are original, discrete cultures (...) which have completely different experiences, instruments, ways of thinking, evaluation techniques, which do and must live together including when they clash, and which must work together. It is the clash of practical inputs - from their discrete experiences, using their respective instruments - that will produce insightful solutions” (cited by Carlos Aníbal Rodríguez in Boix et al., 2002, p. 6).

There is a very long tradition of worker surveys done directly from within the labour movement, best exemplified by Engels’ pioneering investigation of the condition of the working class in England (Engels, 1960 - written in 1843-44) which inspired a vast output in many countries. The feminist movement has also frequently relied on surveys which set the collective perception of women against conventional portrayals of social conditions (Doyal, 1995; Green, Caldicott, 1999). A notable example in the specific area of health is the British breast cancer mapping scheme, which collected the experiences of hundreds of women, asked to identify possible contributory factors of breast cancer in their local area82.

Significant differences are to be found between the two traditions83. Individual subjective experiences have tended to be overlooked in worker surveys done by labour organizations.

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82. See the site http://www.wen.org.uk/health/Mapping/index.htm.
The collective perception of groups regarded as cohorts has taken precedence. The “I” has tended to be overshadowed by the “we”. There was considerable disinclination to make the transition from what was seen as “public” towards what was seen as “private”. It was easier to deal with work accidents than mental illness, economic poverty than sexual poverty, police violence than domestic violence, memberships of political parties or trade unions than male chauvinism and racism. In the feminist tradition, by contrast, the standard barriers between “private” and “public” tends to be reversed, and life narratives can significantly express a collective experience without obliterating the individual subjective experience.

In occupational health, a strong renewed impetus was given to the worker survey tradition in Italy in the 1960s and 70s (Grieco, Bertazzi, 1997). In different ways, the emphasis on direct workforce management of work environment-related problems played a similar role in the Scandinavian countries. Risk assessment is also a political issue in trade union strategies, where the idea is to secure recognition for the relevance and validity of workers’ views as the basis for any improvements to working conditions (Boix, Vogel, 1999).

To some extent, environmentalism can create a more favourable framework, both for more recognition of activist worker surveys and a meeting of minds between feminism and labour demands (see New Solutions, 1999, on the role played by Barry Commoner in United States). Obviously, there is nothing to say that this will happen as a matter of course.

The defining features of the trade union surveys on the gender dimension in occupational health examined for this research are:

- They take the perceptions of men and women workers as the basis for analysing working conditions and their health impacts (on the central role of perception, see Boix et al., 2001). In most cases, the survey has been developed largely through a combination of rank-and-file activism and input from specialists like sociologists, statisticians, occupational health doctors and ergonomists.

- They generally use a multi-disciplinary methodology, and so cannot be pigeonholed as epidemiological studies, quantitative sociological surveys, etc. Even the concept of representativeness is quite different from that normally used in occupational health. A survey leading to industrial action is often the point at which institutional forms of representation (in bodies like health and safety committees) acquire

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84. Points of intersection between the feminist critique of the separation of the “public” and “private” spheres and the worker survey can be found in the autobiographical writings of activists like Flora Tristan, Louise Michel, Mother Jones and Emma Goldman. Most of these writings seem more forthcoming than the autobiographies of activists when dealing with “private life”. But this is far from being a general rule.


86. This is a set of general characteristics, not all of which necessarily recur in each survey.
real legitimacy for workers, when a shift occurs from simply mandating a rep to distilling the workforce’s experience and translating it into action.

- They aim to bring out factors which often are not seen in standard prevention practices, giving a different take on the facts of workplace life. Simply creating a space in which questions can arise out of pent-up social demand helps build a health protection strategy. Often, the “hidden face” of working conditions emerges, and with that, pain ceases to be suffered in individual isolation. FCT (2000) is a telling example of this. This Spanish trade union study on psychosocial risks in the broadcasting industry was done in response to a risk assessment by management of the RTVA broadcasting company, which it felt skirted around most of the risks that staff were most concerned about. Likewise, some trade union surveys highlight workers’ health concerns that are largely disregarded in most prevention practices: a Swiss survey in the graphic arts sector (Comedia, 2002) reveals that 36% of unskilled women workers complain of varicose veins (against 9% of their male colleagues).

- Most are locked into demand-based strategies. The survey procedure is central to the creation of leverage by developing a collective consciousness and working out claims. The feedback of survey findings is crucial in turning ideas into substantive power.

Broken down by country of origin, the surveys reveal a wide range of trade union practices. In many countries, integration of the gender dimension remains a vexed issue and otherwise relevant surveys completely gloss over this key aspect. In other cases, the gender dimension is addressed mainly as it relates to selected specific issues.

Some of the surveys examined for this research helped highlight matters largely sidelined by most prevention policies.

A two-stage survey on women’s occupational health in Tuscany was done by a voluntary organization “Ambiente e Lavoro Toscana” (Work and Environment in Tuscany - ALT) in collaboration with the CGIL trade union confederation’s women’s coordination committee and with support from the regional public health authorities. An initial survey of 230 workers in 12 different sectors (Massai, 2002) was done in 2000-2001, followed by a second survey in 2002-2003 (Arena, Valzania, 2003). Approximately 2000 questionnaires were distributed: 15% by post, 85% at meetings of groups of workers. 1,102 completed questionnaires were returned (72 of the postal questionnaires).

87. This was one of the main failings of the trade union survey on stress done by the Centrale Générale confederation in Belgium (see Kestelyn, Cahiers Marxistes, 2000) and the survey on flexible work done by the CGIL in Rome (Campo, 2003).

88. The CFDT’s very wide-ranging survey - “Le travail en question” (challenging work) - was carried out through a large number of trade union teams, interviewing some 80,000 workers between 1995 and 2001. The summary of the survey findings (CFDT, 2001) includes a systematic gender analysis of working time issues, but not of the other issues addressed (work intensity, management systems, recognition and meaningfulness of work).
The survey was done to inform a critical assessment of prevention policies. Leaving aside the questions linked to maternity, the ALT and trade unions started from the observation that risk assessments did not integrate the gender dimension.

The survey outcomes are interesting in several respects:

- They demonstrate the importance of a broader approach to reproductive health that is not confined to just maternity protection. The number of women workers reporting a loss of sex drive is almost identical to the number reporting sexual harassment (69 cases against 68), and at a comparable level to reported menstrual cycle changes (72 cases).

- When women workers are asked about the health risks of work, chemical risks have a markedly higher prevalence than generally estimated. 192 workers reported exposure to chemical risks (17%) and 180 exposure to carcinogens (16%). Although markedly lower than other reported risks (51% for stress, 32% for risks related to work on VDUs, 31% for air-conditioning, 29% for mental workload, etc.), these percentages are no less significant looked at against the sectoral distribution of workers covered by the survey - 18% work in industry, 3% in agriculture and 17% in the personal and social services - people working in sectors with a higher probability of such exposures. But 39% work in sectors where there is a lower ostensible probability of such exposure (shops, credit institutions, transport and communication, other services).

- The adverse health impact of working conditions is abundantly clear. 40% of the women workers report at least one work-related physical or mental health problem, with musculoskeletal disorders topping the list.

- The risks involved in unpaid domestic work are high. 48% of the respondents thought that safety in the home was a problem against 29% who did not, with 9% “don’t knows” and 13% non-responses. Paid work-related fatigue had caused an accident in the home for 40% of respondents; for 20% it had not, 17% did not know, and 23% did not answer. These data must be seen in relation to the significant volume of domestic work: for 35% of respondents, it exceeds 4 hours a day; for 32%, between 2 hours and 4 hours; for 25%, less than 2 hours (8% non-response rate).

- There is a striking gulf between workers and workplace preventive provision. A significant number of firms are flouting their legal obligations (according to the type of obligation, from 8% to 27% of workers surveyed reported that legal obligations had been breached). But the number of firms in which workers do not know what prevention provision has
been made is much higher (from 29% to 39% of respondents answered “Don't know” to the questions on preventive provision in their firm). Firms in which women workers are actively involved in putting a prevention policy into operation are an exception (only 17% of workers took part in a risk assessment). It should be borne in mind that the sample of responses means that firms with better-than-average conditions will be over-represented. Respondents had an above-average rate of trade union membership, higher educational level, and were more concentrated in the Florence metropolitan district. The preventive provision survey results are summarized in the table below.

<table>
<thead>
<tr>
<th>Table 10 : Preventive provision and worker participation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has a risk assessment been done?</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>35%</td>
</tr>
<tr>
<td>Were you involved in the risk assessment?</td>
</tr>
<tr>
<td>17%</td>
</tr>
<tr>
<td>Has a competent doctor* been appointed for the firm?</td>
</tr>
<tr>
<td>42%</td>
</tr>
<tr>
<td>Has a preventive service been set up in the firm?</td>
</tr>
<tr>
<td>40%</td>
</tr>
<tr>
<td>Are the regular safety meetings held?**</td>
</tr>
<tr>
<td>26%</td>
</tr>
</tbody>
</table>

* The “competent doctor” is Italy's equivalent of the occupational health doctor in other countries; appointment is compulsory.
** Regular safety meetings between the employer, preventive staff and workers' safety reps are compulsory. They are broadly equivalent to other countries’ health and safety committees.


- The survey findings paint a mixed picture of information about work-related risks. Most employers seem not to provide such information on a regular basis: 29% of respondents reported never being informed by the employer, 19% almost never, 25% sometimes, 10% often, 3% on an ongoing basis and 13% did not reply. But information was regarded as adequate by 60% of the workers questioned.

A hundred movements a minute - women or machines? An Italian survey on musculoskeletal disorders

The "Occupational Health Women's Group" of the three trade union confederations, CGIL, CISL and UIL of Milan, comprised of workers' safety reps, trade unionists, technicians and doctors from the public occupational risk prevention services, put together a research programme on the various aspects of women's occupational health with a special focus on ergonomics (DSL, 2000).

The working group got cooperation from the Cemoc, a specialized ergonomics centre working for the public preventive health service, to survey nine firms in different branches of industry employing female labour (food, metalworking,
mechanical engineering, industrial laundering, toy manufacture, data entry).

With no specific standards to refer to, an experimental working method was set up for the individual management of the workers’ safety reps involved in the project. They followed a half day’s training in the questionnaire-based collection of data on women’s self-assessed health disorders and damage, and on work organization issues that were important to risk analysis. The survey population was 380 women and 12 men.

The women workers gave particularly significant input. Relief at finally gaining recognition as human beings, and more specifically as women, produced a vivid outpouring of the many health problems they suffered and the stresses and strains of the way they had to use machinery.

Among the research findings were that:
- women workers can be put under particularly high gestural strain in terms of movement frequency, lack of breaks, uncomfortable positions, etc.;
- the upper limbs are the body part most directly affected, due to arm muscle, tendon and ligament overload;
- as well as carpal tunnel syndrome, shoulder tendinitis, lateral and medial epicondyilitis (tennis and golfer’s elbow), suffocation feelings, cervical radiculitis (spinal nerve root inflammation), etc. are very common.

The completed survey questionnaires were processed by Cemoc ergonomists, who identified the women in need of medical check-ups. There proved to be a serious problem in most of the survey firms, with very high gestural frequencies in some instances (from 40 to 60 actions per minute). In all, 29.7% of women workers had work-related disorders.

Other steps were taken:
- follow-up medical examinations were done;
- collective risk assessments were done;
- compensation and recognition as an occupational disease;
- a campaign was run to raise awareness among various circles (industrial groups, doctors, workers’ representatives).

The biggest problem remaining for the Occupational Health Women’s Group is to counter gender-stereotyped role sharing. The group is now bringing in other issues, like working hours, night work, etc., to highlight the fact that work-related risks are not gender-neutral.

A large number of Spanish trade union surveys address the gender dimension as a matter of course. Some are sectoral, like that on the Valencian footwear industry (San Miguel del Hoyo et al., 2000) or fruit and vegetable processing firms in the Valencian community (Mellado et al., 1997). Others, like the sexual harassment survey (Pernas et al., 2000), are issue-specific. One of the largest-scale surveys covers the various transport and communications allied sectors.
This survey (Martínez, Moreno Jiménez, 2001) is by far the most far-reaching. Its baseline is that occupational health in Spain remains benchmarked by male work. Also, changes in the production system are creating new risks. Increasing job insecurity is a particular factor that more consistently affects women. The survey had three main strands:

• analysis of risk factors;
• analysis of women’s work-related physical and mental health problems;
• developing preventive strategies to eliminate or reduce these health problems.

The main source of information and analysis was seven groups of workers (6 groups female only, one mixed) from different sectors and occupations. These workers’ experiences were compared against other sources (occupational health literature, labour force survey data and working conditions survey data).

The most salient aspects of the survey include:

• Examination of the health impact of working conditions cannot be divorced from a critical analysis of gender roles. The placing of unpaid work and paid work into separate boxes is challenged as unrealistic. As one respondent remarked: “(men) do a monotonous job, but women do two, because not only do they do a monotonous job day after day and so on, but they go straight home from work and carry on with an unpaid monotonous job there. They have to look after the home and the children, and the husband and the parents. That’s what’s gets me”. Another respondent comments: “the (men) at work split their life into separate boxes. So, when they’re doing one thing, they block out the other. That’s because for them, family life is already taken care of. In different ways, if they haven’t got a wife waiting at home that does everything for them, they’ve got a mother or they still live with their parents, or they aren’t as involved as us with family and home life”.
• The flexibility and irregularity of working hours emerges as a significant cause of stress. 75% of transport and communications industry workers are affected by some form of irregular working hours (split workdays, shift work, etc.).
• Unsuitable work equipment, personal protective equipment and sometimes work clothing is a frequently cited risk aggravation factor.
• Employing women in traditionally male occupations rarely results in real job desegregation. A postwoman reports that the afternoon postal delivery by van is done only by men.
• Employment in the entertainment industry is more often on the basis of looks than professional ability. A professional
dancer described television auditions: “they don’t take professional dancers, they take models who never learned to dance because they’re prettier, have flashier hairdos and bigger boobs, while trained dancers are out of work”.

- Work intensity and working in constrained positions are among the main factors of health damage. 33% of women workers reported fatigue-related accident risks. This contrasts with the commonly-held personal view among women workers that they are responsible for accidents due to over-confidence. This shows the value of comparing collective perceptions with individual perceptions which may carry a guilt-ridden view of “risk-taking”.

- Consumption of medicines (painkillers, anti-depressants, sleeping tablets, pick-me-ups, etc.) is high, involving 27% of female workers in the sector (against 15% of male workers). Self-medication often masks the severity of the health problem. Here again, there is a glaring contrast with the emphasis employers’ policies put on policing measures for illegal substances (drugs) and drinking.

The survey was followed up by a trade union campaign to frame claims for collective bargaining and feedback the survey outcomes to workers. A large-scale leafleting campaign was run, and a road show sent out to exhibit the findings around the country.


## Opposing perceptions of discrimination

Gender discrimination is treated as a health risk factor in a number of trade union surveys. And rightly so, for discrimination seldom has economic consequences alone. It devalues all aspects of work, undermines self-esteem, limits agency and the ability to be taken seriously.

A Swiss trade union survey in the graphic arts sector (Comedia, 2002) included the following question amongst others about health problems: “are women discriminated against?”. 33% of female workers replied “yes” against 5% of male workers. 67% of female workers replied “no” against 72% of male workers. The non-response rate was highly significant: all the women replied, but 23% of men did not. Responses could be accompanied by comments. The question of pay recurred most frequently. A number of women also reported that their views were less often heeded than those of men, they had fewer career advancement opportunities, or lacked the means to stand up for themselves against superiors. One woman wrote on her questionnaire: “The one thing you must never do is say “no” to the man working the machine”.
The gender workplace health gap in Europe
Part III

The policy situation
In *Remembrance of Things Past*, Proust’s narrator describes two walks he used to take with his family at Combray. Passing through the same places but observing them from a different perspective, he feels as though he is experiencing totally different universes. The narrator says of the two “ways” revealed by the walks: “I set between them, far more distinctly than the mere distance in miles and yards and inches which separated one from the other, the distance that there was between the two parts of my brain in which I used to think of them, one of those distances of the mind which time serves only to lengthen, which separate things irremediably from one another, keeping them for ever upon different planes. And this distinction was rendered still more absolute because the habit we had of never going both ways on the same day, or in the course of the same walk, but the ‘Méséglise way’ one time and the ‘Guermantes way’ another, shut them up, so to speak, far apart and unaware of each other’s existence, in the sealed vessels - between which there could be no communication - of separate afternoons”[91].

A similar impression emerges from the policies we examined during the course of this survey.

Three policies play an important role if working conditions are to be improved from the point of view of equality: occupational health, public health and equal opportunities. They all tackle the same issues but from different perspectives. The main impression gained when examining these three policies is how compartmentalised they are.

In institutional terms, the most obvious explanation has to do with the functioning of any large bureaucracy. Each sector tends to carve out its own territory and watch jealously to ensure that others do not overstep its boundaries. Historically, occupational health, equal opportunity and public health policies have arisen at different times and have led to the formation of such territories at government level. The same applies to “para-institutional” organisations, whose structures are largely modelled on the operation of government institutions. This phenomenon may be observed, to varying degrees, in innumerable organisations recognised by the State as representative (trade unions,
women’s organisations, etc.). The mimicry is all the greater in that these organisations are embedded in compact networks of advisory bodies which monitor government activity, and in that they are partly government-funded. Even research is largely driven by institutional demand, turning social science research into a sort of satellite of the territory occupied by government action.

This general phenomenon is however exacerbated by intrinsic policy limitations in each of the three fields of activity examined. These limitations, in a nutshell, are as follows:

• the difficulty of including the full range of social relationships in occupational health policies which have been designed in accordance with a risk- and prevention-centred approach;

• the inadequate consideration paid in the field of public health to working conditions as a major factor of social inequality. This phenomenon is even worse in certain countries, where combating health-related social inequalities does not even feature as a basic public health goal;

• the ambiguity in “equal opportunity” policies, torn between a liberal vision (to create the conditions for perfect competition between all individuals irrespective of their sex) and the feminist struggle for far-reaching equality, directed against male dominance in the various spheres of society.

It would also be interesting to take a more detailed look at the links between public health policies and occupational health policies in the light of recent developments in the main European Union countries. That is not however possible within the confines of this volume.

This analysis is based in the main on Community policies; it has not been possible to examine thoroughly the national policies in all fifteen Member States. Generally speaking, national policies do differ in respect of the gender dimension of occupational health. The norm is however as follows: these policies were designed as being “gender neutral” and, in practice, tend to neglect occupational health problems which are more specific or more common among female workers.

Community occupational health policy has been constructed on two main pillars: social policy related to the working environment, and trade policy related to the free movement of goods. The two are interdependent. In some fields, the effectiveness of prevention in the workplace is heavily dependent on market regulation and enforcement. If personal protective
equipment has been badly designed, or if the performance data and instructions for use are unreliable, if a hazardous chemical is wrongly labelled or its safety data sheet has missing information, the conditions for prevention in the workplace will be unfavourable.

Three chapters will be devoted to Community occupational health policy. Chapter 7 deals with the main instrument of this policy: directives concerning the working environment. Chapter 8 looks at one of this policy’s major failures: the maintenance of profoundly different systems as concerns the recognition of occupational diseases. An insight is given into the gender dimension of this problem. Chapter 9 briefly addresses a sadly neglected issue: the gender dimension of policies related to the market in work equipment and chemical substances.

As far as public health policies are concerned, the differences are more significant and the harmonisation resulting from Community policies has been inconsequential. Community public health policies are more recent than those on occupational health; they are not backed by any legal instruments geared to harmonising the fifteen Member States’ public health systems. This phenomenon is illustrated by the abrogation of the directive of 6 July 1998 on tobacco advertising. The directive had been adopted on the basis of Article 100A of the Treaty (which, following its amendment by the Treaty of Amsterdam, became Article 95). This article concerns market regulation. Germany considered that it could not be utilised for public health purposes unless it could be proved that divergences in national regulations were causing distortions of competition or barriers to trade. The Court of Justice upheld the German view and abrogated the directive.

On the other hand, there is no doubt that the pressure placed on the functioning of public health systems by other policies can play an important part in their development. The budgetary austerity measures linked to compliance with public finance constraints have led most Community countries to introduce reforms restricting free access to healthcare and stepping up the role of private bodies in the organisation of public health.

The gender workplace health gap in Europe
A number of authors regard the increased participation of women in paid employment as justification for taking the gender dimension of occupational health into account. Such a view is both naive and misguided. The number of women participating in paid work, and registered as such, has of course been rising steadily for more than thirty years, but even higher rates were already recorded a century ago, in some instances, for industrial employment\(^3\). Statistical methods of calculating employment have always hugely underestimated female employment: women’s role in the production of agricultural outputs, trade and handicrafts has largely been ignored by statisticians. The same applies to work in the home, even where this forms part of industrial activity.

As is robustly pointed out by Sylvie Schweitzer (2002), “Do we think to ask ourselves since when men have been working? No, of course not. Their tasks and occupations are considered to be every bit as old as the world (...). The same does not apply to women. Their work is always presented as being contingent, fortuitous and recent. Thus common sense feigns not to know that women have also been peasants, shop-keepers, blue-collar workers, white-collar staff, nurses and teachers. They always have. So why then this recurrent phrase: ‘ever since women first began working...’? Is it because, as far as women’s history is concerned, amnesia prevails?”

Occupational health policies have always in fact had a very marked gender dimension. The question is whether or not the approaches adopted have helped to reduce male/female inequalities or have legitimised male dominance in the world of work. This is an important question in that it is still topical. Not every gender-based policy necessarily fosters equality and human emancipation; by the same token, there are social policies which heighten inequalities and concentrations of wealth. A brief historical summary will jog our memories and show that, at any point in time, different choices are possible. There is no causal link between a variation in the rate of female employment and a given occupational health policy. There are choices to be made, decisions to be taken.
Kauppinen-Toropainen (cited by Lagerlof, 1993, pp. 71-72) has devised an analytical table distinguishing four possible broad orientations for occupational health policies in relation to gender.

<table>
<thead>
<tr>
<th>Differences of gender are accepted</th>
<th>Gender insensitive</th>
<th>Gender stereotype</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality is actively promoted as a norm</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
<td>Gender insensitive</td>
<td>Gender stereotype</td>
</tr>
<tr>
<td>Yes</td>
<td>Gender neutral</td>
<td>Gender sensitive</td>
</tr>
</tbody>
</table>

Source: Kauppinen-Toropainen (cited by Lagerlof, 1993, pp. 71-72)

An attempt to analyse the general trend in occupational health policies might conclude that they have gone from an approach predicated on protection and exclusion (corresponding in Kauppinen-Toropainen’s typology to an approach founded on gender stereotypes) to one advocating gender neutrality. It goes without saying that this is merely a general tendency and that no occupational health policy corresponds to a totally clear-cut model.

One factor remains constant in spite of all the variations apparent from one period to another, one country to another and one topic to another: the gender dimension has never been seen as a necessity resulting from the deep-seated nature of society. Whenever the problem has cropped up, policies have been devised more as corrective measures than preventive ones, more as specific or partial measures than global ones. The gender dimension has been conceived of merely as an additional way to tackle problems experienced primarily by women, in response to somewhat nebulous “women’s issues”. This is a reversal of priorities. Instead of beginning from collective working conditions which have developed in the context of a gender-based division of labour, the starting point is that women are a group “in need of protection” on account of their “particular sensitivity”. Such a vision characterises women as a biological exception, distinguishing them from the norm and centring on motherhood. In some cases, a paternalistic approach depicts the gender issue as an aspect of “diversity management”, based on an ill-assorted amalgam of sex, disability, age (older workers or very young ones), sexual orientation, ethnic group, immigration, etc.

94. Our main criticism of campaigns by employers or governments in favour of “diversity management” is that they seek to maintain social relationships which permanently produce, perpetuate or exacerbate the creation of inequalities between the sexes or ethnic groups, or based on other criteria. How credible are official campaigns in favour of racism-free enterprises, when government policy makes it a priority to combat immigration, presenting it as a threat to public order, and when the ethnic division of labour serves to justify low wages for immigrant workers or those of immigrant extraction?
A combination of protection and exclusion

“In keeping with a natural commandment, the man must be the bread-winner for his family, and the woman has the task of looking after that family through her work. A woman prevented by her employment from sustaining the interests of her family is a social evil of such magnitude that government measures to oppose it totally are perfectly appropriate. The basic principle is not to ban a given job, but to ban the employment of married women, in that this will benefit the protection of the family.”

Preamble to draft legislation tabled by the Dutch Minister for Social Affairs, Mr Romme, in 1937 (cited by Wierink, 2001, p. 311)

When occupational health policies first came into being at the start of the industrial revolution, women took pride of place. Together with children, they were much more an object than a subject of these policies. That was certainly the case for measures enacted by governments and employers, but the same vision was to be found in large swathes of the labour movement. The earliest occupational health policies were notable for an approach based on protection and exclusion.

Government policies normally took the view that self-regulation by employers should be the general rule to which exception was made, within certain limits, for two categories meriting special protection: women and children. It was a matter not so much of ensuring the health of these individuals as such, but rather of safeguarding biological and social reproduction, which might otherwise have been jeopardised by predatory employers. 19th century hygienics did not always distinguish between health and patriarchal morals; it likewise took issue with working conditions because they created situations of promiscuity and low moral standards, which put the working classes out of bounds as far as middle-class families were concerned.

The protection, or “tutelage”95, of female workers never extended to all forms of employment, but covered above all women over whom the family (either their own or that of their employers) had no hold, in industrial establishments and in the mines. Other sectors, by contrast, were excluded from the protective rules put in place: domestic service (paid or unpaid), work in the home, agriculture, family farms, etc. Only very rarely did the sort of protection laid down in law include collective prevention measures.

95. In some languages, such as Italian, the same term “tutela” is used to designate both the protection of women and children at work (and, by extension, the safeguarding of occupational health) and the exercising of civil rights by another person on behalf of weak individuals (children, women, the mentally ill and disabled, as well as individuals whose profligacy threatens the family’s assets). Thus incipient labour legislation incorporated some of the terminology of the Roman patriarchal family.
The prohibition of female employment was generally justified on three grounds: poor working conditions for women endangered the survival of the species; paid work undermined female morality; and paid work prevented married women from devoting themselves fully to their natural obligations. A fourth argument was often invoked within the labour movement: because their wages were lower, women were in competition with men and stood in the way of wage rises. Mass unemployment in the 1930s was adduced as an additional argument: women were expected to make sacrifices so as to bring down unemployment levels.  

Female blue-collar workers: the object or the subject of occupational health policies?  

“The women themselves join in with these disorderly demonstrations and play a very active part in them. A large number of these brazen individuals, repudiating their sex and dismiss any sense of modesty, showed themselves in the front row of the rebels, outdoing their brothers and husbands with their shouts and threats.”  

Description of the strikes at Marchiennes-au-Pont by the Journal de Bruxelles of 4 February 1867 (cited by Gubin, 1990, p. 40)  

Female blue-collar workers have struggled ever since the start of the industrial revolution to improve their working conditions. The appalling exploitation to which they were subjected as workers, combined with the social oppression they suffered as women, provoked resistance which has largely been overlooked by history. The demands they put forward demonstrate that the main focus of women’s struggles was never their confinement to the sphere of family domestic work. This was however advocated by many men in the labour movement, who viewed relations with their female counterparts more in terms of competition than of common exploitation.  

The struggles of female industrial workers served to inject a new radicalism into the labour movement. In addition to protesting against economic exploitation, they put forward demands calling into question thousands of years of oppression. From Flora Tristan to Alexandra Kollontai, from Louise Michel, Emma Goldmann and Mother Jones to Clara Zetkine and Anna Kuliscioff, for numerous female leaders of the labour movement, a critique of capitalism is inseparable from the struggle against patriarchal relationships and from the affirmation of the right of women both to be full citizens and to have control over their own bodies, in particular through the development of contraception and the decriminalisation of abortion.  

96. The same argument resurfaced in Belgium in the early 1980s, when women in a factory experiencing economic difficulties were obliged to work part-time. This caused the female workers to come out on strike against the collective agreement forcing them into part-time work (Louis, 1983).  

a. In October 2000 the Social History Institute of Amsterdam held a seminar on free love and the labour movement, which revealed the importance of the critique of male dominance within the family to the emancipation of female workers’ organisations. In Great Britain, Stella Browne (1880-1955) emphatically stressed the complementary nature of free choice for a woman, whatever her occupation, and freedom in her sexual relationships (Hall, 1997 and 2000).
Other aspects of this policy introduced in the late 19th century include numerous prohibitions and the enactment of gender-differential regulations in various fields (in particular the carrying of heavy loads, exposure to lead, working hours, etc.). Not only legislation but also everyday practice tended to legitimise gendered segregation in the workplace. Women were ejected from various sectors and from various occupations. It would be pointless to try and rationalise these policies on grounds of safeguarding health. What is more, these measures vary enormously from one country to another and from one set of economic circumstances to another. There is just one very obvious constant factor: the concentration of women in an occupation or sector has always been associated with lower wages. The prohibitions were many and varied: a ban on night work for women working in industry, the exclusion of women from mining and underground work, etc.

Almost all the legislation excluding women from certain occupations or activities has been repealed. Certain provisions do still exist in some legal systems, but their role is only marginal and in many cases they seem to have fallen into abeyance. Where such laws have not been repealed, it is due either to inertia on the part of the legislator or to a refusal to adopt new measures protecting both men and women.

In France, for example, some protectionist provisions still subsist in the Labour Code. Two examples are Articles L 234-2 and L 234-3, which are still in force even though in practice their effect on women is minimal.

Despite today’s almost total legislative equality, segregation in the workplace remains striking. Entire sectors of the economy (construction, mining and quarrying, iron and steel, port handling, etc.) are still almost exclusively male (apart from some “auxiliary” occupations traditionally the preserve of women: administrative secretaries, social workers, cleaners, etc.). The construction sector is a case in point. As noted by a trade union publication in this sector (CLR, 1997): “Why does an Argentinian trade union leader in the construction sector believe it fortunate that in his country women do not need to work in construction? Why does a construction sector trade union leader in the Russian Federation proudly report that 45% of his members are women? Why does an employee on a construction site in Amsterdam remark that ‘building work is hard work - it’s men’s work’? Why is it that on a building site in New Delhi they say the opposite: ‘construction work is hard and dirty - it’s women’s work’?”

Occupational health policies
One significant exception: the *mondine* in Italy

In most European countries, agriculture was excluded from the scope of occupational health legislation adopted between the start of the industrial revolution and the First World War. There is one very significant exception: the *mondine* in Italy. The *mondine* were female seasonal labourers who tended the rice paddies in various parts of the Po Delta in northern Italy, their main activity being to remove the weeds preventing the rice from growing. At the end of the 19th century and during the first half of the 20th, they constituted the most combative sector of the Italian farming proletariat. Their leagues were the first ever organisations of female workers, and they contributed greatly to establishing the Socialist Party in some rural regions before the First World War. One feature of the *mondine* was their relative independence from family structures. In this respect their situation differed from that of the numerous women working in factories, whose lives were still structured around the family as soon as they finished work. This was one of the few sectors where groups composed mainly of women led a communal existence outside of any family control. Most of the time they were housed in dormitories and ate together. In the experience of the *mondine*, there was no separation between collective demands and a shared culture deriving from their identity both as women and as workers. The clergy regarded the lifestyle of the *mondine* as a threat to public morals and attempted - somewhat unsuccessfully - to recruit them into parish organisations. The first Italian law (of 19 June 1902) on working conditions for women and children excluded agriculture from its scope. As early as 1907, however, new legislation was passed specifically for the sole area of rice-growing, the idea being both to forestall the claims being put forward by the leagues of *mondine* and to try to regulate this form of female employment, which appeared particularly threatening from a moral point of view.

a. It was Professor Simonetta Soldani of Florence University who drew my attention to the case of the *mondine*.
b. Title 4 of the sole text on health legislation of 1 August 1907 and the royal decree of 29 March 1908.

Gender neutrality: an implicit male referent

The protectionist approach gradually gave way to one of “gender neutrality”, which took over bit by bit as from the end of the Second World War. The chronology varies from one country to another, but on the whole no further serious attempts were made to exclude women from paid work after 1945.

The final efforts to prevent women from joining the labour market date back to the period beginning with the 1929 economic crisis and ending with the Second World War: automatic dismissal of women who marry (Spain, under Franco); an attempt to confine the proportion of female employment to at most 10% of the labour force except for certain “specifically female” jobs (Italy, under Mussolini). Such measures did not really achieve
their goal as a rule. They were not exclusive to dictatorial regimes or traditionally Catholic countries: in Belgium too (Coenen, 1991), under pressure from Catholic organisations, Catholic-Liberal coalition governments adopted various regulations between 1933 and 1935 aimed at creating maximum quotas for female participation in industry, and halted all new recruitment of women in the public administration. These regulations were largely ignored, and were repealed when a government that included Socialists came to power in 1935. In the Netherlands, the last attempt to exclude married women from paid work dates back to 1937, the initiative of a Catholic Minister for Social Affairs. In Sweden (Nickell, 1994), several efforts were made in the 1920s and 1930s to restrict the employment of married women: three Social-Democrat members of parliament put down a motion in 1927 according to which “a woman can serve only one master at once”. General discrimination against married women finally disappeared in 1939 when, it is true, Swedish industry could look forward to enhanced productivity owing to the Second World War. (For a detailed examination of Swedish legislation, see Carlson, 2001.) From the Second World War onwards, the legal barriers preventing access to certain jobs gradually disappeared. This does not relate solely to occupational health aspects.

Nowadays, gender neutrality is the principal characteristic of occupational health policies pursued in the European Union and its Member States. It consists of addressing occupational health issues from the point of view of an abstract employee, where reference is implicitly made to male workers as the norm. This is an artificial “normality” and clearly does not correspond to the extreme diversity of working men. One need only observe that the turnover and early retirement in certain male occupations are on a par with those in certain female occupations. Construction work corresponds no more to the “male nature” than nursing does to the “female nature”.

Gender neutrality implies a denial of three dimensions:

- Any biological differences are generally ignored, except in respect of safeguarding maternity. Only exceptionally are any rules (in a broad sense - from legislative norms to work practices) passed with a view to properly protecting both men and women on the basis of a separate evaluation of risks to their health where justified by biological differences.
- The division of labour between men and women is regarded as something external, a contextual factor with which preventive policies need not concern themselves.
- Any interaction between paid and unpaid work is regarded as a purely individual matter. In practice this often amounts
to a process of apportioning blame. Women are guilty of neglecting their “health capital” when they engage in family chores or, conversely, of sacrificing their family responsibilities (and the future or the morality of future generations) to their success at work. In some instances they are offered stress management techniques to help them cope with both sets of constraints.

It is noticeable that the transition to “gender neutrality” has had little impact on most of the measures governing maternity protection. Only in the Scandinavian countries have there been moves towards safeguarding reproductive health as a whole (for Finland, see Kauppinen-Toropainen, 1993), with a view to encompassing the reproductive health of both men and women through an overall approach. Measures specific to one gender are justified only where truly specific needs can be demonstrated.

Maternity: the only biological distinguishing feature of women?

When it comes to maternity, it is considered only natural to reintroduce “women” into policies claiming to be gender neutral. Two criticisms can be formulated here.

“Biology” appears here to be used as a means of explaining away what is really a social function. In short, the approach is both too specific and not specific enough...

Too specific: in that most of the factors which are hazardous to reproductive health do not merely affect the health of pregnant women; they affect the health of men and women more generally at various levels. It is still difficult to confront the taboos surrounding male fertility and its links with working conditions. In many cases, specific rules relating to maternity have served to avoid eliminating at source a whole series of agents harmful to health.

What is more, the stratagem of passing off motherhood as an essentially biological issue has never prevented the legislator from discriminating between women depending on their sector of activity. Many legal systems have long excluded women working at home or in agriculture from provisions safeguarding maternity. Even today, the Community directive does not apply to female domestic workers or to self-employed women. Likewise in Belgium, social security cover for periods when a
pregnant employee is removed from exposure to particular hazards varies from one occupational group to another: nurses enjoy less favourable conditions than hospital cleaners, whereas the risk of contagion from biological agents is comparable. This discrimination originates from restrictions placed on the recognition of occupational diseases caused by biological agents.

Not specific enough: in that this sudden interest in female biology is confined to maternity! Other issues linked to specific biological characteristics are hardly ever addressed. Virtually nothing has been written about the relationship between working conditions and menstrual disorders. And yet, in surveys conducted among female workers, this aspect of occupational health emerges as a major priority. Similarly, the relationship between working conditions and a satisfactory sex life is a subject rarely broached by occupational health specialists, whereas it crops up regularly in surveys canvassing the views of groups of female employees (Corradi, 1991; Rotenberg, 2001; Arena, Valzania, 2003). Furthermore, very little attention has been devoted to specific aspects of exposure to hazardous substances, be it in relation to the link with hormone production or in relation to differences in tissue composition.
Chapter 7
Community legislation concerning the working environment

Community legislation concerning the working environment has been adopted within the context of the European Union’s competence over social affairs. The first steps were taken in the 1960s, with the attempt to harmonise occupational medicine and the recognition of occupational diseases. During the first half of the 1980s, the European Union set itself the goal of establishing a harmonised framework for industrial hygiene. This attempt failed due to the substantial differences between the Member States. Following the adoption of the Single European Act in 1986, it became much easier to adopt directives when the requirement for unanimity was replaced by the use of a qualified majority. The 1989 framework directive was the starting point for important legislative acts that led the Member States to reform their prevention systems (Vogel, 1994 and 1998).

All of the EU’s legislation concerning the working environment has been adopted from the perspective of gender neutrality. This can be easily explained. When the European Union began to draw up a policy on occupational health, the approach combining protection and exclusion was disappearing in all the Member States. The question of women’s access to specific occupations or sectors was no longer on the agenda, even though certain discriminatory provisions were still contained in national legislation. Segregation mechanisms for the most part were no longer related to gender-differentiated legal regulations. On the contrary - and the Swedish example demonstrates this very eloquently - formal legal equality was perfectly compatible with the maintenance, or even aggravation, of a highly rigid gender division in the workplace.

This legislation will be analysed here in chronological order. The directives considered cover protection against lead-related risks, the exclusion of paid domestic work from the 1989 framework directive and all subsequent directives, and maternity protection. Other directives will be examined more briefly. This chapter ends with an analysis of the way in which the gender dimension has been integrated into the new Community strategy on occupational health.
A dilemma over lead: equality in sickness or discrimination in health (of the foetus)

The preparation of the directive on the protection of workers from the risks related to exposure to lead gave rise to the only debate between three different approaches: protectionism, gender neutrality and prevention taking into account men and women. Unfortunately this debate failed to elicit much response beyond specialist circles. There is a striking contrast here with the debate that began in the United States with the 1991 ruling from the Supreme Court on the UAW v. Johnson Controls, Inc. case which, on the same issue of preventing lead-related risks, received a great deal of attention and can be considered as one of the clearest affirmations of a legal approach advocating gender-neutral occupational health measures.

It has long been acknowledged that lead and lead derivatives cause many abnormalities. In France, lead poisoning was the first occupational disease to be recognised, long before silicosis. Throughout the 19th century, the labour movement fought long and hard for a ban on paint containing lead oxide. Lead oxide is a basic carbonate of lead and is one of the main causes of lead poisoning.

The widespread use of lead in numerous areas of production has also created a major problem with regard to environmental health. Levels of exposure in urban areas may be very high, and relatively low exposure at work can at times be enough to trigger significant toxic effects. Blood lead levels among the population have nevertheless decreased with the introduction of unleaded petrol and stricter regulations governing the quality of drinking water.

Before the adoption of the 1980 framework directive on the protection of workers against chemical, physical and biological risks, the Commission began to draw up a directive on lead. At first glance, there should not have been a great many political difficulties: all the Member States had long recognised the seriousness of the risks posed by exposure to lead in the workplace, and they had all adopted legislation in this area. The adoption of a directive on lead was considered to be an important test of the Member States’ political will to move forward in establishing a Community policy on occupational health.

In order to avoid any anachronism, I shall provide a brief summary of the evaluation of lead-related risks on the basis of the data available during the debates on the adoption of the
Community directive at the beginning of the 1980s. I am not seeking to enter into a debate about this evaluation. Rather, I hope to determine what information was available to the Community legislators when making decisions. My principal source for the information available on occupational medicine in the early 1980s is Pézerat (1985). It is supplemented by the proceedings of an international seminar organised by the University of Amsterdam on limit values for lead (1976) and documents from the TUTB archives which contain notes drawn up by experts linked to the trade union movement while the directive on lead was under negotiation.

Exposure to lead poses dangers for both men and women. Although lead has many harmful effects, there are no significant differences between the two groups. In particular, lead affects the central nervous system and the renal, cardio-vascular and gastro-intestinal systems. When the directive was drawn up, the carcinogenic effects of lead were considered to be hypothetical.

Lead also has harmful effects on the foetus. Before the advent of medical abortions, lead salts were sometimes used to trigger an abortion. Exposure of pregnant women to lead is associated with miscarriages, foetal deaths, premature births, malformations and impairments of foetal growth. The foetus accumulates lead in its brain and in its bones.

Lead also has a detrimental effect on fertility, manifested through problems with libido, accompanied by a decrease in sperm production among men and changes to the ovarian cycle among women.

The proposal for a directive was presented by the Commission on 10 December 1979\textsuperscript{102}. I shall only provide an outline of it so that I can concentrate on the gender dimension.

The directive is based on two types of limit values:

- Limit values for atmospheric exposure, which establish the quantity of lead in the air (calculated as a time-weighted average over 40 hours per week).
- Biological limit values for the presence of lead in the body. Two parameters are used. One relates to the lead content in the blood; the other is the result of a urine analysis and measures the concentration of delta aminolae vulinic acid. This measurement is an indicator of the extent to which the lead is blocking the production of haemoglobin.
I do not intend to look here at the technical debates over these limit values and shall limit this analysis to two of them.

In September 1976, the Commission took part in an international seminar on limit values for lead\textsuperscript{103}. This seminar was organised by the University of Amsterdam and was attended by 38 international scientific experts. The trade unions were not invited. Without reaching agreement on a limit value based on health, the experts concluded that the blood lead level among male workers should not exceed 60 µg Pb / 100 ml. The experts added that it was nevertheless desirable to remain below this threshold in order to take account of the effects observed between 45 and 50 µg Pb / 100 ml on the production of haemoglobin and between 50 and 60 µg Pb / 100 ml on nerve conduction. For women, the experts considered that a healthy blood lead level was below 40 µg Pb / 100 ml.

The reference limit values proposed by the Commission were some way behind those proposed by the experts. Indeed, the Commission proposal contained the following limit values:
- lead-in-air concentration: 150 µg / Nm\textsuperscript{3}. This level was to be reduced to 100 µg / Nm\textsuperscript{3} from 1 January 1985;
- individual blood lead level: 70 µg Pb / 100 ml. This level was to be reduced to 60 µg Pb / 100 ml from 1 January 1985.

Derogations were available to the Member States to extend the transitional period to 1 January 1989.

The proposal added that “given the potential toxic effects on the foetus”, the following biological limit values would apply to “women likely to become pregnant”: namely, a blood lead level of 45 µg Pb / 100 ml.

For pregnant women, the proposal envisaged that they would be shielded from any exposure to lead yet did not resolve the problems posed by possible loss of earnings or the fact that it might be impossible to continue working.

Where lead-in-air limit values were exceeded, preventive measures were to be adopted to reduce exposure.

Where biological limit values were exceeded, preventive measures were to be adopted. Once these measures had been implemented, workers could not remain exposed to lead if the biological limit values continued to be exceeded.
It was the first time that a proposal for a Community directive introduced the concept of “women likely to become pregnant”\textsuperscript{104}. Almost all female workers are of an age where they can procreate. In addition, the proposal did not specify any means of distinguishing between “women likely to become pregnant” and other female workers. If a female employee wanted to avoid losing her job, would she be allowed to present a medical certificate stipulating that she had been sterilised or that she was sterile for other reasons (after the menopause for example)? The Commission’s explanation concerning the introduction of this category is somewhat confused. It would cover “particularly sensitive workers”\textsuperscript{105}. The use of the masculine form (“travailleurs”) in the French version is revealing, in that it refers to a group made up solely of women: men are the norm, while women are described as being particularly sensitive. Yet what is the point of saying “particularly sensitive”, when it refers to approximately 50\% of the population of working age? Could one envisage a regulation on reproductive risks distinguishing between fertile men and sterile men when establishing different limit values for occupational exposure?

The proposal for a directive gave rise to many debates. I shall look here only at those relating to the different limit values and their impact on health.

The trade unions were opposed to the proposal for two reasons.

They considered that the different biological limit values would lead to the exclusion of women from a number of activities. In fact, it would be in the economic interest of employers to employ men, as that would reduce their obligations to adopt preventive measures based on individual biological parameters.

Moreover, the directive did not require employers to guarantee the job and wages of persons moved from their posts because the biological limit values had been exceeded. There was therefore a two-fold risk of discrimination against female workers: as regards recruitment and in the form of dismissal justified on grounds of medical incapacity.

Added to this, the proposed limit values ensured only limited health protection in relation to the medical data available. Indeed, according to Pézerat (1985), the following table serves to demonstrate the insufficiency of a limit value of 60 µg Pb / 100 ml.

\textsuperscript{104}. Ten years later, similar wording was adopted in the directive on pregnant workers in relation to information on risk assessment.

\textsuperscript{105}. See COM(79)699 final, p. 3.
Table 12: Health effects of blood lead level according to information available around 1985

<table>
<thead>
<tr>
<th>Blood Lead Level (µg Pb / 100 ml)</th>
<th>Health Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-25</td>
<td>First abnormalities detected in chromosomes.</td>
</tr>
<tr>
<td>35</td>
<td>First fertility problems.</td>
</tr>
<tr>
<td>40</td>
<td>Possibility of problems with sexual functions.</td>
</tr>
<tr>
<td></td>
<td>Possibility of effects on the foetus for pregnant women (other contemporary sources put the threshold at 30 µg Pb / 100 ml).</td>
</tr>
<tr>
<td></td>
<td>“Definitely” impairs the production of haemoglobin.</td>
</tr>
<tr>
<td></td>
<td>Other contemporary sources also indicate effects on peripheral nerve conduction.</td>
</tr>
<tr>
<td>45</td>
<td>Risk of anaemia.</td>
</tr>
</tbody>
</table>

Source: Pézerat (1985) and TUTB archives

However, the organisations affiliated to the European Trade Union Confederation did not necessarily all have the same priorities. For some, discrimination was considered to be the most questionable part of the directive. For others, it was above all important to define better limit values. Consensus was finally reached on a proposal for a compromise: the ETUC called for identical biological limit values for men and women to be adopted following a transitional period lasting until 1 January 1989. Blood lead levels should be fixed at 45 µg Pb / 100 ml.

The employers came out in favour of less strict exposure limits than those proposed by the Commission. I was able to consult in the TUTB archives two documents presented by the employers to the Economic and Social Committee in 1980. British employers proposed determining preventive actions based solely on the individual biological limit value. Such an approach makes it possible to minimise the costs of collective prevention at source: it merely requires workers to be rotated. This is common practice in companies undertaking contract work for the nuclear industry, where work is organised according to the level of ionising radiation. Moreover, the limit value proposed by the British employers was particularly high: “the health and welfare of a male worker exposed to lead, whose health is considered to be satisfactory, will not be significantly affected if his blood lead level remains below 80 µg Pb / 100 ml”. This wording is somewhat vague: health will not be significantly affected (after all, a small sacrifice could be justified), and workers’ health must be “considered to be satisfactory”. In reality, the proposed limit of 80 µg Pb / 100 ml is not based on any health assessment; it was the limit that British legislation considered to be “reasonably practicable” at the time. Above all, what is most surprising about the British employers’ text is the absence of any reference to female employees.

106. Circular letter of 9 October 1980 from Mr Hinterscheid to the Members of the European Parliament (TUTB archives). The postponement to 1 January 1989 was an ETUC concession. In an undated note addressed to the Economic and Social Committee (probably from the first half of 1980), the adoption of a single limit value of 45 µg Pb / 100 ml is proposed without a transitional period and it is asked that this value be reduced at a later date. Moreover, the same note calls for a reduction in the lead-in-air level to 100 µg Pb / Nm³.

107. The documents referred to are documents R/CES 304/80 from the European Community’s Liaison Committee of the Non-ferrous Metals Industry and R/CES 305/80 from the “British industry” (this is quite probably a text from the CBI, the Confederation of British Industry).
The proposed limit value is supposed to protect male workers but the text refrains from commenting on the Commission’s proposals concerning women. Either the British employers had no objection to a far more protective biological limit value for women to protect the health of foetuses, or else it took it as read that only male workers should work with lead. For its part, the European Community’s Liaison Committee of the Non-ferrous Metals Industry adopted a much less dramatic approach than the British employers. It did not consider that the proposed directive would result in economic disaster. As a general rule, it supported the Commission’s proposal and only proposed amendments relating to secondary aspects: an increased role for occupational physicians (in determining the intervals for medical examinations and unfitness); a clear preference for respiratory protective equipment as an alternative to preventive measures at source. The note from the Liaison Committee did not contain a single reference to women.

