



European Foundation for the
Improvement of Living and
Working Conditions



Human health sector: Working conditions and job quality

'Work plays a significant role in people's lives, in the functioning of companies and in society at large. But what is work? How can we describe it? Is it changing, and if so, is it for better or for worse? Is it fulfilling the numerous and at times conflicting expectations we have of it? How can we take steps to improve work for the well-being of all?'

Eurofound, *Fifth European Working Conditions Survey: Overview report, 2012*



This report gives an overview of working conditions, job quality, workers' health and job sustainability in the human health sector (NACE 86).¹ It is based mostly on the fifth European Working Conditions Survey (EWCS), which gathers data on working conditions and the quality of work across 34 European countries. Additional information on the structural characteristics of the sector is derived from Eurostat data. The sector includes hospital activities, medical and dental practice activities and other human health activities. The fifth EWCS contains responses from 2,271 workers in this sector. The report compares aspects of work in the sector with the EU28 as a whole.

Structural characteristics

In 2010, some 13,133,200 European workers worked in the human health sector, which is 6.1% of the EU28 workforce. Employment in the sector increased (3.1%) between 2008 and 2010, and kept increasing (1.9%) between 2010 and 2012 (Eurostat, 2008–2012).

Countries where the human health sector is a relatively large employer are Ireland (8.2%), Finland (7.3%), Germany (7.2%) and the United Kingdom (7.2%). The sector has relatively little prominence in Cyprus (3.4%), Romania (3.5%), Bulgaria (3.8%) and Latvia (3.9%). A large proportion of workers in human health (31%) work in large workplaces (250+ employees), compared with 12% of workers in the EU28. Consequently, the percentages of workers in

human health in small and medium-sized workplaces (10–249 employees, 34%) and micro-workplaces (1–9 employees, 36%) is smaller than in the EU28 (46% and 42% respectively). The sector is female-dominated, with 75% of the workers in human health being women. It employs a relatively large proportion of older workers, with 31% of those in the sector aged over 50, compared to 27% in the EU28 (Eurostat, 2008–2012). Self-employment is not especially prevalent in human health, with 4% being self-employed with employees and 7% self-employed without employees, compared to 4% and 11% respectively in the EU28.

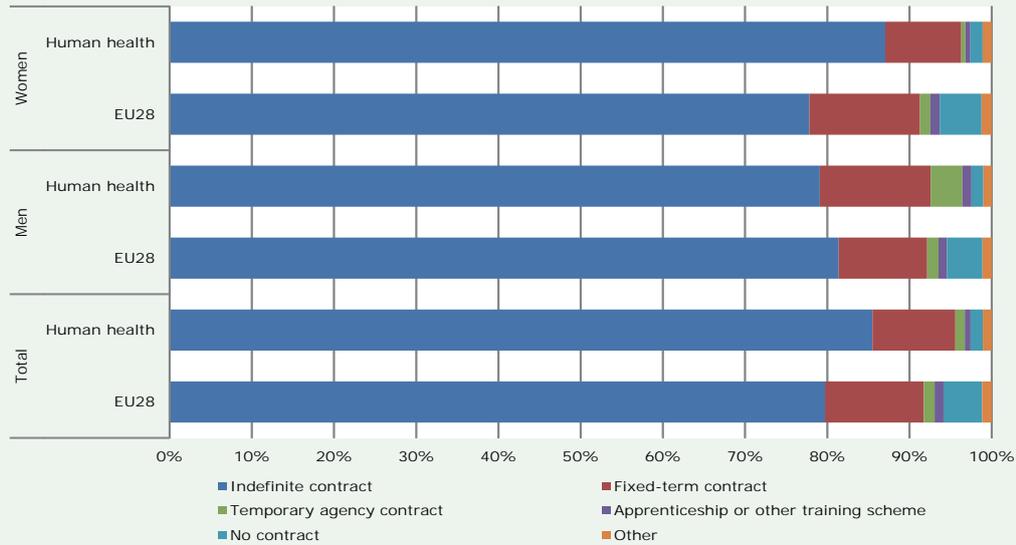
Indefinite contracts are more prevalent in human health than in the EU28 as a whole and, within the human health sector, are more prevalent among women than among men (Figure 1).

