

Gender, sex, health and work

A series from the Health at Work Policy Unit

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In this series of papers we will explore health and work through a gendered lens, focusing in on some key examples of where gender and sex have a significant impact on work and health outcomes, before highlighting some policy levers which we could use to ameliorate any negative effects.

Introduction – why gender and sex are important in health and work policy

A person's gender or sex will play a role in defining their identity and influence their understanding and experience of the world. The nature of one's gender and sex has widespread implications, in physiological, socio-economic and cultural terms, and, as we explore below, in terms of both health and work.

In this introductory paper we **make the case for why gender and sex are workforce health issues which demand specific attention**; providing an overview of the different health conditions, risks and experiences of men and women of working age, and their implications at work. This is placed in the context that, even in the UK in 2017, whether someone is a man or a woman is a considerable predictor of the likelihood that they will be in work, the type and nature of their work, and even their pay.

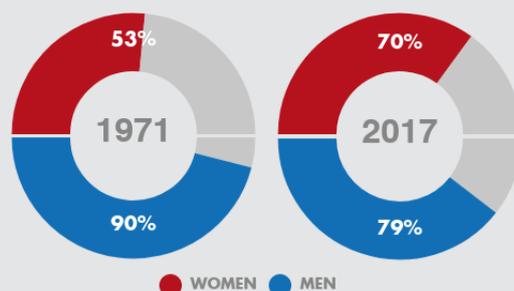
We recognise that for some people, their personal identity does not correspond with their birth sex. This can undoubtedly also have an effect on health and employment. However, for this series of papers, we will not be focusing on the transgender experience specifically, but looking at male and female experiences from both the biological – sex – and role and identity – gender – perspectives.

The changing participation of men and women

The relationship between men and women and paid work has changed considerably over the last 40 years. Today, women represent 46% of the UK labour force. Female representation has steadily increased over the past 5 decades, with employment rates rising from 53% in 1971 to 69.9% in 2017, while conversely male employment rates have fallen, from 92% in 1971 to 79% in 2017¹. Though the gap has shrunk, differences remain, with women much more likely to be in part-time work or unpaid work than men; of the total number of employed women, 41% work part time, compared with 12% of employed men.²

One influencing factor on this change is the increase in working mothers, with rates of employment increasing for both married/cohabiting mothers and lone mothers, rising from 67% and 43% respectively in 1996, to 72% and 60% in 2013³. Parenthood is also relevant for fathers;

THE LABOUR FORCE PARTICIPATION RATE FOR WOMEN HAS RISEN WHILE IT HAS FALLEN FOR MEN



across all age groups, fathers are more likely to be employed than men without children⁴. For men and women who do not have dependent children, the gap in employment rates is just 2% (72.8% and 70.8%).⁵

The gender pay and status gap

Despite the growth of female participation in the workforce, **discrepancies between men and women continue to exist in terms of pay rewards and representation. The gender pay gap in the UK was 18.1% in 2016** (9.4% for full-time employees). This is a global issue; the majority of the top 10% (and indeed the top 1%⁶) of earners globally are male⁷. This is reflected in the status of jobs men and women are in; women represent just a sixth of senior executives at the largest listed British companies⁸, make up just 16% of executive committee members across FTSE 350 companies, and hold only 6% of senior financial roles. Across key sectors, women are far from represented equally; only 1.3% of top army posts, 13.2% of senior judges, 14.2% of university vice-chancellors and 34.7% of senior civil service staff are female.⁹



The gender pay gap becomes much wider from age of 40, most likely to do women taking time out of the labour market to have children¹⁰.

Studies into women's careers indicate that the period after having children is associated with significant financial losses, restrictions and discrimination¹¹, and certainly goes some way to explain the inequalities described above. However, other factors affecting all women, not just mothers – such as the undervaluing of women's jobs and the segregation of labour - all have an influence¹². Gender is clearly a socio-economic determinant, playing a role in how successful one can expect to be.