The Member States were divided in relation to exposure values and discrimination between men and women.

According to an Italian specialist, Luigi Rossi\textsuperscript{108}, at that time national legislations were characterised by substantial differences as regards the exposure of female workers to lead. Three countries did not differentiate between men and women (France, Denmark and the Netherlands). One country (the United Kingdom) agreed with the Commission’s criterion and had adopted provisions restricting exposure to lead for “women likely to procreate” (with a limit value of 40 µg Pb / 100 ml). Germany had decided to discriminate on the basis of age: women aged below 45 could not work with lead if the biological limit value exceeded 40 µg Pb / 100 ml. Two countries had adopted restrictive measures for all women (Luxembourg and Belgium). Greece prohibited women from taking up posts that would involve exposure to lead.

The Member States also differed with regard to the proposed limit values\textsuperscript{109}. Two blocks formed. On the one hand, the United Kingdom, Germany and Ireland supported the toughest employers’ positions and wanted a lead-in-air limit value of 150 µg / Nm\textsuperscript{3} (Greece agreed with them on this point) and a biological limit value of 80 µg Pb / 100 ml. On the other hand, Belgium, Denmark, Italy, Luxembourg and the Netherlands recommended a lead-in-air limit value of 100 µg / Nm\textsuperscript{3} (they were supported by France in this respect). The same countries advocated a biological limit value of 60 µg Pb / 100 ml. France and Greece found themselves in the middle, as they were in favour of a biological limit value of 70 µg Pb / 100 ml.

\textsuperscript{108} Document written by Luigi Rossi of the Superior Institute of Health for a trade union conference in December 1982 (TUTB archives). A summary of the national legislations is set out in a table on page 20. We were unable to verify all of the information contained in this report.

\textsuperscript{109} Information taken from the Luigi Rossi document mentioned above, p. 30.
The discussions on the proposal took place over several stages. The draft was initially examined by the Economic and Social Committee, whose opinion was adopted on 24 September 1980 with 80 votes in favour, one vote against and 20 abstentions. It was based on a report drawn up by a representative of the German employers. The opinion could be used in a guide to the contorted consensual language of certain bodies supposed to represent a “civil society” split between many opposing social interests. It is a winding path between phrases that take up the demands of the unions and others that incorporate the arguments of the employers. It is difficult to find any concrete amendments in the text, apart from some relating to secondary aspects. In general, where a question provoked controversy, the opinion recommends that it should be the subject of a further study carried out by experts. The question of discrimination against female employees is dealt with very briefly in a few contradictory lines.

Under the heading “equal treatment of men and women”, the opinion states the following: “As regards special protective measures for female workers of an age to procreate and workers known to be pregnant, the Committee agrees with the provisions set out in the proposal for a directive. Prevention must seek to reduce the risks linked to harmful exposure to lead in such a way that men and women are no longer treated differently”. In reality, the first sentence accepts the adoption of discriminatory measures whilst the second is limited to an act of faith: technical progress will naturally abolish discrimination. The link between the two proposals lacks any logic. The adoption of differentiated rules will in fact enable employers to continue to make male employees work with higher levels of exposure to lead. Prevention will be organised in a way that maintains discrimination.

The European Parliament’s opinion was adopted on 7 April 1981 and includes two proposals for amendments to the provision establishing a system that discriminates against female workers. It takes up the draft compromise that had been proposed to it by the ETUC, specifying that the specific limit values for “female workers likely to become pregnant” would subsequently be applied to all employees. The biological limit value of 45 µg Pb / 100 ml should be extended to all workers from 1 January 1985 (with derogations allowed until 1 January 1989). The second amendment proposed by Parliament relates to pregnant workers who, it is important to remember, must be shielded from any risk related to lead exposure. In Parliament’s view, following their maternity leave they should be allowed to return to the same post they held prior to their pregnancy.
However, it does not make any reference to the fact that there are no provisions to guarantee their wages in the period during which they are removed from exposure.

Of the other amendments proposed by Parliament, one in particular deserves to be highlighted. Parliament was concerned about lead exposure linked to domestic work where working or protective clothing was laundered in workers’ homes. It proposed a wording that expressly prohibited this practice. The laundering of clothing should be carried out by the company in question or should be contracted out to a specialised firm, which should be informed of the risks in advance and in writing.¹¹¹

The final stage took place in the Council of Ministers. It was impossible to consult the minutes of the meetings. Some documents in the TUTB archives do, however, allow to piece together the main confrontations.

According to Luigi Rossi, the elimination of the provisions concerning “women likely to procreate” had been the result of an alliance between three countries (France, Denmark and the Netherlands), the ETUC, women’s organisations and the European Parliament.¹¹² Italy took an opposing view and wanted to maintain differential biological limit values for men and women. It tried to reach a compromise, not by removing women from exposure when the biological limit value of 45 µg Pb / 100 ml had been exceeded, but by informing them of the risks and offering them the opportunity to stay away from exposure voluntarily. The final compromise scrapped the differentiated biological limit values. At the same time, any specific protection for pregnant women disappeared. Article 1(3) was drafted in vague terms so as to allow Member States to maintain or adopt different limit values for all workers (that went without saying since the directive laid down minimum rules) or “for a particular category of workers”. This wording was designed to allow different rules to be established for men and women.¹¹³

In order to reach agreement on the other aspects of the directive, the structure of the proposal was changed substantially. Each limit value was split into two in order to define a minimum threshold for action and a threshold that must not be exceeded. The majority of the Council’s debate focused on the four limit values.

By December 1981, the differences of opinion had brought the situation to a standstill. The German government supported the employers’ demands; the other countries were in favour of...
compromises backed by the Commission; Italy advocated a higher level of protection and leaned more towards the trade union proposals. The UK Presidency drew up a compromise (somewhat in line with the employers’ positions), which was rejected.

Table 13 indicates the extent to which positions were polarised. It sets out the positions of Germany and Italy, and the United Kingdom’s proposal for a compromise in December 1981; the last column indicates the content of the directive adopted in July 1982.

| Table 13 : Limit values in the negotiations on the Community directive on lead |
|-----------------------------------------------|-----------------|----------------|----------------|-----------------|
| Level of action: air                         | Commission’s initial proposal | Germany’s position | Italy’s position | UK proposal for a compromise | Final agreement |
|                                               | 40 µg / m³ | 75 | 40 | 75 | 40/75 |
| Level of action: blood                       | 35 | 50 | 35 | 40 | 40/50 |
| Limit value: air                             | 100 | 150 | 100 | 150 | 150 |
| Limit value: blood                           | Men: 60 | Women: 45 | 80 | 50 | 70/80 (to be revised three years after entry into force) |
|                                               |               |               |               | 70 (80 under certain conditions) |

Source: circular letter from François Staedelin of the ETUC dated 4 May 1982

As can be seen, for the most part the employers’ positions were accepted. The atmospheric limit values are those proposed from the beginning of the debates by the British employers and taken up by the German government. The biological limit values are slightly better but are still far from those required to ensure complete protection of health. The compromise increased the number of reference values to the extent that it rendered the directive extremely complex. The first level of action (40 µg / m³ or 40 µg / 100 ml of blood) implies only minimal measures: information for workers (in the initial proposal, information would have had to be provided in all cases where there was exposure to lead) and basic health and safety measures (avoiding smoking, eating and drinking in the workplace). The second level of action (75 µg / m³ in the air or 50 µg / 100 ml of blood) requires the monitoring of exposure and medical surveillance. It is only when the upper limit values (150 µg / m³ in the air or 70 µg / 100 ml of blood) have been exceeded that all the preventive measures must be implemented (collective prevention to reduce exposure, individual removal of employees where the blood lead level exceeds the authorised limits).

114. We are greatly simplifying the various levels of action in order to ensure that this paragraph is not totally indigestible. The directive contains specific cases, derogations and provisions that are mere recommendations which we are not considering here.
The Council’s final agreement was subject to a commitment to improve the directive’s provisions after five years. As has generally been the case for directives on occupational health, this served above all to ease guilty consciences. It did not happen. This situation was repeated with subsequent directives: the 1986 directive on noise and the 1992 directive on pregnant workers. In 1998, the 1982 directive was repealed by the new directive on the protection of workers from the risks related to chemical agents\textsuperscript{115}. The limit values laid down at the time of the 1982 compromise might have been expected to be revised. This did not happen. The new directive continues to set a biological limit value of 70 µg / 100 ml of blood and a lead-in-air limit value of 150 µg / m\(^3\). In reality, the approval in 1998 of biological limit values presented as a provisional compromise in 1982 was a clear setback in terms of the levels of prevention required in undertakings. Significant progress has in fact been made in preventing environmental exposure to lead. The introduction of unleaded petrol, much stricter regulations on the quality of drinking water and a reduction in lead exposure caused by dilapidated housing have contributed to a general decrease in the blood lead levels observed among the urban population of the European Union. For example, the blood lead levels of the adult population in Paris, Marseilles and Lyon fell by around 50% between 1979 and 1995 (INSERM, 1999, pp. 267-269). Similar changes have been noted in the other EU countries. Maintaining the same biological limit value in the workplace means that less effort is being demanded now than was required fifteen years ago. That could deprive workers exposed to lead of the benefits of a general decrease in the population’s blood lead levels. As regards the lead-in-air limit value, the experience of other countries shows that it is technically possible to reduce this limit, and that this reduction is essential in order to protect health. In Norway, the limit value was set at 100 µg / m\(^3\) in 1979 and reduced to 50 µg / m\(^3\) in 1981. Despite a significant decrease in exposure to lead in the workplace, damage to reproductive health is still being observed, particularly among women (Irgens \textit{et al.}, 1998).

Such a mediocre compromise means that equality has come at a high price\textsuperscript{116}. Women have obtained access to certain jobs on the condition that they accept the same levels of toxicity as their male colleagues. Yet has the formal, legal introduction of equal access contributed to a genuine desegregation of jobs? It is doubtful. According to statistics of the British HSE (HSE, 2001, p. 112), 17,600 workers were under medical surveillance due to exposure to lead; 95% of these were men.

\textsuperscript{115}. OJEC L 131 of 5 May 1998, p. 11.

\textsuperscript{116}. At the final stage, during the first half of 1982, the question of equality disappeared almost completely from the debates. The central argument in pushing through the compromise related to the future of Community legislative output. Other directives were being prepared (on asbestos, noise and benzene). The adoption of a directive on lead was considered essential in order to avoid compromising the future of the legislative programme (this argument appears, in particular, in the above-mentioned letter from François Staedelin).
Uncertainties in the 1989 framework directive: do female domestic workers belong to the world of work?

In Genet’s play *The Maids*, Claire, one of the two maids, exclaims when identifying herself with her mistress that “Servants are not part of humanity. They slide along. They are an exhalation that lingers in our bedrooms, in our corridors, that penetrates us, that enters through our mouth, that corrupts us”\(^{117}\). In one of the very few books on domestic workers, Judith Rollins (1985) points out that one of the most degrading attitudes most often experienced by domestic staff is that their existence is ignored. They attend to their business in a room whilst their employers converse. In their presence, the most delicate subjects can be discussed and confidences revealed, they can be criticised or praised; everything goes on as if they were invisible, incapable of listening or understanding.

Community legislation has never adopted such a radical position. It recognises the existence of domestic service (it is even a “reservoir of employment”, as is said today). Simply put, there are doubts that “domestic workers” can belong to the world of work.

Approaches based on protection and exclusion have often been characterised by a sort of double standard: stricter rules (possibly total exclusion) concerning industrial work for women whilst entire sectors of the economy remained deregulated as regards occupational health. Thus, prohibiting women in principle from undertaking night work never limited the night work of nurses. The “weaker sex” did not merit the attention of the legislator where it was not in competition with the stronger sex and where the occupational risks were attributable to some of its “natural duties” (especially agriculture, housework and paid domestic work). Although the majority of these sectors are covered by Community legislation, one important exception remains: paid domestic work.

All of the directives adopted exclude domestic staff from their scope. This is a textbook case of indirect discrimination: everyone knows that domestic staff are for the most part women.

The domestic work sector has grown considerably in European Union countries in recent years. Different factors have contributed to this, including the increase in the number of homes where both adults work, the increase in the number of elderly people living alone, and so on. Although the precise volume of

such employment is difficult to quantify, the existing national data are similar

According to the IRCEM, the Institute for domestic workers’ supplementary pensions in France, the number of persons employed in the sector increased from 467,000 in 1991 to 837,000 in 1997, 90% of whom are employed as cleaning women. In Germany, according to estimates made in 1994, 2.8 million households regularly employed domestic help, and a further 1.4 million households employed domestic staff on an irregular basis. In Italy, there are around 1.4 million domestic workers, 90% of whom are women. Furthermore, 50% of domestic workers are immigrants. Of all domestic staff in Italy, only 18% are registered with the social security services.

Moreover, in most EU countries, paid domestic work is mainly carried out by immigrant or foreign women. Their legal status can vary, and cultural or linguistic factors may accentuate the social isolation that often characterises this work. Undeclared labour is widespread even among those who are legally resident. In very few countries are domestic staff covered by collective agreements. The labour inspectorate does not usually operate in this sector. All of these factors leave female domestic staff in a highly precarious situation. If we consider the occupational health problems for this category of employees, it is difficult to see why they remain a no-go area for legislation. Based on the current provisions of Community law, female domestic staff do not have any right to maternity leave or to a day off each week. No limits are set as regards working time and they are excluded from all rules governing protection against the various risks in the workplace. No Community rules protect them against dismissal during pregnancy. The underlying idea behind this exclusion appears to be the following: paid domestic work is considered to be a mere extension of unpaid work that would “naturally” be the responsibility of women. This view of the division of labour makes it possible to deny the risks entailed in such work, from the point of view of the risks inherent in all domestic work (paid or unpaid) as well as the specific risks introduced or heightened by the fact that the work is paid.

The exclusion of domestic staff from the common laws on health and safety is historically linked to the idea that they are under the benevolent guardianship of a family and it is not up to the public authorities to intervene behind a family’s closed doors. Françoise Battagliola (2000) refers to a significant debate held in 1900 during the International Congress on the Condition and Rights of Women. To the participants who stated that female domestic staff should benefit from the same rest and health conditions as female blue- and white-collar employees,


121. Italy is an exception in this instance. The first collective agreement concerning domestic workers goes back to 1974. The current agreement (concluded in 2001) provides for a maximum working week of 55 hours for live-in workers and 48 hours for external workers.

122. In Italy, it was not until March 2001 that the new collective agreement on domestic work prohibited dismissal during pregnancy.
others responded that this demand was unfounded and, besides, domestic workers with free time would be unsupervised, open to the danger of keeping bad company. A study on domestic service in Belgium in the 19th century (Piette, 2001) sets out the challenges: “the control of domestic servants has served as a model for the control of workers, in particular through the requirement for a record book and through the promulgation of Article 1781 of the Civil Code... While workers’ conditions were shaped throughout the century by a series of social regulations and benefits, at the same time domestic work was systematically (and explicitly) excluded from the provisions on protection and regulation. (...) The representation of domestic work throughout the century went hand-in-hand with that of morality. If criminality was the norm for certain servants, it was to become a veritable fantasy and extend to servants’ entire behaviour, becoming an obsession when it related to sexuality. I have therefore tried to comprehend this criminality (for example, domestic theft), but also the violence exerted on servants in return (sexual harassment), their sexuality, and its outcome, motherhood, be it accepted or refused. I will look in this light at infanticide which, although a marginal phenomenon, represented the extreme mirror of a moral solitude that characterised the occupation”.

The few data available on paid domestic work indicate that it is a sector where there are substantial risks.

An examination of the Belgian statistics on industrial injuries reveals that domestic staff are exposed to significant risks. The 1998 data (FAT, 1999) show that the overall rate of seriousness is considerably higher than the average in the private sector (12.1/1,000 compared with 2.18). The 2000 statistics (FAT, 2001) also suggest that a large proportion of employees do not report accidents. In fact, as far as domestic staff are concerned, a quarter of the accidents reported result in permanent disability, whereas this figure falls to 12% for all accidents. More than 2% of the domestic staff covered were permanently disabled as the result of an accident at work in 2000, compared with 0.7% of all the workers covered.

In addition to the risk of accidents, there are other serious risks: exposure to chemical substances regarding which the workers have no information, long working hours, risk of contracting contagious diseases, particularly where there is contact with sick children, risk of violence and sexual harassment or bullying, etc. There is abundant information on practices of coercion verging on forced labour in respect of female domestic staff from...
countries outside the European Union, whose stay is sometimes conditional on remaining in a job with the same employer. In the United Kingdom, the Kalayaan network denounces the confiscation of domestic workers’ passports by their employers, leaving them in a situation of total dependence, not dissimilar to slavery. In France, the Committee Against Modern Slavery has taken steps to combat these forms of forced labour. Of 261 cases analysed in 2001, 76% related to women (most of whom were from Africa). More than 88% of the victims had suffered psychological violence, more than 44% had suffered physical violence and almost 18% had suffered sexual violence.

Added to the specific risks that could be listed at length, the very nature of paid domestic work represents a global social status that can severely weaken individuals. This situation was analysed in France back in 1961. Le Guillant had observed the high number of Breton women committed in his department of a psychiatric hospital in the Paris region. At that time, Breton women made up a substantial proportion of the workforce for domestic service. Le Guillant carried out a study of psychopathological incidences at work among paid domestic staff (“skivvies”, according to the terminology of the time). He set out to demonstrate that the extreme nature of the subordinate relationship was a predominant condition characteristic of all dimensions of their existence. He referred to Hegel’s dialectic of master and slave to explain the extraordinary level of violence in the relationships between “skivvies” and their masters. Society’s repression of this domination is in itself one of the key components of this violence.

The Commission’s initial proposal did not envisage excluding domestic work from the scope of the framework directive. The question was not discussed at the European Parliament’s first reading. It was the Council of Ministers that took the initiative to exclude it when adopting its common position. Only two countries (Germany and the Netherlands) expressed their opposition (Vogel, 1994). For the ten other Ministers of Employment, it seemed to be obvious, a mark of common sense. Society’s repression was confirmed. “Skivvies” would have no right to the medical surveillance granted to other workers, nor to any attention from the labour inspectorate.


126. The documents of the Kalayaan network can be consulted at the following website: http://urworld.compuserve.com/homepages/kalayaan/home.htm.

127. The case of the Papin sisters, two maids who murdered their mistress and her daughter in 1933 in Le Mans had given rise to many debates. Le Guillant wrote a study on the Papin sisters. Eluard, in *Surrealism at the Service of the Revolution*, commented on the case as follows: “For six years, in total submission, they put up with remarks, demands and insults. Fear, exhaustion and humiliation slowly nourished the hatred within them, this sweet liquor that secretly consoles with its promise of blending violence with physical force sooner or later. When the day came, Léa and Christine Papin paid evil back in its own coin, a coin struck with a red-hot iron”.

The exact number of domestic staff in Spain is not known. It is estimated at around 350,000 workers, of whom 88% are women, according to the RESPECT network. Of these, 151,000 are registered with the social security system’s specific scheme for domestic staff. In ten years, the number of workers registered with the social security system has fallen by 20,000, whilst the number of wage earners who declare that they employ domestic workers has continued to grow. This data suggests that the percentage of undeclared labour is on the increase. It also indicates a growing resistance on the part of women with access to the labour market to carry out family chores. In a context where men’s participation in these chores is increasing only very slowly, the result is that a significant amount of this work is being outsourced.

The highly precarious nature of work in this sector is closely linked to the fact that the majority of those employed are women from countries outside the European Union. Of those registered with the social security scheme for domestic staff, 84.4% are foreigners (Parella Rubio, 2000, p. 279). It is likely that the percentage is even higher among workers who are not registered.

In Spain at the moment the bulk of domestic workers come from Latin America (their three main countries of origin are the Dominican Republic, Peru and Ecuador), Africa (mainly Morocco) and Asia (in particular from the Philippines). For immigrant women coming from outside Europe, the labour market is a great deal more segregated than for Spanish women. For non-EU immigrants with a residence permit, the range of activities offered by the labour market is extremely small: 47.7% are employed as domestic staff and 8.2% work in the hotel industry. There is a clear contrast with men, for whom the labour market is more diversified (even though in almost all cases the jobs are badly paid): agriculture (15.7%), construction (10.7%), hotel industry (10.1%), commerce (9.8%), domestic work (6.3%) (figures from the Permanent Observatory of Migration for 1998, quoted by Parella Rubio, 2000, pp. 278-279).

Research into the working conditions of female immigrant domestic workers in Spain highlights two quite different situations. Staff who live in the home where they work generally have very long and poorly defined working hours. In practice, they are required to be available for “low intensity” tasks and this working time is not considered to represent overtime. This overlapping of working time and “attendance time” is set out explicitly in Spanish legislation, which considers that in addition to actual working time (limited to 9 hours per day and 40 hours per week), the contract concluded with the employer may define an “attendance time” when the employee may be called upon to carry out tasks requiring little effort! This system is clearly contrary to the provisions of Community law, which - let me recall - do not apply to these workers. Indeed, a survey of Dominican domestic staff estimates that they work on average 11.9 hours per day, reaching peaks of 16 hours per day in some instances. These very long working hours are a serious problem for the majority of the female workers who participated in the survey. Where employees are in the country illegally, it is not unusual for them to face a type of confinement in their employer’s house. Herranz Gómez (1997) states: “the lack of free time and excessive working hours very often turn into genuine imprisonment for many illegal employees in this sector.
Added to the worker’s fear of being arrested outside the workplace is the employers’ fear not only that their employee will be arrested but also that they might come into contact with the outside world, find more advantageous offers and, ultimately, move to a new job. An illegal married couple working in the same household told us in an interview that not only were they paid just one wage for the work of two people, they were also only allowed to go out only one day a week and never together. They are so unhappy that they are seeking another home in which to work, but because they cannot go out they cannot buy the newspaper. They buy it in secret from the person who delivers bread to the house”.

Live-in work generally involves separation from one’s family even when the family is in Spain. Indeed, a migratory trend is evident, characterised by a high degree of separation of men and women (as regards areas of activity, geographical location, etc.). It is therefore not unusual for husbands and wives to live in different homes and meet up once a week in bars or other meeting places. In this respect, live-in immigrant workers today differ from live-in domestic servants in previous generations who came from rural areas of Spain. The latter were generally young, single women who carried out this type of work for only a few years of their life, before getting married. However, married women make up a significant proportion of live-in domestic staff nowadays. Live-in domestic work is often linked to the need to save a substantial part of a wage that is very low, in order to be able to “send money back home”. For external workers who work for a specific period of time in different homes, the limits on working time are in general better defined although the duties required of them are much more intensive. They are usually paid by the hour while live-in staff tend to receive a monthly wage. External workers have much less stable jobs than their live-in counterparts.

a. The figure for wage earners who declare that they employ domestic workers is taken from the Active Population Survey (APS). In the 1991 APS, this figure totalled around 330,000; it had increased to 390,000 by 2000.


c. The regulations on paid domestic work in Spain are set out in Royal Decree 1424 of 1 August 1985 (BOE, 13 August 1985). In particular, this Decree allows domestic workers to be hired on the basis of a simple verbal contract.

The 1992 directive on pregnant workers

The only directive in the field of occupational health that specifically mentions female workers relates to maternity protection129. In that sense, it follows the logic of the directives on equal opportunities130 and the case-law of the Court of Justice131, according to which a differentiated approach for men and women is legitimate only if it relates to biological conditions or motherhood. Motherhood is thus considered to be an exceptional situation linked to the unique nature of women. In truth, the Court of Justice’s view is not restricted to biology. It has developed around this “motherhood exception” an interpretation that combines biological aspects and the assumption of a sort of natural role of women in relation to children, which it describes


130. Directive 76/207/EEC on the equal treatment of
tersely as the “special relationship between a mother and her child” (for a critical analysis, see McGlynn, 2000).

Far from constituting “exceptional situations” allowing labour law to stray from the rule of equality in relation to a masculine referent, pregnancy and maternity could be dealt with much more coherently through equality legislation designed as an instrument to transform the unequal social conditions with which women are burdened in the organisation of work. By departing from the area of biological exception (which is almost inevitably associated with an abnormality, even a disease) and looking instead at that of workplace relationships, the directive could undoubtedly have been incisive and effective. This would thus entail regulating working conditions in industry so as to make them compatible with reproduction, in its various dimensions: social and biological. That would justify the requirement for all working environments to carry out a risk assessment ensuring from the outset - even before a worker declared that she was pregnant - that working conditions were compatible with pregnancy. That would also make it possible to resolve the contradiction between the option of taking maternity leave and the doubts concerning adequate income guarantees.

Risk assessment plays a key role in the directive. In fact, the directive does not set out any specific prevention measures; it merely lays down risk factors in a non-exhaustive manner and states that these factors must be taken into consideration when establishing prevention measures. The directive is unfortunately very ambiguous when it comes to determining how this risk assessment is to be carried out. On the one hand, Article 4(1) could be interpreted in a restrictive way to mean that a risk assessment is only carried out when an undertaking employs pregnant women, or women who have recently given birth or are breastfeeding, who have informed their employer of their situation, and that it should cover only the posts occupied by these women. On the other hand, Article 4(2) rejects such a narrow interpretation. It stipulates that information regarding

131. In Community case-law, this idea of motherhood and pregnancy based on biological data or linked to the specific relationships between a mother and her young child is set out very clearly in the Hofmann ruling of 12 July 1984 (ECR, 1984, p. 3047).
the risk assessment must be provided to the workers referred to in Article 4(1) and/or their representatives, as well as to workers “likely” to be in one of the situations covered by the directive (in other words likely to become pregnant, to have recently given birth, etc.). It is obvious that for this information to be provided, a risk assessment will have had to be carried out in advance. It is important to clarify that this assessment must cover all of the posts occupied or likely to be occupied by women. In my view, this last criterion means every post, without exception. The vast majority of women of working age are likely to become pregnant and, in any case, it would be discriminatory and prejudicial to private life to allow employers to verify whether or not the female workers they employ are “likely” to become pregnant.

This interpretation is in line with the reminder in Article 5 of the hierarchy of prevention measures in the framework directive. Indeed, if one wants to eliminate risks at source and give priority to collective and permanent measures over individual and temporary measures, a risk assessment carried out after a worker informs her employer that she is pregnant does not allow for an effective prevention policy. The scientific literature indicates that the greatest risks to the foetus are most likely to occur in the early stages of pregnancy. In most cases, once an employer is informed of a pregnancy it is too late to prevent these risks. Even in an environment where it is easy to inform employers of pregnancy at an early stage, on average they are informed after 7.5 weeks of gestation (Von Busch et al., 2002: this study relates to women in the United States Air Force; a study on women in other employment sectors in the United States indicates that employers are informed on average after 10.9 weeks of gestation). The critical period for the development of the central nervous system is between the third and fifth weeks of gestation, and between the third and sixth weeks for the development of the heart. For the development of arms, legs and eyes, this critical period begins in the fourth week. Overall, most of the risks of malformation of the embryo occur between the third and eighth weeks of gestation with different peak periods depending on the organ (Frazier and Hage, 1998, pp. 12-15). This implies that for the vast majority of women, measures to prevent exposure to teratogenic agents will be ineffective, even in the best scenario where they are adopted as soon as the employer is informed of the pregnancy.

The only effective means of prevention would involve limiting maternity protection to certain conditions specific to the situation of pregnant women (mainly as regards ergonomics,
working time and intensity of work, but also as regards enhanced protection against certain infectious agents and ionising radiation), adopting a much stricter policy to prevent chemical risks based on the elimination and substitution of substances harmful to reproduction (in both women and men) and, in cases where elimination would be technically impossible, establishing effective control measures that reduce exposure to the lowest levels technically possible.

This initial ambiguity concerning the timing and subject of the risk evaluation is compounded by uncertainty regarding the assessment criteria. The directive relates to the health and safety of pregnant workers and workers who have recently given birth or are breastfeeding. Yet the non-exhaustive list of agents, processes and working conditions annexed to the directive mentions only those physical agents that endanger the foetus. Experience shows that some work situations, although they may not necessarily endanger the foetus, may have negative consequences for the health of workers in the medium or long term (in other words, extending beyond the period when the woman is protected as a “reproducer”). For example, there is a correlation between working on one’s feet during pregnancy and varicose veins.

In a number of countries, a risk assessment in relation to pregnancy must be undertaken whenever there is a woman working in a firm. This requirement is set out most clearly in Austria’s legislation. However, there are similar approaches in Denmark, Finland, Ireland and Sweden. In the Nordic countries, this requirement also corresponds to the emphasis placed on prevention at source and the desire to cover all reproductive risks in a global approach. Finland has a list of agents that are harmful to reproduction which is more extensive than the annexes to the directive and a list of agents that are hazardous during pregnancy. These two lists are based largely on research carried out in co-operation between the Nordic countries.

Article 5 of the directive contains a hierarchy of the measures to be adopted. First of all, the prevention programme set out in Article 6 of the framework directive must be complied with (priority is given to eliminating risks and combating risks at source), then temporary adjustments must be made. If these are technically or objectively impossible, the employer must transfer the worker to another post. If transferring the worker to another post is not technically or objectively possible, the worker must be granted leave for the period necessary to protect her health. The directive does not provide any criterion to
assess what is meant by an objective impossibility. Is the desire to make a profit sufficient to exclude measures that would entail high costs?

In practice, it seems that the most common option is to transfer the woman to another job if there are substantial risks. Pregnancy thus becomes a disease that excludes certain working environments. This solution poses two problems. On the one hand, the absence of sufficient guarantees concerning pay implies economic pressure that can compel some employees to remain in a job which presents a danger. On the other hand, primary prevention through the elimination of risks at source does not appear to be a priority. A study from Quebec clearly sets out the issues involved in the widespread use of measures to transfer workers to other jobs (Malenfant in: Harisson and Legendre, 2002, p. 17): “The reorganisation of work caused by pregnancy adds tension to workplace relationships. It is not without reason that the most common “protection” measure still consists of removing pregnant workers from their posts where the duties pose a danger to them or their unborn child. On the one hand, undertakings are reluctant to modify the working environment or to rearrange duties in order to allow them to stay in their post, thus demonstrating their reluctance to integrate the reproductive dimension of women’s lives into their workplaces and production processes. On the other hand, redeployment in the workplace upsets organisation, affects working relationships and becomes difficult for pregnant workers to tolerate if it involves constant negotiations with colleagues and employers”.

It is only in those countries where priority has been given to eliminating reproductive risks in all work processes that prevention by transferring employees to other posts is not common practice. In Finland for example, between 1992 and 1996, this measure was applied to fewer than one hundred workers per year, in other words 0.1% of births (Taskinen et al., 1999, p. 57).

Most of the national legislations have not explicitly defined the criterion that makes it possible to move from one option to the other. Employers therefore have substantial power of discretion. In most cases, national legislation reproduces almost identically the provisions of the directive. However, some States have established a more explicit link between the measures concerning maternity protection and the general prevention programme based on the framework directive (Austria, Spain, United Kingdom). In this way, there should be greater legal certainty as regards respect for a hierarchy of prevention measures,
bringing the permanent elimination of risks to the forefront. In the case of the United Kingdom, there are nonetheless significant uncertainties. Although the provisions based on the framework directive are generally contingent on a “reasonably practicable” clause - which seems in itself to contradict Community law - the prevention requirements deriving from the directive on maternity are accompanied by a clause whose scope is even less precise: employers only need take action “where reasonable”. They therefore retain considerable room for discretion.

One of the directive’s weaknesses is that, contrary to the other occupational health directives, no provision is made for consulting worker representatives on prevention measures. This situation could increase the trend towards treating the safeguarding of pregnant workers’ health and safety as a question that relates to individuals in an abnormal situation, rather than as a collective issue concerning occupational health in every undertaking. Practice shows that the degree of effectiveness of the labour inspectorate’s checks depends to a large extent on the activity of collective representative bodies.

It is significant that the limitations of this directive become especially apparent each time it addresses areas of labour law situated outside the traditional health and safety regulations. The links between the right to equality and the right to occupational health are crucial, and the directive does not succeed in treating them entirely coherently. Looking at occupational health legislation as an isolated body of technical rules would be to deprive it of any effectiveness in a context determined by social relationships at work. One of the major shortcomings of the directive on the health and safety of pregnant women is the timidity it demonstrates when tackling these other issues. For instance, the directive does not establish sufficient guarantees as regards maintenance of pay during maternity leave, and it is easy for employers to circumvent the provisions concerning protection against dismissal if they invoke a reason other than pregnancy.

The adoption of the directive gave rise to controversy among the Member States. Italy voted in favour subject to a commitment to improve the directive as soon as possible. This commitment was presented in a weaker form in Article 14(6) of the directive, which stipulates that the Commission will re-examine the directive and, should the need arise, submit a proposed amendment no later than October 1997. The report presented by the Commission in 1999 looked only superficially at occupational health issues. For the most part, it merely described...
the national transposition measures rather than analysing the problems posed by the implementation of the directive. In July 2000, the European Parliament carried out a critical analysis of the implementation of the directive and came out in favour of revising the directive\(^\text{133}\). Parliament’s resolution highlighted some of the amendments needing to be made to the directive. The Commission has not yet presented any proposals at all on this subject. The communication it presented on the Community strategy for health and safety for the period 2002-2006 does not make any reference to this issue.

**Other directives concerning occupational health**

The framework directive, despite emphasising the social relationships within relations at work, makes absolutely no mention of equal access to all employment situations for both men and women as an objective to be achieved.

The directives on specific topics are highly influenced by an approach which, by ignoring the gender dimension, implicitly makes men’s work the standard referent. For instance, faced with the widespread phenomenon of musculoskeletal disorders, the Community approach was merely to regulate the manual handling of loads\(^\text{134}\) in conditions that apply more generally to men’s work rather than women’s work.

The working-time directive\(^\text{135}\) ignores all the issues raised by the women’s movement as regards working time. On the whole, it confines itself to determining some limits on daily rest periods, weekly rest periods, weekly working time, the duration of annual leave and the maximum duration of periods of night work. These limits are often less favourable than those already existing in most EU countries. Moreover, they are accompanied by flexibility clauses that are of particular benefit to employers (even including the possibility of annualising working time on the basis of an average working week of 48 hours!). The very foundations of the directive are questionable: it is as though time were divided up quite straightforwardly between working time and rest time. Time for domestic work, for training, for transport, etc. is ignored. Waiting time between two periods of availability for the employer, which is typical of many part-time work situations, is ignored by these provisions (just as it is ignored by the subsequent directive on part-time work). The transition from night work to day work is considered not to be a right but a simple option dependent on a medical inspection (as if there were no other reasons for wanting to give


\(^\text{134}\). Directive of 29 May 1990 on the minimum health and safety requirements for the manual handling of loads where there is a risk particularly of back injury to workers, OJEC L 156 of 21 June 1990, pp. 9 et seq. For a critical analysis, see TUTB Newsletter No. 5 (February 1997), pp. 6-10.

\(^\text{135}\). Directive of 23 November 1993 concerning certain aspects of the organisation of working time, OJEC L 307 of 13 December 1993, pp. 18 et seq.
up night work!). The subordination of human time, differentiated according to gender, solely to the economic need to make money is pushed to the extreme in this directive, which allows a multitude of derogations, exceptions and flexibility measures without arranging for any consultation of the workers directly affected.\textsuperscript{136}

Musculoskeletal disorders are one of the main ailments affecting both male and female employees today. One of the reasons for this is the intensification of work and the fragmentation of tasks in certain sectors where this was less common in the past. Other factors also play an important role: the absence of job mobility, the inappropriateness of employment from the point of view of remaining in paid employment throughout one’s working life, the downgrading of work and the stress this causes, etc. Strategies to combat musculoskeletal disorders are largely determined by the gender division of labour. As a general rule, the physical stress linked to women’s work is more often characterised by the repetitive nature of the work while the physical stress of men’s work is mostly linked to the manual handling of heavy loads. Moreover, care of people is generally carried out by women. This involves a great deal of physical effort to which it is difficult to transpose the preventive solutions designed for the movement of inert objects. Supporting, lifting or moving a living human being involves work that cannot merely be reduced to the physical effort required.

European Directive 90/269/EEC\textsuperscript{137} adopted a restrictive approach which implicitly prioritises the male activity of carrying heavy loads and neglects the female activity that is more often characterised by repetitive tasks and painful postural strain.\textsuperscript{138}

In France (MES, 1999), the data from the 1994 SUMER survey indicate that manual handling is carried out by 45% of male workers compared with 26% of female workers. The handling of objects is particularly common in largely masculine occupations: 92% of construction workers, 74% of warehousemen, 66% of car mechanics, etc. The handling of people is very common in the healthcare sector where mainly women are involved: 73% of nursing auxiliaries and ambulance assistants, 59% of nurses.

The directive relates mainly to back injuries, based on regulation of the manual handling of loads. Its scope is limited to loads that are considered to pose a danger to health. This raises the problem of assessing situations that are not considered to pose a risk from the point of view of the characteristics of the

\textsuperscript{136} Almost all the directives concerning the working environment contain provisions on worker consultation. Admittedly, their overly vague wording and the framework directive’s straightforward referral back to national regulations and practices is to be regretted; however, the issue is at least raised.


\textsuperscript{138} It goes without saying that this representation is itself an approximation. Nurses are often required to carry “loads” (in this case human beings, who cannot be transported like bags of cement!) that are heavier than those carried by construction workers.
load (weight, volume, balance, etc.) but that nonetheless pose risks as regards the other factors affecting the physical load. The directive tends to give priority to the concept of a load as an object being transported (in the broadest sense) rather than a load as analysed in ergonomics as the result of various factors of work activity. Moreover, it highlights the risks of back injury even though it always puts the adverbial phrase “in particular” before this notion. To illustrate this limitation of the directive, we can consider the following examples. If a worker in the textile industry presses the pedal of a sewing machine thousands of times a day, this is certainly a physical strain that is likely to result in a disorder. This strain seems to be excluded from the scope of the directive insofar as there is no physical object distinct from the work equipment. Lifting a lightweight mail parcel thousands of times a day will be covered by the directive as long as it is linked to another aspect of the work such as “over-frequent or over-prolonged physical effort involving in particular the spine”. This wording and that describing the other characteristics not intrinsic to the object being handled are too restrictive to allow the problems posed by the intensity of work or its repetitive nature to be tackled coherently. Admittedly, it will always be possible to refer back to the framework directive when dealing with these issues, but the fact remains that there is a rather broad grey area with regard to the specific prevention measures which must be adopted.

The new Community strategy: a turning-point?

In March 2001 the Commission presented a communication on a new Community strategy for health and safety for the period 2002-2006. This was a long-awaited document, prepared through numerous debates, and its adoption was far from easy. Its presentation had had to be postponed due to differences of opinion within the Commission. The original version prepared by the Directorate-General for Employment and Social Affairs was amended by other Commissioners, a majority of whom wanted the text to be less ambitious or less detailed on certain points (particularly concerning psychological harassment and violence at work).

The Commission communication contains many interesting features; in particular, an openness to the gender dimension, which is a new direction in the Commission’s thinking in the field of occupational health. It is likely that the efforts made by the Belgian Presidency during the second half of 2001 contributed to this policy shift. Mainstreaming the gender dimension is
considered to be one of the eight objectives of a global approach to well-being at work.

Nonetheless, the communication takes a somewhat defensive view. It turns occupational health into an overly passive element that must “take account” of the division of labour between men and women. In my view, it should play an active role and help to combat job segregation. This aim appears only once, in a paragraph on the fisheries policy. Specific proposals are lacking, except with regard to promoting research and a very general reference to the fact that prevention services should embrace the gender factor. Consideration should also have been given to the question of indicators, and the communication should have encouraged a harmonisation of the systems for the reporting and recognition of occupational diseases, putting an end to the discriminatory practices currently in place. Mainstreaming the gender dimension should also have helped to back up clearer proposals on violence at work and musculoskeletal disorders.

The communication quite rightly emphasises that musculoskeletal disorders are a priority for occupational health. A general directive on musculoskeletal disorders setting out ergonomic requirements would enable significant progress to be made. The contribution of a possible Community action in this field cannot be denied. With the exception of the Nordic countries, no Member State has adopted specific regulations on these issues. The difficulty is political rather than technical: tackling musculoskeletal disorders at source means intervening in the organisation of work and, in particular, combating its intensification. The communication contains two passages devoted to Community initiatives in the field of musculoskeletal disorders, stating that the Commission will submit a communication looking into the causes of MSD and propose amendments or new legal provisions in fields where coverage is still incomplete. This wording is ambiguous. It would have been possible to tackle both elements now: by revising the existing specific directives where they are insufficient, and by preparing a new, more general directive on the essential ergonomic requirements linked to the prevention of musculoskeletal disorders.

The communication also highlights the importance of “psycho-social problems and illnesses”, making particular reference to psychological harassment and violence at work. The text drawn up by the Directorate-General for Employment and Social Affairs envisaged the elaboration of a directive on these two topics. The final text adopted by the Commission is more vague: the Commission “will examine the appropriateness and
The gender workplace health gap in Europe

The scope of a Community instrument on psychological harassment and violence at work. One of the underlying elements of the debate is the following: do psychological harassment and violence at work constitute problems in the workplace that are harmful to health?

The communication rightly examines two key pillars of any prevention system: prevention services and labour inspectorates. With regard to prevention services, it states that they “should be genuinely multi-disciplinary, embracing social and psychological risks, and the gender factor”. The vision is the right one. However, no concrete proposals are put forward to achieve this goal, which is far from the current reality.

The communication does not look at the current scope of the Community directives, which excludes the self-employed and domestic workers. This is a substantial gap in the existing provisions. For domestic workers, the gender significance of this “oversight” is evident (see above).

The communication does not contain any reference to harmonising the reporting and recognition of occupational diseases. However, it does open up the prospect of a convergence of national policies based on the comparison of different indicators (benchmarking). Quantified national targets should be adopted so as to achieve a reduction in the rate of accidents at work, a reduction in the rate of recognised occupational diseases and a reduction in the number of days lost due to such accidents and diseases. The scope of these indicators will not be looked at here other than to say that the second (and, therefore, the third which stems directly from the other two) makes no sense until there is a harmonized system for the recognition of occupational diseases at Community level. From a gender perspective, the adoption of these three indicators would result in a serious underestimation of the damage to women’s health. A comparison of the structural indicators of prevention systems (prevention services, worker representation, percentage of workers actually covered by these tools, etc.) is not mentioned, despite the fact that major efforts should be made in this area to ensure that both male and female employees have genuine access to these prevention structures.

The new strategy has been designed to cover the period 2002-2006. The constraints on Community action are such that if the initiatives are not launched rapidly, they are unlikely to be completed on time. The period between the preparation of a directive or a programme and its adoption is generally quite
long. Therefore, it is important to lay down precise criteria allowing us to determine the extent to which the Commission’s commitment to mainstreaming the gender dimension translates into action.

Some immediate priorities may be set out on the basis of the elements analysed in this volume:

- The gender dimension should be integrated into the report on the implementation of the directives due to be published in the second half of 2003. This report will be an important element in identifying the progress made and gaps remaining and in reshaping, if necessary, the Community’s action. The report on the framework directive should look at changes to the structural mechanisms of prevention systems: preventive services, worker representation, operation of labour inspectorates, etc. What safeguards do these mechanisms provide for men and women, what are their strengths and weaknesses, including from a gender perspective? These are important questions to discuss.

- The Commission’s communication rightly states that musculoskeletal disorders and psychological and physical violence at work are priorities. The adoption of directives on these issues will be an important test in judging the coherence of the proposed strategy.

- The interaction between measures implemented in the field of occupational health and other Community policies should result in a better integration of working conditions into equality policies. The fight against labour market segregation should benefit in particular from this approach. Making jobs accessible to both men and women requires a co-ordinated set of policies where working conditions have traditionally been neglected.

- The revision of the directive on pregnant workers is another important test of credibility. The European Parliament has provided clear indications for certain improvements.

- Minimum harmonisation of the conditions for recognition of occupational diseases should establish the means to be effective (through the adoption of a binding Community instrument) and, at the same time, put an end to the systematic discrimination suffered by female workers today.
A couple of exceptions

Although the general diagnosis suggests that national occupational health policies are still very impervious to the gender dimension, it may be of interest to highlight a couple of exceptions and look at the conditions which made them possible.

In 1998, the Occupational Safety and Health Administration, the public authority responsible for the activities of the labour inspectorate in Sweden, adopted a strategy relating to differences between women's and men's working conditions. The aim of this strategy is to give greater visibility to the gender dimension in relation to all risk factors. It states that gender equality is not a specific goal of the labour inspectorate, which follows a risk-based approach, but adds that this activity must not be isolated from the other policies implemented by the public authorities. The strategy is based mainly on the development of knowledge and of indicators; the concept of visibility plays a key role. In this way, hidden or underestimated risks should be brought to light. However, regulatory developments are envisaged. The available data when drawing up this report does not enable to assess the impact of this strategy.

The occupational health plan adopted by the Autonomous Community of Navarre in 1999 takes a much more ambitious approach. It aims to implement occupational health plans covering the whole population and taking account of segments that are traditionally neglected. The desire to ensure equal coverage of the entire working population led the Navarre authorities to put forward specific objectives for the unemployed, the self-employed, temporary workers, small and medium-sized undertakings, and women. The specific measures for women focus on three major areas: decreasing the double working day by establishing collective infrastructures and introducing measures to encourage men and women to share family responsibilities and chores; working with the labour inspectorate to improve women's working conditions; and establishing co-operation between the public health system and occupational health professionals in the field of reproductive health.
The case of Ms X is covered in a study by Eurogip (2002-c) which compares the recognition of lumbago and allergy-induced asthma in various European countries. We have simplified the facts of the case and the results. Neither the UK nor Ireland participated in the study.

Ms X is a 45-year-old nurse since the age of 25, she has worked in a home for handicapped elderly people. She regularly has to lift patients and put them to bed. Ms X suffers from lumbago. After completing a course of medical treatment, she has developed serious after-effects. She resigns herself to changing her job and accepts a pay cut. In Spain, Luxembourg and Denmark, provided certain conditions are met, her lumbago would be considered an occupational disease. In Italy and Sweden, she would have to provide evidence that the ailment was caused by her occupation; past experience indicates that her claim would probably be rejected. In France, the lumbago would have to be caused by a slipped disc and a very strict combination of additional medical factors – her situation does not match these conditions. The requirements in Germany mean it is unlikely that her complaint would be recognised as work-related. At least in Portugal she would be spared a lot of paperwork, as her claim would immediately be fully rejected. In Belgium, rejection is highly likely. However, she could take consolation from the fact that occupational lumbago is currently being dealt with by a committee of experts. The committee has raised a number of questions and reservations about including this complaint in the list of prescribed occupational diseases, but may change its opinion in the future.

Another study (Hulshof et al., 2002) looks at the hypothetical case of Ms Robinson who suffers from back pain and sciatica, having been exposed to vibrations in her work as a fork-lift truck driver. The outcome varies from one country to another, demonstrating the lack of harmonisation.

Recognition of occupational diseases is too low in all EU Member States (Eurogip 1999; De Brucq, 2001; Vogel, 2001; Eurogip, 2002-a and b).

The most direct effects of this under-recognition are:
- Low visibility for many disorders which are not seen as a priority for prevention policies.
- A massive transfer of resources in favour of the employers. In fact, with the exception of the Netherlands, every EU Member State has set up a compensation system for occupational
diseases, which is mainly financed by contributions taken directly from wages. This failure to recognise occupational diseases generally leads to part of the costs being borne by the victims (for example, a loss of income caused by changing jobs or by becoming unemployed, and most of the other side-effects of a disability), with another part of the bill falling to the general health budget (sickness insurance, disability payments, unemployment benefits, public health system, etc.). In addition, sufferers of occupational diseases tend to find that their health costs are better covered than within the general healthcare system. A recent report estimates that the compensation scheme for industrial injuries and occupational diseases in France leaves the healthcare system carrying a large part of the costs generated by under-declaration. The total amount involved is somewhere between €368 million and €550 million per year. The transfer of costs to the sufferers also has a gender dimension: wives or other female relatives of a person suffering from an unrecognised occupational disease have to provide additional unpaid labour (Scavone, 2002).

What is more, lack of recognition for an occupational disease often causes a great deal of distress for the sufferer. There can be a strong sense of injustice and of confrontation with anonymous powers, which can have disastrous health effects. There are very few trade union officials who do not have bitter tales to tell. Some victims spend years battling through expert medical opinions, administrative and legal procedures. Few emerge unscathed. In some cases, the doctor may even suggest that a sufferer should refrain from reporting an occupational disease, in the knowledge that the procedures involved are cumbersome and the outcome uncertain.