Human health in a nutshell

- The sector is female-dominated
- Salary increases are more common than the EU28 average
- Incidence of introduction of new technologies, reorganisation and restructuring is higher
- Working hours are often atypical and irregular, especially for men
- Workers are very well informed about health and safety risks at work
- Higher than average levels of employer-paid training
- Job strain is an issue, especially for women and young men in large establishments
- The perceived negative effect of work on health needs attention

¹ Nomenclature statistique des activités économiques dans la Communauté européenne (statistical classification of economic activities in the European Community).

Figure 1: Employment status by subsector



In the human health sector, part-time work is slightly less prevalent among women and more prevalent among men, with 36% of women and 13% of men in the sector working 34 hours or less, compared to 38% of women and 12% of men in the EU28.

workplace sizes; workers in small, medium-sized and large workplaces also report that the number of hours they worked increased more frequently than in the EU28.

Working conditions

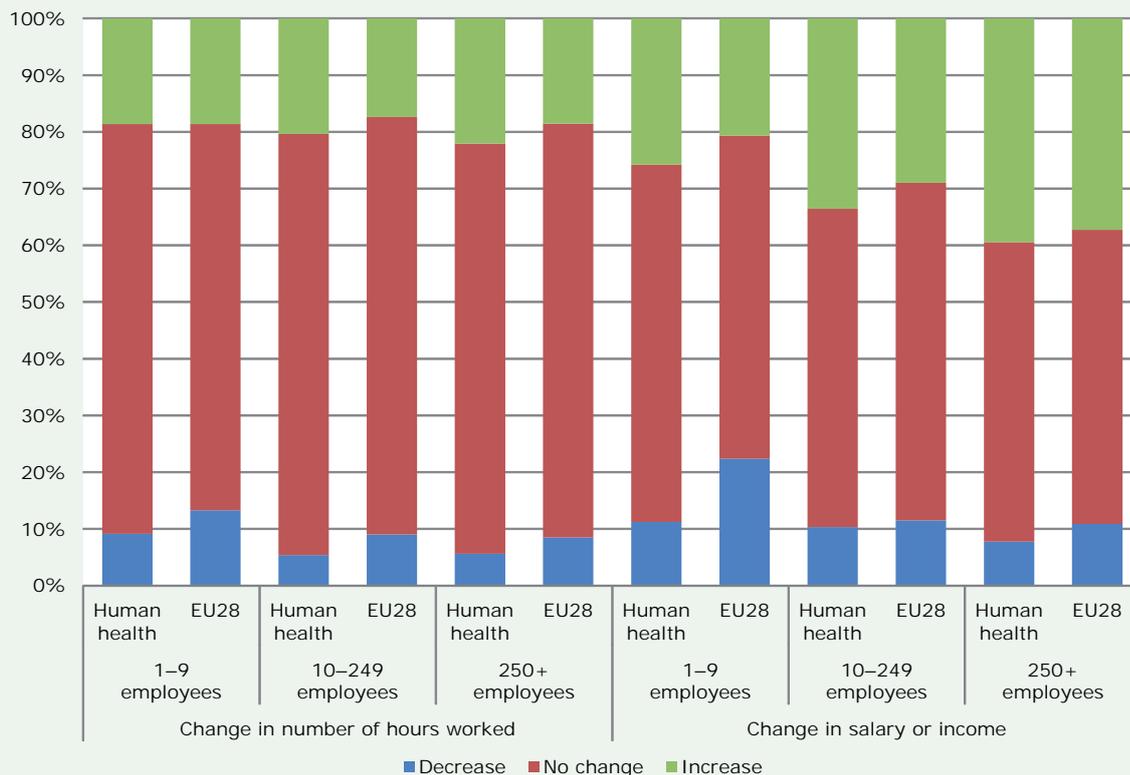
Changes since the crisis

Figure 2 shows that workers in the human health sector less frequently report that their hours decreased in the year before the survey than the average EU28 worker. This trend holds for all

Workers in the sector across all workplace sizes were less likely to see a decrease in their wages and more likely to see an increase than the average EU28 worker.