Gendered education and gendered jobs

The gender pay gap is present regardless of education levels¹³. In the population as a whole, 43% of women in the UK have completed tertiary education compared to 41% of men¹⁴. This gap is at the widest it has ever been; the trend is likely to continue as women are currently 35% more likely to attend university than men.¹⁵

Similarly, more women undertake apprenticeships than men¹⁶. However, they receive lower pay; £4.82 on average compared to £5.85 for their male peers¹⁷. This in part reflects the subject and sector of apprenticeships undertaken, with men significantly more likely to be working in the higher-paid engineering sector and women concentrated in a smaller number of sectors, most of which are low-paid, such as childcare.¹⁸

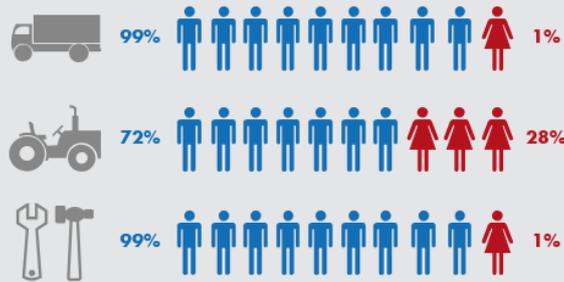
The sectoral gender divide in education continues into the professions that men and women enter into¹⁹. For example, women remain underrepresented in STEM (science, technology, engineering and mathematics) subjects and occupations; in 2012, only 23% of engineering graduates were women²⁰, while men are underrepresented in teaching courses; just one in every five teachers in the UK is male²¹. The data indicates that the sexes are, in many cases, segregated by educational choices and this trend persists into the workplace. Evidence also suggests that this phenomenon feeds into a 'positive feedback loop' meaning that women and men are likely to continue pursuing careers in sectors considered "feminine" or "masculine", according to gender²², influenced by the continued choices of their peers.

The sector and type of job one is in can have specific implications for health – including in terms of psychological and emotional stress, as well as the risk of physical strain or accidents. The evidence on job quality and health – with **low quality jobs associated with a**

range of health conditions, including coronary heart disease, stroke and mental illness²³ – is relevant to the different types of jobs that men and women might be in. For instance, men dominate the most physically dangerous jobs in the UK. Lorry drivers, farmers and workers within the building and construction trades, who make up the vast majority of in-work deaths²⁴ and serious injuries²⁵, are much more likely to be male^{26 27 28}. Activities and traits of certain jobs may be viewed as more “male” or more “female”. Working long hours is, for example, is typically seen as a masculine attribute²⁹; but it is also a risk factor for stress, as well as serious health issues, such as stroke.³⁰

The sectoral composition of the UK labour market also has implications on gender roles and work. Manufacturing, a traditionally male-dominated sector, employed 40% of the workforce in 1952³¹, but by 1997 that figure was 17%, and today it is around 9%. The implications for male workers is clear – while in 1997, almost a quarter of all working men were employed in manufacturing, in 2017 this figure had declined to 13%³². Such changes also have a geographic impact; this reduction in manufacturing has led to job losses, particularly in the North, Midlands and parts of suburban London³³, driving increases in male unemployment. Another element is the loss of identity that came with the decline of manufacturing communities³⁴, with reports of widespread dissatisfaction and lack of decent replacement jobs delivering a comparable sense of pride³⁵. The collapse of male-dominated industries has played a role in the “crisis of masculinity,” seen as a cause of depression and in increasing suicide rates amongst working age men.³⁶

LORRY DRIVERS, FARMERS, AND WORKERS IN BUILDING & CONSTRUCTION, WHO MAKE UP THE MAJORITY OF IN-WORK DEATHS AND INJURIES, ARE PRIMARILY MEN:



COMPARED TO MEN, WOMEN ARE

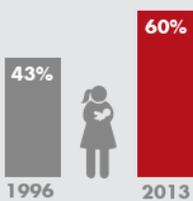
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MORE LIKELY TO HAVE GIVEN UP WORK BECAUSE OF MULTIPLE CARING RESPONSIBILITIES

Additional roles: caring responsibilities

As stated above, many job roles are highly gendered, and this principle extends to unpaid roles. An estimated 58% of unpaid carers are female; with the share of this care provision falling heaviest on women aged 50-64. **Women are also more likely to have given up work to fulfil caring responsibilities, with one in seven taking a less qualified job or turning down promotions.**

RATES OF LONE WORKING MOTHERS HAVE INCREASED:



Caring often means less sleep, or time to relax, and increased levels of stress, and accordingly, the general health of unpaid carers deteriorates incrementally with increasing levels of unpaid care provided; women working full time and providing 50 hours or more of unpaid care per week are 2 to 3 times more likely to report their general health as ‘Not Good’ compared with those providing no unpaid care. This health ‘penalty’ of providing 50 hours of more unpaid care per week has the greatest impact on the general health of young carers (aged under 24).³⁷

The burden of caring on women (and the time spent outside of the labour market) also has implications for pensions. Women who have children lose out on pension contributions from having to take time out of the labour market, and women in general are more likely to have caring responsibilities which can limit the ability to work and pay in. Indeed, of the 4.6 million workers earning less than £10,000 – the point at which auto-enrolment into workplace pensions is triggered – approximately three quarters are women³⁸. Labour market norms do not account for many extra factors commonly faced by women, and as such, they face financial penalties.

Unemployment, inactivity and health

There are strong links between employment status and health outcomes, but this again is a relationship influenced by gender. **Men and women experience unemployment differently**, and there are also notable differences in health, which can limit the ability to work.

Never-worked households make up a small percentage of total UK households, but the problems that arise from long-term unemployment are vast: physical and mental health is affected, as well as the ability to attain a good standard of living. 47% of the heads of households of never-worked families are disabled. Almost half of never-worked households (44%) are lone parents, and it is therefore unsurprising that the majority (65%) of heads of these households are female. Among this cohort, relatively high proportions are economically inactive, due to caring responsibilities and/or disability.³⁹

Unemployment is likely to be bad for one's health, regardless of gender⁴⁰. However, there is evidence to suggest that **men are overall more likely to suffer from adverse health when unemployed than women**⁴¹. Mental health risks are a concern, with evidence indicating that unemployment and redundancy present considerable risks for men; particularly for those who were previously employed in temporary or unstable positions and have a lower socio-economic status⁴². Unemployment is also associated with a higher risk of suicide.⁴³



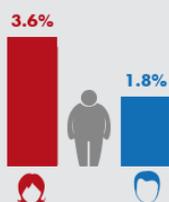
There is a clear relationship between health and employment. People who have long-term health conditions are also less likely to be employed, with employment rates decreasing as the number of conditions increases. The cumulative effect of managing multiple health conditions means that whilst 63.3% of people with one or more long-term conditions are in work⁴⁴, only 34% of those with three or more conditions are⁴⁵. Research has indicated women have an increased likelihood of the co-occurrence of physical, mental, or physical and mental long-term conditions, with women more likely to have two or more long-term conditions⁴⁶. However, there are also significant differences between economically inactive male and females (of working age, non-retired): a third of economically inactive men had two or more long-term health conditions, compared with 1 in 5 of economically inactive women.⁴⁷

It is also worth noting that for those with disabilities in employment, **there is also a 'disability pay gap'**, with disabled women receiving 22% lower pay compared to their non-disabled peers.⁴⁸

Different health conditions and health risks

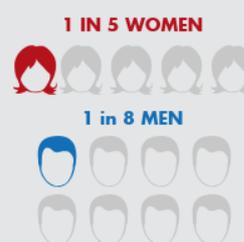
Whether you are a man or a woman places you at higher risk of different health conditions. Obviously, there are some conditions which are only relevant to one gender due to their biology – for example, those conditions which affect sexual or reproductive organs, including different cancers. The added complexity of producing children means that there are more potential threats to the health of women from their reproductive system as compared to men. From having periods, which may be irregular or especially painful for some women, to pregnancy, fertility issues and miscarriage, to the time when menstruation stops (the menopause), there are multiple life phases that women experience that can all pose health challenges; most of which are also associated with depressive symptoms.⁴⁹

Other conditions have a higher prevalence within one gender for more complex reasons, for example, women are more likely than men to have multiple sclerosis and osteoarthritis. Women are also more likely to be severely obese; the prevalence of having a BMI of over 40

SEVERE OBESITY IS HIGHER AMONG WOMEN THAN MEN

has shifted from 1.4% in 1993 to 3.6% in 2014⁵⁰, while for men, the increase has been from 0.2% to 1.8%. This is a major public health concern, given the consequences of severe obesity include a very high risk of developing Type 2 diabetes, cardiovascular diseases, musculoskeletal disorders and some cancers.