It is worth looking at the gender dimension in under-recognition of occupational diseases. Systematic and flagrant discrimination exists, which undermines prevention policies designed for those diseases more commonly encountered among female workers, and which affects women more than men. This discrimination informs any critical assessment of Community policy in this field. Of course, elements of institutional discrimination were established in each national system long before the Community policy came into being; however, it is nonetheless worrying that Community policy has never provided any means of challenging the status quo.

This analysis will concentrate on two questions: to what extent does the under-recognition of occupational diseases affect...
women more than men, and what policy has the European Union pursued in this area?

**Gender and occupational diseases**

Discrimination between men and women is one of the major features of all systems. In countries where statistics include a gender breakdown, the following trends can be observed:

- the level of occupational diseases reported is often lower for women;
- the percentage of rejected occupational disease claims is often higher for applications made by women than men;
- in all cases, the net number of recognitions (calculated from the two previous categories) is always lower for women;
- women are even more dependent than men on the mixed system of recognition working well, in order for their occupational disease to be recognised in those countries where there is such a system. Mixed systems are those systems with a list of prescribed occupational diseases for which causality is presumed and where other procedures exist for the recognition of illnesses which do not appear on the list or do not meet all the criteria laid down in the list.

No exhaustive evaluation has ever been carried out, so I have selected a number of salient facts. This analysis focuses on two countries whose systems of recognition for occupational diseases produce very different results: the United Kingdom and Belgium. Examples from Denmark and Sweden provide some additional information.

Within the European Union, the UK has one of the lowest ratios of recognised conditions to number of workers covered by the system. Belgium, on the other hand, has a very high recognition rate. According to Eurogip (2002-a, p. 22), Belgium ranked first in 1994 with 189 occupational diseases recognised per 100,000 insured workers. In 2000, Belgium had dropped to fifth place (after France, Spain, Sweden and Denmark), but at 112/100,000 still had a relatively high recognition rate when compared with 49/100,000 in Germany and 33/100,000 in Italy. It was interesting to investigate whether the large discrepancies between the results of the two systems had any implications for gender equality. The comparative study is complemented with a quick overview of a third system which could be classed as “sensitive” (high level of reporting) but extremely selective (high proportion of rejections).
Of those countries which provide gender breakdowns, the UK seems to have the most discriminatory system. In fact the data available are limited but do indicate that, in most European Union countries, women make up between 25% and 40% of all recognised cases of occupational disease. In the UK, the proportion is less than 10%. However, the UK is also one of the countries where, in general, the costs related to occupational diseases are borne by social security and are very low, both in terms of the number of cases recognised each year and the total amount paid out. In recent years, fewer than 7,500 cases of occupational disease have been officially recognised each year. This contrasts with just under 20,000 cases recognised in Spain in 2000, where the insured population is much smaller.

In the United Kingdom, recognised occupational diseases are divided into two groups: respiratory disorders and other disorders. The former mainly covers all pneumoconioses, asthma, chronic bronchitis, lung cancers caused by asbestos exposure and mesothelioma. Men represent over 97% of cases. In 2000, there were 65 women among the 2,605 employees recognised as having a work-related respiratory disorder. Even in the case of occupational asthma, women only constituted around 20% of all recognised cases (33 out of 168 cases in 2000), although many epidemiological studies have revealed relatively high levels of occupational asthma among female workers. It must also be stated that the number of recognitions of asthma as a work-related illness fell drastically between 1994 and 2000 - from 506 cases to 168. This reduction is probably the result of changes to the administrative registration procedures (HSE, 2001). The UK figures do not provide any information about the rejection rate (see HSE, 2001). The only information available relates to the final results of the system, in the form of those illnesses which have been recognised as occupational diseases and are therefore eligible for compensation.

The second group covers all other diseases and disorders. Women make up less than 10% of all cases in this category: 436 cases out of 4,690 in 1999-2000. There are only two categories where most cases relate to women: musculoskeletal disorders (305 women from a total of 431 cases in 1999-2000) and disorders related to biological agents (5 women and 7 cases in 1999-2000), but recognition for these disorders is so rare that these figures have no significant effect on the overall picture. In fact, around 70% of cases of non-respiratory ailments relate to just one disorder: vibration white finger (also known as Raynaud’s syndrome). Out of 3,212 recognised cases in 1999-2000, five were women. The United Kingdom is certainly the only country...
in the European Union to recognise more cases of mesothelioma than musculoskeletal disorders (652 to 431 in 2000 and 1999-2000 respectively).

With around 500 women recognised as having an occupational disease in 1999-2000 (roughly 7% of the total figure) it does seem that British women are effectively excluded from the system of compensation for occupational diseases. This exclusion has actually worsened slightly if we look at data from ten years ago (OECD, 1993). In 1990-91, the number of recognised cases of occupational disease was slightly higher at 9,253. The proportion of cases involving female workers was also slightly higher at just under 9% of 809 cases in all.

Other compensation options are also available. Workers suffering from occupational diseases can obtain compensation from their employer if they can demonstrate that the employer bears civil liability for the damage. The judicial route is quite often used in the UK. In certain cases, employers’ insurance companies establish a collective compensation policy to prevent the number of individual court cases from spiralling. To my knowledge, no study has been carried out in the UK to assess the gender dimension in the results of these lawsuits or decisions taken by insurers.

In Belgium (FMP, 2002), the Fund for Occupational Diseases (FMP) received 4,965 initial requests in 2000 for compensation for occupational diseases already appearing on the list (for the private sector). 807, or just over 16%, of these requests came from women. The FMP received 1,610 first-time requests under the open system, 387 of which involved female workers (ca. 24%).

The FMP responded positively to 2,015 requests for compensation for incapacity due to an occupational disease under the list system, with 290 of these cases relating to women (around 14%). 2,180 requests were rejected, including 235 female workers (around 11%). There were far more rejections for those disorders dealt with under the open system. For incapacity to work, 86 positive decisions were issued while 1,261 cases were rejected – a rejection rate of over 94%. 36 of the favourable decisions involved women (ca. 43%). The vast majority of the illnesses for which compensation was requested under the open system were musculoskeletal disorders.

If we add up the figures from the list and open systems, we can see that women make up around 19% of the requests for compensation.
compensation and benefit from around 15% of the positive decisions. Nevertheless, the rejection rate in both systems is slightly higher for men. There is a simple explanation: women are more dependent than men on the open system.

It is difficult to take the analysis much further. The statistics published by the FMP are very impenetrable, making it difficult to obtain more information about the gender dimension. The statistics do not give a gendered breakdown for the rejections nor for the disorders reported. Moreover, the FMP’s publications never include a gender analysis of the impact of decisions taken.

If we compare Belgium with other European Union countries, several trends emerge:

- Relatively high recognition rates for “traditional” disorders which mainly affect men (silicosis, hearing loss).
- A genuine improvement in the recognition rates for disorders related to mechanical vibrations, which also mainly affect male workers. Thus in 2000, out of 1,105 positive decisions relating to permanent incapacity due to occupational diseases caused by physical agents, over 830 cases related to disorders caused by mechanical vibrations, including three women.
- In the list system, it is striking that for all disorders caused by physical agents, only just over 5% of the cases recognised related to women. All the epidemiological data available would lead us to expect a much higher figure, which raises the question of whether the lists have been drawn up in such a way as to exclude more or less systematically those illnesses which most commonly affect female workers. For example, epicondylitis is only recognised as an occupational disease for performing artists. Data from other European countries seem to indicate that if recognition were extended to other sectors, a relatively high number of women would have had their occupational disease recognised.
- The open system does not operate very well (Lecomte 1995). Very few cases are recognised, and certain disorders such as lumbago are systematically excluded. It does seem that failings within the system discourage the reporting of occupational diseases. In many cases, sufferers choose not to jump through all the hoops required for recognition of their occupational disease. This is particularly clear in cases of carpal tunnel syndrome. In 2000, only seven individuals sought recognition under the open system. Six cases were rejected!
- Mental health problems are completely taboo, despite the

154. Hulshof et al. (2002) compared the data for 1999: 763 cases of occupational disorders caused by mechanical vibrations were recognised in Belgium, 269 in France and 16 in Germany. Germany has a very low recognition level for disorders caused by vibration (1-5% depending on the year). This is due to very strict conditions applied when calculating the vibrations experienced during a person’s entire working life.

155. On 8 May 1996, the Management Committee of the FMP (made up of equal numbers of representatives from employer and trade union organisations) rejected the inclusion of any type of lumbago on the list of occupational diseases. This decision was accompanied by a declaration that offers little encouragement to sufferers who are tempted to claim through the open system. The Management Committee “noted that it would be very difficult in practice to prove a determining and direct causal link between the disorder and the occupation itself in any individual case” (Bulletin d’information du FMP, November 1997, p. 42).
adoption of legislation which recognises bullying and sexual harassment as occupational health problems. However, the situation is not very different in other European Union countries.

The Danish system has some interesting features. The list of prescribed occupational diseases is longer than in most other European Union countries. This helps to explain why Denmark currently has the highest national reporting rate, as has been consistently reflected in data collected by Eurogip (2000-a) since 1995. On the other hand, Denmark is also one of the countries where the presumption of causality - supposedly the basis of the list system - offers the lowest guarantees to workers. Rejection rates are among the highest in the European Union; only Italy and Luxembourg have higher rejection rates (Eurogip, 2002-a). It can be assumed that in the medium term these rejection rates will eventually have a dissuasive effect and that a number of employees will choose not to apply for compensation for their disorder. This could explain the fairly steady reduction in the number of disorders reported between 1995 and 2000. But did the rejections have the same impact for men and women? The data in the 1999 report from the Danish office for compensation for industrial injuries are very revealing (AK, 1999). At the outset, the number of occupational diseases reported and sudden injuries caused by carrying a load were virtually identical. The figures are very similar to the proportion of female and male wage-earners: 48.97% of reports came from women, who make up 47.59% of all insured workers. However, by the end of the process, the rejections clearly had a different impact. For virtually identical reporting rates among men and women, 62.41% of recognitions related to men (based on 1999 data). The main reason for this is probably the restrictive clauses applying to the recognition of certain disorders, which is why musculoskeletal disorders have the highest rejection rate (over 93% in 1999). The classification of occupational diseases therefore varies greatly according to whether we consider reports lodged or cases recognised. Skin disorders score the highest number of cases recognised (864 cases in 1999), with joint second place going to musculoskeletal disorders and hearing problems (a much lower rate: 366 and 365 cases respectively). However, if we look at the diseases reported, musculoskeletal disorders come in first with over 6,000 cases, trailed by hearing problems (over 2,000 cases) and then skin disorders (nearly 1,300 cases).
Occupational diseases in Sweden: how austerity measures can endanger equality

Sweden has long been an exception within Europe, with the largest number of recognitions for occupational diseases. In 1993, as part of an austerity package, the government decided to review the 1976 law on insurance for occupational risk. Until then, an industrial injury was defined as being the result of an accident or other harmful factor at work. Since 1993, other factors can be taken into account only if there is a “high degree of probability” that they caused the injury reported by the worker.

On the other hand, previously there was a presumption of causality between the harmful element and the injury which worked in the employee's favour, “unless there were substantially stronger arguments to the contrary”. Since 1993, this presumption in the employee's favour has been diluted considerably: the reasons justifying the causal link have to be “predominant”. In practice, this means that the burden of proof effectively now resides with the victim.

However, Sweden has never distinguished between a list-based system where presumption of causality works in the worker's favour and an open system where the worker is effectively required to prove causality. In the past, the system's flexibility benefited employees, who could receive compensation for various illnesses which do not appear on the lists compiled by European Union countries. Since 1993, the situation has been reversed. Many applications have been rejected, including disorders for which causality would have been presumed in another country.

The effects of the 1993 legislative review soon became clear. The number of occupational diseases recognised fell by nearly 90% between 1992 and 1997. Firstly, fewer occupational diseases were reported. There were two contributing factors: the new system discourages workers from embarking on an unpredictable procedure and the economic benefits of recognition (compared to the general health insurance scheme) have been considerably reduced. Secondly, the number of rejections increased dramatically: from 31% in 1992 to 66% between 1994 and 1997.

This radical cut indirectly created discrimination. Occupational risks for female workers are often invisible, which creates major problems when it comes to proving the causal link between risk factors at work and the specific complaint. In the period 1994-97, 100 industrial injuries were recognised, of which 70 related to men and 30 to women. In particular, the number of musculoskeletal disorders recognised fell considerably.

Table 14 illustrates the discriminatory effect of the new system. It shows the proportion of occupational diseases and injuries recognised compared with cases reported during the period 1994-97.
The gender workplace health gap in Europe

Table 14: Rate of recognition for occupational diseases in terms of diseases reported, with gender breakdown, Sweden 1994-1997

<table>
<thead>
<tr>
<th></th>
<th>Women</th>
<th>Men</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Musculoskeletal disorders</td>
<td>21</td>
<td>39</td>
<td>28</td>
</tr>
<tr>
<td>Chemical agents</td>
<td>47</td>
<td>62</td>
<td>57</td>
</tr>
<tr>
<td>Social reasons or linked to the organisation of work</td>
<td>10</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td>23</td>
<td>44</td>
<td>34</td>
</tr>
</tbody>
</table>

Source: Alexanderson and Östlin in: Marklund, 2001, p. 126

A trade union campaign launched in 1998 had some success, and the recognition system was revised. The number of occupational diseases recognised per 100,000 insured workers hit its lowest point in 1997 (73 cases) but then began to rise gradually with 89 cases in 1998, 126 in 1999 and 138 in 2000 (Eurogip, 2002-a). However, rejection rates have remained high (around 55% in 2000) and are still very different from the pre-1995 recognition levels (1,242 cases recognised per 100,000 insured workers in 1990).

Part-time work, which involves women far more than men, is a further factor in discrimination. The level of compensation awarded for incapacity and disability is earnings-related. If an occupational disease or an industrial injury occurs during a period when a woman has decided she needs to work part-time for a while, the compensation award will be calculated using a base figure lower than her usual full-time wage, even if the employee had intended to return to full-time work at a later date. Various Swedish court rulings have refused to review the basis for the calculation of disability pensions.

But work-related illnesses affect women too

While the statistics are clear, they do not necessarily explain the scale of the phenomenon.

One deceptively simplistic explanation could be that the conditions in which women work mean they are not exposed to so many occupational health risks.

This explanation is contradicted by all the data coming from information systems independent of the bodies which provide compensation for occupational diseases.

In certain European Union countries, the data on recognition of occupational diseases can be contrasted with data from other sources which also assess work-related illnesses. This can include epidemiological monitoring systems set up by occupational physicians or by the public healthcare system, surveys of workers’ state of health, or even research based on epidemiological studies of certain population groups which seeks to extend the principles to encompass all employees and calculate...
the proportion of illnesses (and resultant deaths) caused by working conditions.

Whatever methods are used, all these sources lead us to the same unambiguous conclusion: there is considerable under-recognition of occupational diseases, which is even more extreme in the case of female employees.

Belgium has no system in place. The only available means of comparison is via a declaration from an occupational physician. Occupational physicians are required under law to provide a declaration when they identify an occupational disease in the course of a medical examination. These declarations do not necessarily result in the victim applying for compensation, nor are all applications for compensation triggered by a declaration from the occupational physician. Many applications are submitted after retirement and some are submitted by the family after the victim’s death. In 2000, 526 women (around 40%) were included in the 1,378 declarations of occupational disease (FMP, 2002). There is a significant contrast between this 40% of occupational diseases identified by occupational physicians and the total output of the compensation system, under which women make up approximately 15% of the cases where compensation is paid (326 women out of a total 2,101 workers).

In the United Kingdom, various sources of information can be compared with the data from the Industrial Injuries Scheme.

The best overview of the incidence of work-related disease is provided by the “Self-reported Work-related Illness” survey. Three such surveys have been carried out so far as part of the Labour Force Survey (LFS): in 1990, 1995 and 1998/1999. Those questioned are asked to report any illnesses or health problems in the twelve months prior to the interview which were caused or aggravated by work. This provides a basis for evaluating occupational health problems using a whole range of variables and looking at figures for each occupation.

In addition, occupational diseases reported voluntarily by specialist physicians are recorded by the Occupational Disease Intelligence Network (ODIN). The doctors involved may be occupational physicians or specialists and are selected according the diseases in each register. The ODIN system is currently made up of several different registers. The information provided is not exhaustive because data are not collected for all occupational diseases. The majority of workers in the UK do not have access to an occupational physician, and not all complaints can be
examined by the network’s chosen specialists. However, the data provided by ODIN are much more reliable than the information provided by the compensation system.

We should add that certain occupational diseases are listed and have to be reported to the Health and Safety Executive (HSE) by employers under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR). The RIDDOR system is much more useful for industrial injuries than for occupational diseases, and there is a lot of under-reporting.

Death certificates are used to calculate mortality for certain occupational diseases, mainly cancers and lung disorders.

The results of the LFS in 1998/99 are revealing (Jones et al., 2001). Just over 1,320,000 employees considered that they had suffered from a disorder caused or aggravated by their work during the twelve months preceding the survey. This breaks down into around 600,000 women and 723,000 men. This distribution roughly matches the proportion of men and women in the working population. In fact, male and female incidence levels are identical, at 4.6% of the total workforce.

Musculoskeletal disorders are the main type of complaint reported (around 560,000 cases), followed by stress, depression and anxiety (over 430,000 cases). Incidences of musculoskeletal disorders among women are very slightly lower than for men (1.9% and 2% of the total workforce respectively). Women had higher incidence levels for stress, depression and anxiety (1.7% as opposed to 1.4%).

Examining the data from this study also allows us to postulate that women are worn down more by their work, which could contribute to exclusion of women from the labour market. If we look at the total figures, the incidence rates for men and women are practically identical. However, if we look at gender and age, some nuances emerge. In fact, in the 16-34 age range, the incidence of work-related illnesses is higher among women than men. Between 35 and 44, the levels are more or less identical. Between 45 and 54, women again have higher incidence rates, then a substantially lower rate after 55. This could imply that deteriorations in health caused by poor working conditions contribute to the wider trend whereby women register much lower employment levels than men in the upper age ranges. It could be that in order to safeguard their health, women make a strategic withdrawal from the labour market before their health is impaired.

157. These results only cover Great Britain and not Northern Ireland.

158. This was not the case in earlier surveys carried out in 1990 and 1995, which found higher incidence rates among men (overall figures, not standardised in accordance with different occupations and working hours).
compromised by working conditions. The data would need to be examined in more detail before any conclusions can be drawn.

The total figures obtained for the European Union by Eurostat in a labour force survey in 1999 (Dupré, 2002) indicate that in all countries included in the survey, with the exception of Greece, the incidence of occupational disease was higher among women when the figures were adjusted to correspond to full-time employment.

Table 15: Incidence of work-related health problems, 1999: male/female ratio

<table>
<thead>
<tr>
<th>Country</th>
<th>DK</th>
<th>GR</th>
<th>ES</th>
<th>IE</th>
<th>IT</th>
<th>LU</th>
<th>PT</th>
<th>FI</th>
<th>SE</th>
<th>GB</th>
<th>UE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adjusted total</td>
<td>0.5</td>
<td>3.6</td>
<td>0.8</td>
<td>0.7</td>
<td>0.8</td>
<td>0.8</td>
<td>0.9</td>
<td>0.6</td>
<td>0.7</td>
<td>0.7</td>
<td>0.6</td>
</tr>
</tbody>
</table>

Source: Eurostat (Dupré, 2002, p. 5)

If we look at the issue in terms of exposure to occupational risk, we also see that exposure does not explain the huge differences in occupational disease recognition for men and women. Even if we look at forms of exposure that mainly affect male-dominated occupations, such as vibration, the difference in exposure for men and women is much less that the divergence observed in recognition levels for occupational diseases related to this particular risk. If we go back to the UK data, we find 3,212 recognised cases of occupational disease, of which five were women. The Health and Safety Executive has actually carried out research to ascertain how many workers are exposed to vibrations (HSE, 1999-a and b).

The estimated figures for hand-arm vibrations (HAV) are:

- 4.2 million men and 667,000 women are exposed to HAV at work in the United Kingdom;
- individual daily exposure to HAV exceeds the individual daily exposure limits (equivalent to 2.8 m/s² in 8 hours) for 1.2 million male workers and 44,000 women;
- The female occupations most regularly exposed to HAV include domestic and office cleaners.

The estimated figures for whole body vibrations (WBV) are:

- 7.2 million men and 1.8 million women are exposed to WBV at work in the United Kingdom;
- the individual daily exposure limits (equivalent to 15 m/s¹·⁷⁵) are exceeded in the case of 374,000 men and 9,000 women;
- the risk of lower back pain among women increases significantly with increased exposure to WBV during the week before the pain materialises.
Some hypotheses about mechanisms of discrimination

The data from sources independent of the compensation systems leave no room for doubt: the compensation systems are a source of significant discrimination against female workers. However, in spite of the European directive on equal treatment within social security systems, there have been no moves to remedy the situation. What is worse, there has not even been a rigorous evaluation at Community level.

The mechanisms of discrimination are indirect. The compensation systems appear to deal with men and women on an equal footing. So which mechanisms cause the indirect discrimination that produces the figures we have seen?

A number of hypotheses can be put forward:

- Gender segregation has led to a concentration of men in those sectors where occupational diseases have long been observed and studied.
- Awareness-raising has mainly been via trade union organisations, where men are better represented than women. Consequently the occupational diseases which appear on negotiated lists tend to affect mainly men.
- Where restrictive conditions apply to a given sector or activity, they often cover sectors with a large male presence (for example, lumbago may be recognised in the case of construction workers, but not for nursery nurses). This formulation excluded most of the female-dominated sectors affected by lumbago (healthcare, social services). This discriminatory restriction no longer exists.  (This was the case in Denmark when lumbago was included on the list of prescribed occupational diseases - the only determining factor was the handling of objects. Carrying people was excluded. This formulation excluded most of the female-dominated sectors affected by lumbago (healthcare, social services). This discriminatory restriction no longer exists."
- One barrier to the recognition of occupational diseases is the interruptions in many women’s working lives (see Thébault-Mony et al., 2003 on work-related cancers). Many diseases are hidden among the general morbidity rate (unemployment, long periods away from work, leaving the labour market completely, etc.).
- Insecurity of employment has an influence similar to that of repeated career breaks. Many sufferers do not declare an occupational disease for fear of losing their job. It is possible that this trend affects women more than men.
- In general, occupational diseases related to the organisation of work (intensity, lack of autonomy, etc.) are considered less specific than disorders caused by contact with physical or chemical agents. This is illustrated by the difficulties encountered when seeking recognition for musculoskeletal disorders, where there is a strong gender dimension (see Kome, 1998). The example of the United Kingdom in this field is very revealing.
Taking all these elements together, it can be said that equality will not be achieved unless:

- The lists of prescribed occupational diseases are revised to include those diseases which most commonly affect female workers.
- The majority of restrictive conditions are removed from the lists.
- The mixed system is improved, in particular by altering the burden of proof.

**Symptoms of a Community policy failure**

The first Community initiatives relating to health at work sought to harmonise the systems of recognition of occupational diseases and to create a common framework for occupational medicine. They took the form of Commission recommendations, i.e. non-binding texts. The first recommendation was adopted on 23 July 1962\(^ {160} \) and focused on compensation for occupational diseases. The Commission advised creating a standard list of disorders and agents which could cause them. In parallel with the creation of the list, it recommended opening up national systems to recognise all diseases where reasonable proof of the occupational cause could be provided. The Commission also planned to create a system for reporting certain occupational diseases which did not appear on the list, to ensure that the list could be updated regularly. The recommendation set out Community plans for the future: unifying the conditions for awarding and setting levels of compensation for occupational diseases; developing prevention strategies based on improved scientific and medical knowledge. The establishment of a Community reporting system would have made it possible to compare different countries.

Four years later, on 20 July 1966, the Commission adopted a new recommendation on the conditions for compensation for the victims of occupational diseases\(^ {161} \). The recommendation reiterated the principle of opening up national systems to recognise all diseases shown to be work-related. It stated that the existing restrictive conditions were “generally arbitrary, as demonstrated by the fact that, where such conditions exist in several national legislations for the same occupational disease, they are in no way identical”. The provisions of the 1966 recommendation were much more specific than those of 1962 and, as a general rule, advised removing from the tables “conditions which relate to the description of the clinical symptoms of the disorders, the activities, the work and the work environment,

\(^{160}\) OJEC, 31 August 1962, p. 2188.

\(^{161}\) OJEC, 9 August 1966, p. 2696.
the time elapsed since exposure to the risk and the time elapsed between the end of exposure to the risk and identification of the illness”. Only in a few cases, listed in an annex, did the 1966 recommendation consider that restrictive conditions could be applied. These conditions related to sectors and occupations as well as to the characteristics of the ailment (chronic, serious, incapacitating). The recommendation also advocated the creation of a mixed system. Here, while the burden of proof lay with the victim, the recommendation advised that the insuring body should automatically take “all necessary steps to investigate the occupational origins of the illness”.

The 1966 recommendation planned to establish a system of reports from Member States every two years, to allow for regular updates of the European list.

For the most part, the 1962 and 1966 recommendations went unheeded.

On 22 May 1990, the Commission adopted a new recommendation. Once again, the Commission called on Member States to apply the principles laid down a quarter of a century previously. The European list was updated for the first time in 24 years, although the original intention had been to revise the list every two to three years. The Commission noted that a large number of Community countries were still not applying the mixed system. Only Denmark and Luxembourg seemed to be using a system that complied with the guidelines established in the 1962 and 1966 recommendations.

The choice of a mere recommendation was therefore somewhat surprising. Certainly there were some genuine legal barriers: the support of the Council of Ministers would be required for the adoption of a directive, and many Member States were opposed to any binding instrument in this field. The recommendation contained a final exhortation whereby “the Commission urges the Member States to inform it of any measures taken or envisaged with a view to following up this recommendation at the end of three years. The Commission will then examine the state of this recommendation within the different Member States with a view to ascertaining whether a proposal for binding legal provisions is needed”.

On 20 September 1996, the Commission adopted a communication on a European schedule of occupational diseases in which it concluded that it was “premature to propose any binding legislation at the moment to replace the 1990 recommendation”. The
Commission did however say that it would examine “this possibility... in conjunction with any future updates of the European schedule of occupational diseases”. The schedule is due to be updated very soon - during 2003. However, it will take the form of a new recommendation which will update the list taking into account certain diseases recognised in different Member States. The adoption of a binding legal instrument has been postponed indefinitely.

If the prevention priorities were to be defined on the basis of data coming from the declarations and recognitions of occupational diseases in Europe, we would have to resign ourselves to a whole series of bizarre statements. The data available provide more information about the social practices used to hide problems than about the reality of occupational health. A recent Eurogip study (2002-a) illustrates the huge disparities between the national systems for declaring and recognising occupational diseases, and allows us to gauge the social inequalities these systems generate.

In the EU Member States covered by this study, the number of recognised occupational diseases ranges from the lowest - 3.3/100,000 workers in Ireland - to France at the top with 177/100,000 workers.

No real harmonisation of the national systems can be identified, neither in terms of the total figures summarised in the table below, nor as regards the major diseases. Over the last ten years, the divergence between the most extreme situations has remained virtually unchanged, if we disregard Sweden. Developments over the past ten years vary greatly from one country to another. In the Scandinavian countries, Austria and Italy, there has been a marked reduction in the number of recognised occupational diseases (with a slight upturn in Italy and Sweden over the last two or three years). Austerity packages have been a deciding factor in this decline. There has also been a genuine reduction, albeit less marked, in Belgium. France and Spain have moved in the opposite direction, with a steady increase in the number of recognised occupational diseases, due to improved recognition for musculoskeletal disorders in both countries and for asbestos-related diseases in France. In Germany, the number of recognised illnesses rose between 1990 and 1996, then fell steadily from 1997 onwards. In the United Kingdom, the number of recognised cases of occupational disease is fairly low compared with other European Union countries. There was no significant change during the 1990s: on average, over 3,000 lung disorders and between 4,000 and 5,000 other diseases were
recognised every year. In recent years (1998-2000) there has been a marked reduction in the number of lung disorders recognised, while the figures for other illnesses have stagnated.

Table 16: Occupational diseases declared and recognised in 12 EU Member States between 1990 and 2000

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<td>133</td>
<td>103</td>
<td>78</td>
<td>52</td>
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<td>(51.8%)</td>
<td>(39.3%)</td>
<td>(41.7%)</td>
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<tr>
<td>Belgium</td>
<td>431</td>
<td>336</td>
<td>277</td>
<td>186</td>
<td>204</td>
<td>112</td>
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<td></td>
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<td></td>
<td>(43.2%)</td>
<td>(60.9%)</td>
<td>(40.5%)</td>
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<tr>
<td>Denmark</td>
<td>549</td>
<td>669</td>
<td>545</td>
<td>90</td>
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<td>124</td>
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<td>(16.4%)</td>
<td>(19.6%)</td>
<td>(22.8%)</td>
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<tr>
<td>Finland</td>
<td>320</td>
<td>331</td>
<td>238</td>
<td>160</td>
<td>110</td>
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<td></td>
<td></td>
<td>(50%)</td>
<td>(33.1%)</td>
<td>(27%)</td>
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<tr>
<td>France</td>
<td>63</td>
<td>103</td>
<td>237</td>
<td>44</td>
<td>76</td>
<td>177</td>
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<td></td>
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<td></td>
<td></td>
<td>(70%)</td>
<td>(73.8%)</td>
<td>(75%)</td>
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<tr>
<td>Germany</td>
<td>192</td>
<td>235</td>
<td>211</td>
<td>35</td>
<td>66</td>
<td>49</td>
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<td></td>
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<td></td>
<td></td>
<td>(18.3%)</td>
<td>(27.9%)</td>
<td>(23.1%)</td>
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<tr>
<td>Greece</td>
<td>-</td>
<td>5.3</td>
<td>4.5</td>
<td>-</td>
<td>4.7</td>
<td>3.5</td>
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<td></td>
<td></td>
<td>(90%)</td>
<td>(78.1%)</td>
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<tr>
<td>Ireland</td>
<td>4.4</td>
<td>6.4</td>
<td>7.5</td>
<td>2.3</td>
<td>5.5</td>
<td>3.3</td>
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<td></td>
<td>(52%)</td>
<td>(87%)</td>
<td>(44%)</td>
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<tr>
<td>Italy</td>
<td>354</td>
<td>211</td>
<td>160</td>
<td>93</td>
<td>39</td>
<td>33</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(26.2%)</td>
<td>(18.5%)</td>
<td>(20%)</td>
</tr>
<tr>
<td>Luxemburg</td>
<td>113</td>
<td>49</td>
<td>82</td>
<td>8</td>
<td>15</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(6.7%)</td>
<td>(30.9%)</td>
<td>(16.9%)</td>
</tr>
<tr>
<td>Portugal</td>
<td>-</td>
<td>57</td>
<td>55</td>
<td>-</td>
<td>42</td>
<td>27</td>
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<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>(73.1%)</td>
<td>(48.9%)</td>
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<tr>
<td>Sweden</td>
<td>1,524</td>
<td>642</td>
<td>309</td>
<td>1,242</td>
<td>258</td>
<td>138</td>
</tr>
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<td></td>
<td></td>
<td>(81.5%)</td>
<td>(41.3%)</td>
<td>(45%)</td>
</tr>
</tbody>
</table>

Source: Eurogip, 2002-a

This table uses data from three tables in the Eurogip report, which can be found on pp. 12, 22 and 30. The report gives more details for each year in the period under review, together with an explanation of the methodologies used. The information is not completely uniform due to differences in the systems of compensation for occupational diseases.
The term “mainstreaming” has been fashionable for several years now, to designate a process whereby a given policy achieves its objectives by informing other policies. Such a way of thinking starts from an indisputable premise: different policies are interrelated in a large number of ways. If an objective is acknowledged to be fundamental, it is only reasonable that all policies which could have an impact on the attainment of that objective should be devised, assessed and regularly reviewed in terms of their relationship with that objective. Thus a given policy in the field of social security or education may have a positive or a negative impact on male/female equality. The overarching nature of gender relations means that any policy, whatever its specific field, is liable to be assessed in relation to equality. From agricultural policy to transport planning, from international trading relations to genetic research, from statistical techniques to the allocation of resources for community infrastructures, the relevance of gender analysis cannot be overlooked.

In practice, the role of gender analysis varies enormously from one policy to another in the European Union. It is generally deemed justifiable in all social spheres, in the broad sense of the term: policies such as employment, social security, education and immigration, as well as scientific research, policy-making methods, etc. This does not necessarily mean that such an analysis will result in policies fostering equality, but at least the issue of equality is raised and a debate can take place.

On the other hand, as soon as “hard-core” economic affairs enter the frame, gender analysis is dismissed entirely. Yet it would not be difficult to demonstrate the huge impact of economic institutions on equality. The correlation is perfectly plain in certain cases, where the effects on equality are immediate and direct. For instance, the privatisation of public services affects women specifically: more women than men are employed in them, and women’s quality of life depends more than that of men on the quality of certain public services. Women’s reduced share of wealth and lower earnings tend to make them more reliant on the mechanisms for economic redistribution provided by certain public services. The links may be more complex in
other instances: it might therefore be necessary to analyse the median, indirect or long-term effects before being able to determine any impact in terms of equality. By way of example, intellectual property rights and especially patents on living organisms or medicines have an undoubted gender impact, even if it is not immediately visible (Miese and Shiva, 1998 conduct a stimulating analysis with a number of concrete case studies from an eco-feminist perspective).

No gender analysis has ever been attempted as concerns the impact of market regulation on occupational health. It is only possible to put forward a few feasible hypotheses based on the observation of a number of practical cases. These hypotheses would need to be verified by a more systematic analysis, but that goes beyond the scope of this volume.

**Work equipment and personal protective equipment**

Whenever musculoskeletal disorders are investigated, female employees frequently complain about the poor adjustment of work equipment, which forces them to adopt awkward postures and sometimes considerably increases the overall burden of work. Women quite regularly express the view that work equipment is designed by people who disregard the ergonomic wellbeing of the end user, concentrate on productivity and largely consider occupational health to mean nothing but accident prevention. The problems are particularly acute in traditionally male sectors: the non-adjustment of work equipment and production processes to women in the mining and construction sectors (CLR, 1997) still constitutes a major obstacle to job desegregation.

Similar complaints are made about personal protective equipment. Data relating to the United States (Weaver *et al.*, 1996, p. 60) indicate that: “Personal Protective Equipment (PPE) has been designed for the average-sized male and does not always fit women and smaller men. Approximately 5 percent of males and more than 50 percent of females cannot be properly fitted for protective equipment, with boots and gloves creating the greatest problems for women. Women wearing larger-sized respirators designed for men are at risk for overexposure to hazardous substances. Although respirators have been manufactured for smaller-sized faces, they are not always available to women on the job. In a survey of women coal miners (…), 75 percent of them wore men’s boots because the available women’s boots...
were substandard in quality; moreover, manufacturers could not guarantee the performance quality of their women’s boots. The poorly fitting boots created problems such as ankle injuries and falls due to poor footing”. The situation in Europe appears not to be very different.

These complaints raise important questions in respect of market regulation. It would of course be wrong to place the blame entirely on defective design of work equipment by manufacturers. Many of the problems highlighted can arise at a later stage: when work equipment is selected by company management, or when it is installed and work processes are devised. For example, the fourth Spanish survey of working conditions (1999) examines whether or not employees’ opinions and suggestions are taken into account in various company decisions. Six categories of decision are looked at. The discrepancy between men and women is not very great except in two fields: the selection of work equipment (55.2% of men believe that their opinion is taken into account, as opposed to 47.3% of women) and preventive activity (50.3% of men as against 34.9% of women). A vicious circle is probably created between workplace practices and the very male world of work equipment design. Both within the company and for designers, women are apparently less capable than men of penetrating into the sphere of technology. Their judgement of work equipment is deemed less rational and hence less relevant; yet the equipment manufactured can worsen women’s working conditions if it fails to take their real needs into account. Experience in the IT sector bears out this trend, even as concerns equipment or programmes whose end users in the workplace comprise a large majority of women. Clearly, the stereotype associated with physical strength masks an issue of power.

The instructions for use and the documentation accompanying equipment (both work equipment and personal protective equipment) constitute an important interface between the manufacturing of equipment and its use. Under Community legislation, this interface is regulated by market-related directives.

Regulation of the market in work equipment in the European Union is based on what is dubbed the “new approach”. It was devised during the first half of the 1980s

The contribution made by the “new approach” can be summarised in three points:

- recognition of the role of standardisation as an aid to regulation. Reference is made to technical standards elaborated by
semi-private, semi-public bodies where industry is the main player;
• definition of a new type of directive centring on essential requirements which products must meet if they are to have freedom of movement on the Community market;
• moves towards a policy of conformity assessment (this last point, still the weakest one, was added subsequently).

Thus legislative harmonisation is confined to the adoption of essential health and safety requirements which must be met by all products placed on the market; if products comply, they benefit from freedom of movement in the European Community. The detailed technical specifications must be set out in harmonised standards drawn up by European standardisation bodies appointed by the Commission. These harmonised standards are not binding, but products designed in compliance with them are presumed to conform to the essential requirements contained in the directives. If a product is designed without regard for the harmonised standards - or is only partly in compliance - or if no standards exist, its conformity with the essential requirements has to be assessed. In some cases, conformity must be certified by a notified body in accordance with procedures whose stringency depends on the product’s inherent level of risk. The certification procedures to be followed by manufacturers are laid down in each of the directives.

Twenty or so directives have been adopted under the new approach. The most important one from an occupational health point of view is Directive 89/392 of 14 June 1989 relating to machinery (amended several times, with a consolidated version appearing in Directive 98/37).

The points of greatest relevance to a gender analysis of Community regulation of the market in work equipment are probably the following ones:

• The role of health and, in particular, the status of ergonomics. Technical standardisation has traditionally focused on other priorities: facilitating trade and compatibility of equipment manufactured by different companies, ensuring a high level of productivity and avoiding accidents by building in safety at the design stage. This last objective often appears subordinate to the other two. It is clearly not easy to move from accident prevention to the prevention of all damage to health: that calls for a multi-disciplinary debate, in which ergonomics has an especially significant part to play. In actual fact this interaction often proves problematical. Standard EN 1050, which is important in that it defines the principles for risk...
The gender workplace health gap in Europe

assessment by designers in the field of machine safety, is weak when it comes to incorporating ergonomic requirements. The methodology it proposes is ill-suited to solving ergonomic problems, and the reference it makes to B standards does not make up for its shortcomings because of the deficiencies in these standards in respect of ergonomics.

- The status of biomechanical and anthropometric data. Standards pertaining to anthropometry and biomechanics highlight the need to take into account the characteristics of both men and women. In principle, pursuant to standards EN 614-1 and EN 614-2, work equipment must be designed in such a way as to meet the requirements of the operator population, male and female. The aim is to cover 90% of the target population (from the 5th to the 95th percentile). Where important safety and health aspects are concerned, the population covered must amount to at least 98% (up to the first percentile and/or at least up to the 99th percentile). This is without doubt the only area where it is considered legitimate to incorporate the gender dimension - to a certain extent - into the standardisation process. In practice, according to Ringelberg and Koukoulaki (2002), work equipment manufacturers do not always use these data. This raises the problem of market surveillance, which relies much too heavily on intervention by the private sector, whose economic interests may conflict with observance of safety requirements.

- Feedback from workers, male and female, and their involvement in equipment design processes. This is one of the main weaknesses of the system: there is nothing to oblige designers and manufacturers to take account of real working conditions. The needs expressed by workers themselves currently play practically no part in the standardisation process or in the daily reality of work equipment design. This missing link affects both men and women, but there are reasonable grounds to assume that it produces gender-differential effects. Indeed, according to statistical data concerning all the European Union countries, women are less prone to industrial injuries than men because of the division of labour (fewer women tend to work in those sectors where accidents most frequently occur). To my knowledge, no precise calculation has been made of the proportion of accidents linked to the use of work equipment. On the other hand, women are affected to a greater degree by health impairments typical of the wearing effect of work, such as musculoskeletal disorders. Here again, there has been no assessment of what proportion of these ailments may be related to work equipment. However, judging by the experience of female workers, the inappropriateness of work equipment is often singled out as one important factor.

167. B standards relate to safety aspects for a vast range of machinery.

168. A precise calculation would in any event be meaningless, in that musculoskeletal disorders are usually linked to the combined effect of a number of factors, where the role played by work equipment is combined with the repetitive nature of the job, intensity of the work, time constraints, etc. In an assessment of ergonomic measures taken in Quebec to prevent musculoskeletal disorders in different industrial sectors, 71% of the measures involved work equipment and consisted in modifying existing machinery or hand tools or introducing new equipment (manual handling aids) or new tools (St Vincent et al., 2000).
The machinery directive is currently undergoing revision. The trade union organisations have intervened on several occasions in support of a version which makes more of ergonomic criteria, takes due account of workers’ experience and sets up information systems enabling practical feedback from the workplace to be factored in. The TUTB for its part is attempting - with limited resources - to contribute to this debate: it has for example published a report about assessing the risk of musculoskeletal disorders in machinery design (Ringelberg and Koukoulaki, 2002).

**Regulation of the market in chemical substances**

**Ardystil and Bayer: wholesale job insecurity and the power of the chemicals industry**

On 30 June 2003, more than eleven years after the events, a Spanish criminal court passed judgement on some of those responsible for what has become known as the Ardystil affair. To anyone familiar with the impunity usually enjoyed by employers in the field of occupational health, the sentences were unusual. A six-year prison term was handed down to Ardystil’s managing director, the directors of six other companies in the region were sentenced to lesser terms, and a labour inspector who had neglected to impose preventive measures when he visited the company was sentenced to six months in prison. Yet the verdict of the trade union newspaper Por Experiencia is that justice has not fully been done: the headline chosen for the cover of issue no. 21 is unambiguous: *The ruling that let Bayer off the hook.*

The Ardystil affair has illustrated the kind of health disasters that can be caused by insecure conditions of employment (FIA-UGT, 1993; Vogel, 1995). It has also cast a harsh light on the flaws in Community regulation of the market in chemicals. Was it pure chance that five of the six fatalities and most of the other victims were women? Could there be a gender dimension to the very arbitrary manner in which the chemicals industry manages the risks it engenders?

On 15 February 1992, Isabel Miro died in hospital in Alicante. The initial diagnosis was tuberculosis. In April, two other young women were hospitalised with serious pulmonary disease. The hypothesis that these devastating cases of “tuberculosis” may have a common origin arose when one of their X-rays was compared with those of Isabel Miro. All three victims had worked at the same company, Ardystil. On 8 May, Yovana
Gonzalez (aged 18) died while five women working for Ardystil were hospitalised with pulmonary fibrosis. Over the following months, more than 200 workers underwent medical examinations: approximately 80 had suffered pulmonary damage. Most of the victims were women working for Ardystil, some of whom had also worked in other companies in the aerographic textile printing sector. Four more deaths occurred between August and November. The regional labour authorities in Valencia decided to close down all the companies in the aerographic textiles sector. On 5 November 1992, at the close of a meeting of Spanish and foreign experts, the health department of the Valencia regional government issued a press release declaring that “Ardystil syndrome” is a new occupational disease, unknown in the specialist literature. In 1993 the Spanish government added Ardystil syndrome to the official list of occupational diseases (the only modification made to the list since it was first published in 1978!).

A complex combination of causes lies behind this affair, which resulted in six fatalities (five women and one man) and about 80 other victims affected to different degrees. The casualisation of labour played key role. The working conditions were disastrous in all regards. The companies concerned were attempting to meet the demands of larger textile companies that wanted to obtain spray-printed fabrics at the cheapest possible prices. This is a typical case of subcontracting, where most of the technical conditions were imposed by the dominant firms. The managing director of Ardystil had no particular experience of this type of work. She took in pieces of fabric on which a design was printed, and the fabrics were then returned to the manufacturing companies for placing on the market. The finished products were curtains and tablecloths. The labour was cheap thanks to special contracts for putting young unemployed people into jobs, the technical procedures were very rudimentary and the prices very competitive.

Yet the company had been visited by a member of the labour inspectorate, which abided by a sort of unspoken social compromise. All was well so long as the minimum rules (basically payment of social security contributions) for the avoidance of unfair competition were satisfied, since a highly insecure job could not be expected to provide the same health and safety conditions as a stable job.

Ardystil operated with primitive processes, more akin to the handicraft sector than to modern industry. But that is only part of the truth. This affair brings together an explosive mixture of archaism and modernity, a combination of primitive micro-
enterprises and highly competitive groups of companies which have indisputable scientific know-how.

Ardystil used a procedure devised and marketed in several European countries by a major chemicals multinational, the Bayer group. The procedure in question consists in the use of several products called Acramoll W, Acrafix FH and Acramin FWN. The enquiry identified Acramin (and in particular the modified version of this product) as one of the agents which caused, or contributed to, the cases of pulmonary fibrosis. In conformity with the relevant Community regulations, Bayer conducted a certain number of tests and drew up safety records. These records, in keeping with the existing rules, do not of course contain the chemical formulae for the products; they identify in very general terms the category of substances used. Thus Acramin was simply described as a polyamine salt, and the risks of using it were referred to. Given what happened, these risks were seriously underestimated.

According to A. Calera\textsuperscript{169}, an epidemiological study published in the journal \textit{Lancet} in 1994 identified Acramin FWN as one of the causes of the illness. The explanation given by one of the experts consulted by the Alicante criminal court, Dr Cabrera Bonet, runs along similar lines (paragraph two of the reasons adduced in the ruling). The disorders began to appear after October 1991, when Acramin FWR - a product in powder form - was replaced by Acramin FWN in liquid form. Two hypotheses are worthy of examination: the change in chemical formula may have altered the product’s toxicity; or the transition from powder to liquid allowed for new methods of use which contributed to the change in exposure levels and in the chemical reactions taking place within the working environment. The most serious disorders arose only in the two companies (Ardystil and Aeroman) where liquid Acramin had been used.

Bayer has always declared that the procedure was clearly designed for roller application and not for spraying. This raises an important question of principle. Can tests, commercial documentation and safety records be produced on the basis of what the manufacturer describes as the normal conditions for use of a product, or must they cover all reasonably imaginable uses? In the Ardystil affair, the switch from a powder to a liquid product removed the main technical obstacle to aerographic use. Whereas the documentation supplied by Bayer when the product was placed on the market did not allude to the possibility of aerographic use, neither did it state that such use was especially hazardous.

Given the information currently available, the only conclusion one can draw with any certainty concerning market rules is as follows: the leeway granted to the chemicals industry over risk assessment is such that the information supplied to users will not necessarily be sufficient to guarantee their health. It is worth citing here the conclusion of a toxicity study carried out at the University of Louvain on three products manufactured by Bayer: The Ardystil disaster and these results should serve as a strong warning that conventional toxicity testing of chemicals does not necessarily protect workers against respiratory toxicity” (Clottens et al., 1997). The failure to feed back information from the workplace to manufacturers means that there can be no full assessment of the potential risks arising from actual conditions of use, and above all of any interaction with other chemicals used in the same production processes. The facts were insufficient to achieve a court ruling against Bayer; they are nonetheless vital to carrying out a critical overview of current Community regulations.

Community regulation:
disregard for the gender dimension

Community rules relating to the market in chemical substances and preparations comprise three strands:

- rules on the classification, packaging and labelling of hazardous substances and preparations. My analysis will be confined to this aspect of Community legislation;
- rules concerning restrictions on the marketing and use of certain hazardous substances and preparations;
- rules on the assessment of existing and new substances as well as the drawing up of European product lists.

These rules came into being gradually from 1967 onwards. The main incentive came from the chemicals industry, which was keen to eliminate barriers to the formation of a single market for chemicals in the European Union. These commercial considerations took precedence over the protection of health and the environment. In addition, the dozens of directives amending the basic directives have ultimately created an impressive and complex regulatory framework. There are however significant gaps in these regulations: for example, they overlook a certain number of long-term immunological and endocrinological effects as well as effects on the nervous system and reproduction.

The system put in place is extremely advantageous to manufacturers of chemicals. They are responsible for conducting an
initial risk assessment, on which basis they must classify the product and comply with a number of rules associated with the risks indicated.

The manufacturer or any other person established in the Community who places a substance on the market must notify the competent authorities in one of the Member States about this initial assessment and its conclusions, following a procedure introduced in 1979. Notification must contain four elements: a technical dossier on risk evaluation; a declaration concerning the effects of the substance in terms of the various foreseeable uses; the proposed classification and labelling of the substance in accordance with the directive if it is hazardous; and proposals on precautions to be taken for the safe use and disposal of the substance. Notification forms part of a Community information system. If no objections are raised after a period of 45 days, a substance may be placed on the market. In practice, the public authorities rarely object a product being placed on the market.