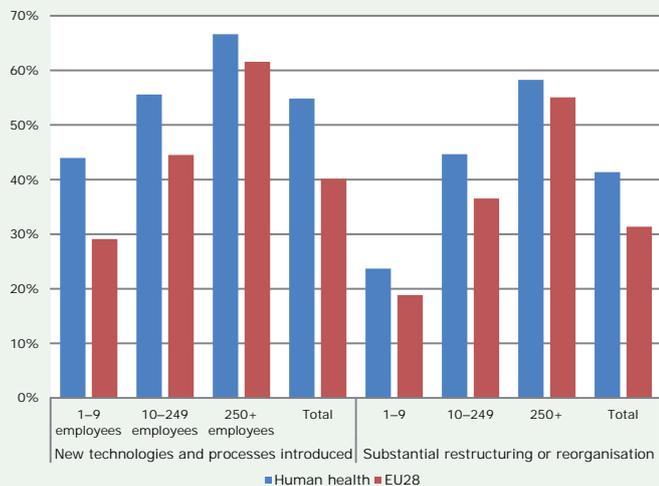
Workers in human health were more affected by restructuring and the introduction of new technologies than the EU28 average (Figure 3). The sector follows the same pattern as the EU28 – the share of

Figure 2: Percentage of employees reporting changes in number of hours worked and salary or income in past year, by workplace size



employees reporting restructuring or reorganisation, or the introduction of new production processes and technologies increases with workplace size – but the difference between the sector and the EU28 is greater in smaller workplaces.

Figure 3: Restructuring and introduction of new technologies in past three years, by workplace size

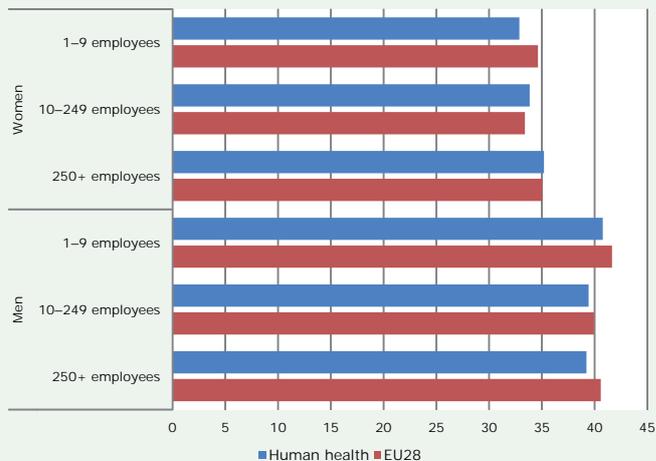


Working time and work–life balance

Workers in human health on average work 35 hours a week compared with 38 hours in the EU28. This difference, however, disappears when looking at the data for men and women separately. As in the EU28, men in the sector tend to work more hours than women, independent of workplace size (Figure 4). In

human health, as in the EU28, working time does not vary significantly across different-sized workplaces.

Figure 4: Average working hours, by gender and workplace size



When comparing the human health sector with the EU28 average, workers in the sector show a higher general preference for working fewer hours than currently compared with the average EU28 worker (Figure 5). This trend, however, depends very much on gender and workplace size, as a smaller proportion of female workers in the sector in small and medium-sized workplaces report a preference for working fewer hours than their counterparts in the EU28.