There are also gender variations in terms of mental illness – while one adult in six has a common mental health disorder, for women this figure is approximately one in five compared to one in eight for men. Since 2000, overall rates of common mental disorders in England steadily increased in women and remained largely stable in men, and women were more likely than men to have severe symptoms. This is more pronounced in younger women (16-24), with symptoms about three times more common in women of that age than men. Conversely, men are more likely to commit and complete suicide – 75% of completed suicides being undertaken by males⁵¹. **Suicide is the greatest killer of men under 45 in the UK**⁵². Men are also more likely to have an antisocial personality disorder, and are twice as likely to have drug or alcohol dependence as women⁵³. Interestingly, it appears that preconceptions about gender may feed into diagnosis rates, with doctors more likely to diagnose depression in women than men, even when presented with the same data.⁵⁴

COMMON MENTAL DISORDERS AFFECT:

Across the world, **life expectancy is significantly lower for men than it is for women**. Men are also more likely to die of common causes; for example, American men are 2.1 times more likely to die from liver disease, 1.5 times more likely to die from heart disease, and are twice as likely to suffer from emphysema than women. It is evident that gender is a health determinant.⁵⁵

Biology vs. culture: men die quicker, but women are sicker

Whilst the average life expectancy is higher for women in almost every country, **women experience higher morbidity**⁵⁶. In the UK, women are more likely to be disabled than men – in 2012/13 there were 6.4 million disabled women (21%) and 5.5 million disabled men (18%)⁵⁷. There appears to be relevance in the aphorism that *“men die quicker, but women are sicker”*⁵⁸. Biomedical models would suggest these statistics reflect biological norms, but the reality is that health inequalities are also caused and prolonged by gender’s role as a social determinant on one’s life experiences, habits and outcomes⁵⁹. Perceptions of health are also gendered; a UK study found that women were more likely than men to say they had poor health, but those that did were less likely to die in the following five year time period.⁶⁰

Higher rates of reporting of ill-health in women have led to concerns that men were not reporting health problems in a timely manner. A significant body of research supports the hypothesis that men are less likely than women to seek help from health professionals or access health services⁶¹. Whilst significant gaps exist in the research evidence on men’s health-related help-seeking behaviour, it is acknowledged that the socialisation of men and the contemporary male role in society may be influencing uptake rates of health care. For example, evidence suggests **that men – particularly of working age – are significantly less likely to access primary care**, with this difference being particularly pronounced in more deprived areas with higher rates of health problems⁶². In many cases, low consultation rates may result in late diagnoses, increasing the risk of mortality.⁶³

Conclusion

One's gender and sex evidently factors in experience and pathology of a health condition. Men and women are affected by conditions that are only applicable to one sex, but also experience common conditions in different ways. These conditions undoubtedly have an impact on labour market participation, and progress. Indeed, many of the issues raised in this paper primarily affect women – and may indeed be **part of the puzzle behind why women remain behind men in the labour market**, in terms of pay and promotion.

Regardless, problems that affect women or men in work clearly impact upon the population as a whole. A strong economy requires full participation of all its members. **What skills, insight and entrepreneurship are we missing through the disadvantages experienced due to gender?** Policymakers have a duty and an obligation to reduce any such disadvantage. Can policymakers address health inequalities and will that help reduce financial ones, too?

This paper provides the background – setting the scene – to a series of papers which seek to take a gendered lens to some of these health and work issues; outlining the issues and the challenges before asking what policies we might introduce to make life better for those experiencing gendered disadvantage, and how can policymakers help overcome health-related gender inequalities within the working population? We hope to provide some of the answers to these queries within these papers, but also to facilitate and encourage conversations surrounding these important topics.

About The Work Foundation

Through its rigorous research programmes targeting organisations, cities, regions and economies, now and for future trends; The Work Foundation is a leading provider of analysis, evaluation, policy advice and know-how in the UK and beyond.

The Work Foundation addresses the fundamental question of what Good Work means: this is a complex and evolving concept. Good Work for all by necessity encapsulates the importance of productivity and skills needs, the consequences of technological innovation, and of good working practices. The impact of local economic development, of potential disrupters to work from wider-economic governmental and societal pressures, as well as the business-needs of different types of organisations can all influence our understanding of what makes work good. Central to the concept of Good Work is how these and other factors impact on the well-being of the individual whether in employment or seeking to enter the workforce.

For further details, please visit www.theworkfoundation.com.

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