The initial assessment plays a crucial role. It leads to:
- classification in one of the risk categories corresponding to physico-chemical and toxicological properties (e.g. explosive, combustive, inflammable, toxic, noxious, carcinogenic, etc.);
- product packaging obligations;
- labelling (with the name of the substance, symbols where appropriate, standard phrases on risk and standard phrases on safe use). Since 1992, the information provided to the end user must include a safety data sheet.

The implication is that, in many respects, the safety of chemicals is left in the hands of manufacturing companies. The drawbacks to this state of affairs could in theory be attenuated by a posteriori checks by the public authorities, which are supposed to undertake their own assessment of chemical substances pursuant to Community regulations\textsuperscript{171}. Risk assessments by the public authorities have however accumulated a huge backlog when compared with the number of substances placed on the market, which is why the manufacturer's evaluation remains the sole point of reference for the majority of substances. The initial risk assessment offers no guarantee of independence, being carried out by companies with an obvious interest in marketing their products. The resulting classification is not always adequate. According to an evaluation published by the European Commission in 1998 (European Commission, 1998), surveys conducted in certain sectors reveal incorrect classifications in 25% of cases and labelling errors in 40% of cases. Moreover,

manufacturers do not declare as hazardous any new substances which they place on the market, even where one might justifiably suspect them to be hazardous\textsuperscript{172}.

No gender assessment of this situation exists, as far as I know. It would however be reasonable to assume that the problems identified have a gender-differential impact.

This hypothesis can be formulated in view of several factors:

- The epidemiological data produced tend to prioritise information concerning men, while assessment prior to placing on the market often falls well short of what is revealed by existing epidemiological studies. Epidemiological findings diverge significantly from the risk phrases used for substances and preparations placed on the market. The number of substances identified as carcinogenic or toxic for reproduction is rather low compared with existing data. Assessments carried out by industry probably overlook in particular the long-term risks or ones associated with low-dose exposure. Recent research into persistent organic pollutants\textsuperscript{173} draws attention to the male/female differential effects linked especially to hormonal differences. Most of the tests normally used to assess the risks associated with chemical substances are inadequate for certain risks such as breast cancer and ultimately serve to minimise or even mask the risks involved (Brody \textit{et al.}, 1998). Feminist environmental organisations have stressed the importance of a gendered approach to combating the risks engendered by the marketing of hazardous chemicals\textsuperscript{174}.

- Irrespective of biological differences, one consequence of the division of labour is that many women are concentrated in sectors where it is extremely difficult to monitor chemical exposure and to adopt adequate preventive measures (e.g. in sectors such as cleaning, textiles, certain branches of agriculture and the food industry). Feedback of practical experience of exposure, its consequences and preventive measures, is crucial in this respect.

- There is probably a gender dimension to the choice of disorders singled out as priorities for prevention. Some risks are paid greater attention than others in risk assessment. While immediate risks to life and limb are obviously given priority (acute poisoning, explosions, etc.), others receive short shrift. For instance, according to researchers in Italy (IPL, 2001, pp. 70-71), reproductive toxicity studies are available for 80% of drugs, biological agents and physical agents, and for 40% of medicines, but for just 13% of industrial chemicals.

\textsuperscript{172} For further details, see Blount, \textit{Riesgo químico y producción limpia}, in Blount \textit{et al.}, 2003, pp. 101-108.

\textsuperscript{173} Persistent organic pollutants (POPs) include industrial chemicals such as PCBs, pesticides like DDT and chlordane, as well as contaminants and by-products such as dioxins and furans. POPs accumulate in living organisms, persist in the environment and produce toxic effects in the long term.

\textsuperscript{174} See in particular the documents of the WEDO (Women’s Environment and Development Organization) on the website http://www.wedo.org/publicat/publicat.htm as well as those of Earth Rights International at http://www.earthrights.org/women/pops.shtml.
The future of market regulation for chemicals is currently the subject of intense controversy at Community level\textsuperscript{175}. The Commission’s proposed reforms of the present system are being thwarted by a campaign orchestrated by employers in the chemicals sector and strongly endorsed by certain governments. Although they do not address all the problems\textsuperscript{176}, the Commission’s proposals do at least have the merit of emphasising the importance of information feedback. They tighten up the criteria regarding the obligations of the chemicals industry; they also aim to end the underestimation of the problems posed by chemicals which are persistent and bioaccumulative pollutants, as well as by endocrine disrupters. It is regrettable that the gender dimension of this debate has scarcely been broached at all until now.

\textsuperscript{175} This debate can be followed in particular on the TUTB website (http://www.etuc.org/tutb/uk/chemicals.html) and on that of the European Environmental Bureau (http://www.eeb.org/).

\textsuperscript{176} Among the limitations of the Commission’s proposed reform, we might mention the maintenance of confidentiality concerning essential aspects of manufacturing in the chemicals industry and the weakness of policies to replace hazardous products with non-hazardous, or less hazardous, ones.
Chapter 10
Public health policies

Public health policies have devoted increasing attention to the gender dimension in recent years. The approach followed has however consisted in prioritising biological differences and individual behaviour (or a combination of both these components, if one thinks of policies on breast cancer). Work, be it paid or unpaid, scarcely even features in public health policies where these deal with the gender dimension of health. The factors highlighted have one thing in common: they largely ignore gender relations while recognising (and this is their most positive quality) that traditional approaches to health have paid too little heed to the “specific problems” of women.

An analysis of the impact of Community public health policy in the areas covered by this study is inevitably limited, since this policy is relatively recent. Its goals are limited, and it has not yet managed to define an overall strategy.

These general characteristics can be explained by various factors:
- The public health systems established by the EU Member States differ enormously. The labour movement fought hard in certain countries for the creation of a national health system geared to planned management of resources and to guaranteeing access to healthcare for the entire population. Such policies generally lent themselves to the definition of priorities for prevention and set out to combat social health inequalities. The first national health system to be founded was the UK National Health Service in the aftermath of the Second World War. It was followed by the creation of national health services in Scandinavia. The Italian health reform of 1978 took an even more ambitious line: the establishment of a national health service was accompanied by a rethink of important aspects of health policy (reform of psychiatric services, creation of public occupational health services within local health clinics, etc.). Italy’s health reform inspired certain aspects of the changes made to health systems in Spain and Portugal after the fall of their dictatorships. The labour movement in other European Union countries raised different priorities, relating in the main to a socialisation of costs by developing mutual insurance companies, and then by forming social security schemes. Whereas on the whole...
these policies have given the entire population access to healthcare, they have rarely resulted in any prevention-based planning of health measures. It is significant that the countries where research into social health inequalities is most advanced are also those where a national health system has been founded.\textsuperscript{178}

• The gradual definition of public health goals at Community level has been hampered by the Member States’ desire to keep control over the bulk of health policy. In reality, Community integration has above all exerted “lateral pressure” on existing systems, pressure resulting not from a public health strategy but from the effect of other policies. Freedom of movement for pharmaceutical products and the harmonisation of conditions for the recognition of qualifications in the health professions, dating back to the 1960s, might be mentioned. Other policies have played an important role more recently. Co-ordination of social security schemes has led to case-law heading towards the gradual establishment of a sort of single market in healthcare for patients. Community competence in the field of environmental protection has also made its mark through the harmonisation of certain provisions with a major impact on public health (measures on petrol, air quality, water quality, etc.).

• The general political context surrounding the gradual development of Community competence has by no means been favourable to combating social health inequalities in a coherent manner. The severe pressure placed on public finances by the introduction of the single currency has been a major inhibiting factor. Various measures have been taken to curb health expenditure, often leading to heightened social inequalities and depriving part of the population of access to the full range of health facilities. Such steps have been justified by so-called objective necessity. Other options did however exist: developing preventive policies or creating a public pharmaceuticals industry would undoubtedly have permitted a more effective use of resources.

Are women nothing but a set of individual “lifestyles”?\textsuperscript{179}

In 1997, the European Commission published a report on the state of women’s health (European Commission, 1997). When reading it one gains an odd impression: women do not work, neither as employees nor on an unpaid basis. Or else they work so nimblly that their work does not have the slightest impact on their health. According to the Commission, the determining factors for health are the promotion of healthier lifestyles in respect above all of nicotine addiction, excessive alcohol consumption, bad eating habits and a lack of physical exercise, together with...
measures on the early detection of heart disease and cancer. Working life is looked at only in terms of employment data (rate of activity, percentage of part-time work, unemployment); the impact of working conditions on health is not addressed. The effect of unemployment on health is likewise ignored. As to “family life”, demographic data alone are examined (marriages, divorces, births, etc.), as though the family were not also an institution where unpaid work is done in conditions that have a major impact on women’s health. It is significant that this report notes an upsurge in heart disease without even analysing the link between such illnesses and stress at work.

The general tendency at national level is not always any different, it would seem. In most cases, consideration of the gender dimension in public health policy goes no further than biological aspects and an individualistic conception of health promotion based on differential morbidity data. For instance, the health scoreboard of the Brussels Capital region (Observatoire de la Santé de Bruxelles-Capitale, 2001) contains a large amount of interesting information enabling the health of the population to be analysed in social terms, but is rather short on gender data and very superficial as concerns the impact of working conditions. It merely gives the number of industrial injuries and recognised occupational diseases. There is no analysis at all of the way paid and unpaid work affects women’s health.

Moreover, in March 2002, Belgium’s Council for Equal Opportunities published a highly critical opinion about the manner in which the survey of the population’s health is organised, pointing out that it basically adopts a behaviouralist philosophy. The opinion states that the national surveys conducted in Belgium in 1997 and 2001 do not provide sufficient arguments to justify directing public health policies towards a reduction in social health inequalities and towards an approach taking account of gender differences.

Public health did not explicitly become a Community responsibility until the Treaty of Maastricht came into force in 1992. Until then, it was mainly regarded from two points of view:

• As a national responsibility of Member States, it was liable to constitute an obstacle to the free movement of goods and justify measures regarded as non-tariff barriers. That is why, as soon as the Community began taking steps towards the formation of a common market, public health appeared to conflict with the organisation of the market. These issues have given rise to a huge amount of case-law.

• Inasmuch as Community provisions served to harmonise market rules, the associated public health issues simply had to be addressed. Regulation of the market in chemical substances from 1967 onwards illustrates the tension between health requirements and the pressure exerted by the chemicals industry to relax public surveillance and guarantee rapid market access for all of its products. The truly catastrophic health effects caused by asbestos demonstrate the price paid by the population (first and foremost by workers) for a policy where public health played second fiddle.
In 1992, the Treaty of Maastricht brought public health into the sphere of Community competence, as the subject of the new Article 129 of the Treaty. This coverage in Article 129 is accompanied by significant limitations: health remains largely within the control of Member States; the European Union merely complements their actions and is not empowered to enact legislation. The description of the Community’s fields of action reveals a rather narrow conception of public health, namely “the prevention of diseases, in particular the major health scourges, including drug dependence, by promoting research into their causes and their transmission, as well as health information and education”. The term “major scourges” is a legacy of 19th century hygienics and tends to confuse health issues with social control over the “dangerous classes”. The choice of drug dependence as the sole field explicitly laid down in the Treaty is questionable: health problems linked to drug dependence are considerably less significant in public health terms than those resulting from the marketing of legal substances. Drug dependence seems in some respects to play the role nowadays that tuberculosis played a century ago. But public health is only a minor element of the prohibitionist policies being pursued; the main activity is police repression combined with pressure and intervention in producer countries, often with disastrous social consequences.

Following the Treaty of Maastricht, Community policy was structured around specific programmes of action, basically aimed at stimulating the collection of data, research, information campaigns and exchanges of experience. The eight action programmes covered a variety of fields (health promotion, cancer, drug dependence, AIDS and other communicable diseases, health monitoring, rare diseases, accidents and injuries, and pollution-related diseases). Other initiatives involved the drafting of reports on the state of health in the European Community, recommendations on the safety of blood products, etc.

The advantage of such a piecemeal approach was to circumvent Member States’ differences of opinion as to priorities; the drawback was that it was not conducive to a comprehensive policy. In a sense, public health policy resided in the gaps left between other already existing Community policies on the one hand and national policies on the other. Social health inequalities did not feature as a major topic for Community action, even though they were mentioned here and there (for example, Community documents on drug dependence drew a link between this and unemployment). Similarly, the gender dimension of health policies was addressed only intermittently, without any cohesive...
The only document dealing systematically with women’s health is the report on the state of women’s health in the European Community, adopted by the Commission in 1997 (see Box above). This report followed on from a general report on the state of health in the European Community, unveiled in 1995. It prioritises “lifestyle” factors to an almost absurd extent and describes disease prevention in terms of early detection alone. Since the presentation of this report, no specific programme has been put in place to take account of a gendered approach.

The Treaty of Amsterdam (1999) somewhat extended Community competence in this field. The new Article 152, replacing Article 129 of the former Treaty, maintains the pre-eminence of national public health policies and continues to regard drug dependence as a priority area for action. In essence, certain public health concerns are incorporated into other Community policies (freedom of movement for goods, protection of the environment, etc.). The European Union’s role is confined to stimulating national policies and fostering co-operation in the context of certain programmes. In addition, the Community is granted regulatory powers in two fields: under the co-decision procedure (Art. 152(4)), the Council may adopt by a qualified majority:

- measures setting high standards of quality and safety of organs and substances of human origin, blood and blood derivatives;
- measures in the veterinary and phytosanitary fields “which have as their direct objective the protection of human health”.

The choice of these two fields harks back to the crises over contaminated blood and bovine spongiform encephalopathy (BSE or “mad cow disease”), which so deeply shocked the public.

The restricted nature of the powers laid down by the Treaty of Amsterdam helps to account for the very broad array of Community initiatives, most of which fall outside of policies explicitly assumed to be pursuing public health objectives.

For instance, pharmaceutical products are still regulated in the framework of commercial measures: the regulations are drawn up and administered by the Directorate General for Enterprise. European Union support for multinational pharmaceutical companies in resisting the attempts of Third World countries to develop the production of medicines at affordable prices demonstrates that public health concerns are not paramount. By the same token, the bulk of agricultural policy is still defined

180. This was the subject of the European Union’s complaint against India at the WTO (Case DS79/1). The European Union considered that Indian legislation did not confer sufficient protection on patents for pharmaceutical products and agricultural chemicals. The WTO Dispute Settlement Body ruled in favour of the European Union on 2 September 1998.
in a context where public health considerations play only an ancillary role.

Various programmes followed on from the Treaty of Amsterdam. In 1998, the Commission proposed moving from partial programmes to the definition of an overall strategy. This strategy was to be backed by a programme running for a period of at least five years and covering different aspects of Community public health policy. The genesis of the programme was somewhat laborious. Its launch was initially scheduled for the end of 2000 on expiry of earlier programmes; it finally saw the light of day for the period 2003-2008.

The preamble setting out the goals of the second programme contains a major innovation concerning the social determinants of health. It states: “The overall aim of the public health programme is to contribute towards the attainment of a high level of physical and mental health and well-being and greater equality in health matters throughout the Community, by directing action towards improving public health, preventing human diseases and disorders, and obviating sources of danger to health with a view to combating morbidity and premature mortality, while taking gender and age into consideration. To fulfil this aim, actions should be guided by the need to increase life expectancy without disability or sickness, promote quality of life and minimise the economic and social consequences of ill health, thus reducing health inequalities, while taking into account the regional approach to health issues. Priority should be given to health-promoting actions that address the major burdens of disease. The programme should support the development of an integrated intersectoral health strategy to ensure that Community policies and actions contribute to protecting and promoting health.”

On this basis, the programme advocates the establishment of “a sustainable health monitoring system to establish comparable quantitative and qualitative indicators at Community level on the basis of existing work and of accomplished results, and to collect, analyse and disseminate comparable and compatible age- and gender-specific information on human health at Community level concerning health status, health policies and health determinants, including demography, geography and socioeconomic situations, personal and biological factors, health behaviours such as substance abuse, nutrition, physical activity, sexual behaviour, and living, working and environmental conditions, paying special attention to inequalities in health.”
It is too soon to know whether these intentions will be translated into practical initiatives addressing gender inequalities in connection with social health inequalities. Reading the texts, one is struck by the exhaustive list of factors. A policy’s distinctiveness lies in its definition of priorities and means of action. One might wonder in this respect whether the search for a consensus is bringing a surfeit of factors into the equation. A choice has yet to be made between health promotion policies focused on individual behaviour and policies to reduce social health inequalities which prioritise collective prevention.
Chapter 11
Community policies on equal opportunities

“For the support of the public force and the expenses of administration, the contributions of woman and man are equal; she shares all the duties and all the painful tasks; therefore, she must have the same share in the distribution of positions, employment, offices, honours and jobs.”

Olympe de Gouges, 1791, Article XIII of the Declaration of the Rights of Woman and the Female Citizen

So many missed opportunities

Setting aside issues connected with the creation of a single labour market, Community law-making in respect of social affairs has focused on two main areas: equal opportunities for men and women, and occupational health. The first Community programme of social action dating from 1974 attached no particular priority to these two themes or, more precisely, they were mentioned only in passing. Male/female equality in relation to access to employment, vocational training and working conditions was in fact mentioned only as one of the factors meant to ensure full employment and better-quality jobs. Occupational health constituted one facet of harmonisation towards improved living standards and working conditions within a much broader context (reform of work organisation, extension of social protection, etc.). In the absence of political agreement on ambitious goals, Community law-making was compelled to fall back on two apparently more marginal or technical fields.

These appeared to be two very separate matters. Equal opportunities had barely been touched on by national legislation at the time when Community powers in the social arena began to be fleshed out. This was uncharted terrain, comparable with certain regions of Africa on 19th century maps: no State had yet proclaimed sovereignty over it. Community measures apparently did not perturb institutions which were rather indifferent to the problem. In the early 1960s, the Belgian government’s first reports on wage disparities between men and women doing the same work were disconcertingly ingenuous. Could this really be described as discrimination, when these differentials were
written into collective agreements formally concluded by joint bodies of employer organisations and trade unions? How could the State encroach on the autonomy of the “social partners” (see Coenen, 1991)? Occupational health, by contrast, had been the source of prolific amounts of legislation dating back at least a century. The inoffensiveness of Community measures seemed to be confirmed by another factor: legislation had done everything possible to depoliticise occupational health, reducing it to an immense and disorderly amalgam of technical problems.

Despite the discrepancies, some common elements did exist between the two themes:

- They were largely peripheral to what the main players in industrial relations at the time regarded as strategic issues. It was easier for the Community to take action, in that this was not considered likely to destabilise individual national systems.
- There was a close connection between these topics and harmonisation of the conditions for competition. As early as 1958, Article 119 sanctioning the principle of “equal pay for equal work” was included in the Treaty of Rome under pressure from employers in France, who believed that substantial male/female wage disparities such as were evident in the Italian textiles industry in those days might distort competition. Article 118A on the working environment was inserted by the Single Act in 1986 under pressure from the Danish government. In Denmark this initiative was backed by both trade unions and employer organisations, the latter believing that policy differences between northern and southern European countries concerning the working environment could result in distortions of competition.
- The third common factor was that both subjects came to the fore in no uncertain terms during industrial action in the late 1960s and 1970s calling into question the social compromises of Fordism. This factor certainly appears crucial if one looks at the history of Article 119. Between 1958 and 1974, the Member States and Community institutions regularly infringed this clause of the Treaty, whose role had seemingly been reduced to a mainly decorative one. It was at the end of the 1960s that this “Sleeping Beauty” was awoken through campaigns waged by female workers. Similarly, as concerns occupational health, from the early 1960s onwards Community powers exercised on the basis of Article 118 singularly lacked any overall vision or effectiveness. This state of affairs continued until the first policy rewrite in 1975. Faint echoes of debates about workplace democracy could be heard throughout the negotiations leading to the framework directive of 1989.
The directive’s provisions about consultation of workers on the introduction of new technology constitute a very slimmed-down version of much more ambitious proposals regarding the role of workers in technological change.

Whereas the bulk of social affairs legislation produced between 1975 and 2000 focused on these two issues, that did not prompt any thinking about their interrelationship. The need for equality did not become a dimension of occupational health, while equal opportunity policies did not consider the impact of working conditions on health. Community policy is little different from the Member States’ national policies in this sense.

Maternity protection did necessitate a minimum amount of reflection about the links between health and equality. But this terrain was a minefield in two respects. As concerns occupational health, maternity protection was the subject of some incoherent provisions from a preventive point of view. Instead of prioritising primary prevention of reproductive risks to both women and men, a set of mainly voluntary rules was introduced (see above, Chapter 7). In terms of equality, maternity was viewed in an ideological framework based on traditional stereotypes concerning the “special relationship” supposed to exist between a mother and her children. Case-law by the European Court of Justice (ECJ) illustrates the often illogical juxtaposition of certain principles of fundamental equality and a belief in traditional patriarchal family values. The affirmation of a special relationship between mother and child as a basis for the definition of rights dates back to 1983. The Commission had appealed against Italian legislation on adoption leave, which stipulated that only the mother may take leave where a child aged under six years is adopted. This case had the merit of avoiding any possible confusion with biology. The Court rejected the Commission’s appeal, on the grounds that Italy had a legitimate concern in wishing to safeguard the relationship between the adoptive mother and her child during this very tricky initial period.

The ECJ confirmed this view in the 1984 Hofmann judgment, where a father had been caring for his child after the mother had resumed work. German legislation accorded this type of parental leave to mothers only at the time. Subsequent case-law has repeatedly argued that there is a “special relationship” between mother and child which forms the basis of a differentiated legal definition of parenthood. This perception goes hand-in-hand with the recognition of “family” status only for heterosexual couples, be they married or not.
Turning away from maternity, it becomes clear that all the opportunities which have arisen to date have been missed:

- The question of night work was initially tackled mainly from the point of view of equal access for men and women to all forms of employment. Subsequently, some very inadequate measures concerning night work were adopted in the working-time directive of 23 November 1993. They bear the stamp of gender neutrality.

- Sexual harassment has been addressed only in the context of individual discrimination. The Community strategy (generally followed by national policies\(^{188}\)) has preferred an individual approach where the issue is dealt with in terms of the relations between the perpetrator and victim of harassment. But this remains a very narrow perception: sexual harassment is also related to work organisation and tends to preserve male domination. The scale of this phenomenon in occupations traditionally closed to women is significant. Moreover, it tends to hit particularly hard at women who escape the control of traditional family structures. This leads us to posit that, beyond the individual sexual function, there is a collective function which is not so much sexual as symbolic and political, geared to preserving hierarchical relationships where the gender dimension plays an important part. This helps to explain the persistence of forms of violence, of which sexual harassment constitutes only one manifestation. In addition, sexual harassment constitutes a very real hazard to health. Nonetheless, up until 2002 it was never regarded as a matter of any concern to Community occupational health policy and in need of regulation.

- Part-time employment has never been looked at as one of the principal factors of segregation, which is also connected with numerous occupational health problems.

- Job desegregation is not a priority and is not the subject of any binding measures. The correlation between segregation and working conditions which stand in the way of a gender mix has never been addressed.

- Community policies on the sharing of unpaid work are very weak. At best, they advocate a “reconciliation” between the anti-egalitarian family and paid employment. Most of the economic incentives permitting the segregation of some women in unpaid domestic work are not called into question by Community policies: pro-family taxation, social security provisions establishing “derived rights” for women at home\(^{189}\), etc.

The combination of all these elements compels us to question the coherence and the limitations of equal opportunity policies.
I shall not reiterate here the overall analysis of the hindrances causing such policies to be ineffective where occupational health issues are at stake (Vogel, 2002). A few aspects do however merit a more detailed analysis.

**Different interpretations of the notion of working conditions**

Community law on equal opportunities has been constructed around a gradual expansion of the principle “equal pay for equal work”. The notion of pay has quite rightly been interpreted broadly. It is a matter not merely of wages as such but of a set of work-related allowances and benefits quantifiable in terms of money or time: pension schemes, access to training paid for by the employer or held during working time, various benefits, etc. The positive influence of Community law in this sector has been undeniable. All direct wage discrimination has been eliminated as a general rule, while indirect wage discrimination has been affected where it could not be justified on “objective” grounds. Tolerance of possible reasons for discrimination has been fairly broad, so as not to throw gender relations into turmoil. Such tolerance has been even greater in respect of government policies. The European Court of Justice tends to accept a good deal of indirect discrimination deriving from Member States’ policies on the grounds of “legitimate social policy objectives”\(^{190}\). Moreover, a degree of tension is perceptible between the Commission and the Court in this field\(^ {191}\).

The other half of the definition, namely equal work, is much more problematical. What is equal work? No problem arises where an identical job is performed by a man and a woman for the same employer, but such situations rarely arise owing to job segregation.

Community law has not tackled this difficulty head-on. Devised as a means of remedying discrimination between individuals, it has never really tackled the collective determinants of such discrimination. Where conflict has arisen between a breach of the equality between individuals and the achievement of substantial collective equality, it has often come down on the side of men individually wronged by policies intended to combat segregation and collective inequalities. In practice, Community law considers that equal access for all individuals to jobs available on the labour market will ultimately put an end to discrimination. This is the thrust of the directive of 9 February 1976 on equal treatment for men and women\(^ {192}\). Access to

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190. We would cite by way of example the Petra Kirsammer Judgment of 30 November 1993 (ECR, 1993, p. 6185): aid to owners of small businesses justifies indirect discrimination.

191. The Commission wished to penalise Belgium for indirect discrimination in respect of unemployment benefit. The Court of Justice found that the goal of saving money in this field was a legitimate aim justifying the discrimination put in place (Commission/Belgium, 7 May 1991, ECR, 1991, p. 2205).

192. OJEC, 14 February 1976, L 39, pp. 40 et seq.
employment, training, promotion and “other working conditions” should enable men and women to compete on the labour market in conditions which do not disadvantage any individual on grounds of gender.\(^\text{193}\)

The term “working conditions” in this directive means no more than the combination of measures allowing for the creation of legally watertight conditions for competition. The only aspect of working conditions specifically cited by the 1976 directive is dismissal; all other aspects are largely redundant as concerns the other provisions of the directive. Thus the idea is to guarantee non-discriminatory access to a labour market as shaped by gender relations. There need not necessarily be any change in the type of skills required, tasks set, vocational training or working conditions; the sole condition is that gender-based discrimination between individuals must be avoided.

A slight nod was however made in the direction of the principle “equal pay for equal work”. The equal pay directive of 10 February 1975\(^\text{194}\) extends this principle to all work of “equal value”\(^\text{195}\). Yet there is a contradiction inherent in this extension. An aircraft cannot fly without wings: the Community legislator raised a live issue without creating any means of addressing it effectively. It is in fact impossible to combat wage inequality merely by enabling individuals wronged by a particular employer to demonstrate that another individual working in the same company is better paid. The struggle against male/female wage inequality is inseparable from the struggle against wage inequality per se, because the mechanisms that create inequalities at work are not distinct; they are coherent and originate in working relationships. The “equal value” - or unequal value - attributed to two jobs does not exist in isolation from workplace relationships. Why is it that higher value is attached to the work of a marketing director than to that of a supermarket checkout operator? All attempts to attribute objective economic value to human work are inspired by such a disparate array of factors (training, rarity, difficulty, appeal, drudgery, etc.) that ultimately they explain nothing (Castoriadis, 1974). Changing a baby’s nappy is unpaid work for its mother (when not simply regarded as the natural expression of that “special relationship” between a mother and her child), very poorly paid work for a domestic servant, slightly better paid for a nursery nurse and potentially extremely well paid during an advertising film shoot. Community case-law has added to this fundamental limitation an even more absurd restriction: comparisons may relate only to work carried out for the same employer and within the same legal relationship\(^\text{196}\). In so doing, it has found an ideal solution for

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\(^{193}\) The link between the notion of working conditions and competition was spelled out in the conclusions presented on 6 November 2001 by Advocate General S. Alber in the Lommers case (C-476/99). The issue was whether making nursery places available exclusively to female staff constituted a discriminatory measure. The Advocate General distinguished this matter from the recruitment problems which had been the subject of previous cases and stressed that “this measure is (…) much less relevant to competition between men and women in the workplace” (paragraph 74 of conclusions). While considering this to be an aspect of working conditions, the justifications given in the conclusions and the ECJ judgment are different from what they would have been if there had been a quantifiable element or if the decision had impacted on competition between men and women.

\(^{194}\) OJEC L 45 of 19 February 1975.

\(^{195}\) This term was taken up by the Treaty of Amsterdam in the new wording of Article 141 of the Treaty.

\(^{196}\) This is the subject of the judgment in A. G. Lawrence and Others of 17 September 2002, which authorises an undertaking (in this case a local government authority) to maintain wage discrimination for work of equal value since the female employees suffering discrimination had been transferred away from the main body of the workforce and were now working as subcontractors.
anyone wishing to circumvent the principle: the work merely needs to be contracted out, and all comparisons are outlawed!

The notion of working conditions has an entirely different meaning with respect to occupational health: it refers to the full set of specific characteristics - material or immaterial - of a given job. Certain aspects overlap partly with the abstract conditions envisaged in equal opportunity legislation. Working time is a unit of measurement relevant to pay and at the same time an important factor in analysing work processes. The job description, where it is formally recorded, is relevant to defining equal work or work of equal value. It also plays a definite role in the actual work done, constituting a prescribed framework of reference which will occasion a sort of permanent renegotiation of that particular activity. On the other hand, a large number of practical aspects of an actual job which are taken into account when examining working conditions completely disappear from sight in equal opportunity provisions. Co-operativeness, communication with colleagues, the dignity attaching to a job, most material factors making work disagreeable, and work intensity: such aspects hardly ever feature in legal considerations of equality. This invisibility helps to legitimise wage inequalities and contributes effectively to perpetuating male/female segregation in paid employment.

Equal opportunities in relation to part-time work

Almost 80% of net job creation in the European Union is attributable to part-time jobs. Two thirds of these jobs have been taken by women (Sarfati, 2002, p. 30); part-time work is overwhelmingly women’s work. Its growth in the European Union countries has occurred in very different ways from one country to another. It is the main form of female employment in the Netherlands and extremely widespread in a group of north European countries, but follows very different patterns because of a complex set of factors: the rate of female labour force participation, female unemployment rate, standard of community childcare facilities, national models for organising unpaid work, etc. Fagan, O’Reilly and Rubery (in: Maruani 1998, pp. 263 et seq.) offer a typology of different models for recourse to part-time employment in Europe. They demonstrate that, whereas the distinctive features of each system may differ considerably, the gender dimension of part-time work always constitutes a key element in understanding national patterns.

From an equal opportunity point of view, part-time employment has always been rightly perceived as a possible source
of indirect discrimination. An abundance of case-law tends to frown on manifest departures from the equal opportunity directives, applying a fairly large measure of equal treatment to part-time work in respect of quantifiable working conditions (hourly pay, access to training, the calculation of proportional benefits, etc.). On each of these points, as a general rule, a part-time employee will be placed on the same footing, pro rata, as a full-time colleague. I shall look below at the inherent limitations of this approach with regard to overtime.

Such an approach might be justified if part-time work amounted to nothing more than its definition: exactly the same thing as full-time work with a certain percentage less time. But “part-time” means much more than that. It was analysed in Japan some time ago as a highly precarious status typical of female employment (Hirata in: Hirata and Senotier, 1996, pp. 187-198). Japanese part-timers are lower-grade employees whatever the actual duration of their working time. Legal differences in status are much less pronounced in the European Union but, even so, part-time work has virtually become standard practice for female employment in certain countries. It can be described as the principal form of female employment in the Netherlands, affecting over 70% of women, and is the norm in other countries where, at approximately 40% overall, it affects the majority of women who have children below a certain age. Thus, data published by the European Commission in 1996 (cited by Perista, 1999, p. 73) reveal a strong correlation between women’s part-time work and their number of children. In most countries there is a very clear progression, with relatively low rates of part-time employment among childless women (except in the Netherlands), higher rates for women with one child and often much higher rates for women with two or more children. This profile - clearly visible in Community averages - is very marked in the following countries: Germany, Austria, Belgium, Ireland, the Netherlands, Sweden and the United Kingdom. It is less evident for Italy, Greece and Portugal. Certain anomalies are apparent in Spain, France and Finland (where the rate of part-time employment is slightly higher for women with one child than for those with two children).

In all the European Union countries, part-time employment is associated with particular working conditions, where contractual working hours are just one element among others. Some posts in highly feminised sectors are offered only on a part-time basis. Added to an initial constraint, namely inadequate community childcare facilities and the unequal distribution of domestic work, there is a second constraint imposed by
employers: it is often apparent in the case of posts offered only part-time that the other rhythms of life are largely subordinate to the requirement for workplace flexibility. These circumstances can take a very heavy toll on health: working hours may be cut, irregular, fixed with little notice and are often combined with overtime which is hard to refuse because wages are so low. Part-time employment is associated in many cases with the idea of drudgery or auxiliary work that has a lower social status. See D. Meulders (in: Maruani, 1998, pp. 247-248). Yet studies have shown that the adverse impact of part-time work is itself variable depending on different factors: government policies, the balance of power in the workplace and the degree of constraint, i.e. whether a real choice exists (both on the labour market in relation to a given level of skill and in unpaid family chores, according to the sharing of these chores or the availability of support from community structures).

Part-time work, as a new employment norm, allows for unemployment to be redistributed to the detriment of women (Torns, 2001; Maruani, 2002), in that part-time unemployment is not usually reimbursed by social security systems. The transition from part-time work to full-time unemployment often entails the loss of any unemployment benefit. It is interesting to note that, in several Community countries, the apparent similarity between the female and male rates of employment - defined without taking into account the type of employment - masks the persistence of considerable inequality if employment rates are calculated in full-time equivalents. Table 17 illustrates this phenomenon. I have taken two countries where part-time work is very widespread and two others where it is rather limited. The rates of female employment unadjusted for working time are almost identical in the Netherlands, the United Kingdom and Finland. Once they are adjusted, a 20% difference emerges between Finland and the Netherlands.

<table>
<thead>
<tr>
<th>Country</th>
<th>Male employment rate</th>
<th>Female employment rate</th>
<th>Male employment rate - full-time equivalent</th>
<th>Female employment rate - full-time equivalent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Netherlands</td>
<td>82.8%</td>
<td>65.2%</td>
<td>75%</td>
<td>41.6%</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>78.3%</td>
<td>65.1%</td>
<td>74.8%</td>
<td>50.2%</td>
</tr>
<tr>
<td>Finland</td>
<td>70.9%</td>
<td>65.4%</td>
<td>69.8%</td>
<td>61.8%</td>
</tr>
<tr>
<td>Portugal</td>
<td>77.5%</td>
<td>61.1%</td>
<td>77.5%</td>
<td>57.7%</td>
</tr>
</tbody>
</table>

Source: European Commission (2002-b)
An employment norm can however only take hold if other social conditions are met; it must fit into a sort of “social contract between the sexes” (Fagan, O’Reilly and Rubery in: Maruani 1998, pp. 263 et seq.). This explains the failure of attempts to exclude women from the labour market in various countries during the 1930s.

In the case of part-time work, the employment norm is connected with two other social norms. The first concerns the unequal distribution of domestic work: part-time employment should be the ideal means of reconciling unpaid domestic chores with paid employment. Incidentally, it also enables certain governments to keep their expenditure on childcare provision to a minimum (the best example of this trend being in the Netherlands). The second social norm concerns paid employment itself: part-time work confirms the auxiliary nature of female employment and contributes to downgrading it. Some economic research illustrates that this downgrading is a means of exploitation. In actual fact, part-time work is usually associated with higher productivity than its full-time equivalent (see Frey, 1999, pp. 79-84 and Bollé, 2001). Various factors contribute to this phenomenon: it is possible to bear particularly disagreeable working conditions when these are concentrated within a relatively short time-span; the duties are more concentrated and the work more intensive, etc. As a rule, part-time work is particularly advantageous to employers when it concerns jobs where flexible working hours are an important element and where it allows for an intensification of work in posts regarded as easily interchangeable. Flexible hours and intensity of work are not accepted as qualities specific to female part-time workers; they are deemed to be an automatic consequence of management systems. From this point of view, part-time employment operates as an effective mechanism for downgrading women’s work.

In France, for example, the prevalence of part-time work is inversely proportionate to the level of skill. Fewer than 10% of female company executives work part-time, as opposed to 50% of women providing direct services for individuals and almost 40% of unskilled female workers.

A kind of vicious circle is created. Given their comparatively low pay, female part-timers are not in a position of strength to renegotiate the unequal distribution of unpaid domestic work, while this work is so burdensome that the transition to full-time work becomes more difficult, even where such a possibility exists. Torns (2001) cites surveys conducted in the Netherlands according to which, in households where both the man and
the woman work part-time, the division of labour still remains hugely unequal: the man frees up time for himself whereas the woman “frees up” time for domestic work. The same phenomenon was apparent when working time was drastically reduced at Volkswagen in Germany, where both men and women were obliged to work part-time (Seifert, 1997).

Table 18: Women’s part-time work by socio-professional category in France, 1998

<table>
<thead>
<tr>
<th>Category</th>
<th>%</th>
<th>Number of women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managers</td>
<td>19.2</td>
<td>197,000</td>
</tr>
<tr>
<td>incl. company executives</td>
<td>9.9</td>
<td>28,000</td>
</tr>
<tr>
<td>Semi-professionals</td>
<td>24.1</td>
<td>525,000</td>
</tr>
<tr>
<td>incl. technicians</td>
<td>16.4</td>
<td>18,000</td>
</tr>
<tr>
<td>White-collar</td>
<td>38.7</td>
<td>1,914,000</td>
</tr>
<tr>
<td>incl. staff providing direct services for individuals</td>
<td>54.5</td>
<td>633,000</td>
</tr>
<tr>
<td>Blue-collar</td>
<td>31.6</td>
<td>369,000</td>
</tr>
<tr>
<td>incl. skilled workers</td>
<td>20.9</td>
<td>88,000</td>
</tr>
<tr>
<td>incl. unskilled workers</td>
<td>37.4</td>
<td>259,000</td>
</tr>
<tr>
<td>Total</td>
<td>31.6</td>
<td>3,178,500</td>
</tr>
</tbody>
</table>

Source: INSEE in: Bihr, Pfefferkorn, 1999, p.40. This is a simplified version of the table. I have omitted non-wage earners, although these groups are included in the total. I have restricted the data to the year 1998.

Yet this circular relationship between poor working conditions in paid employment and a deterioration in working conditions at home is not confined to the issue of pay-related social status. It may also derive from a loss of control over time, resulting from workplace flexibility, as was observed by Cattaneo (1997) in a comparative study of nurses and checkout operators working part-time in France. The first group managed on the whole to keep control over their working and personal time, whereas the second group found itself in a very weak position. Line managers demanded unlimited availability and enforced it through an individualised, repressive system of management. Cattaneo (1997, pp.76-77) states: “So one can see from the checkout operators the extent to which a loss of control over working time, in respect of both duration and organisation, perverts not only paid time but also personal time. In this context, the loss of value suffered by the checkout operators at work can lead to a personal loss of value, especially because they have no outlet for their anger, rage or rebellion, no body to defend them or simply to ensure respect for their freedom and rights. (...) The permanent availability demanded at work prevents the checkout operators from having any freedom at all in their private lives and organising their own time, all the more so because their superiors take the liberty of interfering in their private lives, contacting them by telephone so as to order them.
to change their rest periods into working time or else to inform
them that a scheduled time slot is to be moved or cancelled”.

The 1993 working-time directive\textsuperscript{199} overlooked the problems
posed by part-time employment. It is structured around rela-
tively high limit values (such as a maximum working week of
48 hours), and impacts only marginally on part-time work.

The 1997 directive on part-time work\textsuperscript{200} side-steps all the is-
sues arising from job segregation and the physical conditions
in which part-time work takes place. It lays down the principle
of equal treatment in terms which add nothing to what had al-
ready been achieved thanks to case-law of the European Court
of Justice\textsuperscript{201}. Thus it may perhaps make a contribution to legal
certainty: a fairly modest claim for the sole Community instru-
ment concerning this overwhelmingly female form of employ-
ment, especially since the express purpose of this directive is
to put pressure on Member States to dismantle any obstacles to
the systematic use of part-time work as a preferred instrument
of flexibility.

The Stadt Lengerich vs Angelika Helmig judgment of 15 De-
cember 1994\textsuperscript{202} reveals an inability of the Community’s legal ap-
proach to gender-based discrimination to take into account the
specific nature of actual working conditions. This judgement
relates to a total of six different cases. These were questions re-
ferred for a preliminary ruling by German courts, concerning the
non-payment of an overtime supplement to part-time workers.
Such provisions are written into various collective agreements
in Germany. The ECJ carries out a formal comparison between
part-time workers (mostly women) and full-timers (mostly
men). It detects no discrimination because, it says, if staff have
worked 19 hours, they will receive the same pay (18 hours plus
1 hour of overtime in the case of part-timers; 19 hours as a fra-
tion of a larger amount of time for full-timers). This straight-
forward mathematical calculation deliberately leaves aside the
practical implications of overtime for life in the workplace.

The Court bases its arguments on an abstract legal analysis of
time as a perfectly interchangeable unit. By refusing to exam-
ine the specific nature of the part-time status, this judgment
takes full-time employment as the standard point of reference.
It is agreed in all the Community countries that overtime at-
tracts additional pay. This can be explained by various factors:
overtime is arduous for employees because it makes working
time irregular and normally contributes to greater fatigue. In
addition, overtime represents an undoubted advantage for the

\textsuperscript{199}. Directive of
23 November 1993
concerning certain aspects
of working time, OJEC L
307 of 13 December 1993,
pp. 18 et seq.

\textsuperscript{200}. Directive of
15 December 1997
concerning the Framework
Agreement concluded by
UNICE, CEEP and the ETUC,
OJEC L 14 of 20 January

\textsuperscript{201}. By providing for
possible derogations from
the principle of equal
treatment, it could punch
holes in achievements
made through Community
case-law.

\textsuperscript{202}. ECR, 1994, l, p. 5727.
employer, who benefits from additional flexibility in managing the workforce, can utilise work equipment over longer periods in accordance with his own output requirements, may perhaps avoid having to recruit new staff by sharing out part of the workload among the company’s employees, etc. Bearing in mind the unequal division of unpaid labour, female employees probably find overtime more arduous than men. It might furthermore constitute a real obstacle to seeking an alternative, better-paid job.

In justifying the non-payment of a higher overtime rate for persons working part-time, the ECJ rules out any consideration of the practical significance of overtime in terms of working conditions. It applies a purely arithmetical test to check whether part-time work is being discriminated against as compared with the “model” represented by the male referent of full-time work.

The outcome is an analysis no more profound than this: “There is unequal treatment wherever the overall pay of full-time employees is higher than that of part-time employees for the same number of hours worked on the basis of an employment relationship.

In the circumstances considered in these proceedings, part-time employees do receive the same overall pay as full-time employees for the same number of hours worked.

A part-time employee whose contractual working hours are 18 receives, if he works 19 hours, the same overall pay as a full-time employee who works 19 hours.

Part-time employees also receive the same overall pay as full-time employees if they work more than the normal working hours fixed by the collective agreements because on doing so they become entitled to overtime supplements.

Consequently, the provisions at issue do not give rise to different treatment as between part-time and full-time employees and there is therefore no discrimination incompatible with Article 119 of the Treaty and Article 1 of the directive” (paragraphs 26 to 30 of reasons for judgment).

Advocate General Darmon went even further in his conclusions: he found that the rules allowing for an overtime supplement in the case of part-time work might amount to discrimination against men! (paragraph 31 of his conclusions). And as so often happens, the economic dimension did not escape his
notice. He shared the argument of the UK government about the payment of a supplement: “the effect of that approach would be to dissuade employers from taking on part-time employees whose pay for the same number of hours worked would be more costly for the undertaking which finds it necessary to have recourse to overtime”.

The Advocate General did address himself to working conditions as a peripheral matter, noting that for full-time employees overtime is the source of greater physical effort and a reduction of their leisure-time. Such a stereotype would imply that part-time employment generates time for oneself, devoted to relaxation, leisure pursuits or in any event activities requiring no particular physical effort.

This vision is starkly belied by every analysis of the real working conditions of female part-timers. A summary table produced by Doniol-Shaw (2000, p. 5) indicates the extent to which part-time work is normally associated with more onerous time constraints.

<table>
<thead>
<tr>
<th>Table 19: Part-time work and time constraints in France, 1991</th>
</tr>
</thead>
<tbody>
<tr>
<td>Same hours every day</td>
</tr>
<tr>
<td>----------------------</td>
</tr>
<tr>
<td>Part-time</td>
</tr>
<tr>
<td>Full-time</td>
</tr>
</tbody>
</table>

Source: Doniol-Shaw (2000)

A French trade union survey analyses as follows the recourse to overtime among female checkout operators in department stores (CFDT, 2001, pp. 175-176): “The checkout operators interviewed mostly work part-time (70%), not out of choice: 84% of them said that they were given no choice at the time of their recruitment. It is therefore not surprising that many of them are dissatisfied still to be working part-time. Almost half would like their contracts to be switched to full-time ones, and a third of them would like to find a second job. But the latter solution appears difficult to put into practice, because just 3% of the checkout staff interviewed stated that they had a second job. The main obstacle they identified to taking another job was their irregular working hours.

This irregularity has a number of causes, the first being the existence of additional hours, as well as overtime. The responses reveal a discrepancy between contractual working hours and
real working hours. Whereas the contractual hours of the check-out operators interviewed numbered between 21 and 29 in 41% of cases, and between 30 and 38 in 42% of cases, their real working hours (calculated for the week preceding the survey) were higher: 54% had worked between 30 and 38 hours. This difference can be explained by the frequent recourse made to additional hours and overtime. Indeed, 61% of the checkout staff said that they had worked additional hours; 62% had done overtime. These extra hours are paid - and perceived - as an extremely useful top-up to the basic wage. Earnings are moreover the reason given by employees to explain their acceptance of additional hours. This is easy to understand, in that their pay very often remains below the official monthly minimum wage: 62% of female checkout operators earn less than FF 5000, and 29% of them claim to earn less than FF 3000 per month”.

These findings are borne out by other surveys. D. Meulders (in: Maruani, 1998, p. 247) summarises several French surveys according to which:

• part-time work does not seem to rule out very long working days and split shifts;
• part-time work does not seem to rule out longer working weeks;
• part-time work is characterised by more frequent variations in work schedules from one day to another, set by the company, and by variable numbers of days worked from one week to another;
• part-time employees are obliged more often than full-timers to work at weekends.

Surveys in other European Union countries arrive at similar findings (Goudswaard, de Nanteuil, 2001, pp. 94-96). For instance, a German survey among manufacturers of car parts states: “In the context of stepping up flexibility, working conditions are generally characterised by enhanced pressure to perform and by increased unpredictability of work schedules. The workload and stress caused by flexibility are therefore combined with insecure working conditions and with the highly flexible deployment of part-time workers and above all people doing marginal amounts of part-time work. Gender discrimination is evident in this field, since there is a particularly large proportion of women in these categories”.

It might perhaps be argued that this social analysis does not necessarily result in convincing legal arguments. That is open to doubt. Instead of regarding male full-time employment as the reference norm, an alternative legal conception of equal oppor-
tunities could be put forward: the pay supplement is due here on account of the disruption to the rhythms of life caused by any work done in excess of the contractually agreed schedule. It also represents a modest redistribution of the profits derived by the employer from flexible working hours. This is moreover what the UK government was indirectly acknowledging when it argued in favour of discrimination. In this respect, the same principles apply to a condition which overwhelmingly affects women - part-time work - and to a condition applying mainly to men - full-time work.

The examination of part-time work has enabled us to exemplify the pitfalls of an approach that reduces equal opportunities to the abstract legal notion of equality for individuals on the labour market. Action to combat male/female segregation inevitably calls for alternative strategies. Occupational health can make a considerable contribution by prioritising an analysis of real working conditions and their impact on health and quality of life. As long as they incorporate the need for job desegregation, occupational health measures can facilitate access for both women and men - under favourable conditions - to the full range of jobs. The demand for a gender mix in the workplace will probably constitute a decisive element in the struggle for equality at work, an element largely masked by liberal and individualist approaches to equal opportunities.
Conclusions

“One day a woman goes to the doctor:
- Doctor, examine me!
- You are mistaken, Madam,
  I don’t treat human beings.
  That’s the point, Doctor,
  I feel like an animal.
When I get up in the morning, believe me,
  I rush through the house,
  Breathless as a dog or cat,
  I gallop to work like a horse,
  In the bus I cling on like a monkey,
  I am laden like a camel,
  I defend my family life like a lioness.
Returning home from work in the evening
  I am already asleep, and above my head
  I hear my husband murmuring
  “Get a move on, old bird!”
  So perhaps you will find
  A miracle cure
  That will turn me into a human being.”