Figure 5: Working time preference, by gender and workplace size

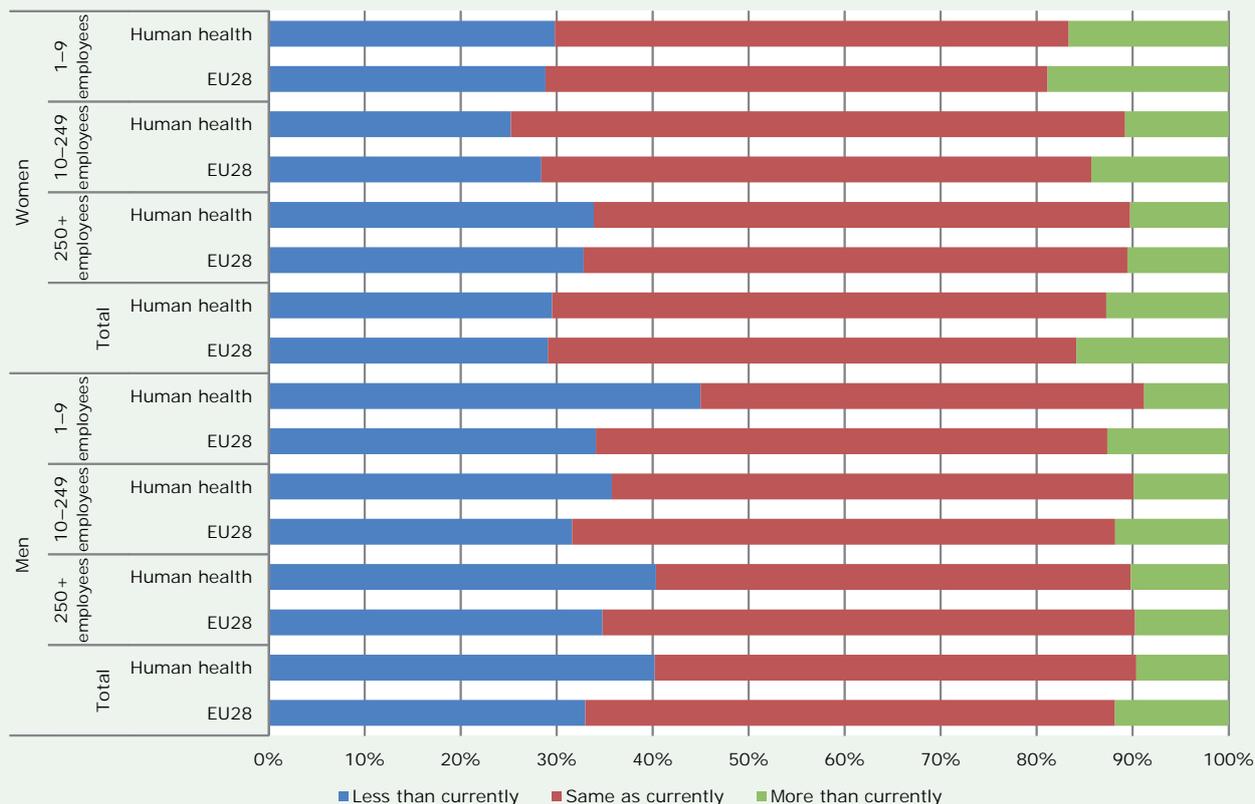
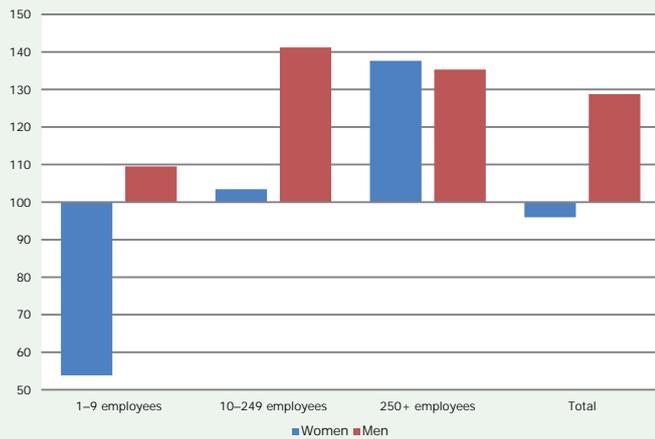


Figure 6 shows that working atypical hours (weekends, evenings and/or nights) in human health depends very much on gender and workplace size. Women in micro-workplaces report working atypical hours much less frequently than the EU28 average worker. For all other gender by workplace size categories, however, workers in the sector tend to work more atypical hours than the EU28 average worker. The difference is particularly large for men in small, medium-sized and large workplaces and women in large workplaces.

Figure 6: Index of working atypical hours (EU28=100), by gender and workplace size



When looking at the regularity of working time (working the same hours every day, the same days every week), strong differences by gender and workplace size appear again (Figure 7). Men in the human health sector tend to have less regular working times than the average EU28 worker – this difference is larger for men in micro-workplaces than for those in larger ones. Differences for women are small: women in micro-workplaces and in small and medium-sized workplaces tend to work more regular working times than the average EU28 worker, while female workers in the sector in large workplaces report having less regular working times than the average EU28 worker.

Figure 7: Index of regularity of working time (EU28=100) by gender and workplace size

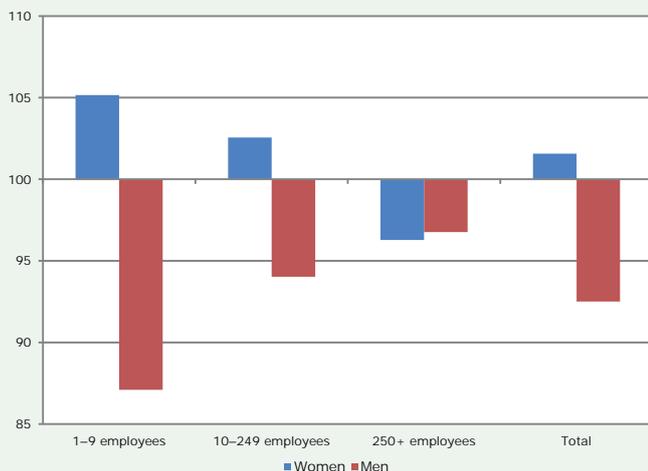
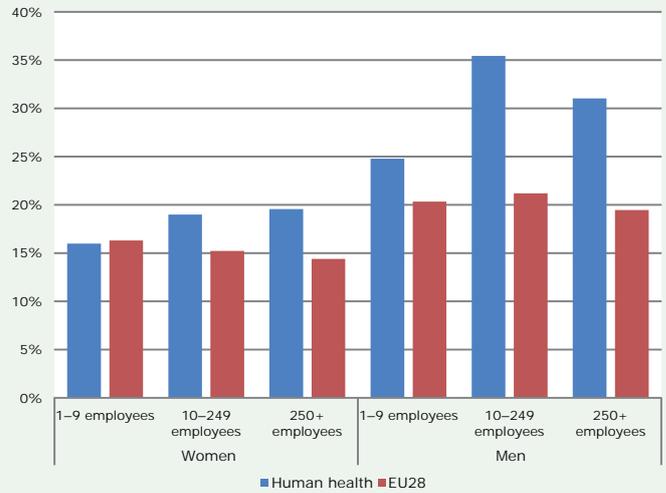


Figure 8 shows that work–life balance (the fit between working hours and family or social commitments) is worse for those working in the sector than in the EU28 as a whole.

Figure 8: Poor work–life balance, by gender and workplace size



In the human health sector, as in the EU28, more men report a poor work–life balance than women: the most striking difference can be seen in small, medium-sized and large workplaces where almost one-third of men reported a poor work–life balance, compared with only 19% of women.

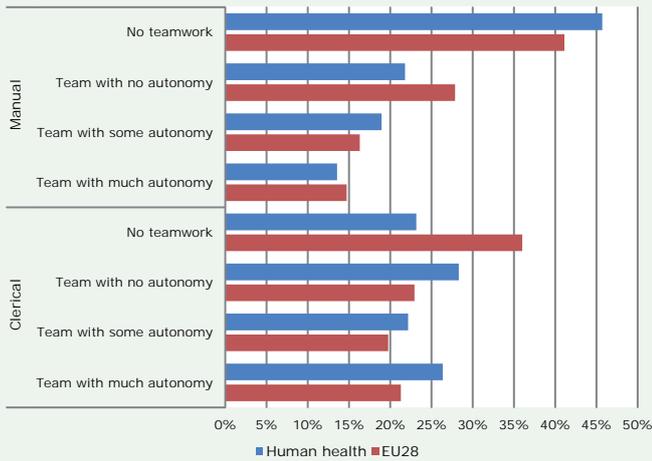
Work organisation

Teamwork

Teamwork has been proposed as an alternative to work organisation models based on high levels of labour division. As teamwork reflects a variety of practices, it can also assume a variety of forms. Different types of teamwork can be identified using the EWCS by looking at the level of autonomy within the teams.

For manual workers, teamwork is slightly less prevalent in human health (54%) than in the EU28 (59%; Figure 9). However, for clerical workers, teamwork is more common (77%) than in the EU28 (64%).

Figure 9: Teamwork and team autonomy, by occupational category



Task rotation

Task rotation is also an important feature of work organisation. Depending on how it is implemented, task rotation may require different skills from the worker ('multiskilling') or may not ('fixed task rotation') and is either controlled by management or by the workers themselves ('autonomous'). Task rotation has been shown to be beneficial for workers' well-being, and autonomous multiskilling systems in particular are associated with higher worker motivation as well as better company performance.

The percentage of workers in human health working in a task rotation system is larger than in the EU28 as

a whole (Figure 10). This is true for all workplace sizes, but especially for larger ones. Furthermore, more workers in the EU28 who have task rotation tend to work with management-controlled fixed task rotation systems, while management-controlled multiskilling and autonomous multiskilling are much more common in the human health sector.

Female bosses

In the human health sector, the percentages of women (57%) and men (46%) who report having a female boss are above those in the EU28 as a whole (47% and 12% respectively). The difference is especially large for men, as almost half in human health report having a female boss, while in the EU28 this proportion is close to one in eight. The only exception to this pattern seems to be women in micro-workplaces working in human health, only 33% of whom report having a female boss, while in the EU28 the percentage for similar workers is 45%. It must be noted that the sector is female dominated and that the percentage of female workers still exceeds the percentage of workers with a female boss.