Song sung by women on strike in Gdansk (1980)

This volume has offered something of a bird’s eye view. Many issues have been left out. To some extent, this was deliberate. The gender dimension of occupational health can be broached from several different points of view. One fairly common approach is to investigate the respective positions of men and women by risk category, thereby obtaining a sort of overview of the potential fields of preventive action and drawing attention to the gender aspects which ought to be taken into account. I have opted for an altogether different approach, namely to identify the obstacles which, in a number of areas, have introduced distortions and served to conceal occupational health problems among women. The decision to do so was based on three considerations.

1. Every single aspect of occupational health is affected by gender relationships at work. We could hardly produce an encyclopaedia of occupational health, rewritten in the light of gender analysis. Nor was it a priority to do so, in that merely

drawing up a list of fields for action is no guarantee that the obstacles I have sought to identify can be overcome.

2. Risk-based approaches to occupational health do not take full account of social determinants. Working part-time or in contact with the public does not mean “being exposed to risk”: these are working conditions that interact with a plethora of other conditions, a combination of which determines potential damage to health, strategies to combat it and impediments to the effectiveness of these strategies.

3. Although there is a real knowledge gap, the main obstacle - not least to generating that knowledge - is political. That is perhaps one of the most paradoxical impressions to have emerged from this investigation: ultimately we know a good deal and also very little. Once we seek the information, we find out a good deal. The bibliography includes only a small amount of the research completed and data available. When we seek the information, we can learn something even from data generated in a context which oozes bias: the recognition of occupational diseases. On the other hand, we could draw up a very long list of research needing to be carried out, point to hypotheses requiring further analysis, etc. We know very little, because a huge quantity of information is dismissed as not worthy of analysis; it is regarded as having curiosity value but no real interest for a proper policy of prevention.

**Understanding the obstacles**

The main question that arises is “how can the vicious circle be broken?”. It is a matter not so much of attracting attention to a long list of problems as of understanding the nature of the obstacles and seeking ways of overcoming them. That is why this analysis of the gender dimension in occupational health is not a response to a desire for theoretical perfection; it has profound implications for the design of preventive policies and strategies.

Developments in the world of work have done more to create new frontiers of inequality than to bring about job desegregation in both paid and unpaid work. The division of labour takes various shapes but its differentiated impact on the health of men and women remains unchanged.

If the problem merely amounted to a different distribution of risk from one occupation or sector to another, that would pose no fundamental difficulties with regard to preventive policies. But an analysis of the impact of working conditions on health
demonstrates that the distribution of risk between men and women is not merely random. In other words, one of the determinants of the gender-based division of labour itself is a trivialisation of the risks linked to male/female stereotypes.

According to a typology established by Philippe Davezies (1999), health impairments fall into three groups:

- direct injury to physical well-being, generally from material agents (machinery, substances) or physical factors;
- extreme stress, due to the inappropriate or excessive use of men and women. The work activity itself - its intensity or repetitive nature - is at issue here;
- injury to self-respect. Forms of psychological violence have proliferated (humiliation, bullying and mental harassment).

These three groups do not exist in isolation; all the different types of health impairment interact with one another. For various reasons related to the gender division of labour, women are nowadays more prone to injuries of the second and third types. There is evidence in particular of increased Taylorisation in a certain number of female industrial activities, and certain forms of Taylorism have been introduced in female-dominated service activities (hospital work, distribution, call centres, etc.).

Preventive practices tend to prioritise the first group of health impairments, ones which can to a certain extent be separated out from normal work operations, and can be presented as “accidents” or “incidents”. In some cases, damage to health can also disrupt production, and there may be a common interest in implementing preventive measures.

Most studies of working conditions indicate that women tend to be over-exposed to the phenomena of extreme stress and injury to self-respect. Such data must of course be treated with caution: they correspond partly to reality and partly to the stereotypes which have shaped that reality and led to an inaccurate perception of it. The ways in which women are exposed to physical and chemical risks often lead to an under-estimation of those risks. The most specific hazards as far as women are concerned are the ones least easily passed off as hitches in production. Extreme stress and injury to self-respect are, on the contrary, directly related to work intensity (and its profitability for the capital side) and to its hierarchical organisation. Direct damage to physical well-being does not necessarily derive from normal production operations, but to recognise it would call into question the lowly status of female labour. We see this in sectors such as cleaning and textiles, where there is ample scope
for improvement without posing a direct challenge to “normal production”. Occupational health could be improved simply through a better choice of chemicals or more well-adjusted work equipment. But the acknowledgement of these problems and, above all, a pro-active attitude to altering working conditions could bring about a shift in the balance of power which, ultimately, might have a knock-on effect in other fields (a challenge to low pay, flexible working hours, etc.).

In addition, taking into account the gender dimension also means taking account of the relationship between paid and unpaid work. Here we are touching on a central issue in the reproduction of social inequality.

Finally, the close link between working conditions and stereotypical roles prompts a critical analysis of the constructs of masculinity (or virility) and femininity.

Preventive practices therefore need to look at the key determinants of work organisation and social reproduction. Yet by doing so, they cease merely to be preventive practices, losing the status of technical neutrality which often characterises such strategies. They cannot but form part of a political and social transformation that goes much further than the mere elimination of occupational risk. Arguably, that explains the potency of the mechanisms of concealment which we have observed.

A vital coming-together of trade unionism, feminism and ecology

Ascertaining the magnitude of the obstacles could provoke a reaction of despondency. What can be done to overcome oppression dating back millennia? Are we not expecting too much of preventive practices? These objections can be countered by means of two decisive arguments.

By taking into account the gender dimension, we can focus attention specifically on the key aspects of occupational health, for women and for men too. This is neither a theoretical indulgence nor an expression of particular concern for working women. The challenges associated with new methods of work organisation and with the changes brought about by the globalisation of capital necessitate a reinvigoration of policies in the field of occupational health. Primarily technical approaches are bankrupt, and not solely in relation to the gender dimension. The catastrophes caused by subcontracting in the chemicals
industry and by fierce competition in the shipping industry, the disastrous health effects of asbestos and the numerous consequences of insecure forms of employment are all elements which highlight the incompatibility between the organisation of production activity and the needs of human beings. Perhaps, by mainstreaming the gender dimension, we might avoid missing the vital link between the prospects for change in paid work and the fight against inequalities between men and women.

This potential coming-together of different perspectives - trade unionism, feminism and ecology - also constitutes a powerful resource. Trade union action around occupational health has for too long, and all too often, been hampered by a vision confined to the relations between employees and employers. Major improvements have been made in this context, depending on the balance of power and on the controversiality of the issues raised. This remains true today for a certain number of problems, and “classic” trade union action still has a long future ahead of it. Nevertheless, it appears that a growing number of occupational health problems cannot be properly solved within such a narrow framework. There can be no doubt that effective prevention of chemical risks entails changing our basic conception of production methods which are acceptable in the light of the long-term interests of humanity and its environment. It is impossible to combat the upsurge in certain manifestations of violence at work without tackling the more deep-seated societal problems. Sexual harassment and violence against women outside of the workplace are part of the same continuum. Addressing occupational health from a gender perspective thus releases an immense amount of energy for change; it means acknowledging hidden aspects of pain and suffering, and channelling them into collective demands. Nothing ventured, nothing gained: the obstacles identified above might eventually get the better of us. But it is worth a try.

**A pooling of efforts based on practical experience**

How can this long-term agenda be reconciled with everyday action, on the part of trade unions but also of everyone else involved in prevention? It is without doubt in this area that the conditions for triggering a dynamic approach are most favourable. Occupational health issues speak the language of gender even when they are not part of any theoretical vision; they speak it on a daily basis because they arise out of relationships at work where gender inequalities are omnipresent. In terms of immediate measures, there is no need to seek out pastures
new; we merely have to sharpen our focus when observing the old landscape. Experience gathered in fields such as combating musculoskeletal disorders, stress or psychological violence can serve as a basis for pooling efforts. It matters little in this respect that the solutions found are partial and respond to only some of the problems. The main thing is that they enable the tables to be turned: the key to altering the organisation of work lies in the experience of workers, female and male. Their health problems can be solved only by paying heed to their points of view about work organisation and its implementation. All practical changes made as a result of seizing the agenda in this manner boost the confidence of the individual and of the workforce as a whole. Only in this way can we stop asking the doctor for “a miracle cure that will turn me into a human being”.
Case studies
The gender workplace health gap in Europe
Case study 1
Germany : Female-dominated jobs exposed to hazardous substances

by Marianne De Troyer,
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G. Kliemt’s book stands out in the literature on chemical hazards for giving both a statistical analysis of women’s changing labour force participation over the period 1977-1992, and an examination of female-dominated jobs that have rarely been studied or researched.

The research fell into three key stages.

Stage One

Statistical research was done into the volume and changing patterns of women’s work, especially in industrial production and manufacture, to highlight changes in women’s labour force participation between 1977 and 1992 in traditionally female-dominated sectors of activity like the clothing industry. Sectors of activity and occupations where women have made the biggest inroads in recent years were also looked at. This revealed an increasing feminization in both total numbers and relative terms in the printing and plastics industries, for example. Among occupations, more women were found to be taking jobs as technicians, maintenance workers, and nursing aides.

Over the same period, large numbers of women entered training for traditionally male occupations, most significantly for trades in food production, the timber industry, house painting, furniture varnishing and as mechanics.

Stage two

The study then turned to female-occupied jobs that were exposed to hazardous substances and their likely health impacts by sector of activity and, where possible, occupation. Following a review of the scientific literature, panels of experts were consulted.

The research and analyses done for the Bundensanstalt für Arbeitsschutz on a different issue were also used as a basis for this study.

especially on the glass-making and ceramics industries, and the health care occupations.

A summary review of this stage showed that many women in different sectors of activity and occupations are doing jobs that are exposed - and especially, multiply-exposed - to dangerous substances. This was at odds with the conventional picture of women workers having little exposure to chemical hazards.

**Stage three**

Plant visits and targeted studies were then carried out on selected jobs both in terms of work processes and hazardous exposure measurement by specialized agencies. Workplaces were visited in various sectors of activity, in particular the electronics, metallurgical, printing, jewellery and optics industries.

The findings of this final stage were:

- Women often do work that requires a high degree of dexterity and deftness, i.e., special manual skills. This means they are literally “risking their hide”, because the nature of their work increases their risk of skin contact with dangerous substances, and so the likelihood of developing skin disorders (eczema, rashes). Most get far too little protection from the protective gloves supplied, which provide only a very limited barrier against dangerous substances. In fact, protective gloves are not really suitable where manual dexterity is required because they stop the job being done properly. Also, protective gloves create a negative microclimate for the skin which severely diminishes the natural resistance of the epidermis and can cause allergies.

- Women are often found in “marginal” manual jobs that exist only to offset specific failings in automated production processes or to mop up production peaks. In neither case are these “real” jobs but makeshift solutions devised by technocratic management. As a result, these workers are often looked on as “secondary” non-career relief labour. These stereotypes impact women’s work environment and the preventive measures taken to improve working conditions, so the work-related risks they run are often under-rated.

Arguably, the failure to recognize the extent of women’s exposure to dangerous substances in these “marginal” jobs stops the problem from being seen as a workplace safety issue. For example, a woman worker whose job was to manually store just-welded printed circuit boards was necessarily exposed to welding fumes because the storage pick-up located at end of the cooling tunnel that was usually closed and fitted with an extractor system was unable to distinguish a particular type of circuit board. The invisibility of women’s work leading to the
invisibility of their health at work is a question that still awaits an answer... particularly in view of such anecdotal evidence as: a worker in an optics company whose “skin has the whole weekend to get over it anyway”; a jewellery polisher who was “at fault” because, in an attempt to cut down the noise pollution from the extractor hood, she did not use the additional filter, thereby exposing herself to added dirt and dust. Or the similar misconception expressed by the foreman in charge of women thermal relay switch calibrators who suffered allergies and eye irritation from glue fumes in saying that: “no-one ever actually told me about eye irritation being caused this way”.

The general finding is that both female and male workers are under-informed or not informed at all about the substances they handle and their potential hazards. This lack of information can mean that dangerous substances are not handled properly, increasing the risk of exposure. A good case in point is jobs studied in a silk screening workshop. In most cases, the real problems for women came not from the most significant and obvious exposures, but rather from a wide array of small, relatively unobserved exposures like work surfaces contaminated by glue. Basically, it is skin contact more than air concentration of a substance that is the main source of exposure in such cases.

This failure to inform at-risk workers is mainly due to the fact that in some companies, even supervisory staff know little about the dangerous substances for which they are responsible, and have little awareness of the problem. So even where supervisors have technical descriptions, safety data sheets or instructions for use of the dangerous substances used, the printed information does not automatically prompt them to act preventively.

In some companies, too, there is a wide gap between company-supplied printed information and on-the-job practice. For example:

- The handling instructions for a solvent said “do not splash or over-turn”, but to clean an inkjet printer, the worker was supplied with the solvent in a spray gun with instructions to spray the parts to be cleaned and catch the run-off in a bowl.

- A safety data sheet recommended that when using cyanoacrylate glue, naked flames or hot objects should be kept away from the work area (due to the risk of adhesive fume decomposition). But small alcohol burners were positioned at the work stations, and the women gluers used the flames to unclog the glue gun nozzles that were blocked with cyanoacrylate glue.

The fact that available information is not put into workplace practice can also be seen within a company where in one department, a glue applicator system may be cleaned with water, but in another, glue is removed with a trichloroethane solution, creating a hazardous exposure...

Case study 1 - Germany: Female-dominated jobs exposed to hazardous substances
to the women workers concerned. Here, there was no inter-departmental information flow, not least due to a lack of a company-wide policy on hazardous substance management. Where companies do have a comprehensive hazardous substances management policy, such inconsistencies and discrepancies in workplace practice do not occur.

But intra-company inconsistencies and discrepancies are fairly commonplace - e.g., from the safety department - is required before starting to use a dangerous substance, or where a block authorization is issued for general company-wide use rather than in one particular job or for one specific use. Such cases are likely to produce unsupervised handling which has no direct bearing on the production process or is inappropriate for the working conditions.

This under-information is found not only in relation to dangerous substance handling, but also the use of safety devices (flexible extractor fans for work areas, personal protective equipment (PPE) or skin barriers) when using dangerous substances.

In some workplaces visited, for example, the workers were unaware that they had to change extraction filters. So, at one welding station, a woman was working with a completely useless clogged filter. When asked whose job it was to change the filter, the foreman answered “the women do it; it’s up to them”, while the worker concerned said “I’ve been working here for two years and this is the first time I’ve heard that it’s our job. No-one has ever told me or shown me how to do it”.

A company’s awareness of the issue of hazardous substances can be gauged by the type and set-up of workstation extraction systems and how suited they are to all the characteristics of that job.

There are instances where problems have been properly addressed by collecting detailed basic information instead of just fitting a general-purpose extraction system.

This holistic approach to job analysis includes, for example, taking readings of the chemical and physical reaction of dangerous substances (volatility, heavier- or lighter-than-air fumes, etc.), the forms they take (fumes, droplets, etc.), (seasonal) weather conditions for the workstation and its environment (draughts, temperatures, relative humidity, etc.), on required job skills and actual work processes, ergonomic aspects, potential sources of in-process emissions and ways of avoiding them, etc.

Other companies take a much more rough-and-ready approach, and there is evidence of extraction systems with effectiveness levels that vary even with the specific job conditions.
Companies may even have different orders of technical solution to what is basically the same ventilation problem: welding stations and plastic injection machines are cases in point where no real problem analysis or experience sharing is done.

Perennial failings include:

- Extraction systems are not properly set up to extract dangerous substances ahead of the operator interface. Polluted air circulates in the breathing area before being extracted. Heavier-than-air hazardous fumes may be sucked counter-gravitationally upwards (i.e., through the breathing area), so that not all toxic substances are extracted.
- Extraction systems are not properly set up to extract all dangerous substances, so large quantities bypass the system and end up in the breathing area or ambient air. Vents are often too small to properly clear the volumes of toxic substances abruptly released, particularly where high concentrations are involved (e.g., test runs of a plastic injection machine).
- Too little account is taken of draughts at workstations and in workshops. There are reported cases of welding or hazardous fume blow-back into workers’ faces caused by draughts, at welding stations in particular.
- Extraction systems designed to cope only with the main work activity. Often, no worker protection is designed into the more ancillary jobs (cleaning and transfer, shut down and repairs), which can easily result in short-term over-exposures in particular, which are easily overlooked in routine checks.
- Extraction systems designed mainly for main work activity emission sources (e.g., gluing or varnishing stations), while other emission sources at the same workstation (e.g., from hardening or drying glued or varnished parts) are disregarded. This can result in quite high concentrations of hazardous substances at a workstation which is actually fitted with an extraction system.
- Extraction systems may not properly checked for side effects (e.g., noise) or appropriate for the general working environment. Extraction systems that are too noisy and interfere with concentration, for example, may not be well-accepted so that workers look for alternative solutions which may include by-passing this “safety system”.
- Ventilation systems, whose effectiveness depends chiefly on how workers respond to them, tend to be less effective than fully built-in systems. This is especially so for work area extraction systems, one of whose strengths is their flexibility, but whose drawbacks are clear: most are not used because they are regarded as too noisy for comfort. Also, they are often wrongly-fitted, and so fail to pick up welding fumes. And failure to change filters in good time reduces their capacity to absorb dangerous substances.
It was also found that some women workers who do not handle hazardous substances are still at risk from exposure to dangerous fumes emitted elsewhere that spread throughout the workshop. This, for example, may result in pregnant workers being exposed to risks for the unborn child (premature birth, foetal malformation) with no proper workplace risk assessment having been done.

Generally, hazardous exposure analyses do not reveal immediate acute risks for many female-occupied jobs, but more general air pollution coupled to adverse climatic conditions can increase individual sensitivity to exposure to dangerous substances at work, and this can create discomfort, general unwellness or even ill-health.

It is important to bear in mind here that women workers see workstation and general work environment exposures as one, i.e., the effects of the various factors of multiple exposure are displayed as a syndrome experienced by them. The symptoms of this syndrome may be partly non-specific, but they are nonetheless a subjectively-perceived reality for these women which is still poorly understood by industrial hygiene specialists.

The researchers were surprised at the incidence of actual ill-health caused by dangerous substances in jobs held by women. Significantly, women workers more often take their problems to their GP than the company doctor.

The research found many instances where neither the jobs nor the women at risk had been identified by the company medical service. Company doctors seem to have some difficulty identifying exposure and the resulting risks for a given job related to the work process. The question asked by a company doctor in regard to the analysis of a female job exposed to dangerous substances is illuminating: “But what exactly is it in this job that you find so important to be so bothered about?”. The visibility of damage caused by work and the role of occupational medicine in keeping women workers’ problems hidden or unrecognized are issues that must be addressed.

To conclude, this research clearly shows that the standard methods of measuring environmental factors (metrology) in work activity are not enough to create decent working conditions for jobs done by women. A multidisciplinary whole-job and work process analysis is essential to the provision of good working conditions. As well as en-gendering the system, better models for analysing complex work-related risks to women and men are needed that go beyond a basic analysis of working conditions. This is not always easy, because such models may only be developed out of protracted research. Getting the women workers concerned involved in that research as experts in their own working conditions has proved to be a highly successful approach.
Case study 2
Germany: Women, health and work –
Main findings of the first federal report
on women’s health

by Dr. Antje Ducki,
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and Prof. Ulrike Maschewsky-Schneider,
Technical University of Berlin, Institute of Health Sciences

The first federal German report on women’s health was published in 2001 (BMSFJ, 2001). This report has its origin in the 1994 initiative “Women’s Health Counts” of the European bureau of the WHO, requiring each European state to produce a national report on the state of women’s health. The 700-page global report is the result of an interdisciplinary project conducted by several research groups in Germany. It considers the particular situation of women after German reunification and was supported and financed by the German Federal Ministry for Family Affairs, the Elderly, Women and Youth.

One chapter of the report deals with the health consequences of gender segregation at work. The gender-specific health risks and resources related to paid and unpaid work and the gender-specific aspects of unemployment and health are described.

Different data sources were used:
• a gender-specific reanalysis of representative German studies concerning occupational stress and strain;
• sex-differentiated representative data on general work-related health indicators e.g. absenteeism, occupational accidents, work-related diseases and early retirement; data are taken from the German health insurance funds, accident insurance agencies (Berufsgenossenschaften) and the Ministries of Health and Employment;
• the results of a literature review on gender differences in unemployment and health, and unpaid domestic work and health.

The main findings regarding gender segregation at work and its consequences for health are presented below.

Paid employment

On April 1998, 63% of all German women aged between 15 and 65 were employed. In West Germany the female employment rate was 60.5%; in East Germany it was 73.5%.
Gender segregation at work in Germany is pronounced and extends both across and within occupations:

- in 1996 three quarters of all female German employees worked in the service sector. More than half of all female German employees (8,500,000 out of 15,276,000) were working in offices, in cleaning services, shops, social services or the health service. Women’s jobs are mostly characterised by elements of so-called ‘people work’: caring, nurturing and support;
- in all economic sectors (industry, service sector, education and science) fewer than 5% of the top positions are occupied by women. The family-related effects of reaching the top are considerable: only 39% of women in top management have a child, compared with 89% of men. 44% of female top managers are married, compared with 90% of male top managers (Tischer/Doering, 1998);
- German women’s income is one third less than men’s in equivalent positions;
- 87% of German part-time workers are women.

In summary, women in Germany are working in particular sectors and particular occupations, and they are less likely to be in senior/managerial positions. Their income is lower than men’s income in equivalent positions, and many women work part-time. This situation is an expression of gender segregation and at the same time strengthens it.

**Women’s occupational risk factors**

A gender-differentiating analysis of the representative *German National Health Survey* (NUS, 1990/1992) yielded the following main occupational health risks for women:

- time-related burdens such as time pressure, overtime and long daily working hours;
- intense concentration requirement;
- unpleasant physical demands;
- major responsibility for people.

Especially for women who have to coordinate family and work demands, burdens like time pressure, overtime and long working hours are very problematic and often have negative consequences for family life in general. The limited differences between women and men might be determined by the fact that the risks surveyed are geared to typical male working conditions in industry.

One example of a female-specific burden is sexual harassment: in a nationwide survey more than 4000 women were asked about their experiences of sexual harassment. 70% of all women said that they have already been confronted by obscene jokes, lewd looks, cat-calls and
inappropriate bodily contact. Furthermore, 15% say they have been forcibly kissed (Beerman/Meschkutat, 1995).

| Table 1: Selected workloads, differentiated for sex and for East/West Germany (%) |
|-----------------------------------------------|---------------|----------------|---------------|
|                                               | Heavy workloads |               |               |
|                                               | East Germany   | West Germany   |
|                                               | Women (n=203)  | Men (n=396)    | Women (n=217) | Men (n=1413) |
| Time pressure, fast pace of work              | 20.1           | 21.2           | 24.8          | 24.2          |
| Unpleasant physical demands                   | 18.1           | 14.6           | 21.2          | 15.7          |
| Intense concentration                         | 16.9           | 18.1           | 13.7          | 17.6          |
| Overtime, long working hours                  | 15.4           | 14.6           | 14.3          | 13.8          |
| Major responsibility for people               | 17.9           | 16.6           | 8.1           | 16.0          |

Source: German National Health Survey (NUS, 1990/1992)

**Resources**

Resources make it possible to achieve aims in spite of difficulties, to cope better with stress factors and to reduce adverse impacts. Important situational resources in the workplace are for example broad scope for decision-making and action, complete tasks that require complex goal and action planning and the monitoring of results, variability of tasks required, flexible time management and social support.

There are no representative data about resources in the workplace, but some studies show that women have fewer resources at work than men. Women often work at the lower end of the job hierarchy with a high level of standardisation and regimentation. Some studies have shown that women have less scope for decision-making than men even when they hold a comparable post (Lüders & Resch, 1995; Moldaschl, 1991; Ellinger et al., 1985).

**Occupational health**

The occupational health indicators generally used in health monitoring systems show that:

- women in West Germany have fewer days of absenteeism than men. In East Germany there is more absenteeism among women;
- in both East and West Germany women have a lower rate of occupational diseases and occupational accidents than men, in not only absolute but also relative terms;
- regarding early retirement, the data show that even though the absolute number of early retirements for women is lower than for men, the relative rate is higher. In 1996, 1.2% of all female employees and 0.98% of all male employees retired early.
Clear gender differences are found in the types of illness suffered. During the period from 1991 to 1996 the main occupational diseases among women were skin diseases, allergic respiratory diseases and tropical diseases. The main occupational diseases among men were noise-induced hearing loss, pneumonoconiosis (black lung) and asbestosis.

<table>
<thead>
<tr>
<th>Table 2: Most frequently reported occupational diseases 1991-1996, differentiated by sex (absolute numbers)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
</tr>
<tr>
<td>Noise-induced hearing loss</td>
</tr>
<tr>
<td>Skin diseases</td>
</tr>
<tr>
<td>Pneumonoconiosis (black lung)</td>
</tr>
<tr>
<td>Allergic respiratory diseases</td>
</tr>
<tr>
<td>Asbestosis</td>
</tr>
<tr>
<td>Lung cancer</td>
</tr>
<tr>
<td>Meniscus injuries</td>
</tr>
<tr>
<td>Asbestos-caused mesothelioma</td>
</tr>
<tr>
<td>Tropical diseases</td>
</tr>
<tr>
<td>Infectious diseases</td>
</tr>
<tr>
<td>Total occupational diseases</td>
</tr>
</tbody>
</table>

Source: HVBG, BK-Dok, special analysis

Specific occupational factors

The work situation of women differs fundamentally according to the job they do: the health risks and resources of a nurse or a social worker are completely different from the health risks and resources of a woman providing cleaning services, a clerk or a shop assistant. Correspondingly, the health of working women may also be different. For that reason the health report looked especially at the state of health of women in occupational groups with a high percentage of women (office work, cleaning services, shop assistants, social services and health service).

A female-specific data analysis of the representative German National Health Survey (NUS, 1990/1992) showed that each of these occupational groups has its typical risk pattern:
- In office work the main risk factors are high time pressure, interruptions and disturbances and unpleasant physical demands caused by constant sitting.
- In cleaning services the main risk factors are environmental burdens such as wetness, heat and cold, unpleasant physical demands caused by kneeling and heavy lifting and monotonous work.
- A fast pace of work, time pressure, long working hours, unpleasant physical demands caused by one-sided muscle use and long daily
working hours: these are the characteristics of shop assistants.

- In the social services (only social workers were surveyed) the main burden is the high degree of responsibility for people, but unpleasant physical demands and noise are also relevant stress factors.
- A very problematic risk pattern consisting of extensive responsibility for people, time pressure and a need for very intense concentration was found in the health service (nursing). This risk pattern is not only relevant to the health of employees but also to that of patients.

A common trend emerges across these five occupational groups: women's workload is a combination of organisational burdens, working time burdens and physical demands.

Several studies also found occupational differences in work-related resources:

- In office work, decision-making scope exists in situations where the worker has prime responsibility for his/her file of customers or clients (Ducki et al., 1993).
- Decision-making scope in cleaning services exists when the cleaning women are given the key and the responsibility for a whole building and can decide in what way they will clean the building (Duda, 1990).
- In sales, complete and complex tasks are more often given in small shops than in discount or department stores. In small shops, shop assistants mostly have to purchase and prepare the merchandise, and they are responsible for customer relations (Straif, 1985).
- In social services and the health service there is more decision-making scope, complex tasks and task variability. The possibility of realising fundamental moral and human values is often mentioned as an important resource (Becker & Meifort, 1997; Büssing et al., 1995).

The range and availability of these resources depend largely on gender segregation because most of these resources exist in better-qualified jobs and at higher hierarchical levels. Even in the occupations selected here, which are characterised by a very high proportion of women, women are not represented at all in the upper echelons (Lüders & Resch, 1995).

As the following table shows, the pattern of occupational diseases is also different:

- The main occupational diseases of female office workers are skin diseases, tropical diseases and typist's neuritis.
- In cleaning services and the health service, the main diseases are infections and respiratory diseases.
- Social workers suffer from skin and infectious diseases and carbon monoxide poisoning.
The most important diseases among female shop assistants are skin and respiratory diseases and diseases caused by contact with animals.

### Table 3: The three main occupational diseases of women in different occupational groups, 1991-1996 (absolute numbers)

<table>
<thead>
<tr>
<th></th>
<th>Office work</th>
<th>Cleaning services</th>
<th>Shop assistants</th>
<th>Social workers</th>
<th>Nursing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin diseases</td>
<td>12</td>
<td>229</td>
<td>401</td>
<td>134</td>
<td>1,360</td>
</tr>
<tr>
<td>Infectious diseases</td>
<td>33</td>
<td></td>
<td></td>
<td>164</td>
<td>954</td>
</tr>
<tr>
<td>Allergic respiratory diseases</td>
<td>17</td>
<td>456</td>
<td></td>
<td></td>
<td>235</td>
</tr>
<tr>
<td>Diseases caused by contact with animals</td>
<td></td>
<td></td>
<td></td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>Tropical diseases</td>
<td>28</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tenosynovitis/Typist's neuritis</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carbon monoxide poisoning</td>
<td></td>
<td></td>
<td></td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>Total occupational diseases</td>
<td>118</td>
<td>357</td>
<td>926</td>
<td>355</td>
<td>2,787</td>
</tr>
</tbody>
</table>

Source: HVBG, special statistics

In summary, the specific features of female workloads and resources differ substantially depending on occupation and the specific work activity. Therefore health promotion activities for women in the workplace should always consider the specific working conditions.

### Home and family work

In spite of women’s increasing role in the workforce, their traditional family responsibilities persist. As representative time management studies show, women in East and West Germany carry out 5.5 hours per day of unpaid work - twice as much as men (BMFS/StBA, 1994; StBA, 1995).

The following table shows that, irrespective of the time devoted to paid employment, women invest more time in unpaid work than men in all cases.

### Table 4: Daily hours spent by women and men on unpaid work

<table>
<thead>
<tr>
<th></th>
<th>Women</th>
<th>Men</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not employed</td>
<td>6.0</td>
<td>4.0</td>
</tr>
<tr>
<td>Full-time employed</td>
<td>3.3</td>
<td>2.2</td>
</tr>
<tr>
<td>Part-time employed</td>
<td>5.3</td>
<td>2.5</td>
</tr>
</tbody>
</table>

Source: Blancke et al., 1996
The main activities around nurturing are the responsibility of women: talking to teachers (64%) and childcare (61%) are activities mostly done by women. Playing with the child is the only activity that women and men often do together (38%) or alternately (27%).

Cleaning (80%) and cooking (78%) are mainly done by women; if men do anything in the household, they are most likely to do the shopping (48%) (BMSFJ, 1996).

**Domestic accidents**

Corresponding to the main responsibility of women for housework and cooking, most of women’s domestic accidents happen while carrying out these activities, as the following table shows.

<table>
<thead>
<tr>
<th>Domestic activities</th>
<th>Approximate number of accidents</th>
<th>Percentage of women</th>
<th>Severity of accident</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Health impairment in days</td>
</tr>
<tr>
<td>Work around the house</td>
<td>250,000</td>
<td>13</td>
<td>21</td>
</tr>
<tr>
<td>Housework*</td>
<td>440,000</td>
<td>70</td>
<td>24</td>
</tr>
<tr>
<td>Cooking</td>
<td>220,000</td>
<td>75</td>
<td>20</td>
</tr>
</tbody>
</table>

* Cleaning, washing, tidying, ironing, washing
** Average days of hospital stay

Source: BAuA 1998

**Nursing in the home**

In Germany 1.2 million persons in need of care are living in a private household. 73% of these persons are cared for or nurses by their wives, mothers or daughters (Schneekloth, 1996). Most of the middle-aged female carers work outside the home and are often forced to reduce their working time or to give up work completely. Financial, social and career restrictions, isolation and a loss of personal life opportunities are the negative consequences for the female carers. Apart from this, home-based care is mostly combined with many psychological and physical burdens for the carer.
Housework - workload and resources

Furthermore, the following burdens of housework are considered in several German studies (Becker-Schmidt, 1984; Ochel, 1989; Klesse et al., 1992; Brüderl, 1993; Häussler et al., 1995):

- public and private inferior status of housework;
- material and social dependency;
- simultaneity of different time patterns (children, housework, job);
- isolation;
- boredom, monotonous work;
- physical demands.

Positive aspects of housework might be close personal identification with the work and greater decision-making scope than in paid work.

State of health

Many studies exploring the implications of home and family work for women’s health have compared the state of health of employed women with that of non-employed women. Although the majority of the studies found a better state of health among employed than non-employed women (Hermann & Hiestermann, 1995), there are also some studies which found negative effects of employment on health in respect of women’s mortality (Häussler et al., 1995). The different findings can be explained by the different research questions, different study designs and different health indicators used.

New studies show that women’s state of health depends on several factors, e.g. the actual life context, the quality of work, the quality of marriage or partnership, the woman’s individual life plans and projects (Bochert & Collatz, 1994; Klesse et al., 1992; Gavranidou, 1993; Gramm et al., 1998). Klesse et al. (1992) demonstrated that the most important criterion for women’s health is the compatibility of their life plans, personal goals and the actual life they live.

These findings are in line with international discussions: multiple roles have a positive effect on women’s health when the roles are voluntarily chosen, and when working and family conditions are satisfying and of good quality (Baruch & Barnett, 1986; Sorensen & Verbrugge, 1987; Hibbard & Pope, 1993; Lennon, 1994).
References


Case study 3
Belgium: Working conditions of female check-out staff

Interview of Irène Pêtre,
National officer for the national white-collar workers’ federation, CSC, Belgium
by Lorenzo Munar Suard,
Centre for the Sociology of Health, Université Libre de Bruxelles

Irène Pêtre is the national officer (retail sector) for the national white-collar workers’ federation1 (CNE) in charge of mass distribution (supermarkets, large retail stores and food shops employing more than twenty workers), and small shops (small food shops and independent retailers). She started out as a regional secretary with the Confederation of Christian Trade Unions2 (CSC), moving up to national officer in September 2001. She is the CSC’s only female national trade union officer.

Relations between trade unions and firms in the sector

Q. The retail and distribution sector is in turmoil at present. The industry leaders are restructuring and waging a fierce price war to keep customers and win market share. Unions are constantly either on strike or threatening walk-outs because you claim that workers are paying the price of this competition. What’s your take on the situation in the sector?

I.P. The general context - recession, a ten-year wage freeze and a wage standard3 - has also been very bad for the distribution sector. The retail sector can’t relocate in same way industry does, because customers live here. So instead of relocations, we get cutthroat competition between the different forms of distribution within Belgium. Competition for market share generally is at the workers’ expense, mainly by using the different joint industrial councils4 to prevent trade unions mounting a collective defence (202 and 202.1). Things are pretty parlous on the jobs front, too. There is a very big threat nowadays from the growing trend towards franchising, where the big supermarket chains are setting up franchise chains that compete with their own-name stores. The franchise bogeyman is for ever being used to cow the unions into submission. But the general outlook is picking up. A couple of years ago, industry employers started having problems finding workers in some areas. No-one wanted to work in distribution for two main reasons: low

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1. The national white-collar workers’ federation (CNE) is affiliated to the Confederation of Christian Trade Unions of Belgium, the CSC (Confédération des Syndicats Chrétien).
2. There are two historical strands to the Belgian trade union movement - one Christian, the other socialist - now represented by the Confederation of Christian Trade Unions (CSC) and the General Federation of Labour of Belgium (FGTB). There is also a third, much smaller liberal strand - the General Confederation of Liberal Trade Unions of Belgium (CGSLB).
3. The expression “wage standard” in Belgium refers to a fairly restrictive form of compulsory pay bargaining. It sets a maximum limit for pay rises by reference to a series of benchmarks.
4. Joint industrial councils are statutory consultative bodies under the Collective Agreements and Joint Industrial Councils Act of 5 December 1968. Joint industrial council are set up by regulation on application by industry unions and employers’ organizations or as a
pay and unsocial hours. If the jobs situation generally picks up, employers are going to have to change the way they go about things or they will have problems finding staff. That’s how bad it is. The Cora superstore that recently opened in Anderlecht (an inner-city borough of Brussels) can’t find staff who can speak both French and Dutch who are willing to work for them, so they end up having to employ agency workers.

Obviously, distribution firms themselves are caught up in market changes driven by consumer demand for lower prices. People want it all, now and cheaper, even if it means eating an increasingly poor and unhealthy diet. Carrying on down this road could lead to health disasters that don’t bear thinking about... Meanwhile, downsizing goes on...

Q. How has the unions-business power relationship evolved? How has the Common Trade Union Front evolved in the sector?

I.P. Often, the Common Trade Union Front has trouble being more than just nominal - the different demands are just lumped together, each union argues its own case and leaves the rest to get on with it. So the outcome varies with each union’s bargaining power, and the most pragmatic - the most compromise-oriented and most inclined to co-management - obviously do best out of it.

Q. Does the trade union strategy differ with the type of organization where check-out operators work: hypermarkets, local supermarkets, minimarts, and so on?

I.P. There is certainly a difference in approach, because the check-out operator’s job is in many ways worse in superstores than in local supermarkets: being just a face in a large workforce; a lack of sales staff at peak times leaving check-out operators to deal with irate customers; inconveniently flexible working hours; short-hours contracts; last-minute, extra-hours filling-in; lack of consideration from customers and management, etc.

Q. Is there separate industry bargaining for different jobs (check-out staff, shelf stackers, etc.), or does it always cover all workers?

I.P. Part-time work is the basic reason why working conditions are so bad. So bargaining tends to be from the part-time angle, except for pay bargaining, where the benchmark is always full-time. So we don’t bargain specifically for check-out operators, but part-timers generally.

Q. Have relations with employers got more complicated?

I.P. Yes, they have different strategies. The Carrefour supermarket chain, for instance, wants all bargaining to be individual store-based government initiative. There are about a hundred joint industrial councils in Belgium, mostly dealing with industry issues on a national scale, but not necessarily with issues covering all industry employees because most are either blue- or white-collar only. Which JIC a company falls under depends on its core business.

5. The different trade unions try and align their activities in the event of major nation-wide disputes, when they often act as a “common front”.

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between the store manager and its union steward. But we won’t have that. You don’t learn to be a union steward at school: you get started, you learn on the job, and your training comes from experience. So not all stewards are at the same point on the learning curve. They might well negotiate a local deal that goes against the interests of the wider company workforce. Employers want individual store opt-outs from collective agreements, using things like some workers’ requests for split hours. Some workers would rather work split hours for personal convenience; for example, they may live close to the store so they can collect their children from school at lunch time. I understand that, but as a matter of policy we’re against it because the employers plan to make split hours working the norm, when it doesn’t suit everyone. As a matter of individual choice, we could accept it, but it never stays an individual choice. Some stores, for instance, have negotiated night work with the union steward on very advantageous terms. You often find agreements negotiated with union stewards that go against collective agreements, which management try to foist onto all stores and the union, with claims like “what do you mean you won’t agree to night work in this store when the CNE has approved it in others”.

Many employers would really like to personalize bargaining completely with each individual employee on the grounds of individual liberty and each person knowing what’s best for them. They say that only the spineless and those who aren’t squeaky clean need the union, but they would say that, wouldn’t they?

Q. So, not easy to frame a general strategy, then...

I.P. It has to be said that the distributive trades unions still have a fair amount of leverage. We can get good rank-and-file action going. When we call a common front general strike, it shuts most stores down. The workers trust us, and we trust them. What is harder is to spread strikes to other joint industrial councils, even as part of a common front. Workers tend to say: “I work for Carrefour, so why should I strike for customers to go to Delhaize”. Employers would see reason much quicker if they were the only ones being closed. The Waterloo Carrefour dispute dragged on for ages, for example, then suddenly - all solved. I asked one of the management whether strike threats from the Brussels stores if no agreement was reached in Waterloo was what made them give in. He said it was nothing to do with that, but simply that the workers were solid behind the union stewards and there was no way to beat that. So it is vital to win the workers over. Obviously, you’ll always get some who think they can go it alone.

Case study 3 - Belgium : Working conditions of female check-out staff
Occupational health of check-out operators

Q. The CNE report based on a 1994 study by the Liège CNE on the health of check-out staff clearly identifies working conditions issues (work intensification, profitability demands, hours) and work-related health issues (stress, musculoskeletal disorders, back pain, environmental factors, draughts, manual handling of goods, head rotation movements, pace of work, and so on) for superstore checkout staff. What strategies have unions pursued to address these issues since the early '90s?

I.P. For working conditions, we’ve mainly worked on improving the status of part-timers and kept a focus on work schedules to try and curb uncontrolled flexibility. As I said before, part-time work is what brings conditions down. In fact, the union hasn’t traditionally been that concerned with working conditions as such, preferring to cost out poor working conditions by arguing that a very early start or very late finish are unsocial hours that merit extra pay, for example. It was the best we could do. Store opening hours are the problem in the retail trade: up to 8 p.m. every evening and 9 p.m. on Fridays. We argued that anything after 6 p.m. was unsocial hours and demanded extra pay. There are countless examples of poor working conditions being traded off for bonus pay. That said, there are some conditions that we can’t do anything about. We can’t force employers to shut up shop at 6 p.m., for example, so some workers are going to have to work from 6 to 8 p.m. The only redline point would be to stipulate that a worker can only do so many lates per week. “Being on lates” means working up to store closing time.

Often, one reason the union hasn’t done too much on working conditions is because check-out operators’ top priority is getting better terms of employment.

Q. And by terms of employment, you tend to mean higher pay?

I.P. Mainly total working hours because that dictates the pay. But getting back to working conditions, we have taken a few initiatives. A good 10 years ago, the health and safety committee reps and the then full-time union official forced the Delhaize-Le-Lion supermarkets to buy much more ergonomically-designed check-out stations than the cheaper but unsuitable ones they had chosen. What we did was go to see the check-out station manufacturer with union reps first and then with check-out operators. We compared those the company had chosen with ones the manufacturer showed us as being most ergonomic. In the end, the union and check-out staff managed to get the most ergonomic - and most expensive - check-out stations. That was a one-off, though, and didn’t really have effects for other stores.
Table 1: Women and part-time workers in total employment in retail trade, 1999 (%)

<table>
<thead>
<tr>
<th>Country</th>
<th>Female employment</th>
<th>Part-time employment</th>
</tr>
</thead>
<tbody>
<tr>
<td>EU-15</td>
<td>58.5</td>
<td>29.8</td>
</tr>
<tr>
<td>B</td>
<td>57.0</td>
<td>23.3</td>
</tr>
<tr>
<td>DK</td>
<td>57.0</td>
<td>34.9</td>
</tr>
<tr>
<td>D</td>
<td>66.8</td>
<td>36.0</td>
</tr>
<tr>
<td>EL</td>
<td>46.7</td>
<td>5.1</td>
</tr>
<tr>
<td>E</td>
<td>56.1</td>
<td>10.5</td>
</tr>
<tr>
<td>F</td>
<td>58.4</td>
<td>25.6</td>
</tr>
<tr>
<td>IRL</td>
<td>60.2</td>
<td>34.3</td>
</tr>
<tr>
<td>I</td>
<td>45.6</td>
<td>10.2</td>
</tr>
<tr>
<td>L</td>
<td>63.4</td>
<td>14.0</td>
</tr>
<tr>
<td>NL</td>
<td>60.3</td>
<td>59.3</td>
</tr>
<tr>
<td>A</td>
<td>68.0</td>
<td>32.0</td>
</tr>
<tr>
<td>P</td>
<td>54.1</td>
<td>9.0</td>
</tr>
<tr>
<td>FIN</td>
<td>65.4</td>
<td>31.9</td>
</tr>
<tr>
<td>S</td>
<td>61.7</td>
<td>40.0</td>
</tr>
<tr>
<td>UK</td>
<td>60.5</td>
<td>48.8</td>
</tr>
<tr>
<td>IS</td>
<td>62.0</td>
<td>44.3</td>
</tr>
<tr>
<td>NO</td>
<td>64.6</td>
<td>47.9</td>
</tr>
</tbody>
</table>


Q. But has the situation worsened since then, making it more difficult now to contemplate that kind of action?

I.P. No, because we did that in the middle of a recession, when people were being held to ransom over jobs. We could do it again today. What we did at Cora was to set up working groups with health and safety committee reps and members of the management in each store, including check-out operators, to analyse all the issues around workstations generally. It was a big job. We had to bring in specialists because the health and safety reps and union reps don’t have the specialist skills.

Q. Working conditions and OSH don’t feature very strongly in collective bargaining...

I.P. The examples I’ve just given you show that we are doing things, but yes, there should be a bigger focus on occupational health. We have been battling for many years to get recognition for carpal tunnel syndrome as an occupational disease. It’s a widespread problem, and
even though it is in the schedule of occupational diseases, it is rarely recognized. We haven’t made much headway with this.

Q. The CNE study and press reports talk about turning it into a more multitasking job so that check-out operators can be assigned to other tasks. Did this union suggestion get any follow-up?

I.P. Multitasking by check-out operators should become a general demand in the distribution sector because combining different types of work - check-out staffing, shelf stacking, etc. - not only means job improvement, but also less fatigue and stress. You find that more in small supermarkets than hypermarkets, but shelf stackers are against it. They don’t want to work on check-outs. Their argument is that they were hired to stack shelves, which is much less taxing, and they have no desire to work a three-hour stint on the check-out. This is the problem of what we call “check-out reinforcement” (you often hear calls over supermarket PA systems for “so-and-so checkout reinforcement please”), which they always have to repeat several times because people don’t want to go. So it’s very hard to get straight multitasking with people switching between check-out and shelf stacking. There is internal resistance.

Q. Are the employers in favour of more multitasking?

I.P. Absolutely. And that’s another problem for the unions. The employers want it in order to cut jobs. If workers are jacks-of-all-trades, you need fewer workers.

Q. But maybe the workers could then go full-time...

I.P. That’s true, we could improve terms and conditions and that is a discussion that is now going on in Carrefour. In fact, there already is some multitasking, but we want it to be better structured. Their computer system could include the job changeover time in work schedules. They say that it might ultimately be possible to increase people’s hours. We’re thinking about it. We won’t agree to the system without immediate trade-offs. But it would certainly be a way of pushing up total hours. Having said that, increasing total hours could involve cuts in the workforce. So it has to be tied to an across-the-board reduction in working time.

Q. So working on the check-outs is much harder?

I.P. All check-out staff want to regularly go and stack shelves.
Supermarket workers' health
Study of the links between work and health hazards

The study on supermarket workers' health done by a group of occupational health doctors in the Centre region of France aimed to put a public spotlight on the psychological health problems of distributive trades workers. 1000 staff from hypermarket and supermarket chains were surveyed during works medical check-ups to study the linkages between work organization and health hazards. The linkages were established using General Health Questionnaire (GHQ 12) in particular, comprising a graduated series of twelve multiple-choice questions on well-being at work. The table below very clearly shows the links between work and health hazards.

<table>
<thead>
<tr>
<th>Work organization-related factors</th>
<th>Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part-time work</td>
<td>1.51</td>
</tr>
<tr>
<td>Untrained for the work done</td>
<td>1.55</td>
</tr>
<tr>
<td>Meal-breaks at non-standard times</td>
<td>1.57</td>
</tr>
<tr>
<td>Rostering not known ahead of time</td>
<td>1.65</td>
</tr>
<tr>
<td>Cannot leave work early if necessary</td>
<td>1.72</td>
</tr>
<tr>
<td>Rosters can not be changed</td>
<td>1.80</td>
</tr>
<tr>
<td>No recognition for good work by customers</td>
<td>2.19</td>
</tr>
<tr>
<td>No scope for initiative in the job</td>
<td>2.53</td>
</tr>
<tr>
<td>Not enough time to do the job</td>
<td>2.72</td>
</tr>
<tr>
<td>No recognition for good work by superiors</td>
<td>2.99</td>
</tr>
<tr>
<td>No attention paid to suggestions</td>
<td>3.00</td>
</tr>
<tr>
<td>No promotion prospects</td>
<td>3.63</td>
</tr>
<tr>
<td>Sense of being unfairly treated</td>
<td>4.05</td>
</tr>
<tr>
<td>No scope for self-fulfilment in the job</td>
<td>4.73</td>
</tr>
<tr>
<td>Harassment at work reported</td>
<td>5.17</td>
</tr>
</tbody>
</table>

The table shows the probability levels of psychological distress among supermarket workers in France by reference to organizational stressors, selected psychosocial factors and work experiences. Analyses based on other health indicators like drug abuse, addictive behaviour (smoking, drinking, etc.) give similar results. All the results of this table are statistically significant.