Skills and training

Overall, the majority of workers in human health say that their present skills correspond well with their duties (Figure 11). However, in human health workers are slightly more likely to be under-skilled than in the EU28, and less likely to be over-skilled. The pattern is more or less the same across different age groups, but both in human health and in the EU28 younger

Figure 10: Prevalence of task rotation, by workplace size

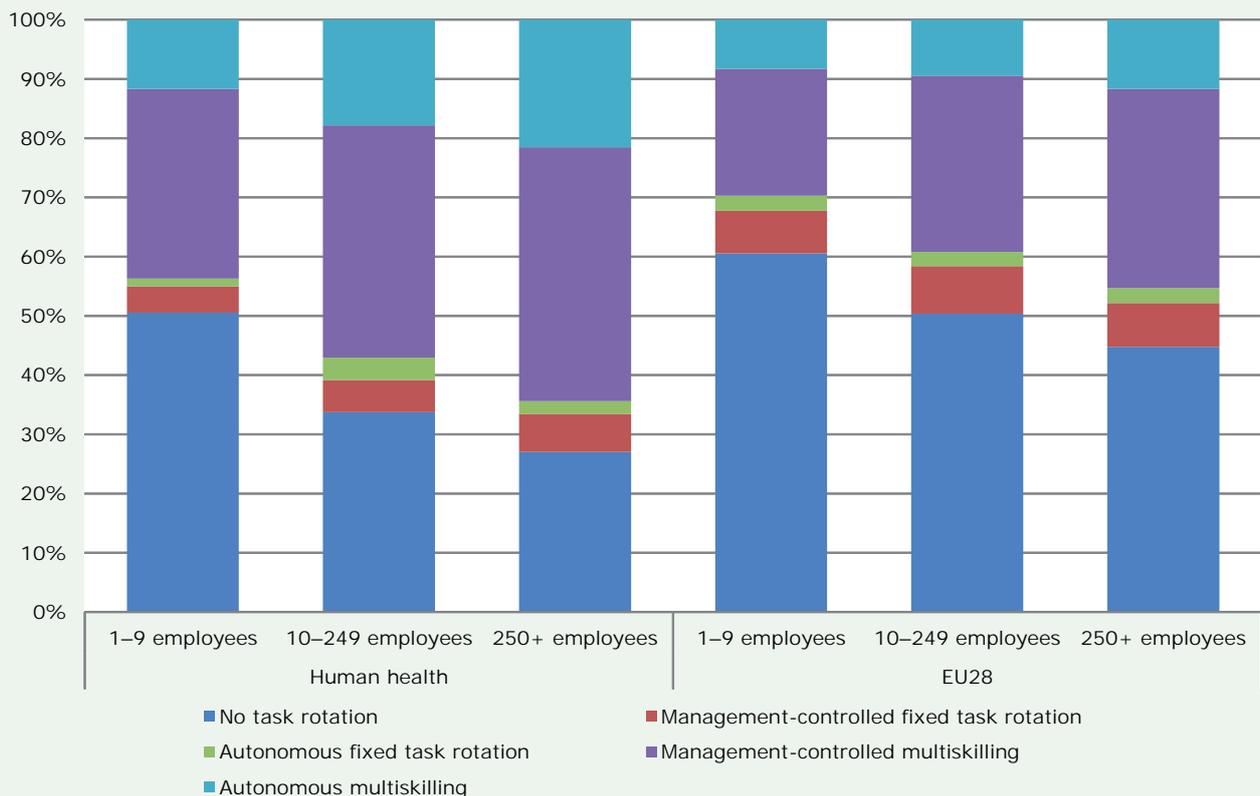
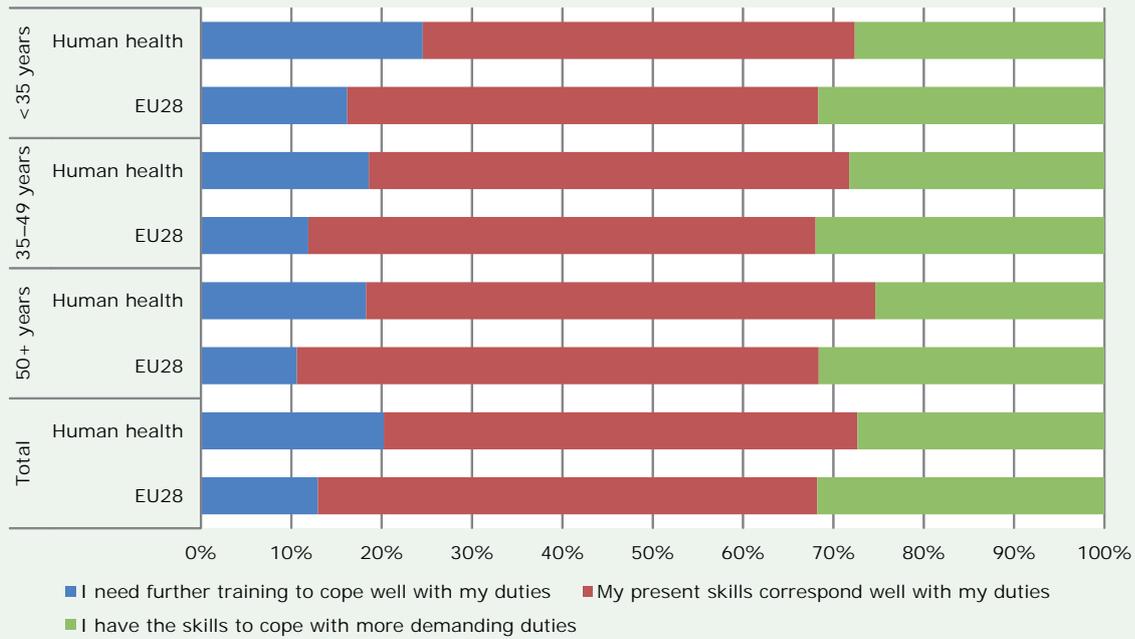