Interpretation:
Suggestions disregarded: 3.00. The probability of psychological distress for an employee whose suggestions are disregarded is three times higher than for an employee whose suggestions are heeded.

a. The information here is taken from the article “Santé soldée en grande surface” (Health going cheap in superstores) by I. Mahiou published in the review Santé et Travail, No 39 - April 2002, pp. 17-19.
Q. What makes it such a wearing job; what sort of problems do they have exactly? Customer relations, I suppose...

I.P. That’s one thing. The check-out is the only place where customers are certain to find someone, because restocking is increasingly done morning and evening out of customers’ way. So disgruntled customers take it out on the check-out operators. There have been instances of check-out girls being assaulted by customers. So there is a risk of violence. Also, it is a very mechanistic, automatic job. After about four hours, the check-out staff don’t see the people any more. They can’t chat to each other. In fact, the check-out stations are set up so that the operators can’t see one another’s faces. They have to turn around to talk. Employers are so scared of the operators talking to each other that they arrange the workstations to make communication more difficult. It used to be in supermarkets that check-out operators would sit facing each other in pairs. That has all changed.

Q. What are their demands?

I.P. Working conditions, like the distribution sector as a whole. There is never a meeting where working conditions don’t come up. It’s a constant theme.

Q. And what about health at work?

I.P. That, too. A lot of health problems are stress-related. And a lot of work in distribution is stressful, especially part-time working. Many check-out staff are employed to work an 18-hour week, and on their first day they get a rider to the contract for another 18 hours a week. So for two or three years they might be working a 36-hour week, and the day when for some reason or other they are no longer needed, the rider is cancelled and they’re back to an 18-hour week. So the company takes no risks - the workers take all the risks. How can you make plans on a wage as uncertain as that?

Q. That’s down to employment policies. The priority is getting people into work.

I.P. The first thing is to agree on what you mean by “a job”, and an “appropriate job”, which has increasingly fallen to one side. We have tried to negotiate agreements with a degree of flexibility built in, where workers had to be given a 24 hour contract, for example, but where their weeks could vary between x hours and 30 hours a week, to get a fixed monthly income. That was a sound agreement. When we negotiated it, we thought it would give more structure. Workers were given their work schedules in December for the whole of the following year. They knew how many hours they would be working each week throughout
the year, and they knew their actual work roster a month in advance. After a few years, the employer dropped the scheme because it was too difficult to organize. The workers didn’t like it either, because they were tending to be given the longer 30-hour weeks at Christmas and New Year, which were the weeks they normally worked a lot of overtime to boost pay-packets. The way part-time work is organized in the sector is very bad. It isn’t voluntary part-time. It’s hard to get the work-life balance right; there’s a lot of stress; work schedules are forever changing, and so on.

Q. Was work-life balance an issue in the negotiations for the last agreement? Did you tackle the time credit issue?

I.P. We had to negotiate on the time credit scheme in the last agreement to take account of National Labour Board Agreement 77. We negotiated individual schemes for achieving work-life balance, but it has to be said that they’re only for those who can afford it. It was a genuine result. The problem is that the work-life balance isn’t addressed in collective agreements, even though it is part of our trade union strategy. So, to reduce flexibility and promote work-life balance, we negotiated for check-out operators - well before Agreement 77 - at the old Waterloo Biggs (now Carrefour) what is known as “check-out staff pools” - 20 working groups of around 15 check-out operators each. They were mixed groups of people with very different lifestyles: single people, women with young children, women with older children, older women. Each team was allocated a total time bank of hours calculated on the number of check-out operators in the group to divide up between themselves. They were assigned a work load at the beginning of the month, which could be set in advance because the peak periods for the distribution sector in any year are well-known. The different time bands for each pool were posted up and they could put themselves down for the hours they wanted, within the collective agreement rules, obviously. For example, they can’t work less than three hours a day, because that is against the Agreement. Each team has some check-out operators who are flexible and others who are not, i.e., check-out staff who have an 18-hour contract and want to keep those hours and do extra hours occasionally, but not regularly, while others would prefer a flexible 24-hour contract and be willing to work 12 hours some weeks and 30 hours other weeks. They make their choices and negotiate their time band slots among themselves.

At the start, we were accused of setting up worker self-organized flexibility, and that it was shameful. And in fact the sector’s biggest union still doesn’t agree with the system, even though it is working fine. We just invite the Doubting Thomases to go and see for themselves along with the union rep and store managers. There is no question that it has vastly improved the situation of check-out staff. What would also be
interesting, is to do a survey on stress there and elsewhere to see what
the differences are.

Obviously, if they all wanted to have Wednesday afternoon off, they
couldn’t because they would have to negotiate it with the others who
also wanted it off. But they can always swap. Issues can arise, so a co-
ordinator is appointed and given a number of extra hours to run things
for three months. Coordinators change every three months. Their job is
not to resolve disputes; that’s management’s job. The joint union stew-
ards’ job is to oversee it all, and especially keep a close eye on group
total hours.

Q. And the check-out staff form their own groups?

I.P. We set up the groups to reflect a mix, and they are fixed. There’s no
moving between groups. It’s now settled by a collective agreement. It
has been improved over time by the union reps, and the company now
wants to bring it into general operation. Whether that will be under
the existing agreement or whether they’ll try and propose a different
system, we don’t yet know.

Q. It might be one less source of conflict for the employer.

I.P. Absenteeism certainly dropped to begin with, although it did creep
back up again afterwards. But that doesn’t seem to worry them over-
much. We were also able to reduce the number of fixed-term contracts.
And even those without a flexible contract can help someone out oc-
casionally or work an extra three hours to cover for someone off sick
if they don’t mind and are willing. If the workers are happy with it,
ascenteeism is down, and we’ve cut fixed-term contracts, what’s wrong
with that? It was a store that had had two 12-day strikes in two years,
which shows the sort of tensions there were.

Q. Are things less tense now?

I.P. They certainly are. It’s a good agreement. In other circumstances,
the system might not work. For my own part, I’m particularly happy
with it. It operate in France and doesn’t restrict the employer. We’ve
brought all the collective agreements into play. In France, the ground
rules are much less clear-cut.

Q. That’s quite interesting. Check-out staff can organize their own
work, staying within the collective agreement rules, obviously.

I.P. It’s called “working hours by choice”. But there are so few con-
straints on French employers that if they tried to foist their system onto
us lock, stock and barrel, it would end up in a dispute.
Gender equality

Q. Are there many female union reps in the sector?

I.P. Our union has a lot of female reps. We also have a lot of women on health and safety committees (CPPT), but many fewer in the works councils.

Q. Are women reps involved in collective bargaining?

I.P. Not only do we not have enough women reps in collective bargaining, we don’t have any, full stop. I have been fighting to get that changed ever since I took up the job. I am the only woman involved in bargaining in the sector because I am the only female national officer and it is the national officers that negotiate agreements! And it is very hard to be the only woman. If there were more of us, we could back one another up and force certain issues onto the agenda. As it is, when I finish talking about gender issues, the next speaker moves onto a different issue and what I’ve said gets forgotten. You can’t move things forward all alone. I am pushing to get women into positions of authority in trade unions. The CNE is more receptive to having women full-time officials. But it’s nigh-impossible to go out arguing to employers the exact opposite of your own situation (work-life balance). Because any woman with young children who wants to become a full-time union rep is going to have a hard time of it. I personally had a lot of guilt feelings. And a lot of women think “that’s not for me”. It’s hard to find women who are up for it, because the union itself isn’t run in a gender-sensitive way. Workplace bargaining, for example, doesn’t usually start until 5 p.m. And that’s all well and good for men. But for women, five o’clock is when the kids get home from school and you have to be there for them. And bargaining can go on from 5 p.m. until 2 or 3 o’clock in the morning... because the later into the night you go when bargaining, the tougher and more important you look.

Q. So the post of trade union rep is still a male-dominated one?

I.P. Absolutely. To get it right for women, you have to have women. Changes will come the day there are more women. When I started with the CNE, there were 4 women full-time officials out of 40; now, there are 13. It’s still not enough, but change is in the air. We lead different lives. When you talk about an earlier start in shop work, men immediately think about travel into work - no public transport - or the cost of getting in. Women’s first thought is about the children and school. You have to make allowance for both viewpoints.

Case study 3 - Belgium:
Working conditions of female check-out staff
Women in trade union policy bodies

Having more women members does not seem to ensure proportional representation of women in executive bodies, nor guarantee that “women’s committees” and/or “equality committees” will have a measure of “independence” (either they get no financial support or are not a full part of traditional policy bodies).

Whether or not there is “full representation” of women in policy bodies, for there to be real “positive action” programmes (reserved seats and/or quotas) there must be an overall policy of equal rights within the trade union (in other words a political commitment).

Where you have a situation of low female “engagement” in trade unions, reserved seats and/or quotas are almost certainly the only way of ensuring women’s representation in union policy bodies. Combined with other measures (especially a strengthening of union women’s sections, women’s committees and equality committees), such positive actions can do much to increase women’s representation, especially in trade union executive committees.


Q. Is enough weight given to women’s specific risks, concerns and interests (particularly check-out operators) in collective bargaining?

I.P. Check-out staff - through the part-time issue - are often a key focus in bargaining BUT always in terms of employment and very rarely in terms of job quality or working conditions.

Q. Do you see any changes in this under-representation of women in trade union policy-making or as regards women’s more specific interests and issues.

I.P. Very gradual changes. For example, in the agreement we have just negotiated, we demanded that a working group be set up to review job gradings industry-wide using a gender-blind analytical method among other things. Take the grading used by Delhaize for example: it has a category 3C which is the highest-paid line job, and most of those in it are men doing the same work as the women in the supermarket. We told the company this wasn’t on. Management’s argument was that it was right, that the 3C grade was for workers whose jobs included unloading lorries, which meant carrying heavy loads. But that isn’t true, because they put trade union reps in that job category to keep them tame. Some men who don’t unload lorries are on 3C, but no women ever are. We decided to put this inconsistency right. Lifting loads is accepted as deserving a higher wage, whereas some so-called “feminine qualities” in work - hospitality, customer focus, etc. - are seen as
normal female attributes. They are not valued. Men are never put on reception, but there are risks to working on reception, too.

Q. What you are saying is all bound up with the gender divide at work and the way employment statuses are allocated based on the recognition of risks, like handling loads, that are “specifically” male, whereas women run other risks, like the risk of assault, that are discounted.

I.P. It’s seen as normal, and the analytical classification we are putting forward aims to point that up.

Q. This analytical classification review aims to promote equality?

I.P. Absolutely. It’s a CNE demand, which has been supported by other colleagues. It has been taken up and there’s widespread interest.

Q. It’s an extremely interesting initiative, because it links equality to the issues of health at work.

I.P. It certainly does. Men handle more heavy loads than women, but after a certain amount of time they develop bad back problems. So we have to demand fork lifts and trolleys, and equipment to lighten men’s work and make it doable by everyone. That’s starting to come onto our agenda.

Q. How do see the future of health and safety at work for check-out operators?

I.P. The fact of having more and more women union reps makes us better able to act on working conditions (health, stress, safety). Looking at how successful individual forms of working time reduction (time credit) have been, it is clear that these are often individual demands to cut working time by people who are worn out. The issue of safety at work from the risks associated with handling money and mounting violence (verbal and physical assaults are everyday occurrences) are also rising up the trade union agenda.
Case study 4
Belgium: Flexiworking and mental distress: women’s unheard burden

by Jacqueline Martin,
trade union rep in the banking industry, Belgium

Radical changes in the nature and organization of work are giving rise to new health issues for both men and women workers. Or rather, there is a rise in different kinds of health damage in addition to traditional work-related illnesses, and a different, more holistic approach is needed to define them and analyse their causes.

The dematerialization and virtualization of work, combined with extreme job insecurity, seem to be creating new forms of mental distress among workers, manifested in symptoms of both physical and psychological illness.

When the professionals concerned - i.e., occupational health doctors, safety and injury prevention consultants, shop stewards, human resource managers, etc. - do take note of these symptoms of quite deep-seated ill-being, they tend to lump them together under the catch-all label of stress.

Leaving aside the many different theories about it, the reflex description of virtually all workers’ emotional problems as stress-related shows how professionals either cannot or will not accept mental distress as a real illness.

Changes to work organization and processes cannot be dealt with in isolation from their effects on work situations. Some of these are down to enforced flexibility, which may be numerical, technical or functional¹.

Its visibility means that working time flexibility seems to be most widespread. But it would be mistaken to single out this and disregard the other forms of flexibility that overlay it, such as the demands related to new work tools like information and communication technologies (ICT), which require ongoing adaptability, new technical and behavioural skills, ever-more on-call working, not to say effective (involuntary) servitude.

The working conditions created by these forms of flexibility can be perceived and experienced gender-differentially, as emerged clearly from

¹. Numerical flexibility is adjustment focused either on the number of workers needed, or on working time (number of hours worked, or flexible work schedules); technical flexibility is about adapting production techniques to enable short-notice changes to production processes; functional flexibility is about demand-driven changes to the assignment of duties (taken from Vendramin & Valenduc, 1998, p. 22).
a qualitative survey of call centre staff. A gendered analysis of the survey findings revealed the added oppression of women created by the particular flexibility involved in these jobs, because of all the workers interviewed, female workers experienced fatigue and demoralization that men did not.

Presentation of the research

Aims. The study aimed to look at flexible working hours, gender and power relations in the workplace to highlight the reality of how flexible working arrangements oppress women from both a feminist and political perspective:

- Feminist
  Observing and studying a type of flexible working arrangement involves analysing a form of economic production, and more specifically one factor of that production, labour. It also involves a gender analysis of the linkages between capitalistic economic production (in firms) and domestic economic production (within the family). As a new form of work organization, flexibility epitomizes a trend shift in economic production and creates new social arrangements in workers' personal lives. In this respect, work time overflows into and predicates another time - the time for domestic work which is done - free of charge - by women. Work-life balance is achieved only by encroaching on personal time. In other words, the share of personal time given over to domestic production is expanding.

- Political
  Couch these terms, flexible working time is clearly in part a political issue - a way of exploiting women that must be opposed.

Occupational scope. This qualitative research was done in a leading Belgian bank. The banking and insurance industry, with its “jobs-for-life” reputation, has traditionally been sheltered from attempts to dismantle employment conditions experienced elsewhere. More recently, however, growing competition has led financial businesses to follow the mass distribution sector in expanding customer service delivery. Banks’ aims to be more accessible than in the past are reflected in enforced flexibility of branch staff working arrangements and the development of new forms of essentially telephone-based customer-facing, and so new jobs - call operators. These are people that work in call centres that customers can call at times convenient to them (within a wide band of working hours) for a growing range of services running from simple inquiries to basic or more complex transactions, like insurance, investment or personal asset advice. Deregulated working hours are accompanied by intensification of work, which has become faster-paced and more stressful. The combined service delivery demands of management and customers forces staff to step up the pace of work and

2. On this, see Delphy (1998).

Case study 4 - Belgium: Flexiworking and mental distress: women’s unheard burden
adaptation to proliferating changes in banking products, data processing procedures, and regulations of all kinds.

**Respondent profiles and jobs.** Anecdotal evidence was collected from men and women in jobs whose main characteristic is double flexibility, i.e., staggered and variable working hours. In banking, this kind of flexible work pattern is mainly found among call centre staff, so they were the sample population.

Broadly, two types of activity can be distinguished in call centres:
- *standard customer services* like supplying basic information (bank charges, branch business hours, bank services, etc.), carrying out simple transactions, tracking overdrawn accounts, conducting telemarketing campaigns or surveys, etc.;
- *direct banking*, handled by specialists whose job is to advise customers on the management of their investment portfolios and carry out stock transactions on all markets.

In the call centre studied, work schedules were split into five bands between 7 am and 10 pm as follows:
- 7 am - 3 pm; 8 am - 4 pm; 9 am - 5 pm; noon - 8 pm; 2 pm - 10 pm.

**Siting and facilities.** The call centre we visited is housed in an old factory redeveloped as offices about fifteen kilometres from the company’s head office. There is a clear division between the two services which occupy two separate floors: one for the specialists, the other for the generalists or call operators.

Each service has its own floor of the building where individual workstations are grouped together in two- to three-person units. But because of the wide range of work schedules, call operators “hot desk” - i.e., they are not allocated private individual workstations. Workstations consist of an integrated telephone/computer unit with the telephone set as a computer peripheral. The call operator does not need a separate telephone set to take or make calls: a mouse click does it. The technology (ISDN) also allows combined data and voice transmission over the same telephone line so that, for example, a customer’s details can be called up while taking the call.

**Content of the interviews.** The interviews aimed to inform three aspects of the work situation:
- Time relationship: is it experienced gender-specifically both as regards work-life balance and within work times.
- Professional identity: how call operators see themselves in relation to their function, job and employment status. What view of their professional identity have they formed from signs and tokens of recognition given.
• Social relationships: how have their work lives influenced the kind of inter-personal and inter-group relationships formed, be it with their life partner, colleagues or superiors. What issues and tensions arise in these relationships.

Direct and indirect effects of flexiworking on men and women workers

In the accounts collected, we distinguished four areas affected by flexible work schedules and types of work associated with them that result in unwellness, some kinds of which were more female-specific.

Combining flexible work schedules with private life

Flexiworking disorganizes private life, but flexible work schedules disrupt it altogether. It is a fact that women still bear the main burden of running the home and housework. That men help is accepted and acknowledged by both sexes: “staggered working hours let me take some of the load off Anne” ... “what I can’t manage, my husband does”.

Women’s main complaint is bearing the sole burden of planning: they alone cite responsibility for running the home. This is not a new finding, except that the mental strain involved in planning and running the home while flexiworking represents an added burden - because they work rotating schedules and do not always get enough advance warning; because their hours of work may not fit in with the business hours of other sectors (government departments, shops, etc.); because commuting journeys are longer and more tiring outside the main working hours. These forms of difficulty from running a home and flexiworking are mainly reported by women. As one said: “the exhaustion, the stress, all the small household stuff to think about, it all gets too much”.

It is not just running the home that concerns women, but also looking after, worrying about and raising their family: “you have to think about the kids: what are they going to wear tomorrow, the creche is closed, so the baby sitter will have to feed them ... I’m really stressed out because I’ve just found out that in a fortnight, she won’t be there to look after the kids...”.

As we saw, women that work staggered and alternating working hours bear as much of the main responsibility for home management as other women. But their jobs make organizing these tasks harder and more complicated, and they do not seem to benefit from what might ironically be called “positive discrimination” by their partner.
Flexible scheduling has a bigger impact on the time arrangements of workers that are subject to it. Workers who work at times non-synchronous with how society runs are marginalized by their work pattern. It interferes with social life, and makes meetings with friends difficult to arrange. Even partner relationships can suffer from this time mismatch: “My bloke is home by 5.30 so he spends all his evenings alone. We only see each other at weekends, but he works one Saturday in four, and I work every other Saturday... You can see how restricting it is”.

While both men and women experience frustration from this situation, the main difference lies in how non-work/family free time is used. Women value the free time when they are alone, the children are at school, and their husband is at work to get on with the various household tasks and general paperwork quietly and in peace. In other words, it is not free time for them, but a second block of working time - housework time. In reality, women have little genuinely “me-time” for themselves. 

The social conditions of flexibility

Although considered a full part of the bank, the call centre is actually a subsidiary and so comes under a different, much less advantageous joint industrial council. By setting it up as a wholly-owned subsidiary, the bank avoided having to negotiate the collective agreements which would have ensured pay and employment conditions in line with those of other bank staff. Given the symbolic importance attached to staff recognition, this difference was taken very badly by the interviewees, both because of the unsocial hours of work - “I don't think it's enough, they demand an awful lot from us” and discrimination compared to other bank colleagues.

This category of workers is further marginalized by their different employment status within the bank and their geographical location away from head office. Because of this enforced demarcation, the staff feel cut off from the bank workforce as a whole. What women staff mainly seem to miss is the community aspect: they are not integrated and lack the social contacts they would like. “You sometimes feel a bit like the fifth wheel... We're sort of tacked-on”. “It’s an island out here”. Men more reflected a feeling of inferiority to other bank staff: “Management plays up the fact of us being different”.

As well as flexible scheduling, call centres are often associated with job insecurity. Banks use these departments as new customer service delivery vehicles, generally using behavioural surveys to detect new needs (or presumed emerging needs...). Even once the service is up and running, therefore, question marks remain over its real popularity.
with customers, and this uncertainty also affects the situation of the
staff concerned. This was the case with one woman respondent who at
her recruitment interview was promised a career which was cut sadly
short: “at my interview, I was told that people can work their way up
to head up a team, the service will certainly be expanding... The prob-
lem is that it didn’t really work how they wanted...”. At our follow-up
review some months after, the service had shut down, she had just
returned from a month’s sick leave for depression, and found herself
alone, stuck in a corner, with no work or telephone, and just a desk and
PC as her work environment.

The call centre maximizes fixed-term contract working. The staff are
young, but see no future in the job: “Most of us see it as a fill-in. We’ll
be here for a while until we can find something else”, one said.

Insecurity and instability (staff turnover is high) in this sector affect the
lower-skilled jobs in particular. One interviewee told us that only when
promoted to the job of specialist did he get a permanent contract.

**Deep-seated job dissatisfaction**

Most of the job dissatisfaction in call centres, among call operators and
specialists alike, is caused by inconsistent work directives.

**Versatility, responsibility, but little autonomy**

Call operators must demonstrate an aptitude for telesales (empathy,
conviction, speed) and familiarity with the bank’s products and serv-
ices, current marketing campaigns, etc. to answer customers’ queries
or refer them to the right sources. They have to be resourceful, find the
right information, act and react appropriately. Investment specialists
must be conversant with new investment schemes, from the simplest
to the most complex, keep abreast of financial developments so as to
properly respond to any customer demand. “They demand a huge
amount of us; we have to know all the products...; we have to have a
lot of skills, always be briefed, keep abreast of things... there’s always
something new!”, said one.

But there is little scope for autonomy and initiative. Operators work in
a tightly defined and circumscribed setting, with strict rules govern-
ing time, behaviour, and spheres of responsibility, whether as regards
work organization (“only management can change working hours”) or
designing sales aids, “initiatives don’t get far”. Managers’ demands are
seen as exacting if not excessive, with no compensating relationship
of trust. The accounts reveal the confusion between an expansion of
workers’ responsibilities which is not compensated by the autonomy
that would be a mark of recognition of that responsibility. In the words
of Yves Clot: “the challenge represented by the demand to assume responsibility without having real responsibilities”.

**Under-trained and under-informed**

Another inconsistency is under-resourcing in terms of the training or information tools needed to do the job. Two kinds of training are needed to work as a call operator. One is practical training in the job’s sales hardware (telephone-computer system): using the technology and its business use. The other is theory learning - training in financial products and services. In both cases, the training leaves much to be desired, which creates significant feelings of frustration: “At the start, they gave us a quick run-down on how the call centre worked... Then I worked out what to do myself; someone gave us a telephone test, but no-one told us what we had to say, or how to reply... My colleague got no sales training either, like what to say, or how to reply to customers. She came to listen to me to start off, but she was really stressed-out”.

There is clearly no specific training provision for call centre staff. The company training department operates to standard office hours as do most of the staff, and makes no provision for non-standard working hours. So these staff are doubly penalized by their working hours, since the failure to make provision for reducing their marginalization actually marginalizes them further still.

Complaints about lack of information regarding the work itself are also common: the objectives, where the service fits into general company business, the general context of the firm. Information is on a “need-to-know” basis. It is not unknown for staff to be actually misinformed, most seriously of all, about the employment relationship: “What they told me at the employment interview bore no relationship to the advert”.

Whether due to their greater need for communication or a greater concern for transparency, lack of information or difficulty accessing it was found to be a failing mainly stressed by women.

**Work pace and pressure**

One aspect of work in call centres that is equally arduous for call operators and specialists is associated with the technical equipment and the physical circumstances. Sitting for long hours, permanently attached to the telephone and PC, with constant incoming calls rivetting their attention on work at all times..., it is hard to mentally switch off, and they reach saturation point. But where the job is more standardized, and the activity runs to specific rules, the perceived effect of work intensity and pace is more marked. Added to that is the repetitiveness of gestures which gives the entire organization an undeniable Taylorist aspect - an organization where pressure is exerted both by the customer on the other end of the line (with the telephone setting the pace once dictated by machinery or the production line), and by the quota of calls
to be handled. These two constraints - the pace and repetitiveness of the work - leave call operators no discretion and affects their mental health: “That's all we do, repeat the same old thing all day. You've barely hung up before there's a new call on the line. We spend the entire day doing that”. Obviously, the word stress crops up regularly in the accounts, especially when call operators talk about management’s strict monitoring of call rates and numbers. A flashing console display shows the calls queued, and the percentage rate of calls being processed. The principle is that no caller should be left on hold, so there is no opportunity to leave the workstation unless another colleague is available. The pressure of the constant presence requirement and the stressor it represents is voiced mainly by women who seem to suffer most from being tied to the workstation: “We also have call targets, quotas that have to be met, a level of 95%. They, the management, obsess about it. They come, they look at the display, they see you’re only at 86%. But that’s normal: one’s on a private call, another is in the toilet. But you can’t stop people going to the toilet...”. The impression conveyed to us by that is that our respondent felt that management might be taking a fault-finding attitude to call levels - the fault of not being sufficiently available to keep up the level, the fault of occasionally being absent for a few minutes. But after a non-stop high rate of calls for several hours in a row, the workers go past saturation point and have to find ways of switching off: taking a cigarette break, going to the toilet: because there are no rest breaks apart from the lunch break. So, they must make their own...

**Expectations and frustrations**

Disappointment and frustration are equally in evidence as regards anticipated career prospects and perceived professional identity. There are hopes for - but little real belief in - career advancement. And yet all respondent evidenced desires: for better career prospects or recognition at work (men), and personal fulfilment or fulfilling intra-personal relationships (women). These were matched by equally strong feelings of disregard by company management, and the stigma attached to their job in the public mind, as the men especially recount: “A lot of people don’t like to admit that they work in a call centre. A call centre is as low as it gets. Some comments from customers make it clear that they think answering telephones is all we’re good for”. Women seem to make up the something that is missing by emphasizing atmosphere, and relations with co-workers, which they find pleasant and friendly.

**Nature of social relations**

As a workplace and work space, the firm - even a department of a firm - is a microcosm of society in which different kinds of social relations are struck up and sealed that divide or unite individuals to create a
certain kind of social environment riven by “us-vs-them” tensions. The organization of work through the social bonds established goes beyond the merely functional and has “a political and social dimension that is tied into the power relationships in society”.

*Domination through control*

The relationship of domination wielded by the call centre management arguably goes far beyond the needs of the business. It uses the instruments to hand - computer monitoring, hours, lack of information, assessment scheme - and a total lack of transparency, as if to subjugate the staff totally to its will.

This “control-freakery” obviously includes the work and the worker, but also the integrity of the worker’s person itself: “We’re controlled by computer every minute of the day... when we go to the toilet, when we’re taking a break, when we go back to work, when we stop for lunch,... it’s all logged, customer calls and private calls, they know absolutely everything (...) if you make an outside call, they know how long it lasts...” (a female call operator). This kind of control, which is an invasion of privacy, is particularly resented by women, who experience it as a sort of symbolic violence: “I don’t like being recorded on principle, it’s like a police state”. Control is not exerted directly, face-to-face with superiors, but remotely by computer and unbeknown to the individual. This reinforces the feeling of powerlessness, of being constantly at the mercy of the system. One explains how it works: “They regularly print out lists showing when your calls started and how long they lasted right down to the second”.

But what is felt most acutely, particularly by women, is the lack of a borderline between oversight of work and oversight of the individual. This constant supervision is felt as an intrusion, an invasion of privacy, creating feelings of both oppression and disempowerment. They complain bitterly of being deprived of personal time and space within the work setting, and being effectively “galley slaves”. The issue of having no time out or personal time invaded by superiors was not cited by their male colleagues. It should be noted that the department’s control activity was carried out exclusively by male supervisors, so it is legitimate to suggest that, in addition to the power relationship inherent in the chain-of-command relationship, this working relationship will be perceived as “a social construct of male power in the workplace”.

The men described this control as a basic evaluation tool, which does not imply acceptance of it as either fair or reliable. Rightly so, because the evaluation criteria are not openly known and the evaluated staff are given no feedback document - added reasons for deeper mistrust.


Relations with superiors
Following on from that, we found that in addition to mistrust of the control methods used, our interviewees reported strained relations with their superiors. We gathered that some supervisors used the line relationship as a lever to impose a social relationship on the workers in their work situation that created job stressors. This was function- and gender-neutral and found in all work situations. The setting up of a union delegation exemplifies it: “When we said we wanted to set up a union in the firm, it met with a lot of hostility (...) It wasn’t necessarily just knee-jerk opposition, but for practical reasons. It meant losing their freedom...”.

Relations with co-workers
Unlike the tense not to say confrontational relations between staff and supervisors, relations with same-level co-workers are characterized by being on good terms and mutual support. All our interviewees stressed the quality of the social ties between them and their colleagues, reporting it as sociable and even fun to work together. Women went further to add mutual support and help. The quality of this relationship is what helps develop a positive work identity. “Everyone pulls together here, everyone’s made welcome, we all fit in. It would even make me think twice about changing jobs!” said one call operator.

It is probably to counter the pressure of domination that the workers have developed a solid and united, emotionally-based system of inter-colleague relationships. It was observable that the bond between call staff was most in evidence where the influence of domination was strongest.

By way of a feminist summary

The time constraint

Whether controlled (managed) or controlling, time is the main shaping factor of private and work life. In flexiworking, it becomes the linchpin on which what may be oppressive elements are overlaid. The trend towards enforced flexibility of working time is growing in all walks of life.

But the different flexible scheduling situations reveal gendered work distribution inequalities. Men and women workers are a far cry from equality: a cleaner working for a cleaning services contractor obviously has less negotiating clout than an executive in a civil engineering firm!
Overlapping times: from personal to work

The broad categories of personal time and work time themselves break down into different sub-times, which women and men experience differently - and that gap widens with flexiworking: time organization creates real problems for women which men tend to accommodate.

These difficulties cut across the different bands of personal time - domestic, family, parental, social. This is because the activities performed in it are essentially left to women who, also subjected to the dictates of staggered and alternating working hours, experience them as an added burden.

Work scheduling does enable a work-life balance to be achieved, but it is mainly men who use the opportunities for their own benefit. Women’s personal time is still essentially one for domestic production, made harder by flexiworking.

Work time also breaks down into distinct bands which may intermingle. Personal time and socializing time intersect or overlay one another within work times. Enforced flexibility of working time is a factor here, too. Working hours are set as much in line as possible with production requirements. Attendance rates for call operators are set by reference to peak customer call periods.

The personal and socializing times which cannot be separated out from time spent at work are controlled and limited. Where just-in-time working prevails, every hour spent at work is an hour of intense activity. This certainly puts an added strain on women/mothers, who often use the brief lulls in the workday to plan domestic duties: dealing with officialdom over the phone, making shopping lists, planning the evening meal, thinking about the children’s needs for school, clothes, birthdays, an endless “to do” list!

Flexible time: a power issue

Subjectivity of flexible work schedules
Irregular work schedules that cause real mental distress to women may arguably be an objective element. They form part of the overall organization of businesses that operate them in the same way as job content and are generally argued to be a business necessity. Top management leaves the detailed practical arrangements to the managers of teams subject to work schedule flexibility. Management of these arrangements is a complex task and managers are apt to impose the schedules without consultation. Workers see this failure to consult as evidence of abuse of authority, a feeling compounded by the sense of
total disempowerment when, in addition to this arbitrary imposition, work schedule rearrangements made with co-workers have to be put through official channels.

Work schedule flexibility goes from being objective (organizational and business imperatives) to subjective in its application: it is experienced as an arbitrary decision by one subject, the manager, against another, the worker. Given how invidious flexible work scheduling can be for women, its imposition is experienced as symbolic violence, especially when the imposing power is wielded by an exclusively male chain of command.

**Alienation of time**
The introduction of work schedule flexibility in service businesses tends to go in hand with the introduction of new technologies which permit greater control of time within work processes. Call centres are a textbook example of “Big Brotherdom”. Every break in the work flow is logged by the computer system and known to superiors who can check why the phone is off the hook or the operator not on station. Presence time - even that taken out for pressing calls of nature - is company property.

As remarked elsewhere, this oversight of time which seems to go as far as people's most private moments is experienced by female call centre interviewees as an intrusion into the individual’s personal domain.

**Fixed time**
Time is also strategically important in workplace social relations. As well as non-standard working hours, jobs themselves are becoming increasingly non-standard and increasing the insecurity of workers. Contingent work (temporary agency staff, part-time, fixed term) is increasingly rife in occupational sectors of traditional job stability (banking, insurance, government service), more specifically for low-skilled jobs where staff turnover does not harm production. As Danièle Meulders\(^9\) shows, these contingent, insecure jobs are female-dominated.

Here again, call centres are textbook. They are a comparatively new industry segment: the services or subsidiaries set up for them are new. They employ large numbers of young people, mostly on temporary contracts (agency staff, fixed-term renewed to the legal limits sometimes with the performance carrot of a full-time contract). For these workers, this framework of relations creates insecurity associated with the contingent nature of the employment and added dependence on superiors. Fear of unemployment, not having their contract renewed, makes workers more submissive and allows management to rule by pressure if not threat.

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Footnote:

Mental strains: out of sight, but not out of mind

The job of having to run, plan, and organize the home, care for and see to children which is inseparable from the practical and physical organizational problems that deregulation of work hours brings puts a big mental strain on women. All these daily tasks which, particularly where children are involved, require balanced hours of work, remain largely women’s responsibility. This conflict between the children’s needs and the simultaneous energy drain of professional work, makes these responsibilities seem more onerous, harder to assume with a flexible work schedule. Destructured working time adds to the mental stress of work.

What our male and female interviewees had to say, especially about seeing to young children, suggests that roles are still highly gender-divided. Identification with the role of mother, with all that involves in mental engagement, remains very strong among women: childless interviewees said they would stop this job (but not stop work altogether!) when they had children. This is supported by men who readily maintain that women with children should have standard hours of work.

Mental stress and paid work

Women’s central role in the domestic sphere and the cultural baggage that goes with it are often used as explicit or implicit legitimation for assigning them to jobs that require so-called feminine qualities. In service firms, this means empathy, other-centeredness, patience. In telephone-related jobs, it is about their “telephone smile” and staying power with repetitive and monotonous tasks.

Male call operators more readily complain about mental stress from monotony. Women complain about mental stress from management pressure to achieve call response targets. The mental stress felt by skilled operators is linked to the tension created by the financial issues at stake (bank call centre) and operation (or malfunctioning) of the computer programs used for the telephone transactions.

Customer pressure also creates significant mental stress for those in sales jobs, and this is growing in most service activities.

Mentally imprisoned

One regularly reported mental stressor associated with flexiworking was loss of autonomy. There are various causes. Lack of “me-time” - because time before and after work is taken up with children and household tasks, and means going straight home from work without doing anything else. That is women’s plight. Their accounts tell of this lack “me-time”. Even the staggered time bands they have are used for home management and administration, almost never for themselves.
Loss of personal freedom is also felt as an effect of the controls on working time use, cited above, but also performance checks. Most firms have computerized methods for collecting large amounts of information, including on what workers are doing. Call centres are textbook, as call operators can be listened in on and assessed for the quality and business effectiveness of their conversations and number of calls taken at any time.

Computers are also used to roster staff in sectors where staggered working hours are used. Lack or loss of control over work scheduling is the fear expressed about this form of computerized management which can even further restrict work time organization. Manual rostering still allows scope for change and flexibility. Not so computerized systems: there is widespread apprehension at this further restriction in work schedule organization among both men and women workers.

Conclusion

We sought to verify whether situations identified in previous studies on labour flexibility were entrenched. We found evidence of a new phenomenon: an intensification of mental stress where workers have to work at non-standard paces. In such circumstances, the lack of time synchronicity further intensifies mental fatigue.

Flexiworking therefore acts on domestic work to widen the gender gap within and outside the domestic and professional spheres, and consolidates the workplace balance of power by increasing workers' subjection to management.

The individual narratives gave voice to an oppression informed by different feelings. Feelings of belittlement, of not being worth the bother of being given knowledge that would enhance their identity as a worker. Feelings of insecurity and uncertainty from the tenuous employment relationship, lack of dialogue with management or lack of information about job goals. Feelings of isolation due to the geographical situation, compounded by the technology: more than keyboard or screen, the purpose and action of phone calls make demands on voice and ear that cut the operator off from the surrounding world. And cutting through all that is the feeling of no longer owning their time, no longer being their own person because of the unforeseeable, total control wielded over them.

What is most striking about and common to the processes revealed is their insidious nature. The reality of the oppression that they constitute is hidden beneath the veneer of normality, masked by mechanisms of social reproduction or distorted by cultural patterns.
It is normal in society’s eyes that women should bear the bulk of family, domestic, parenting responsibilities, and that they should be disempowered as a result, in a position of dependence and subservience. An oppression cloaked by the emotional bonds between them and the beneficiaries - husband, partner, parents, children.

It is normal for a command relationship to be established between employers and workers who make their labour available to the firm. But how far does that availability stretch, where do the bounds lie? When does possession of labour become possession of the person? It is safe to say that the line not to be crossed is the one that leads to oppression.

**Mixed prospects**

The destructuring of time specific to imposed work schedules in call centres, the nature of the work and its attendant pressures, the technological and human environment emerge as key causes of the distress expressed in the interviews.

Alleviating this mental distress - if it cannot be cured - would require an increased awareness from all concerned of the *pathogenic potential* of the different factors mentioned. The greater burden of domestic responsibilities on women’s bodies and minds is increased when working time and social time overlap. Reducing and alleviating this burden through shifting equal responsibility onto the partner would doubtless be the answer, but that would require more of a cultural than an organizational revolution. A revolution which if not unrealistic would at least be incremental over the very, very long term...

That should remain the aim, but the more practical and direct alternative would be to call the community, public authorities and politicians to account for their duty to organize society. Their job is to devise a means of redistributing time that allows real balance between working time and non-working time. This new time structure must be devised from a collective and feminist angle because women are the ones mainly concerned. Some towns already have working examples of a general reorganization of government office and leisure facility opening hours10.

As well as the scheduling constraints inherent in this kind of job, call centre staff complain about marginalization within the bank. As explained earlier, this bank’s call centre was set up as a subsidiary and so because of the nature of the job (call operator), falls under the white collar and ancillary staff joint industrial council (CPNAE) whose pay scales are extremely variable and in any event far lower than those of most of the banking sector (JIC 310). This puts the subsidiary’s staff in

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an inconsistent position since, like the company’s other departments and services, they deal exclusively with bank customers and carry out banking transactions and service requiring the same level of expertise and knowledge. But, being employed by the subsidiary rather than the bank, they have no alternative but to pursue their career on the same unfavourable hours, pay and working conditions however much expertise they have developed after years of experience.

This discontent is exacerbated by having two sets of workers alongside each other in the same department employed on different pay structures, i.e., bank staff and the subsidiary’s staff. This “two tier” staff, as the workers describe themselves, are the focus of intensive, difficult negotiations with the unions in the company over increased flexibility against a gradual, partial integration of subsidiary staff into the bank. All-but insoluble within the bank, the debate seems to be shifting (for the good) towards industry discussions aimed at extending the remit of the joint industrial council for the financial sector to include other workers (self-employed workers, subsidiaries, etc.). This debate is just beginning.

As regards the conditions and organization of this call centre activity (control, misuse of authority, disempowerment, etc.), it is hard to see any changes or improvements. But it is also difficult to include them as bargaining issues because of their subjective nature. Management have, however, come up with proposals on one aspect of these working conditions (still using more flexibility as a bargaining counter): call recording would in future be limited to just what was needed for business (rather than control) requirements, and could not be done without the worker’s knowledge. Changes to this practice are important, inasmuch as it is an essential element of the domination relationship, but are not enough. More fundamentally, it is the spirit and culture of labour relations as practised in the call centre that need to be turned around.
Case study 5
Denmark: Women up front - Female painters in the male dominated construction industry

by Elsebet Frydendal Pedersen,
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Gerda began her painter's apprenticeship in the 1960s and became a journeywoman in 1967. In her childhood, her family lived in a rural area 40 km from Copenhagen. "I was a tomboy in school and did not want to be a hairdresser or such like, as did many of the girls in my class". A master painter, a friend of the family, offered her an apprenticeship, which she gratefully accepted.

As a newly trained journeywoman, she worked in small firms, primarily to improve her overall skills. She had no problem getting jobs, but felt in those years that she had to prove her professionalism to her male colleagues over and over again. More subtle harassment took place, for instance when her male colleagues classified any criticism on her part as "PMS problems". "Funnily enough this changed later to be problems in relation to the menopause!" she now adds.

For more than 20 years, Gerda has been employed by the Danish Railway System. Here she is "the best man in the firm". She gets the more complicated jobs, acts as a safety representative, is leader of the gang and supervises the apprentices.

"The working environment during the first years of my working life was very poor. The paint we used was based on white spirit and we often worked without masks or other protection". Today, she finds work has changed and has become more physically tiring, often to be performed under heavy time pressure and in conflict with the demands for quality.

Gerda is now in her late fifties and suffers from migraines and pains in her musculoskeletal system, which has brought her to consider early retirement.

She met her husband at the technical school where she trained to become a painter and he to become an electrician. They got married, built their own house and now have two sons. When she was pregnant with the older one, she worked for a period in the new build sector. "But I never feared for my child; however, today I probably would have been scared stiff". Her mother-in-law looked after the children when they were young; later they both attended a public kindergarten.

"Oddly enough, Gerda comments, I have not worked with many female painters in my career and I have never taken part in any women's network - or in union work for that matter". She welcomes, however, the development that naturally allows more women to work in the trade. "Because, in spite of everything, you are well paid, and you have an interesting and challenging work situation". (Pedersen, Elsebet Frydendal, 1993)
Introduction

The object of this article is to present a point of view about the ongoing - everlasting - discussion of equality between men and women. The focus is on the Danish construction industry and the groups of workers involved, one example being the painting trade.

It is a somewhat astonishing fact that female house painters in Denmark today constitute close to a third of all trained operatives and more than half the apprenticeships in the trade. These numbers are in contrast to other trades in the construction industry, where the number of female operators is between 1-3%, and thus, in this respect, level with most countries in Europe.

The construction industry is often defined as being conservative, low on technology, and characterised by regular fluctuations in the production flow. It is also described as one of the industries most dominated by men and male values.

A third assertion is that the construction industry is generally characterised by very strenuous workloads and working conditions. Research has documented health effects and early retirement as a part of this picture (Bygge og Anlæg, 1995; Damlund, Marianne et al., 1988).

How the women manage to maintain their employment and their health, working as painters in the male dominated construction industry, has not been explored in any depth. This article is an attempt to pinpoint some of the important issues that women in the construction industry face.

Background

Historically, women have had limited access to work in the construction industry, and few have made it into the trades, as shown in table 1 below. The historical reasons for this are many: labour market laws, barriers in the industry itself, moral restrictions, etc. (Wiene, Inger, 1991).

When Gerda grew up and was trained as a painter the social situation in Denmark between 1950 and 1970 was characterised by an economic boom during which the welfare state developed and flourished. The need for homes was urgent due to high birth rates, urbanisation, low production outputs and resource shortages during and after the Second World War.

The State took on the role of prime mover, and industries developed prefabrication and mass production of building parts and materials.
The traditional Scandinavian model of collaboration on the labour market between the State and the social partners was consolidated.

The construction industry changed technology, with the introduction of earth-moving machinery, the use of cranes and new job functions. This made room for changes from craft-based methods to “modern” industrialisation methods. The transfer of work traditionally done on site to mechanised production in factories changed many job functions to assembly work. This also gave employment to the unskilled labour available (Damlund, Marianne et al., 1988).

| Table 1 : Skilled men and women in the construction industry |
|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
|                | M   | W   | M   | W   | M   | W   | M   | W   | M   | W   | M   | W   |
| Carpenter      | 7,356 | 36 | 8,430 | 85 | 17,671 | 0 | 46,873 | 4,303 | 33,453 | 288 | 28,868 | 231 |
| Bricklayer     | 11,398 | 25 | 8,745 | 61 | 13,968 | 2 | 13,176 | 39 | 10,020 | 49 | 9,002 | 100 |
| Joiner         | 10,625 | 96 | 11,846 | 126 | 19,064 | 57 | 404 | 7 | 790 | 0 | 4,962 | 33 |
| Glazier        | 404 | 7 | 790 | 0 | 8,549 | 17 | 7,209 | 21 | 9,245 | 27 | 11,123 | 2,875 |
| Plumber        | 1,859 | 156 | 2,429 | 64 | 4,758 | 1 | 8,549 | 17 | 7,209 | 21 | 9,245 | 27 |
| Painter        | 4,962 | 33 | 6,739 | 74 | 13,256 | 141 | 14,056 | 1,990 | 8,387 | 1,510 | 11,123 | 2,875 |
| Electrician    | 497 | 5 | 9,346 | 4 | 23,928 | 62 | 22,978 | 138 | 30,178 | 263 | 82,047 | 4,396 |


Note: There are some inaccuracies in the table. 1901 includes all workers, the following years only skilled workers, except for carpenters in 1921. 1901 and 1921 joiners include workers in the cabinet industry, and plumbers include workers in the tin goods industry. 1985 includes all workers organised in the specific trade union. Upholsterers and others were for example organised in the Danish Union of Joiners, Cabinetmakers and Carpenters (Wiene, 1991).

The situation of women

In the 1960s, a large number of women were introduced to paid work on the labour market for the first time. Many acquired an education, graduated from high school, went to university, graduated from college or worked as unskilled or semiskilled workers in industry. The number of publicly funded childcare institutions expanded steadily, as did the number of married women with paid work. In the home, the washing machine and TV dinners were introduced to ease the increasing strain of running a household and going to work at the same time.

In the 1970s, gender equality was discussed. In 1976, the Equality Act was passed in the Danish Parliament, aiming to ensure equal opportunities and equal pay for men and women. The endorsement from the social partners was strong (Ligestillingsrådet, The Committee of Equality, 1975).
An attempt was made in the labour market to change both the horizontal and the vertical division of labour and gender segregation. Women were invited to join education programmes in traditionally male dominated professions and trades. Many women-only courses and other initiatives were introduced, both in the general industry and in the construction industry, funded by special gender equality funds. Many women joined and experienced the development of both professional identity and professional pride by obtaining an education in a male dominated trade such as blacksmith or carpenter. However, most women left again after a few years, finding the going too hard. Some retrained in typical female trades, such as nursing; others went on to further education and became construction architects or joined other trade related educational programmes (Pedersen, Elsebet Frydendal, 1993; Wiene, Inger, 1991).

The painting trade

The painting trade is as old as history. Its purpose has been and still is to preserve and beautify houses and other living areas. It has traditionally been based on simple technology: grinding and mixing of paints, use of brushes and manual dexterity. Some of the solutions and paints used were, however, poisonous. Barnado Ramazzini already pointed this out in the year 1700, but it was through industrial change in the construction industry that it was really considered a valid health and working-environment issue.

In the 1950s and 1960s technological changes in the painting trade introduced ready-made paint based on white spirit, new tools, such as paint rollers and applicators, and the use of spray paint methods in new buildings, to speed up the painting process.

In the early 1970s, two very controversial research reports were published, produced by university students and critical painters. The most alarming result brought to light was that more than 1000 (out of approximately 15,000) painters suffered from various degrees of brain damage due to high exposure to white spirit, resulting in major limitations in their daily life and for their families (Malernes Fagforening, 1972).

A long and at times bitter fight between the Danish Painters’ Federation, The Painters’ Masters’ Organisation, the chemical industry and the Danish Environmental Service followed. Eventually, this resulted in an extensive ban on the use of paint based on organic solutions. Water based paint became widely used.

The situation for the trade following this course of events - from the awareness of the seriousness of the occupational hazards resulting in
brain damage to the changing of paint and other preventive measures - was that no young people (men) wanted to become painters. To change this situation the Painters’ Employers’ Organisation and the Painters’ Federation campaigned together, organising meetings in public, at elementary schools, for school counsellors etc. throughout Denmark to assure “everybody” that the situation was under control in terms of the working environment. Another subject of the campaign was that the painting trade was open to both male and female apprenticeships and journeymen/women. This initiated a definite change in gender relations in the trade. Many women have since then trained to become painters, so many that the trade today is “almost” a woman’s trade in Denmark. In 2001, 58% of building painter apprentices were women (Malerforbundet i Danmark, 1997).

Today, the length of training in the painting trade is 3½ years, alternating between technical school and apprenticeship in a painting firm. A new educational reform introduced in 2001 aims, in addition to trade specific skills, to give general qualifications such as increased adaptability, more individually based training and a life long learning perspective. Working hours are 37 hours in a 5-day week.

Three central issues in relation to being a woman painter today will be discussed below: being both a mother and an employed worker, being pregnant and in work, and working conditions and health.

**Torn between family and work**

Gerda married an electrician and they lived as a nuclear family with their two sons. When the children were very young Gerda’s mother-in-law looked after them, later they attended the kindergarten in the municipality. Today an increasing number of households in Denmark consist of children and one parent only, which places a special emphasis on the balance between working hours and childcare. Here, clear gender differences are seen.

Comparisons between male dominated professions, such as the police, and female dominated ones, such as nursing, show that men tend to focus on work content and keep it separate family issues. Women, on the other hand, tend to try integrating the needs of the family into their working situation (Holt, Helle, 1994).

Often the interplay between formal and informal structures at the workplace and the interaction between colleagues can create options allowing for individual flexibility. In the construction industry, however, female painters are often stressed by requests for extra work to enable the employer to meet a deadline. They also miss out on the more
informal part of collegial and social gatherings (Hauge, Marianne, 1998; Malerforbundet i Danmark, 1997).

Married women in the construction industry tend to choose a partner/husband with a close knowledge of working conditions, either in that trade himself or close to the industry in other ways. This is claimed to result in better-shared conditions in the household in relation to cleaning, washing, cooking and childcare (Pedersen, Elsebet Frydendal, 1993).

The future offers good prospects for more gender equality in relation to the interplay between family life and working life. Generally, in Denmark, more men have childcare responsibilities than before, either because they are single parents and thus live full-time with the child, or they have shared parenthood with the mother and in that case have the child/children often and in everyday situations. Female painters find this development helps in discussion of the conflict and sometimes it can be the basis for an alliance between her and often younger male colleagues when having to convince the master or an older colleague why they cannot work overtime.

Part-time work and reduced time in certain parts of a person’s working life could offer a solution to the dilemma between work and family. This was proposed at the general assembly of the Danish Painters’ Federation a couple of years ago. The female painters, however, turned down the proposal, as they feared that although this would on the one hand solve an immediate problem for many single parents, these being primarily female painters, it could on the other hand also result in a grouping of painters into first and second rate painters (Hauge, Marianne, 1998).

Equality of earnings is basically an established fact. However, some female painters point out that gender differences in wages often show up in a more subtle way. It could be that the male master will grant his male journeyman small privileges, for instance lending him the firm van for some private errand and, as he then has the van, paying him extra for transporting materials to the next site, though it was never discussed who should bring the materials in the first place.

**Pregnant and in work**

Gerda went to work while she was pregnant, but later, once the discussion about the dangers of white spirit arose, she feared what might have happened to her or her sons.

For many years, the health effects of chemicals in the construction industry in general and in the painting trade specifically, was only related to risks of brain damage. But later the discussion has also
revolved around concern for the embryo and the pregnant painter and other responses to chemical exposure, such as skin problems (Peder sen, Elsebet Frydendal, 1993).

Female painters are generally much more concerned than their male colleagues about health and safety issues in the workplace, and they express critical concern in relation to all chemicals used, and to water-based paint. They do not find the water-based paints adequate or a good enough replacement for paints formerly based on white spirit and point out that an increased number of skin diseases are being reported, which may have something to do with the preservative content added to water-based paints to prevent them from rotting (Bygge og Anlæg, 1995).

“No risks are to be taken in relation to pregnancies.” This policy statement from both the Painters’ Employers’ Organisation and the Painters’ Federation brought about for many years the practice of putting the pregnant woman on sick leave as soon as her physician had confirmed the pregnancy. This meant, apart from the safety aspect of course, a loss of income and a higher unemployment rate for women, especially after maternity leave. The latter showed up in the statistics, but was often hard to prove in relation to a specific master or to the actual situation. Increased criticisms were raised in terms of the negative impact associated with considering pregnancy as an illness. It has never been shown that children borne by female painters have a higher risk of being handicapped. So gradually, the general practice in managing the situation changed. Research has moreover shown that other risks such as heavy lifting and long term standing also have to be taken into consideration.

The master painter must today provide a safe environment for the pregnant woman at all times. That is, he must offer an indoor job with minimum exposure, or a replacement to outdoor work. Ergonomic demands, such as heavy lifting and work involving extensive standing and walking, should also be reduced to a minimum. Only if this cannot be provided should the woman go on sick leave. But before this happens the master must enter a dialogue with the Working Environment Service or the Painters’ Occupational Centre to try to work out a suitable solution (Organisationernes Sikkerhedsudvalg, 2001).

Working conditions and health

The specific working conditions are closely related to where and how painters work. Whether in newly built houses, with a high degree of repetitive work, or maintenance and repair in private homes or elsewhere. Sometimes, this involves standing on scaffolding and sometimes on a ladder. Sanding work can be done by hand or with a sanding machine. Brushes, rollers and applicators can be small or large and
differ according to the specific paint used. Customer contact may or may not be a part of the job, etc.

The four major areas in the working environment are chemical hazards, accidents, physical and mental strain.

**Chemical hazards**
Chemical hazards, as has been stated, have high priority in the painting trade. Here we would only add that code markings and the use of instructions are widely used today. Whenever in doubt, the Occupational Health Service and the Painters’ Occupational Centre offer support through a well-developed database.

Pregnancy is of course an intrinsically female issue; however, in relation to chemical hazards, being fertile is also a male issue. The sperm are produced only a few weeks before making the woman pregnant and thus very susceptible to environmental pollution. However, this issue has so far had little attention in the trade.

**Physical strain**
Gerda suffers from pain in her musculoskeletal system to such a degree that she is considering early retirement.

Physical strain is a major problem everywhere in the construction industry. Between 60 and 70% of all employed male and female construction workers in Denmark suffer from symptoms of strain and pain from the musculoskeletal system, half of them to a severe degree. Both genders experience pain to the same degree in the lower back region, whereas men in addition experience more pain in the hips and knees than women, who mostly suffer from pain in the shoulder-neck region (Bach, Bodil og Allan Mortensen, 1993; Bygge og Anlæg, 1995; Damlund, Marianne et al., 1988; Olafsson, Barbro, 2000).

In relation to working life, especially in situations where men and women work on equal terms, it is important to be aware of some of the basic differences between men and women in regard to physical capacity. The average man is, for instance, 30-40% stronger in terms of muscle strength than the average woman. In terms of muscular endurance, women and men are more or less compatible. Anthropometric measurement also shows differences. In relation to height, this shows that the average Scandinavian woman is 172 cm tall whereas the average man is 180.5 cm (Sharp, Marylin A., 1994).

The impact of these differences in relation to comparisons between male and female skilled workers has been shown in a Swedish research project, where comparisons were made between men and women in three manual trades: joiners, electricians and painters.
All workers had approximately seven years of experience and were tested performing typical skills of their trade in relation to workload, quality, endurance etc. The result showed no difference between men and women in relation to quality and mastery of the skills. There were, however, differences in terms of the anthropometric data and in terms of the workers' reflections on their future in the trade. The male workers were both taller and stronger than the average Swedish man, whereas the females had the same height and strength as the average Swedish woman, except for a stronger handgrip. There are thus indications that female skilled workers have to work closer to their maximum physical peak capacity than their male counterparts (Olafsson, Barbro, 2000).

**Mental strain**

Gerda experiences high job satisfaction and has only now and then been exposed to what she describes as subtle harassment. Other journeywomen describe how they manage being “one of a kind” on site. Some state that they walk round each new site “so everyone is sure to have seen me”, others that they put on a tough attitude and others still that they “flirt” their way through. Journeymen from other trades are often described as being prejudiced and judgmental, whereas the male painter colleagues show more solidarity (Pedersen, Elsebet Frydendal, 1993).

Lack of quality in work and stress are described as factors that almost “drive” painters, male or female, out of the trade. The conflict between producing quality work to be proud of, on the one hand, and time pressure, low tenders and piecework on the other, is one of the factors that makes many painters consider whether or not they want to stay in the trade (Hauge, Marianne, 1998; Larsson, Pär, et al., 1989; Malerforbundet i Danmark, 1997).

In general, female construction workers experience a high degree of satisfaction in their jobs, significantly higher than their male counterparts, as shown in Swedish research on gender differences in the construction industry. At the same time, women tend to reflect more on their long-term capacity to stay in the trade. In particular, they fear and worry about whether they will be able to continue working in the trade due to musculoskeletal problems (Frankenhauser, Marianne, 1987; Olafsson, Barbro, 2000).

Masters/employers are described as “backward” and often singled out as the reason for many journeymen/women considering leaving the trade. Many find the way in which the master/employer tackles gender policies in relation to employees and in relation to children and parental obligations extremely poor. They want to be seen as a whole person, not just as an employee. This is especially important, as most painting firms are very small, - only a few are larger than five persons including
the master/employer himself. Interpersonal relations thus have a high impact on working life (Malerforbundet i Danmark, 1997).

**Accidents**
Over a five-year period from 1995 to 2000, a total number of 297,628 accidents were reported in the Danish construction industry. Of these “only” 645 happened to women. Male workers are thus approximately 40 times more often in danger of being involved in an accident than female workers. There are differences between trades and in the rate of employment, both between genders and over time. But all in all, the difference in the danger of being involved in an accident in the Danish construction industry is that male workers are involved in an accident five times more frequently than female workers. The painting trade has an incidence for reported accidents of 9 accidents for every 10,000 employed painters per year, but this has not been broken down by gender (Ulykkesstatistik 1995 – 2000, Arbejdstilsynet, 2001).

**Staying in the trade**
Surveys carried out both in Sweden and Denmark reveal that many painters leave the trade within a 10-year period. The Swedish survey, which did not include women painters, showed that stress, harassment and low respect from other trades were the main reasons for leaving or considering leaving the trade.

The Danish survey was based on 53% male painters and 47% female painters who had left the trade. They were between 27 and 37 years of age when they terminated payment to the Painters’ Unemployment Fund. The survey showed that a large group of female painters left the trade within the first year of employment. An equal number of both male and female painters left after 10 years, and more male painters than female painters left after over 10 years in the trade.

30% more female than male painters leave the trade altogether. The reasons given for leaving are different for the male and the female painters, however, centring around six themes: children, work strain including organic solutions, lack of quality in work, stress, dissatisfaction with masters/employers, and a desire for change.

42% of the male painters had only left the journeyman position and continued in the trade as self-employed, masters, supervisors or work assessors. Only 7% of the journeywomen had taken a similar course, 4% had become teachers in the trade at technical schools (Larsson, Pär, et al., 1989; Malerforbundet i Danmark, 1997).
Conclusion

It can initially be concluded that women have made their way into the Danish painting trade, so much so that the trade can be characterised as the number one women’s trade in the Danish construction industry. Hence, it follows that a group of women like this physical kind of work and that they will take the opportunity if offered.

Whether the women stay on in the trade depends on a range of conditions and circumstances. Here the issues around pregnancy, parenthood and children are clearly gender specific. Though male painters also mention problems in relation to being a painter and having a family with small children, it is still mainly considered a women’s problem. Single mothers especially have problems and terminate their careers on this account. There is a need for opportunities for flexible working hours, part-time jobs and better understanding on the employer’s part when having to stay home if the children are sick.

The female painter likes being in the trade - even more than her male counterpart. She focuses on health and safety issues but has concerns about whether she will continue in the trade when she experiences pain in her musculoskeletal system.

Both male and female painters suffer from long-term strain of the musculoskeletal system. Improvements in the ergonomic design of the tools to improve individual fit, changes in the work process and the organisation of work, variations in workloads - these could offer solutions to reduce part of the strain.

Female painters are up front about demanding equality in the male dominated construction industry. Their example may in turn open the door to other women and other trades. However, reducing and controlling the health damaging and health threatening demands of work are crucial in order to allow them to stay in such trades. This will be beneficial to both female and male workers in the long run.

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Case study 5 - Denmark: Female painters in the male dominated construction industry
Case study 6
France: Prevention of work-related wear and tear in ageing hospital staff

by Dr. Philippe Davezies,
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University of Lyon I

Survey objective. This study aimed to produce outcomes capable of giving focus to a preventive health policy for ageing non-medical care staff. The research team set up means for analysing the age-sex-specific breakdown of hospital staff in relation to job stressors. The breakdown shows the accommodation processes used by staff to minimize health damage at work. Conversely, it reveals the constricting characteristics of work experienced as adverse to the development of a long-term career in the hospital.

Method. The research was done in two university hospitals in Lyons: Hospital 1 employing 1900 and Hospital 2 employing 1000 non-medical care staff. A combined qualitative and quantitative study was first done of Hospital 1, repeated with variants for Hospital 2.

Qualitative approach: job stressor analysis
The occupational health doctors conducting this study aimed to produce an analysis, but also to stimulate and support debate among the players on management of the issue. The approach chosen was to work from knowledge of the work to be found in the hospital. The researchers chose not to interview the staff concerned but rather the second line personnel who receive complaints, claims and demands, and so are best-placed to give an overall assessment of the stresses and strains on hospital staff. It was these officials that the study aimed to make aware of the ageing in place issue.

Three working groups were set up:
• a group of doctors and nurses from the hospital occupational health service;
• a group of nursing care and personnel managers;
• a trade union group (CGT and CFDT).

Each group met several times to examine staff job stressors and three analyses of hospital job stressors were produced. These analyses made broadly similar findings, and were discussed at inter-group meetings. Finally, a summary was written based on the common ground between the three groups.
Quantitative approach: job stressors and staff demographics
A multiple correspondence analysis was performed on personnel record particulars of marital status, grade and department/service supplied by the personnel department, and a descriptive structure of the analyses done in each hospital was produced in order to graphically map the working groups’ descriptions of the job stressors.

A two-stage statistical analysis was then done to compare staff demographic characteristics according to whether or not they were exposed to the job stressors identified:

- univariate analyses to give the gender- and age-specific structure, in particular, of the exposed population for each work characteristic and occupational category;
- a multivariate analysis to identify a combination of independent variables capable of giving a good summary accounted of all the information collected.

The analysis aimed to identify within the information collected, statistically significant outputs which could be surmised to be career determinants.

A statistical analysis of staff demographic characteristics was performed by reference to job stressors, not as reported by the scientific literature but as anecdotally reported and categorized by the hospital staff. The analysis brought out comparatively new, non-traditional factors since the most traditionally cited stressors (lifting, proximity to death, etc.) were relatively non-explanatory.

The study began in 1993, and the outputs were processed, presented and discussed in different scientific and professional forums in 1997 and 1998.

Outputs. The research produced three types of result:
- a working conditions analysis;
- a gender-specific analysis of job stressor distribution;
- identification of the work characteristics particularly adverse to older staff.

Analysis of working conditions
The analysis aimed to capitalize on the knowledge possessed by those with formal responsibilities for the general running of the hospital: personnel department, nursing care department, trade unions, occupational health service.
It revealed that all these players saw staff problems in comparatively similar terms. The three main aspects which provided the template for analysis in each hospital are set out in Table 1.

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<th>Hospital 1</th>
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<td>Care of severe chronic illnesses</td>
<td>Close emotional involvement</td>
</tr>
<tr>
<td>Occurrence of disruptive events</td>
<td>Highly technical treatment</td>
</tr>
<tr>
<td>Obstacles to personalization of relations</td>
<td>Many medical staff involved</td>
</tr>
</tbody>
</table>

The differential analysis of the two hospitals can be readily explained by their specific characteristics.

The focus put on the emotional aspects of work by the Hospital 2 working group clearly reflects the importance in that hospital of two departments providing special ongoing support services: the geriatric ward and the infectious diseases ward (AIDS). The existence of a major intensive care unit is also a partial explanatory factor. Hospital 1, by contrast, has an A&E department which Hospital 2 does not.

The working groups’ analyses therefore reflect the specific characteristics of each hospital, but also the scale of common concerns. The emphasis in both is on working relationships and care, and potential disrupting factors.

Finally, the study follow-up show the working groups’ analysis to be a highly effective means for studying hospital staff’s career paths in the hospital. That is an initial result.

It is worth making a specific point about method here: academic analyses are not appropriate to hospital-wide studies of working conditions because they do not apply to all cases. What must be drawn on are the sources of experience and understanding of the situation found within the hospital itself. These resources are very important and relevant and are exploitable at the cost of a relatively small conversational effort. A demographic analysis based on this can give a significantly more accurate assessment, moving from socially-constructed perceptions of job stressors to a selective real-life impact analysis of them on a given category of staff.
Male and female hospital staff

Use of male hospital staff

There are two points about the use made of male hospital staff:
- there is a higher proportion of males in the lower-skilled posts. This is more marked in Hospital 2 than in Hospital 1 (Table 2);  
- male staff are not randomly assigned, but concentrated in departments with particular stressors - mainly rotating shift work with night shifts, dealing with demanding patients and patient lifting (Table 3).

<table>
<thead>
<tr>
<th>Occupational group</th>
<th>Hospital 1</th>
<th>Hospital 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing staff</td>
<td>11.2%</td>
<td>5.2%</td>
</tr>
<tr>
<td>Health care assistants (ASD)</td>
<td>10.8%</td>
<td>9.8%</td>
</tr>
<tr>
<td>Ward staff (ASH)</td>
<td>24.0%</td>
<td>36.1%</td>
</tr>
<tr>
<td>Total</td>
<td>13.4%</td>
<td>11.1%</td>
</tr>
</tbody>
</table>

Table 3: Characteristics of care units with a significant male staff surplus (results of logistic regression analyses)

<table>
<thead>
<tr>
<th></th>
<th>Hospital 1</th>
<th>Hospital 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing staff</td>
<td>Rotating shift work with night shifts</td>
<td>Rotating shift work with night shifts</td>
</tr>
<tr>
<td></td>
<td>Demanding patients</td>
<td>Demanding patients</td>
</tr>
<tr>
<td>ASD</td>
<td>Rotating shift work with night shifts</td>
<td>Heavy lifting</td>
</tr>
<tr>
<td></td>
<td>Unsuitable premises</td>
<td></td>
</tr>
<tr>
<td>ASH</td>
<td>Heavy lifting</td>
<td>Heavy lifting</td>
</tr>
<tr>
<td></td>
<td>Demanding patients</td>
<td></td>
</tr>
</tbody>
</table>

An employment structure of this kind must give concern to occupational health professionals. Systematic job segregation by sex is by and large an easy option taken to avoid addressing what are actually work organization issues. But this soft option often takes a toll in terms of individual health damage and increasingly inflexible work organization.

The comparative surplus of males in lower-skilled jobs is linked to two things. Firstly, there are more males in unskilled groups because hospitals need men to help lift patients, meaning that men are partly selected for their supposedly greater aptitude for heavy lifting. For males as a category, this may be so, but it is hugely overestimated in individual terms. The loads to be handled in hospitals very often exceed men’s as much as women’s capacities. The AFNOR standard on the acceptable
limits for manual handling of loads by individuals recommends a top limit for occasional lifting of 25 kg for men and 12 kg for women aged 45 to 65 years. While men on average have a third more muscle strength than women, that advantage is not enough to bridge the wide gap between physical capabilities and the job requirements. Men are little more suited than women for lifting the loads found in hospitals. This is particularly clear when that difference is further eroded by advancing age and work-related wear and tear. Men who suffer from low back pain are unfit for the manual handling of heavy loads. And overestimating their ability to do so increases the risk of low back pain. Figure 1 shows that ASHs in Hospital 2 have difficulty with advancing age in staying in heavy lifting jobs. This trend is not found in Hospital 1 where the ASHs are younger (the age after which only 10% of male ASHs are found is 47 years in Hospital 1 against 55 years in Hospital 2).

Another reason for the greater share of males in lower-skilled jobs is that the very lack of skill requirements makes these jobs more accessible to job-seekers, so the manpower structure of these jobs will more naturally reflect that of the job-seeker population. These men are therefore occupying lower-skilled jobs under the authority of female superiors, causing them something of an identity crisis. This issue is further compounded by what was said earlier about the use of men for lifting work.

The fact is that if work organization and other people’s attitudes limit the work contribution and identity of male staff to patient lifting, ageing assumes particularly dramatic proportions for them, as their lifting capacity diminishes or is lost altogether.
The need to take special account of this category of staff’s identity formation and occupational recognition needs was pointed out during discussions as being a management issue.

In the higher-skilled groups, men are mainly employed on 3x8 hr or 2x12 hour shift systems, again, to address a particularly bad stressor for women - flexitime that includes night shifts complicates the running of the home, which is mainly their job.

Here again, however, male adjustment to shift working should not be overestimated. After the age of 45, they become less resistant and must be redeployed off night shifts. The financial gains of three-shift working may lead employees to disregard adjustment-related disruptions, and defer a move to working hours more suited to the human body clock. Here, recent studies have shown that a return to normal work hours is no guarantee that the symptoms of disruption - especially sleep disorders - will disappear.

Figure 2 shows that ageing nurses in Hospital 2 have difficulty continuing to work a 3x8 hours system. Here again, this is not found in Hospital 1, where the nurses are younger (the age after which only 10% of nurses are found is 43 in Hospital 1 against 51 in Hospital 2).

<table>
<thead>
<tr>
<th>Age groups</th>
<th>Share of nurses working a 3x8 hours system (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>19-29</td>
<td>100</td>
</tr>
<tr>
<td>29-39</td>
<td>80</td>
</tr>
<tr>
<td>39-49</td>
<td>40</td>
</tr>
<tr>
<td>49-59</td>
<td>20</td>
</tr>
<tr>
<td>59-69</td>
<td>0</td>
</tr>
</tbody>
</table>

In Hospital 1, departments that accommodate demanding patients (A&E, penitentiary ward, etc.) are also predominantly male-staffed. This is common in psychiatric hospitals where men are employed for their physical strength, useful when restraining measures are needed.
Here again, the invariable question has to be: how far does reliance on physical strength mask what are essentially work organization issues?

These findings should lead to measures to:
- limit manual lifting (grouped manual and mechanical handling arrangements organized as part of care provision);
- make new arrangements for rotating shift work with night shifts (creches, transport, food, including sleep breaks in night shifts, surveillance of health disturbances, introduction of flexible, non-punitive arrangements for returning to less onerous work patterns);
- analyse the violence generated by work situations and organization, and in departments with demanding patients.

**Is hospital work women’s work?**

The female domination of the caregiving professions was discussed on many occasions in the two hospitals’ working groups. While the high proportions of males in lower-skilled job groups raises self-perception problems for the workers and medium- and long-term management issues for the employers, the shortage or total lack of male nursing staff was shown up as a potential issue for workplace social relationships. This was a mainly female-reported view, and the research team sought to clarify their assessment.

Three main arguments were collected for gender balance:
- More attention is paid to projected self-image where opposite sex colleagues are present. Acceptable forms of same-sex collusive behaviour are avoided when both sexes are present. More attention is paid to personal image, and relations are more open and relaxed.
- The male presence halts the traditional emphasis on the mothering role of nursing. It changes attitudes from seeing the job in gender to professional terms.
- The male presence helps attenuate the demands made on nursing staff by patients and doctors alike. A gender-mixed staff is less easily put upon than an all-female staff.

This need to enlist numbers of men into non-niche jobs was strongly argued by the members of the Hospital 2 group, which has a particularly low proportion of male nursing staff.

Over and above these general considerations, the analysis helps delineate the characteristics of strongly female-dominated units.

Table 4 shows that men avoid nursing posts which involve dealing with *many medical staff* and health care assistant posts exposed to *particularly distressing deaths*. Patience with potentially inconsistent
instructions and the ability to cope with suffering thus seem to be more specifically female skills.

<table>
<thead>
<tr>
<th>Hospital 1</th>
<th>Hospital 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses</td>
<td></td>
</tr>
<tr>
<td>Many medical staff involved</td>
<td></td>
</tr>
<tr>
<td>ASD</td>
<td></td>
</tr>
<tr>
<td>Particularly distressing deaths</td>
<td></td>
</tr>
<tr>
<td>Particular interpersonal skills</td>
<td></td>
</tr>
<tr>
<td>Multiple skills required</td>
<td></td>
</tr>
<tr>
<td>ASH</td>
<td></td>
</tr>
<tr>
<td>Multiple skills required</td>
<td></td>
</tr>
<tr>
<td>Special technical skills required</td>
<td></td>
</tr>
<tr>
<td>Particular interpersonal skills</td>
<td></td>
</tr>
</tbody>
</table>

The predominance of women among ASHs in Hospital 2 in units with a high patient turnover may also be due to the rising costs of running a household, and so, here again, turning to account socially-assigned “women’ skills”.

Interpretation of the other characteristics is less straightforward. In Hospital 1, men are under-represented in ASD and ASH posts in units requiring interpersonal skills or a particular multi-skilling.

This finding may be interpreted as a tendency by male health care assistants and male hospital service staff to avoid these job stressors. But that is debatable because in the working groups’ analyses, the work situation’s characteristics apply in principle not to a given occupational category but to the care unit. However, the research team noted that the analysis emphasized the nurse’s viewpoint, especially on the multi-skilling issue. Where a care unit has a high multi-skilling requirement, it is the nurses, not the ASDs or ASHs that have to be multi-skilled. Likewise, particular interpersonal skills refers to units where this attribute is centrally important, and so first and foremost the work of doctors and nurses. Part of the reason why so few male health care assistants and male hospital service staff are found, then, may be due to an extension of nurses’ sphere of activity and a reduction of that of ASDs and ASHs. This may therefore reflect gender role conflicts and men’s issues with working in a position of subordination to female staff.

Male under-representation in units requiring special technical skills could be put down to the same factors. This could further marginalize the job of ASH as compared to the activity of the other occupational groups.

Whatever interpretation is accepted, it is arguable that while men’s positions are partly determined by their lifting abilities, that of women
depends essentially on their forbearance (of inconsistent instructions, patient suffering, subordinate roles, etc.).

To conclude - the analysis of the gendered division of labour in hospital work gives a tentative indication of the job stressors which are addressed through group-specific selection rather than work organization. What still remains to be seen is how these “capacities” change with age.

**Work characteristics adverse to older staff**

The analysis produced unexpected outputs: the traditional stressors (lifting, 3x8 or 2x12 hour shifts, etc.) have an age-specific selection effect, but for women that appeared only in stressor-specific analyses. By contrast, these factors did not emerge in the overall comparative analysis of the different effects. These traditional variables of working conditions analysis are overshadowed by other variables which ostensibly have a more dominant influence on career paths. These variables are shown in Table 5.

<table>
<thead>
<tr>
<th></th>
<th>Hospital 1</th>
<th>Hospital 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unpredictable activity</td>
<td>Special technical skills required</td>
</tr>
<tr>
<td></td>
<td>High chemotherapy workload</td>
<td>Many medical staff involved</td>
</tr>
<tr>
<td></td>
<td>Many medical staff involved</td>
<td></td>
</tr>
<tr>
<td>ASD</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Heavy general workload</td>
<td>Relatively new supervisor</td>
</tr>
<tr>
<td></td>
<td>High level of interpersonal skills</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Relatively new supervisor</td>
<td></td>
</tr>
<tr>
<td>ASH</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Relatively new supervisor</td>
<td>Permanent medical supervision</td>
</tr>
</tbody>
</table>

The most striking result is the relation to the work prescribers and organizers comprised of doctors and supervisory staff. Striking because unexpected, but also because of the influence of these aspects on all three occupational groups and in both hospitals. Notwithstanding the differences between the Hospital 1 and Hospital 2 studies, and although both have their own specific profile, the findings on this point are surprisingly convergent.

The instructions issue is not the same for the three occupational groups as the remark by a supervisor during the discussion of these outputs in one of the groups illustrates: “A nurse reports working in Professor X’s department, whereas a health care assistant reports working with Ms Y”. Relations with doctors seems to be a central issue for nurses, whereas relations with supervisors are central for health care assistants.

2. Supervisory staff = Nursing Branch.

Involvement by a large number of medical staff is a limitation for nursing activity. Wards with large medical staffing complements tend to employ younger nurses. Older (and male) nurses may lack the necessary patience...

In one way, this finding simply bears out the well-established fact that cooperation between doctors and nursing staff is vital. But it is also of interest in that the issue is objectively rather than subjectively identifiable. This is because the processing included statistical variables more directly connected to the subjective, adversarial aspects of the relationship (“staff felt care delivery was lacking”, “too little account taken of staff’s difficulties”). But, these aspects did not emerge as career path determinants. In light of this outcome, and in contrast to standard findings, doctor-nurse cooperation is seen as much more of a work organization than a psychological issue. In other words, disagreement and even conflict are less material than objective obstacles to cooperation.

This first points offers prospects for action: informing doctors about the facts elicited by the study, promoting a process of collective discussion and analysis of work organization in units staffed by a large number of doctors.

Supervisors with relatively little time-in-service are an adverse factor for health care assistants. The study data inform this finding. The first run flagged up the fact that some departments were employing older staff whose characteristics ought to have dictated otherwise, e.g., health care assistants nearing sixty in lifting-intensive wards. The research team had meetings with the matrons of these wards on this prominent finding. Valuable as it is to identify selection mechanisms, it is more valuable still to identify how staff manage to thwart them.

Two striking points were observed:

• While the research team had difficulty in getting many contacts (especially doctors) to understand its interest in ageing-in-place, the supervisors understood almost instinctively. They were acutely aware of what work on their wards entailed for older staff, and explained how the work organization had been adapted for the work to be done at no risk to the health of the staff concerned.

• The supervisors were clearly embarrassed talking about these adjustments, and engaged in approval-seeking behaviour. Making allowance for the actual condition of individuals requires changes to work allocation. This involves “task shifting”, which is officially discouraged by management. Such adjustments require a sound knowledge of individual strengths and weaknesses. They can only take place when relationships of trust have been built up over time. But, when supervisors change, so does the status of the adjustments. The new supervisor sees them as “bad habits” to be quickly phased...
out. In any event, the new supervisor lacks the knowledge of the staff which would enable them to assume the risks associated with these practices as an acceptable compromise. The research team noted that this issue of “bad habits” and the tension between strict operating rules and the practical requirements of care team managers was discussed between supervisors and trainee nursing managers. It is a vexed issue. It must be understood, though, that “bottom-up reviews” that occur with changes of supervisor wreck the strategies that allow older staff to continue working usefully in the department while remaining healthy. Changes of supervisor are therefore highly adverse to older staff.

As regards action, the findings could throw open to question the managerial mobility policy which inevitably puts a greater focus on abstractly-defined work organization.

As things stand, the search for necessary trade-offs between job requirements and staff resources is at fault. Issues are addressed locally and as unobtrusively as possible, so the quest for improvements cannot be informed by collective experience. It is questionable whether this approach can resolve the tensions between theoretical and actual work that are set to worsen with the foreseeable ageing of care staff.

Job characteristic-related selection factors also emerge, though less overwhelmingly, from the analysis. They are:

- the unpredictability of the work and the chemotherapy workload for Hospital 1 nurses;
- the special technical skills requirements for Hospital 2 nurses;
- the overall workload for Hospital 1 ASDs.

Unpredictability of work appears as an age-related selection factor for Hospital 1 nurses (no A&E department in Hospital 2) - a finding that bears out established knowledge. Ageing is not just about dwindling capacities, but also the development of experience which enhances forward planning and organizational abilities that enable older staff to match or out-perform younger staff. This age advantage reduces as the unpredictability of the work increases. It is hard to see how preventive provision could be made against this.

The chemotherapy workload in Hospital 1 and the technical skills requirements in Hospital 2 have a similar influence on nurses’ career paths. A similar pattern is observable in other professional circles. New technologies are often introduced without sufficient appropriate training for employees-in-post. Also, innovations tend to be introduced in a vacuum, when they necessarily involve changes not just to how individuals do things, but to the organization of work as a whole. These issues need looking at in the hospital. Technical developments not only
can but must be accompanied by special training provision for older staff because technical upskilling is one of the best guarantees against the risks of ageing-related marginalization. Also, any innovation must be taken as an opportunity for reviewing the objectives and procedures of work and cooperation in the department.

Our outputs showed that a particularly high overall workload in a department was especially adverse to health care assistants. This finding bears out the clinical observations of the occupational health doctors which suggest that health care assistants are the group most exposed to the risk of both physical and psychological work-related wear and tear.

Not only do health care assistants do most of the patient lifting work, they very often have most to do with patients despite lacking the defensive resources of technical skills and knowledge of doctors and nurses. It is not wholly unsurprising, therefore, to find an age-selection effect on health care assistants in Hospital 1 in departments requiring particular interpersonal skills. We should not jump to conclusions, however. Proximity to suffering and death are often claimed as factors that make hospital work onerous, so it is hard to resist the conclusion that ageing health care assistants are shunning departments with particular interpersonal skills requirements because this is precisely what involves this particularly upsetting contact. Several things suggest otherwise, however. Firstly, the analytical check-lists for both hospitals included items describing this psychological workload (“care for terminally ill patients”, “long-term support”, and “particularly distressing deaths” in Hospital 1, “strong psychological involvement”, “close emotional involvement with patients”, and “long-term support” in Hospital 2). But none of these items appears linked to a deficit of health care assistants aged 45 and over. This suggests that the radically different gender-selection interpretation already mentioned may be the right one. Some but not all departments with high interpersonal skills demands involve contact with highly emotional situations. They also include departments where a large part of caregiving is done just through talking, such as endocrinology departments where the issue is to train patients in treatment protocols. More than contact with suffering and death, departments with high interpersonal skills demands are those in which interpersonal relations are central to the work and involve doctors and nurses proactively, which limits the sphere of independent involvement by health care assistants, and it is this lesser scope that is arguably behind the depleted numbers of older health care assistants.

Here again, it is highly instructive to note that the statistical outputs militate for an explanation in work organization rather than personal psychology terms. The issue is not directly about contact with suffering and death, but the type of organization and cooperation established to cope with it, and the importance given to the different occupational

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groups in that set-up. To that extent, the demographic analysis changes the picture of job stressors initially built up from institutional players’ perceptions.

Finally, interesting similarities are observed between the factors linked to the deficit of males and those ostensibly connected to a deficit of females aged over 45. The study shows that male nurses leave departments with heavy medical staff involvement while male health care assistants leave departments requiring particular interpersonal skills. From this gendered division of labour, it was concluded that work organization was based on women’s ability to withstand a number of mental stressors (especially inconsistent instructions and subordinate roles). It now appears that this “aptitude” is no more resistant to advancing years than men’s capacity for the manual handling of heavy loads.

These findings show the limitations of the approach to resolving work issues through the use of specific groups with presumed special aptitudes. They suggest that prevention of the effects of ageing among hospital staff should be addressed through work organization far more than through personnel management.
Case study 7
Spain: Achieving the work-life balance

by Lorenzo Munar Suard,
Centre for the Sociology of Health, Université Libre de Bruxelles

Taking its lead from a Madrid Supreme Court judgment recognizing a woman shift worker’s right to adjust her shift for childcare needs even though already on short hours, the Navarre CC.OO\(^1\) -Volkswagen branch union took action to get the right extended to the company’s entire workforce.

The action was to claim women’s right to a better balance of work and home life responsibilities. Company management turned down the initial approaches, leaving the union no option but to go to law. Two women workers already on short hours took action through the courts supported by CC.OO’s legal services to get the right to choose their shift and working hours to fit around caring for their pre-school children.

In two separate judgments, the Navarre Labour Court\(^2\) held that both women were entitled to choose working hours to fit in with childcare. The court said it was for the worker to determine what hours and how short a day they wished to work in order to provide childcare. In other words, the right to appropriate childcare comes before the company’s interests. To that extent, the judgments echo the Spanish Work-Life Balance Act’s requirement to “establish a system that reflects new forms of labour relations and a new means of cooperation and commitment between men and women that allows for a balanced allocation of work and home responsibilities”\(^3\).

This was a major victory for the union, and management finally had to yield to the two women’s claims. Based on that, the branch union pressed management to extend the benefit of the two rulings to all similarly-placed men and women workers that wanted it\(^4\).

This action is an object lesson in the problems workers have in achieving the work-life balance and raises a series of issues that will be addressed here.
A double work day: double duty - double default

The latter half of the 20th century saw women increasingly entering the workplace. Data from 1999 report an EU female labour force participation rate of 52.6\%, with the highest rate in Denmark (71.6\%) and lowest in Spain (37.3\%). Luxembourg, Greece, Italy and Spain are all below 50\%; Belgium, Ireland, France, Germany, Portugal and Austria between 50\% and 60\%; and the United Kingdom, Finland and Sweden between 60\% and 70\%. Denmark is the only country to top 70\%. The rising trend in the female labour force participation rate has panned out in all fifteen EU countries, but with glaring differences between national situations. This mass influx of women into paid work has produced radical changes in family relationships and responsibilities.

Women’s traditional focus on hearth and home is now increasingly shifting towards the labour market, and so a balance must be found between the public (paid work) and private spheres hitherto seen as irreconcilable opposites. The public sphere (typically male) is arguably focused on what might be called “work, politics, business” ruled by criteria like success, power, the universal rights to freedom and property, etc. It is also a sphere inextricably linked to satisfying the more objective (and only socially recognized) component of human needs - that of goods and services. By contrast, it is argued, the (typically female) home-centred private or domestic sphere is based on emotional attachment and affection, and hence alien to participation in the wider world of work, politics and business. It is also claimed to be directly linked to individual subjective (emotional-relational) needs which are seriously socially undervalued despite their importance to the physical and emotional stability and personal development of family members\(^6\).

With women’s increasing labour market participation, the traditional family model, distinguished by the antithesis between the male/public and female/private spheres, evolved towards a new model which is becoming entrenched. In this, the male role remains virtually unchanged, while women are tending to assume a double role as homemakers and workers. Women’s growing labour market activity has not changed their relationship to domestic responsibilities. Also, since women’s domestic work remains invisible and goes socially and politically unrecognized, it is women that are bearing the brunt of these radical society-wide changes, which are largely passing both institutions and men by.

The double working day (home and job) stems from having to shoulder the responsibilities of both spheres of activity every day and sometimes at the same time, both during working time and personal time. This is the “double duty” phenomenon, when a woman has to organize domestic responsibilities during paid working time, and encroach on personal time to organize or manage her work responsibilities as best


she can. The emotional and mental drain involved in juggling responsibilities in this way can take a major toll in terms of burn-out, anxiety, stress, etc. When reconciliation becomes too hard or plain impossible, the individual may experience feelings of “double default”, i.e., having failed to deal with either the demands of work or family.

Double duty and social time

Social time - time for personal maintenance, paid work, household tasks, community participation and leisure - is central to the “double duty” issue. Interesting insights are therefore to be gained from examining the unequal gender division of these times, and especially the impacts of how they interact and clash with one another. The “time use” (or “time budget”) surveys done in most European countries show that the huge rise in women’s labour market activity has not been accompanied by an equal - or equally-proportioned - rise in male uptake of domestic tasks. Notwithstanding sweeping social change, the gendered division of labour still puts the main burden of childcare and homemaking on women. This is why achieving the work-life balance is mostly a women’s issue, even though also affecting men.

A survey done by the Instituto de la Mujer in Navarre, the region in which Volkswagen was taken to court, found that the gender division of child care is very unequal. So, even where both partners work, only half of male workers share child care duties with their partner, while up to a third of women are the primary carer. Gender gaps in a long series of household tasks like cooking, cleaning, laundry, dishwashing, shopping, ironing and so on are also wide. Most of these jobs are done by women. The survey also shows that it is mainly women industrial workers that assume a disproportionate share of household responsibilities.

More recent national data\(^7\) for Spain show that women spend an average 4 hours 12 minutes more a day on housework, while men spend 1 hour 36 minutes more on paid work and 42 minutes more on leisure. The same trend is repeated at EU level. Data published by the Dublin Foundation\(^8\) leave no doubt about the unequal gender division of cooking, housework and child-rearing responsibilities: 85% of women but only 25% of men assume domestic responsibilities. These data show beyond doubt that time use is still ruled by traditional gender divisions. What the work-life balance issue shows, therefore, is the need to analyse the family and work in terms of interlinkages. Attempts to achieve that balance have forced women to develop individual ways of fighting back, adapt to new situations, and make a range of choices that may involve cutting back on family duties, organizing their family care work and their particular method of labour market participation (short-time working, fixed-term contracts, etc.)\(^9\).

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8. Las mujeres en cifras, data based on the “Usos del tiempo” survey, Instituto de la Mujer (http://www.mtas.es/mujer/mcifras/).


But analysis should not stop at examining the linkages through the prism of a more stable model of family and work. It must be made clear that the balance issue affects all adults, especially the “non-standard” in family and work terms, e.g.:

- lone parent families;
- contingent and unemployed workers (balancing insecure employment/unemployment with family life and responsibilities);
- single people, divorced with no dependents (balancing work/home without family responsibilities).

Family, employment, public health and occupational health policies must also take account of the additional or specific problems faced by such groups.

**Measures and arrangements to promote balance**

The new social given of women’s labour market activity has consequences for individuals, families, civil society, the State and business. The overriding need for families is for a shift towards a fairer division of family responsibilities, but these changes must in part also be promoted by policies or initiatives that go beyond the strict family framework. Employment and family policies are what set the framework within which women and men apportion their social time for and between themselves. Changes in the state and society are also needed. While balance is rising up the national and Community family, equality of opportunity and employment policy agendas, the types of provision may have very different approaches that do not necessarily work to reduce job segregation. Some firms are slowly making changes to work organization that ease balance, but there is no overall assessment of these schemes that we know of. The available literature focuses on descriptions of “good practice”.

**The creation of childcare provision**

National and/or regional governments have set about developing early childhood provision (infrastructure, services and benefits) for working parents. While these services are generally improving, parents still have trouble with recurrent problems like inflexible opening hours (where they work non-standard or irregular hours), and rules and regulations that create practical problems, like turning away sick children. Family policies generally, especially on pre-school childcare, are key for women’s status since they can maintain or widen as much as narrow social gaps and the gendered division of labour in the home. The current debates on professionalization of childcare occupations (childcare workers and childminders) are also major issues for women’s status,
because child care is still “the woman’s job”\(^\text{11}\) whether as paid work or an unpaid family-based activity.

One example of good practice in childcare provision comes from Finland\(^\text{12}\). The policy decisions and measures in Finland to develop comprehensive childcare provision were taken not, as in most European countries, to expand women’s access to the job market but because women’s economic activity rates were and had for years been very high. Measures taken by the Finnish State to help working parents include:

- an integrated system of state subsidies for maternity (18 months), paternity (1-3 weeks) and parental leave (26 weeks);
- municipal child care provision guaranteeing a place for all under-7s since 1996;
- parents allowed to stay at home to raise preschool children until the age of 3. The parent’s job is held open and the family receives financial assistance in the form of a “home care allowance”;
- either parent can take a maximum of ten days’ leave to look after a sick child under 10. There is no statutory entitlement to pay for this period, but most collective agreements provide for it.

All these measures, and Finnish family policy as a whole, are outstanding compared to other European countries, and a very good example of formal gender equality. Despite this, however, it is Finnish women that still do most of the child care and so take most of the maternity and child care leave, even though men could take it on the same terms. Paternity leave has increased in popularity of late, and about two-thirds of new fathers now take it. But only 2% to 3% of fathers, compared to nearly 100% of mothers, take parental leave and for increasingly shorter periods: the average length of parental or paternity leave taken by men was about 15 days according to figures for 2000\(^\text{13}\).

### Care provision for dependent older people

Similar population trends are confronting the different European countries with population ageing and issues of caring for elderly persons who are unable to perform activities of daily living or are frail and infirm. A wide range of provision and initiatives have attempted to address these issues: networked domiciliary care services; community-based care services for the elderly; working arrangements to enable workers to care for dependent parents; granting official paid carer status to daughters and daughters-in-law; professionalizing the occupation of elder care worker, etc. But all schemes face the same difficulties of the interconnections between the family, market and state, funding the provision, and the impact on women’s status, because once again, women are the main voluntary and paid providers of care and help to

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families\textsuperscript{14}. The Navarre survey cited earlier, reported 16.1\% of women workers living in the same household as an elderly person (over 65), and 9.2\% reporting to be providing care to an elderly person, compared to just 1.3\% of men\textsuperscript{15}. So, whether as family members or home help and care professionals, women are exposed to the consequences of what are supremely political choices.

Sweden\textsuperscript{16} typifies these tensions. The crisis in the welfare state, growing doubt and criticism of public monopolies, and censure of care provision for the elderly have produced a dual trend towards privatization and informalisation of elder care provision. There is a growing trend to buy in or pay for services previously provided free of charge by local social services, accompanied by a sharp fall in the numbers receiving formal elder care sector help. In 1980, 62\% of elderly people were receiving home or institutional care services; by 1997, the figure was only 43\%. There are no official figures from which to evaluate the amount of informal care provided by families (especially wives, daughters and daughters-in-law)\textsuperscript{17}. But there is a discernible increase in family care provision to elderly people. These changes have come about incrementally, with no drastic questioning of public sector responsibility for elder care provision, but in a context of some financial retrenchment. Women seem to bear the brunt of public spending cuts here\textsuperscript{18} in terms of working conditions, their chances of finding or keeping a job and the scope for reconciling paid work with housework.

**Incentives to increase fathers’ participation in family life**

Work-life balance is not just an issue for women, which is why Spain’s Work-Life Balance Act mentioned earlier and EU Parental Leave Directive 96/34/EC brought in major changes to the law to enable workers to fulfil their family life obligations and thereby advance on the road towards equality of opportunity. The Directive forms part of a broader policy to promote and support increased participation by men in child-care (see the EU Council’s Child Care Recommendation 92/241/EC).

**Parental Leave Directive (96/34/EC)**

The Directive calls for an individual entitlement to 3 months parental leave for men and women on the birth or adoption of a child. The leave can be taken at any time before the child’s 8th birthday. Regrettably, the Directive does not provide for it to be paid leave, which severely limits its practical benefit.
Council Recommendation on Child Care (92/241/EC)

This recommendation promotes the development of measures like:
- making childcare provision for parents who are in employment, education or training;
- making workplaces more responsive to the needs of workers with children;
- promoting and supporting greater participation by men in the care of children;
- introducing incentives for the uptake of parental leave.

Adapting work organization to workers’ needs

The idea of “double duty” brings into prominence and sharp focus the private aspect of working time and the public aspect of family time. The pressure on business to put in place measures to promote balance makes companies central to the issue. The irreconcilability of working hours with the demands of family life is a source of stress and constant dissatisfaction, and amounts to a hazard which, while not strictly occupational, must nevertheless enter into the equation for protecting workers’ health. Employers therefore must take account of the health risks posed by work-life balance issues. Examples of company-led good practice in work-life balance can be found.

Examples of good practice

In Germany, male workers at the Freising-based firm Freie Holzwerkstatt have a "bankable" monthly entitlement to several hours’ paid leave as “child care time”.

Portugal’s telecommunications carrier, Telecom Portugal, set up a “time bank” scheme for flexible working time management to allow employees to get a better balance between working lives and their family and personal responsibilities. The firm also runs a home teleworking scheme for employees with a disabled dependent family member.

Reduction and reorganization of working time

Early legislation and measures on the reduction and reorganization of working time were mainly brought in under employment policies, chiefly to promote job creation and reduce unemployment. Work-life balance as such was not really an issue, or not a priority at least. Changes are in the making, however. In France, for example, the 35 hour work-week legislation is intended among other things to help parents achieve a better work-life balance. In the Netherlands, too, work-life balance
has come onto the political agenda, and between 1995 and 1997, two multipartite commissions were tasked with framing recommendations on part-time work in particular. One of these commissions recognized that “firms were not automatically giving balanced consideration to the conflicting interests of workers and firms in the organization of working time, whence the need to strengthen the position of workers in negotiations with a right to adapted working hours”\textsuperscript{19}. The question is, however, whether part-time or short hours working is the right way to promote balance?

Pre-1960s labour market gender gaps were mainly about differential labour force participation rates. Now, these gaps are closing significantly, and the main differences are in working hours: women still mostly work shorter hours, and part-time is still the most gendered form of employment. So, juxtaposing the age-specific charts for female part-time employment and full-time employment rates for countries like Germany, Denmark, France, the Netherlands and the United Kingdom “part-time can be seen as ‘taking over’ from full-time work at the time of family formation”\textsuperscript{20}. This trend is clearest in the Netherlands, where part-time work tends to be claimed as a way of achieving work-life balance. But is not the real conclusion to be drawn that women cannot juggle a full time job with shouldering most of the family and domestic burden as they currently do\textsuperscript{21}? Is part-time work in fact prone to widen the gender gap by marginalizing women (mothers) even more on the labour market by locking them into short- or very short-hours jobs and increasing their dependence on their partner or the State\textsuperscript{22}? Part-time and short-time working may be a good way to promote balance, at least in equality of opportunity terms, when it is equally shared by men and women, when they are less associated with poor working conditions and job insecurity, and when domestic work is more equally shared. But statistics and societal trends suggest that is still far in the future.