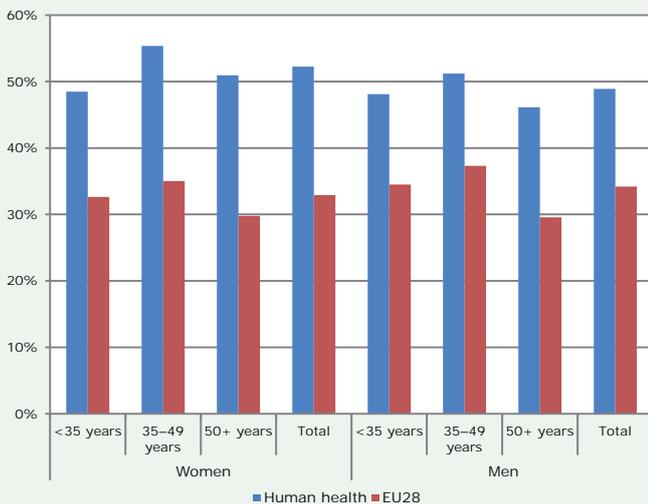
Figure 11: Match between skills and tasks, by age group



workers are slightly more likely to report being under-skilled.

The percentage of workers in human health who report having received training is much higher than in the EU28 for both women and men (Figure 12). The difference between the human health sector and the EU28 exists for workers of all ages.

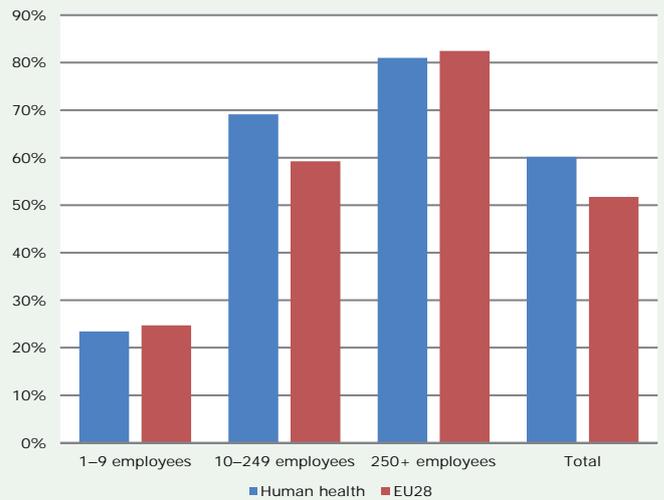
Figure 12: Employer paid training, by gender and age



Employee representation

The EWCS contains fairly limited information on formal employee representation. It asks whether an employee representative is present at the workplace and whether workers have raised an issue with an employee representative in the past year. Figure 13 shows the combined results of these questions (an employee representative has been considered to be 'available' if they are present at the workplace or when an issue was raised).