Gender and class relations

The issue of work-life balance plus the need to analyse the interlinkages between family and work life must be seen through the prism of gender and class relations in order to look at how individuals’ gender category connects with their place in their social class\textsuperscript{23}. “Time use” and “time budget” surveys reveal an entrenched gender division of labour and persistent gender gaps in the time spent on household tasks. But are these inequalities found in the same way or to the same extent according to the social status category to which the individual belongs?

Generally, more affluent women can make private arrangements to ease their domestic workload, buying cleaning, home sitters/childminder,
elder care and other services. These are options closed off to low-paid women, increasing their vulnerability to the stresses of “double duty”.

Finland’s *Quality of Work Life Survey 1997* offers instructive insights into the work-life balance. “The survey shows that gender differentials over the issue of work-life balance are surprisingly small and that the encroachment of work on family life and vice versa is more connected with socioeconomic grouping than gender or age. So, among the white-collar group, only a slightly smaller proportion of women than men replied that they managed to put work from their mind once back home, and thought that the family might sometimes take second place to work because they were often more involved with their work than the men”\(^{24}\).

Surveys done in Sweden\(^{25}\) reveal a link between women’s social status and their husbands’ contributions to housework and child care. The share of housework done by men with wives in unskilled manual jobs has not risen as much as for other men. Other studies show that women manual workers are comparatively more stressed than other groups of women because of the very limited control they have over their work and home life situations.

The Navarre survey cited earlier suggests that women in all lines of work and all qualification levels generally shoulder more household and family responsibilities than men, but that the proportion of shared household tasks increases as women’s educational levels rise (apart from child and elder care, which remain essentially female activities)\(^{26}\). So, women who are skilled business service providers, scientific, professional and clerical workers share more of the family responsibilities and carry less of the burden alone than women industrial workers\(^{27}\).

An analysis\(^{28}\) of the 1994 *Encuesta de Salud de Catalunya* survey data on gendered workplace health inequalities between married and cohabiting couples makes instructive reading. It showed that any study of gender health differentials must consider not only paid work and household work but also the interaction between gender and social class. Among women manual workers, family demands are linked to reported ill-health, long-term restrictive illnesses, and chronic disorders. The same women living with people aged over 65 were also more likely to report ill-health and at least one chronic disorder.

The findings of all these surveys clearly bear out the importance of the gender/class relations interaction to a better understanding of work-life balance issues. Gender inequality in achieving work-life balance is also partly dictated by social standing.
Health impacts of work-life balance

Working a double shift (home and work) significantly affects the psychological health of many women forced to cope with the overlaid demands of private and work life. “Double duty” and overwork are therefore risk factors - in particular stress factors - for women workers.

An increased range of responsibilities (work, family, domestic, etc.) can produce conflicts of interest between the different roles, which may create stress and so place health at risk. Having to assume and juggle different roles and responsibilities is not harmful per se, anything but. They may come out of it better than those who do not - being able to turn their positive experience in one sphere of activity to account in dealing with stress from another, for example. Also, the experience and skills developed at work and/or in private life (family, home, etc.) may aid social integration and so greater control over one’s life: self-confidence and economic independence can reduce or even cancel out the added stress of juggling multiple responsibilities. Generally - and this applies to women and men alike - involvement in both spheres of activity has health benefits if stress is kept at a moderate, manageable level and those concerned are able to influence their own life course and personal development29.

This is well exemplified by a Swedish study30 on the interaction between multiple role fulfilment and the well-being of workers. The survey of a base population of 1764 male and female graduate employees with children, finds among other things that combining family roles and functions with those of paid work is important for well-being. But it also shows that if the “added” responsibilities are too great, they begin to adversely affect health and well-being, especially for women. “Modern” families (where domestic work and financial responsibilities are shared between partners with equally demanding jobs) seem to be most beneficial to men’s and women’s well-being. Where such sharing takes place, women report less fatigue, a lower perceived psychosocial workload, and better career prospects than other women in the study. Men who share the burden of domestic work and child care more equally also seem to win out on all fronts. They are less fatigued and stressed by their paid work and report having the same career prospects as other men in the study. Multiple role fulfilment and burden-sharing in private life can promote health and well-being for men and women alike, provided stress is kept to manageable levels.

The study makes two other findings:

- Women who work part-time do not report any less fatigue or any more leisure or personal time than full-timers. This suggests that reducing paid working time is not an effective means of improving women’s well-being (or at least not unless accompanied by other

31. It bears pointing out that the study population was very pro gender equality to begin with, and with a more modern approach to family life.
Part-time work is frequently associated with worse and more insecure working conditions.

- Notwithstanding the limitations of the study (not generalizable to all Swedish men and women workers nor to other countries, given the specific features of Swedish family policy and cultural norms), it can be conjectured that favourable working conditions help promote not only well-being for women and men, but also gender equality by enabling household tasks to be shared.

The health impacts of the interplay between paid work and domestic work are largely unexplored. Very few studies on the issue were found when researching this subject, and those that were mainly focused on assessing male and female workers’ own perceived difficulties in achieving work-life balance and their mental and/or physical health. They show that the difficulties of juggling different roles and responsibilities are a source of stress and psychological distress and that a positive correlation exists between difficulties in achieving balance and some forms of illness, for certain groups of workers at least. More in-depth studies are needed to give a better understanding of the conflicts and interfaces between the double working day and the mental and physical toll it takes on the individual’s health, family life and jobs. The issues are key, especially for women’s status, because the gender division of labour combined with the horizontal and vertical segregation that exists in Europe’s job markets may mean that some employment policies or methods of work organization may seriously affect their health, not to mention their opportunities to access certain jobs, occupations and positions of responsibility in business.

**Implications of the CC.OO action**

The action taken by the CC.OO.- Volkswagen Navarre branch union and the court rulings that childcare rights must come before business interests show that “reconciling family and working life by workers” gives Spanish men and women legal standing to rely on at work. The right to reconcile work with family responsibilities has become a personal right enforceable against the employer. With the Spanish legislation, reconciling work and family goes beyond measures that depend on the employer’s good will and becomes a matter of the workers’ right to organize work-life balance.

Notwithstanding its shortcomings and failings, the *Ley sobre la Conciliación de la vida familiar y laboral de las personas trabajadores* has turned out to be a practical and effective means for asserting workers’ rights to choose their working hours so as to achieve a better work-life balance. Use of the legislation and the struggle to get it applied are clearly a major trade union strategy for action. The two cases cited

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are not alone. Spanish courts of differing levels of jurisdiction have already ruled in favour of workers on these issues in a series of cases. Employers are therefore increasingly compelled to be mindful of the work-life balance issues that workers face, and organize the work with that in mind.

But the CC.OO union’s action on work-life balance issues goes further than that. Its Secretaría Confederal de la Mujer (Women’s National Secretariat) has mapped out a strategy for revising collective agreements in light of recent legislative reforms (in particular Act 39/1999, above) both when they are up for renegotiation and in the joint industrial councils responsible for interpreting and monitoring them. Collective bargaining is a key means of regulating and improving working conditions, but is not doing its job in guaranteeing and promoting gender equality or, more practically, incorporating measures that will facilitate work-life balance. A critical review of collective agreements by the Secretaría de la Mujer revealed a clear split between collective agreements that produce or perpetuate discrimination, and collective agreements that promote equality of opportunity. Most collective agreements include terms or provisions that are not only out of step with legislation, but are in some cases outright discriminatory.

For all these reasons, the CC.OO trade union confederation’s strategy is to:

• Get collective agreements brought into line with recent legislative reforms. CC.OO’s Secretaría Confederal de la Mujer has published a brochure for negotiators setting out the different aspects and fundamentals that any collective agreement must include to be in line with the law, plus trade union proposals for other measures which go beyond and improve on statutory provision.

• Making cross-cutting application a fundamental and embedded principle of collective bargaining and making general anti-discrimination provision to promote the inclusion of measures and policy approaches to facilitate work-life balance.

• Promoting greater involvement by women in the bargaining process so as to help en-gender and improve understanding of work-life balance issues.

• Promotion training and awareness-building in work-life balance for negotiators (men and women) on both the employers and trade union sides.

• Promoting men’s uptake of existing child care and/or family responsibility leave opportunities.

All these measures are designed to uncover and eliminate existing discrimination and include terms and initiatives which amount to progress in both words and fact towards equal opportunities for men and women workers.
Many of the difficulties that many women have in making real and effective inroads not only into the labour market, but also in other areas of participation like politics, cultural life, etc. can be put down to work-life balance issues. As stated earlier, work-life balance is not an individual problem, but a social problem produced by changes in society and interactions between the world of work and the family sphere. Trade unions as social advocacy groups can be behind strategies and actions that bring improvements not only to women’s working conditions but women’s status in general.

Arguably, CC.OO’s trade union strategy on work-life balance has succeeded in framing demands and get actions going that put a focus on equality in the workplace and work-related health which is regrettably far from common in trade union practice. In seeking to make the interconnectedness of gender relations across all spheres an embedded, fundamental principle of collective bargaining, with all it involves, that strategy to its credit takes the work-life balance issue outside the narrow confines of the workplace to become a force for societal change.

Case study 8
Finland : The worklife of Finnish women

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This case study has three aims. First, it will try to show the point and value of producing data on working conditions drawn from a gender-sensitive national survey. Working conditions surveys are far from commonplace in Europe, and ones with a gender dimension next to nil. Finland is particularly interesting in that the same survey, using the same basic questionnaire, has been done regularly for over 20 years, enabling changes, and especially new trends, to be tracked.

Secondly, it will seek to demonstrate the point and value of mainstreaming women’s occupational health, which stands at the intersection of equal opportunities, public health and occupational health policies. Although one of the most advanced EU countries in many ways, Finland has much ground to make up in this respect.

Finally, it will point up a paradox in that despite policies put in place to promote equality and well-being at work for Finnish women, the broad trend has not led to improvements in working conditions. In some ways, indeed, they have got worse, in part due to increased labour flexibility and competitiveness, and the crisis in the welfare state.

Introduction

Finland is an informative case in many respects as regards women’s occupational health. Firstly, because a picture of changes in the working lives of Finnish women can be built up from the gender perspective included in the national Quality of Work Life Surveys over a 20-year period (1977-1997). Secondly, because women have had a large presence in the labour force for four decades - a peculiarity to Finland. Thirdly, because Finland has taken equal opportunities policy much further than most European countries, at least in most areas of social life, which may suggest that at least formal equality of opportunity has been achieved. Finally, the country has statistical indicators of a broad array of gender-specific data on employment, occupational health, public health and equality of opportunity. Used of this data in many publications over the years has helped give visibility to the points of similarity, difference and convergence in men and women’s working conditions.

1. This case study is based on information collected from the survey for this book.

2. This case study refers throughout to equality at work - a concept which has been and still is variously defined and widely discussed, with no general consensus having been reached. Since this study is based on the publications of Anna-Maija Lehto, it refers to the concept of equality used by her: the same opportunity for men and women to achieve self-fulfilment and their worklife objectives.
changes and current trends. Finally, these indicators have been a policy instrument for framing employment, family and other policies aimed at promoting equal of opportunity and well-being at work.

Finnish women and paid work

Finnish women’s labour force participation rate is particularly high, especially among young women. In 1920, 10% of married women worked; by 1980 that figure had topped 70%, and even now is still about 64.6% (compared to 70.2% of men). International employment statistics show that Finnish women were long exceptional. Since the 1960s, women’s participation in paid employment was higher in Finland than any other OECD country. It has now been overtaken by the other Scandinavian countries, but only because of the higher proportion of part-time working in these countries. The real volume of women’s employment in Finland remains higher when calculated in terms of full time equivalents (the current percentage of female part-time workers in Finland is 17%, compared to 38% in Sweden, 34% in Denmark and 68% in the Netherlands).

These high labour force participation rates by Finnish women are connected with two main factors:

- The characteristics of the Finnish economy and culture. In 1906, when Finnish women were enfranchised, Finland was one of Europe’s most agricultural societies. At the turn of the 20th century, three-quarters of women worked in agriculture, and in 1910 almost a third of industrial and craft workers were female. Agriculture remained the main employer until the 1950s. Since then, Finland has experienced far-reaching structural changes, rapidly evolving into a supremely urbanized country and a welfare state with at least 60% of jobs in the service sector. That brought new employment opportunities for women.

- Gender equality of educational levels. In 1901, Finnish women gained access to higher education. By the end of the 1990s, the share of women over 15 with at least upper secondary education was 69%, compared to 67% of males. The proportion of men and women with higher education diplomas and first degrees is now identical (7.7%). Disaggregated by age group, however, it is clear that the share of the youngest females having achieved this level of qualification is higher than that of males.

This mass entry of women into the world of paid work, with educational levels equal to or better than men, does not, however, mean that equality on the labour market has been achieved.
Equal opportunity policy and work

The feminist movement became active in Finland in the mid-60s. In 1966, Group 9 (yhdistys 9) was set up demanding a society of universal opportunity for self-fulfilment regardless of gender. This approximately 500-strong association had a major influence on the committee set up in 1966 by the Council of State, tasked with examining the status of women in Finnish society and recommending ways of promoting equality of opportunity. The committee’s report was published in 1970 and among other things suggested setting up a Council for Equality. This was done in 1972, since when the Council has been an equality watchdog, proposed measures for eradicating gender discrimination, monitored proposals on equality and the Equality Act, and funded gender studies and research, etc.

The Finnish Equality Act which came into force in 1987 applies to the various areas of social life. It aims chiefly is to promote gender equality and prevent all direct or indirect gender discrimination. Compared to other countries’ legislation, Finland and Norway have the most far-reaching equality legislation. Worklife is central to the Equality Act, which takes account of the different aspects of discrimination at work: recruitment, pay, working conditions, sexual harassment and abuse at work, etc. This major binding legislative framework thus established a measure of public and social control on business activity.

The Act was amended in 1995 to ensure equality at work. Employers who employ at least 30 people must now include measures to promote equality in their annual staff development and training plan or workplace risk prevention plan. Employers also have a statutory duty to facilitate work-life balance for men and women and take a series of measures including making available information on pay and the ability to compare pay between individuals and groups of employees, etc.

In 1996, the Equality Council set up a “labour market subcommittee” as a specialized body on worklife equality issues. Among other things, the subcommittee has studied the equal opportunities impact of changes in non-standard working, working hours and social security.

The most recent amendments to the Equality Act reflect the persistent gender gaps at work despite the measures taken. Most of what remains to be done, and the equality goals to be achieved, lie in worklife.

Gender-specific statistics

Gender-specific statistical data have been collected in Finland for at least two decades, but the analyses have not always been gendered, nor

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have the data always been published\(^{13}\). More recent efforts were made in the late 1990s to compile gendered statistical data and indicators to monitor developments\(^{14}\). This demonstrates an enabling political agenda and climate for developing studies to gain a clearer picture, analyse and follow up the impact of the gender dimension generally, and the worklife gender dimension in particular.

The **Gender Equality Barometer** cannot go unmentioned. This is a joint venture of the *Equality Council* and *Statistics Finland*, which sets out to monitor changing public perceptions of equality of opportunity and collect men and women's experiences and perceptions of equality in their interpersonal relations, organizations, worklife, family life and society\(^{15}\).

### Occupational health

Occupational health in Finland has been significantly en-gendered for many years. To that extent Finland, with the other Scandinavian countries, is a case apart. Public occupational health research bodies have been applying a gender perspective for years. This has been reflected in a highly active research policy in this field. This is an example which could usefully be followed by all national occupational health research bodies. The research done by the TUTB reveals the low awareness of women’s occupational health in most countries, other than “standard” women’s issues like maternity.

As part of the TUTB survey, the *Finnish Institute of Occupational Health* (FIOH) reported at least 12 lines of research in which a gender sensitive approach is taken:

- reproductive health;
- ergonomic risk factors;
- the health impacts of working hours;
- psychosocial risks (stress and burnout): gender-specific differences regarding burnout, psychosocial resources and burnout among women, psychosocial vulnerability and gender, etc.;
- work-related cancer in Finnish women;
- health issues related to workplace air quality;
- sickness absence: psychosocial predictors of sickness absence by men and women, etc.:
- sexual harassment at work;
- moral harassment and bullying at work;
- workplaces as a source of gender health inequalities;
- gender equality and well-being at work.

Finland’s Ministry of Social Affairs and Health has mapped out its own strategy for implementing the Finnish government’s worklife programme in the social services and health sector. It is a programme\(^{16}\)

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15. Ibid, p. 3.
16. See http://www.occuphealth.fi/e/fioh/1e.html.
that could positively impact women’s working life, because the State - and more specifically the social and health services - are the main employers of women.

**Public health**

The National Public Health Institute (KTL) monitors health-related changes in individual behaviours and lifestyles of the Finnish population. Since 1978, the Institute has been running postal surveys to collect data on the behaviour of Finns - mostly on changes in smoking and diet, but also on drinking, exercise, oral hygiene, personal perceptions of health, the use of health services, etc. The survey also touches on the world of work, although to a very minor extent in as much respondents are asked about sickness absences, work-disabling illnesses and injuries, the inability to perform work-related tasks, exposure to tobacco smoke at work, their workload and work injuries. All the 200-plus questions and variables are also disaggregated by respondent’s social status category, which provides added information. The respondent's social status categories are: agricultural work, industrial work, office work, students, inactive persons, pensioners, unemployed.

This data is of interest, even though only marginally work-related and over-focused from the public health viewpoint on individual behaviours that are not determinants of workplace gender health gaps. Most national and Community reports on public health do not even mention work situations. All the tables are disaggregated by gender and social status category, so the information can be compared to develop working assumptions. The fact that not all working conditions are included is a limitation, and restricts the analysis of the social determinants of health. The focus on lifestyles and individual behaviours prevents a proper analysis of the public health impact of work. Hopefully, a new generation of public health reports will factor in working conditions as a whole.

**Worklife: surveys on work life quality**

The work life quality surveys are in-depth studies based on a representative sample (3000 to 6000 people) of Finland’s working population. *Statistics Finland*, the surveying agency, has conducted four surveys: in 1977, 1984, 1990 and 1997. They are personal interview surveys using a standard questionnaire. Interviews take approximately just over one hour, and include questions on the physical, mental and social work environment, employees experiences/practices in relation to these environments; experience of work; labour market status; terms of employment; frequency of a series of physical and psychological

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symptoms; work commitment; job satisfaction; practices regarding equality of opportunity. The identical questions were repeated in each survey, enabling changes in worklife in Finland over a 20-year period to be assessed. The survey incorporated a gender perspective from the beginning, enabling a gender analysis of the impact of these changes on workers.

The last survey (1997) introduced a combination of qualitative and quantitative methods in order to make good some of the shortcomings and failings of previous surveys. The inclusion of open questions in the interviews gave researchers a better purchase on workers’ daily lives and individual experiences.

One aim of the surveys is to produce data on worklife for use in employment, labour, equal opportunity, health, and other policy-making. To this extent, the survey data should also facilitate an impact assessment of policies on the working life of Finns.

**The segregated labour market**

Much of the growth in Finland’s female labour force can be attributed to changes in the economic structure: a decline in the male-dominated primary and secondary sectors and expansion of the service sector which has become the main source of female employment. In Finland, as elsewhere in Scandinavia, much of the service sector is publicly-run, making the Finnish State the biggest employer of women. The public sector is female-dominated (70%) and 46% of the female labour force is employed in the public sector (compared to 17% of men), especially in education, health care and the social services. The female industrial workforce has declined over the 20 years of the survey from 18% to 8%, but continues to dominate the textile, clothing and leather industries (the lowest-paid sectors). Female employment growth is clearly linked to the transition from an industrial to a post-industrial labour market.

It is plain to see that the services developed by the welfare state have both generated employment opportunities for women, and an unprecedented gender division of labour. Segregation is so acute that it would even be possible to refer to female and male labour markets. In recent years, some jobs have become feminized, and others masculinized, but the horizontal segregation, despite structural changes in the economy and employment, has remained very pronounced.

Economic recession and the crisis in the welfare state have had an evident impact on the structure of the economy. Fixed-term contracts, contingent working (including in public sector jobs), budget cuts (especially in health care) have led to job losses and an excessive workload.
on those remaining. Women have borne the brunt, and segregation in the labour market has magnified the negative impact of these changes on women’s health.

Latterly, extensive research has been done into the impacts of labour market segregation on women’s (and men’s) health\(^\text{22}\), and various studies conclude that it has negatively affected both. Both men and women have a lower rate of ill-health in gender-mixed occupations, a higher rate in male- and/or female-dominated lines of work, and the highest rate of all in almost exclusively male or female jobs.

There are a number of explanatory factors\(^\text{23}\):

- Self-selection. People with more vulnerabilities and illness tend to gravitate towards same-gender-dominated occupations\(^\text{24}\).
- The male standard. Postures and work equipment are designed for males, increasing the risk of accidents and musculoskeletal disorders for the female minority in historically male jobs.
- Autonomy in work. Both men and women in gender-mixed occupations report having more discretion in their jobs, but less so in historically male/female jobs, with the negative health impacts this may have.
- The risks of sexual harassment are much higher for minority gender workers.

The key issue with labour market segregation is less that men and women work in different sectors and occupations than the general negative impact this has on\(^\text{25}\):

- Men’s and women’s perceptions of one another, reinforcing and perpetuating gender stereotyping, broadly to the detriment of women’s status and empowerment.
- The efficiency, working and flexibility of the labour market (many competent women are excluded from positions of responsibility, etc.).
- The education and training of future generations because parents, young people and schools take decisions by reference to stereotypes and real or assumed employment opportunities.
- The gender pay gap (labour market segregation is the main determinant of pay differentials).
- Women’s pay (segregation contributes to women’s lower wages and women’s greater social vulnerability).

Finland and the Scandinavian subregion generally (to use Anker’s terminology) have the highest occupational segregation rates of all OECD subregions in the OECD. But this does not necessarily imply worse pay discrimination against women, anything but. This is because these countries’ discrete labour markets (male and female) are broadly gender-equal in respect of pay differentials for full-time jobs, at least\(^\text{26}\).


\(^{24}\) A more forensic analysis of the extent to which self-selection towards highly-segregated sectors is both social selection (with multiple determinants) and health selection would be informative.


\(^{26}\) Although a combination of retrenchment policies and the spread of part-time work could act to widen the gap.
But the consequences of occupational segregation are not just pay-related, other factors include the type of female-dominated occupations and the working conditions associated with them; the scope for self-actualization and personal growth in these occupations; changes in these occupations in terms of job creation, working conditions etc.\(^\text{27}\).

The argument that occupational segregation may also shelter women from male competition is the focus of much debate. The fact that at some points in the business cycle, job creation has taken place in historically female sectors may also work to women’s (and so against men’s) benefit in employment terms. Obviously, the converse also happens, and that is currently the case in Finland where the communication, information and technology sectors are major sources of new - but chiefly male - jobs.

One view is that, lower-paid, more insecure and dead-end though they may be, these female jobs are still jobs. This is a no-win situation faced daily by many women - that a substandard or “McJob” may be better than no job at all.

**Working hours**

Over the last two decades, working hours\(^\text{28}\) remained broadly unchanged. Now, split days, night work and others types of non-standard working hours have increased and women have borne the brunt. This has resulted in increased flexibility not offset by an overall reduction in working time. One singular feature of Finland is the broadly similar numbers of women and men working overtime. The many difference lies in the fact that men by and large receive pay for overtime, while women tend to take days off in lieu. This is particularly interesting in that women shoulder the bulk of family and domestic responsibilities. Unpaid overtime - or, rather, “bogus voluntary overtime” - has also risen significantly, once again linked to the negative effects of time pressure, and mostly affecting women.

**Work-life balance**

In two-thirds of families, women still perform most of the household duties. Some progress was made in household task sharing during the 1990s, especially as regards child care\(^\text{29}\). According to the most recent figures (2001), 60% of household tasks are done by women\(^\text{30}\).

Pressure at work and increased competitiveness on the labour market during the 1990s have had major impacts on the relation between the domestic and paid work spheres. More workers than before take work home with them. The number of workers unable to switch off from
work once at home has also risen. The feeling of neglecting their families for work has also increased among workers. A growing number of women who cannot balance family and work end up “choosing” work over their family, with all that entails in terms of guilt feelings, remorse and stress. This change of attitude is particularly significant in women fixed-term workers. Also, having a paid job is now seen as a very important aspect of life, partly due to recession and unemployment. This new outlook is particularly noticeable among women with a partner and children\textsuperscript{31}.

New trends affecting working life - fixed-term contracts, non-standard employment, workplace collective agreements - have also impacted the work-life balance. The solutions to working hours and work organization issues have not helped the working conditions of Finnish women due to unequal household task sharing and work-family conflicts. Finnish women more than their partners take up parental leave and more often work part-time, mostly on fixed-term contracts with less-secure terms of employment. In the final analysis, if women continue to bear the same share of household responsibilities as at present, part-time and fixed-term contracts may become women’s sole preserve. That would add to inequality and discrimination, and throw open to question gains made by the forerunner generation who were generally employed on permanent, full-time contracts\textsuperscript{32}. That poses a real threat both to women’s occupational health and their empowerment.

\textbf{General aspects of work\textsuperscript{33} and changes in work organization}

In 1977, the incidence of monotonous work, especially among women, was relatively high - a third of women compared to a fifth of men claimed their jobs were monotonous. That gender gap has now closed, probably with the growth in service jobs and the decline of industry, or at least female jobs in industry.

By contrast, the physical effort demanded by work has anything but decreased. For women, it has even risen slightly of late, partly due to the hugely increased numbers of women in elderly and child care work, and in the health sector (nurses, health care assistants).

Psycho-social workload has increased in the same proportion and directly relative to work intensity. This is more a female than male issue, because work has become more stressful for women. They report higher stress due to understaffing, while men claim harder targets and growing competitiveness as the main causes of their stress.

During the 1990s, downsizing, lay-offs, increased flexibility, time pressure and increased work intensity, especially as regards working hours,
had the most serious ill-effects\textsuperscript{34}. They contributed to the rise in work-related stress, mental fatigue and feelings of job insecurity.

These changes occurred all across Europe, but Finland topped the league for the impact of time pressure. The survey respondents were asked to pick from a series of factors those that most affected their working environment, and especially those that were most stressful. Of these, time pressure was the factor that had most increased in recent years\textsuperscript{35}.

Time pressure has gradually evolved from being a predominantly male to predominantly female issue. Working time pressure has risen sharply, for example, in the heavily female-dominated health-care sector (86\%). In 1997, 45\% of health care workers reported time pressure as the main stressor, compared to an all-worker average of 33\%. From female workers in mainly processing industry jobs, the highest reported incidence of time pressure at work now comes from women in jobs demanding high educational levels\textsuperscript{36}. Feelings of being unable to break off from work, approaching burnout and working under pressure are now more widespread among women than men. Time pressure is particularly associated with work situation, while family situation and age are less relevant factors. Contrary to received wisdom, the survey findings tend to show that having dependent preschool children does not increase the impact of time pressure on women.

Gender differentials in time pressure may also be connected with structural changes affecting the working environment, especially work organization. But these differences are less to do with the scale of the problem than how it is addressed, and the health impacts of time pressure. Women report that time pressure has a negative impact on workplace social interaction, and makes for a more conflict-riven work atmosphere, whereas men claim an increased error frequency and accident risk. Above all, time pressure affects all the aspects that women particularly value for well-being at work (the social aspects of work), which may be why it causes - or at least is perceived to be - more of a problem by female workers.

**Workplace social relations**

Workplace relations\textsuperscript{37} have become more conflict-riven and competitive, but new forms of support and recognition at work have also developed. More women than men feel that under-staffing has a negative impact on the work atmosphere. They also report greater satisfaction than men with the support received from their work colleagues and superiors. This is a constant long-term trend.
Competitiveness and conflicts at work have risen steadily since the 1980s. Perceptions of this are highly gender-differential, with men stressing rivalry and conflicts between subordinates and superiors (a rising trend over the survey periods) and women mainly emphasizing inter-individual and inter-group conflicts among staff.

16% of the working population reported being or having been subjected to intimidation, threats or verbal violence at work, and 40% had observed it happening in their workplace. Within those percentages, females outnumbered males. All these practices were associated - aside from increased time pressure, rivalry and job insecurity - with certain occupations and sectors, with the highest incidences in the public sector and particular sub-sectors like education, the health services and processing industries.

**Recurrent pain and disorders**

The surveys report a higher female than male incidence of recurrent pain and disorders. The two decades of the surveys have seen a rise in neck, spinal and shoulder pain, while lower back, pelvic and knee pains have decreased.

**Psychological and somatic symptoms**

Workers generally are suffering fewer psychological and somatic symptoms than before, but women report a higher incidence of night wakefulness (one in three respondents at least once a month), fatigue, apathy and listlessness (three in four women at least once a month). Other problems affecting women more than men are: tenseness, restlessness and irritability (experienced by two in five women at least once a month). Headaches remain a common problem: half of all women and one in three men report suffering at least one headache a month. 78% of workers who report these symptoms at least once a week regard them as work-related or due to work-related problems.

**Conclusion**

The *Quality of Work Life* surveys, with other research and statistical data produced and developed in Finland, yield a picture of changes in the working conditions of the Finnish population and a gender perspective on the differentials between men and women workers.

The changes documented by the *Quality of Work Life* surveys over the twenty year study period show that women’s labour market status has 38. Including in particular the *Work and Health in Finland 2000* survey which yielded extremely valuable insights into changes in working conditions in Finland in the late 1990s. See the report by Piirainen H. et al. (2000).
grown more insecure, with the attendant effects that has on their health and well-being at work. These changes have doubtless been influenced by processes that are not exclusive to Finland: the internationalization of economic relations and the intensification of global competition; the impact of new technologies in the different spheres of work life and the rolling-back of the welfare state. These have gone in hand with the spread of flexible work practices and new management methods. These surveys offer a means of gauging the impact of these changes on workers, and more specifically on women. A particular focus is needed on work intensity (brought to light by time pressure) and job insecurity (materialized in fixed-term contracts in particular).

It was seen earlier that time pressure mainly affects women and manifests in ill-health through stress, physical and mental fatigue, neck and shoulder pain, etc.

Fixed-term working affects women more than men. Statistics Finland’s figures for 1997 show that 21% of women and 14% of men were on fixed-term contracts, and in 2000, the situation was substantially unchanged (20% and 13%, respectively). A study done by the Finnish trade union SAK in 2000 reported substantially higher figures - approximately one in three women and one in five men.

These surveys clearly show the impossibility of addressing equality and occupational health without including general trends in work organisation. Flexible working practices, work intensification and competitiveness form a framework common to all European countries and a further obstacle to equality and well-being at work. The question is to what extent these overall trends may challenge the gains made under Finland’s particularly proactive gender equality policy, which are tangible enough, though not measuring fully up to expectations. Will the higher incidence of female job insecurity allow these gains to be preserved in a labour market where stable, full-time jobs with a future are an increasing rarity?

Finnish equality legislation is creditably wide-ranging and covers all aspects of working life. Its overall impact seems not yet to have been assessed, but it is sure to have had significant positive impacts (on public opinion, social dialogue between the employers and unions, etc.). Unfortunately, empirical data suggest that it has not yet had a real impact on the gender pay gap, household task sharing, work-life balance, horizontal and vertical segregation etc. In work life, entrenched practices remain based on the gender division of labour and stereotypes, and prejudices which systematically strengthen and recreate gender inequalities. All this goes to show that even where legislation and policies on equality and well-being at work are conducive to positive change, it does not automatically happen. Social resistance to change...
at all levels is deeply embedded in the mentality of individuals, in families and at the workplace.

Finland is among the countries that have done most to develop indicators and a policy for an en-gendered monitoring of changes in occupational health. If the aim is to ensure a better understanding and greater visibility of women’s work-related risks, and improve their well-being at work, then such indicators and policies must be developed. It is the only way to break the vicious circle of preventive health policies and programmes for women not being established for want of indicators to flag up the specific risks and problems of women at work. Without indicators to provide these insights, the risks will stay unrecognized or invisible, and so no need will be seen for establishing prevention programmes. It takes little working out to see that there will be no policy change without alarming indicators.
Case study 9
Netherlands: Work intensity: a new agenda for trade union action – Selected trade union initiatives in the service sector

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During the period 1991-1996, the Dutch trade union federation for the service sector, FNV Dienstenbond, launched a major research project on work intensity. That project led on to trade union schemes to reduce work intensity in various branches and groups of companies in the service sector. Jan Warning has looked at eight trade union initiatives in more detail, focusing on high street shopping, banking, clothing multiples, pharmacies, printing, tourism, broadcasting and supermarket groups. In every case, the trade union investigated the reasons for work intensification. A database was compiled from the data collected, including data profiles of over 12,000 workers. What makes this database particularly valuable is the worker population covered by it, and the range of work functions and occupations compared.

As well as a survey questionnaire, the research project used more qualitative methods of investigation, including company visits, work activity observation, interviews with workers, etc. Warning’s study includes a more in-depth analysis of the database, with a specific focus on the reasons for work intensification and fatigue by individual profiles and nature of work function. A secondary analysis was also done on the research material, and selected trade union initiatives followed up.

The survey methodology used to collect the database material is based on the “quality of work” methodology widespread in the Netherlands, in which information is collected on four discrete aspects of the work situation, namely working conditions, work environment, work content and work relations.

For this, working conditions are defined as the conditions in which workers provide their labour. These include the pay offered by the employer in exchange for the work done, but also fringe benefits and any variable component of pay (production bonuses, sales commission, etc.). All these elements make up the “primary” working conditions. The “secondary” working conditions include working time adjustments (overtime, flexitime, etc.), job security (the type of work contract), paid holidays. “Tertiary” working conditions include all company-specific measures affecting career progression, training opportunities, advancement and dismissal.
The second aspect of “quality of work” is the work environment\(^2\), which includes job atmosphere, physical loads, and the level of safety and protection against work-related accidents. One way to measure the work environment is through a “work discomfort” scale. “Work discomfort” refers to work where most of the surrounding factors are uncomfortable: dirty work, work subject to unpleasant environmental odours, extremely strenuous work; environmental noise; work in a hazardous, unsafe environment, or in uncomfortable temperatures.

**Work content** comprises all the tasks to be performed, learning opportunities offered by the work, workers’ freedom to determine how to perform the work, take decisions, etc. Work content is often assessed by seven criteria in this methodology: the function as a set of tasks, organizational tasks, short cycle tasks, task difficulty, the worker’s autonomy, contacts, cooperation received in carrying out certain tasks, and information supplied to him.

The methodology also assesses the prevalence of special practices (aimed at improving the quality of work content) within the organization, e.g., multitasking, job enlargement, job enrichment, etc.

**“Work relations”** refers to the labour relations climate in the company, the opportunities for worker participation and consultation, the issues discussed in participation and consultation bodies, etc. Work relations are generally assessed on the basis of three criteria: management style, contacts between workers, workers’ rights of participation and consultation.

**Intensification of work in pharmacies**

The case study on pharmacies is particularly apt due to the high proportion of women working in this service sector, and because it is a relatively unexplored area of work activity. The terms of reference were to analyse work intensity in a sector of activity combining very small enterprises and a mostly female workforce. Very few pharmacies employ more than 10 people, and almost all the women workers are in the same occupation - pharmacy assistant. It is also interesting that the research was overseen by the Stichting Bedrijfsfonds Apotheken, a jointly-run employer/trade union foundation set up in 1989 to stimulate, promote and analyse labour relations and the work environment in the sector. The foundation is funded from a levy on the income of public pharmacy employees. The Ministry of Public Health also gives the SBA budgets for projects relating to the labour market, training and prevention of sickness absenteeism. Another factor of interest in the

\(^2\) We have translated as “work environment” the Dutch term *arbeidsomstandigheden*, which literally means “work circumstances”. This notion encompasses all aspects liable to have an effect on health and well-being at work.
work intensity approach is that labour supply in the pharmaceutical sector is also determined by a third party - the State.

The study focused on high-street pharmacies, which are distinct from hospital, health centre and GP pharmacies. The Netherlands had approximately 15,000 pharmacies and 10,000 pharmacy assistants in 1993. As well as the pharmacist and pharmacy assistant, pharmacies may also have a second pharmacist, clerical and delivery staff. Pharmacies are small, neighbourhood service enterprises. Very few employ more than 15 workers.

The pharmacy business has long been a highly lucrative one. Pharmacies earn their income from prescription refunds and wholesaler and pharmaceutical industry discounts. Since the 1980s, the State has been trying to curb the rising cost of medicine reimbursements. So, on 1 January 1994, some medicines (especially so-called comfort medicines) were dropped from the refund list. The State also faces competition from drugstores/chemist’s, supermarkets and the wholesale trade, trying to capture market share through other distribution channels. There is a view that the response of pharmacies should be to refocus on better service delivery and customer information.

In 1993, a shortage of pharmacy assistants pushed work intensification in pharmacies up the agenda of union/employer discussions in the sector. The worst shortage was in Randstad Holland\(^3\). The all-sector average shortfall was 0.7 full-time equivalent (FTE) pharmacy assistants per pharmacy. Approximately 15% of pharmacies had vacancies for at least two FTE pharmacy assistants.

Promotional campaigns and courses for female returners were staged in the early 1990s, when shortages were so acute that some pharmacies resorted to offering leased company cars or accommodation as recruitment incentives for assistants.

Contract research was commissioned from Nijenrode University on long-term forecasting of the structural shortage of pharmacy assistants. Their report was published in early 1993 with the evocative title *When a pill doesn’t help* (Ott. *et al.*, 1993). Pharmaceutical sector unions and employers saw the Nijenrode University report as the first step in professionalizing personnel policy. The report highlighted very strong vertical and horizontal gender segregation in the sector, where most pharmacists are male and all pharmacy assistants female. This segregation is partly historical in origin. In the 19th century, when pharmacy assistant was an occupation for young males, upward mobility from pharmacy assistant to pharmacist was possible. But the 1865 Health Act made career advancement much more difficult, and pharmacy assistants - a demanding but relatively low-paid position - could no longer be

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3. Randstad Holland is a vast urban area comprised of distinct cities in the western Netherlands (Amsterdam, Rotterdam, The Hague and Utrecht) encircling a central area.
promoted. The “solution” to the shortage was therefore to recruit women. So, after a period of adjustment, pharmacy assistant changed from a male-dominated to a female-dominated occupation.

When the study was done, work intensification in pharmacies was as much the consequence as the cause of the shortage of pharmacy assistants... the shortage of workers increased work intensification. Over half of pharmacy assistants of all age groups had experienced work intensification. At the same time, intensification was also a key reason for leaving the profession, cited in third place by pharmacy assistants after dissatisfaction with working conditions and increased family size (birth).

In view of the Nijenrode report outputs and the “work intensity” project run by the FNV Dienstenbond union, the Stichting Bedrijfsfonds Apotheken set up fresh research into “work intensity and sickness absenteeism among pharmacy assistants”.

The social partners’ aim with this research was to achieve more stability in workforce totals by identifying the causes of work intensification in pharmacy work.

The research report was published under the title *Hypertension and reducing tension*. As well as a glancing reference to medical terminology, the title implied that work intensity was not equal for all pharmacy assistants. Notwithstanding a wide range of similar factors (gender, job characteristics, size of enterprise), there are equally significant differentials between pharmacy assistant cohorts. The report divides the pharmacy assistant population into three broadly equal groups. The first are satisfied with their work situation and judge work intensity as acceptable. The second are generally satisfied but identify many problems in their work situation. The third group of pharmacy assistants are generally dissatisfied - they see their work load as too heavy, recognition of their job as minimal, and are considering working shorter hours (possibly part-time), or leaving the profession altogether.

The research - quantitative and qualitative - comprised a sample survey of 2500 pharmacy assistants plus observation of work activity and work organization in three different pharmacies selected by region and size criteria.

The pharmacy assistant’s job is to deliver medicines to customers; she is involved throughout the process from receipt of the prescription to physical delivery of the medicine to the customer. This process can take two forms. One is presentation of a new prescription. The prescription particulars are keyed into the computer, and the assistant checks the customer file to see whether other information is required. The computer program checks whether the newly-prescribed medicine
is compatible with other medicines taken by the patient, and gives an indication or opinion. Once this process is completed, the assistant prints out a label and fetches the medicine. She checks whether it is the correct drug, and whether the manufacturer’s and prescription dosage indications match. It is then second-checked by another assistant. If it is an extemporaneous preparation, the customer will be given a time at which to collect it. If the medicine is not held in stock, it will be ordered, and again a time will be set for collection. The medicine is then supplied to the customer. Pharmacy assistants answer customers’ queries and information requests. The process for repeat prescriptions is shorter. They are requested by telephone (often by the doctor’s assistant), usually towards midday. One pharmacy assistant will often enter all the prescriptions into the computer and print out the labels, while another takes the medicines and performs a first check. Another pharmacy assistant (or the first who keyed the prescriptions in) performs the second check and stores the medicines alphabetically by customer name in a cupboard. This enables customers to retrieve their medicines fairly quickly.

Apart from this core work activity, pharmacy assistants have a series of other daily tasks. Firstly, administrative follow-up. In small pharmacies, assistants perform their own administration. Secondly, ordering medicines, for which there are different methods from computerized stock control and telephone ordering to fully computerized systems combining computerized daily stock control with orders sent to wholesalers by modem. Thirdly, laboratory housekeeping - a task done in larger pharmacies by the (second or third) pharmacist, but in some smaller pharmacies by the assistant. Fourthly, making up extemporaneous preparations and ingredient preparation. Each pharmacy will always have at least one pharmacy assistant doing this in turn. These previously time-consuming activities are now less so, as most medicines are manufactured. Fifthly, delivering medicines to customers.

Work allocation in pharmacies is size-related. It is not cost-efficient for small pharmacies to employ separate staff for administration, medicine ordering, etc., so small pharmacy assistants multitask more than large pharmacy assistants. Geographical location also influences pharmacy work intensity. Randstad Holland has an acute shortage of pharmacy assistants. Vacancies remain unfilled, so the work must be redistributed between too few staff, making it difficult to take leave. Obviously, replacement in case of sickness absences is also a big problem.

A large number of difficult (stressful) situations in pharmacy assistants’ work were observed. The mental workload is most striking. Supplying the wrong medicines can have fatal consequences. While this mental workload is admittedly inherent to the work, different aspects make it more onerous. Medicine and prescription control systems differ
between pharmacies. Medicine controls are essential, but involvement of multiple assistants in the process may add to the mental workload. The number and position of computer terminals in pharmacies also adds to the workload - uninterrupted information retrieval is difficult where terminals are located at customer reception points.

Some difficult situations in assistants’ work activity result from physical circumstances that disturb concentration. One physical problem in pharmacies is the lack of sitting opportunities, and this affects virtually all pharmacy assistants. Even the ergonomic adaptations that have been made in some pharmacies often fall short: seats are rarely height-adjustable. One pharmacy had no laboratory scales, so the substances that should be prepared in the laboratory fume cupboard were habitually weighed in the pharmacy.

Noise pollution is another issue. Loud printer noise can interfere with communication between pharmacy assistants and telephone answering. One case study pharmacy was so designed that pharmacy assistants were literally unable to understand one another when speaking in the public area.

One major finding of the research is the existence of wider inter-pharmacy differentials related to task distribution, communication and management styles. In one pharmacy, the workers themselves set the time and method of work execution. In another, the working time arrangements (working hours, leave, etc.) and work organization are collectively-decided. In other pharmacies, by contrast, the pharmacist barely delegates any work, but manages the entire work process personally. This makes him indispensable, which can create problems if he is absent or unreachable.

The incidence of consultation also varies between pharmacies. 42% of pharmacy assistants report no regular workplace consultations. In one case study pharmacy, the assistants felt that no open communication was possible. Their remarks had no influence over how the pharmacy business was run. The pharmacist communicated with the assistants in writing.

Another finding was that only part of the pharmacy staffing shortage was due to the length of recruitment procedures. In other cases, it was due to mistimed planning and under-replacement of staff on maternity or sick leave.

In short, various issues with the regulation of pharmacy assistant work arise:

• situational issues that interfere with concentration on work;
• the lack of scope for attenuating the physical strain of the work
The gender workplace health gap in Europe (protracted standing, ergonomic adaptations almost nonexistent);
• lack of control over their own work allocation and dependency on the pharmacist in contingent work situations.

The heavy work load impacts both the quality of pharmacy customer service delivery, and the fatigue and health of pharmacy assistants. Whence the sharp fall in the supply of pharmacy assistants...

The report concludes with pharmacy assistants’ own proposed solutions for reducing their work load. The first solution is to reduce their working hours: a quarter of pharmacy assistants wish to work shorter hours, partially for work-related reasons. They also feel that the work load is better supported by a (small) team of part-time staff. Their second solution is to leave the job - actively considered by 10% of the pharmacy assistants. Coupled to this is the dissatisfaction of pharmacy assistants with their primary working conditions.

Neither solution is a desirable outcome for the sector, since the result would be to further increase recruitment problems.

The researchers argue the case for a strategy focused on increasing the professionalization of pharmacy management - “a management that is able to communicate, delegate, and take account of pharmacy assistants”. The report concludes with more detailed recommendations in different areas: greater attention to pharmacy working conditions, expanding pharmacy assistants’ control over their work, better pharmacy staffing, improving communication within the pharmacy, training and support for pharmacists, promoting exchanges of experience between pharmacy assistants.

While no real negotiations took place between sector trade unions and the KNMP on the research report findings, a range of other steps were taken. In 1994, the researchers and research support committee published a general information brochure for pharmacists and pharmacy assistants containing a list of recommendations on how to deal with work intensification. It was sent out to all pharmacies in Holland. At the same time, the research findings were reported in various trade magazines, like Receptarius, where the researchers described the situation as “serious but not hopeless”.

Along with the presentation of the research results at the pharmacy trade fair (Farmavisie), FNV Dienstenbond launched another initiative - “Pharmacy assistants talk to other pharmacy assistants” - through its Education and Vocational Training department. Six pharmacy assistants were given training as telephone work load solutions advisors for their colleagues.
All these initiatives took place against a specific background, however. On 1 January 1994, the government scrapped refunds for all non-prescription drugs. This caused a sharp drop in turnover for pharmacies - in some case by up to 20 to 30%. Pharmacists reacted swiftly, with a near-immediate hiring and recruitment freeze. This produced an almost overnight labour surplus as the success of recruitment campaigns under the banner “be sure of a job, be a pharmacy assistant” had increased enrolment in some schools by 50%. A returners project set up in autumn 1993 in Amsterdam descended into farce: of 40 participants, only one found employment in the sector at the end of the project.

The “Pharmacy assistants talk to other pharmacy assistants” scheme was evaluated in autumn 1994. The brochure had had a significant initial impact, but the number of calls had rapidly fallen off. An explanation for the low response rate was sought in the fact that workload had ceased to be an issue after the drop in turnover. In early 1995, the SBA had a brochure impact assessment done by outside consultants. Spontaneous recall of the brochure contents proved to be near-nil. When the survey taker described the brochure, 20% of pharmacy assistants said they knew of it; 80% claimed never to have received it from the pharmacist. Of assistants with assisted recall of the brochure, only a quarter could recall specific recommendations. In the same group, 10% of workers reported effective measures having been taken in the pharmacy following publication of the brochure. This concerned only 2% of all pharmacies in the sample. The research evaluation concluded that the brochure had had little impact.

The project is still ongoing for the sector, however. The sector fund is staging functional communication training for pharmacists. FNV Dienstenbond will be setting up training on consultation procedures in pharmacies. The SBA regularly sends out the brochure to pharmacies on request. The sector has also contracted with a public relations firm in a bid to improve communication between pharmacies and the SBA.

These sectoral actions on functional communication and consultation are not to be seen as exclusively the outcome of the workload research. Afterwards, training fund officials stressed that the key recommendation of the research - efforts to professionalize pharmacy management - has become a solid guideline for many activities in the sector.

A decisive factor in the negotiation process is obviously the measure of 1 January 1994 which effected a radical change in the perspective of everyone concerned in the sector. Some years on, researchers at Erasmus University (Van Rooij et al., 1995; De Wolf et al., 1997) brought this change in labour supply into evidence through a calculation of the number of prescriptions per assistant per hour (see figure 6.8). The number of prescriptions had risen since 1989, peaking in 1992.
followed by a significant drop in 1994. In 1995, the labour supply again increased.

In light of this change, it is unsurprising that the social partners should have focused heavily on the workload issue. It is equally unsurprising that the pharmacy business should be so unresponsive on the workload issue at this time, although the SBA observed a renewed focus after the campaign centred on the brochure. Ultimately, the main value of the research was to have set a discussion in motion on task allocation and improved communication. Workload reduction was not the only aim. Other reasons for transforming work include the threat of monopoly in the pharmacy business, the need for better customer information, and changes in the sickness insurance legislation. It is the combination of these factors that opened a window of opportunity in the sector to discuss professionalization of management and worker consultation.
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