Figure 13: Availability of an employee representative at the workplace, by workplace size



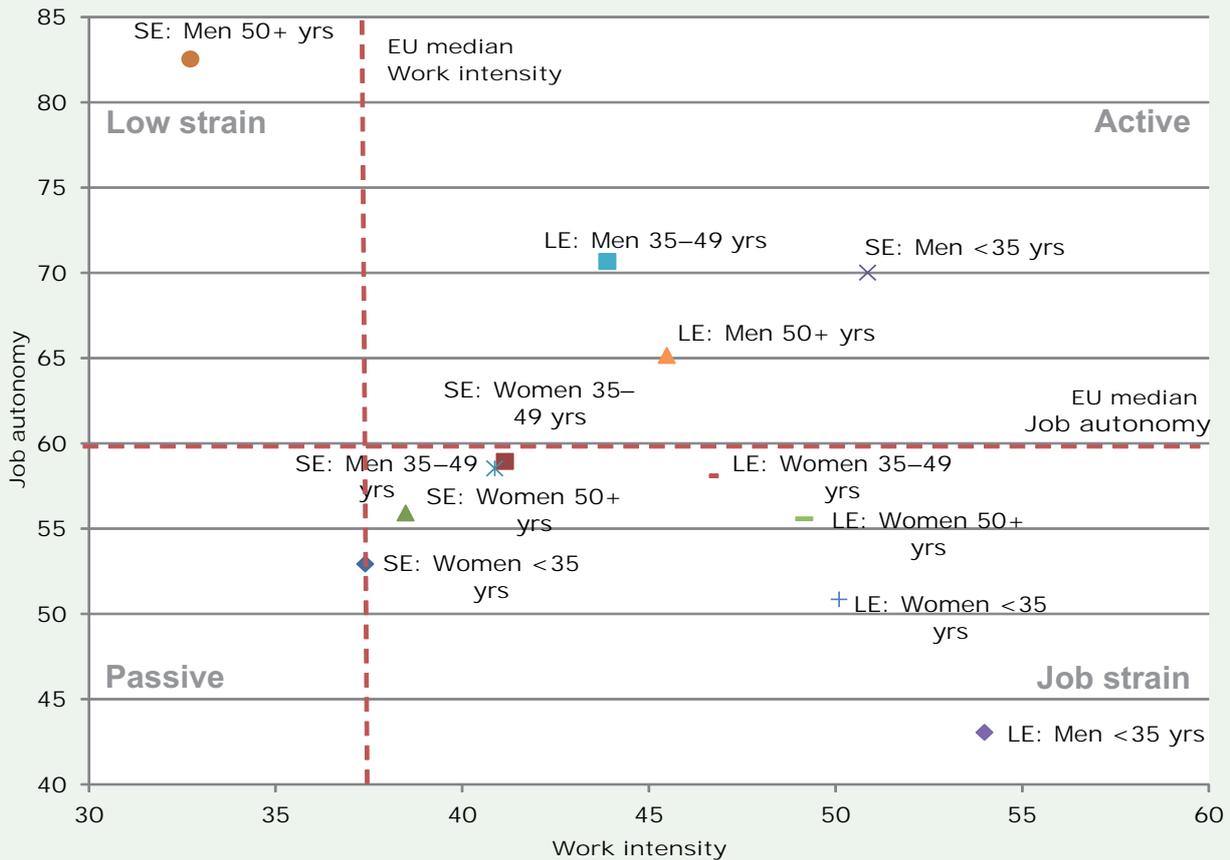
In 2010, 60% of employees in human health reported that an employee representative was available, compared to 52% of workers in the EU28. However, this difference is clearly related to workplace size. In micro and large workplaces in the sector, the percentage of workers who report having an employee representative available is slightly lower than the EU28 average for similar workplaces.

Psychosocial and physical environment

Job autonomy and work intensity

The psychosocial and physical environment impacts heavily on workers' well-being. According to the job demand and control model of the American sociologist Karasek (1979), workers are more likely to suffer from work-related stress when they are faced with high level of demand while being limited in the control they have over the way in which they carry out their job.

Figure 14: Distribution of groups of workers by average levels of job autonomy and work intensity



Note: LE = large enterprise; SE = micro, small or medium-sized enterprise

Figure 14 shows the likelihood of workers in the human health sector suffering from work-related stress. Groups of workers are plotted along two axes: job autonomy and work intensity.

In the human health sector there are no averages in the bottom left quadrant of Figure 14. These workers are likely to be in so-called ‘passive’ jobs, characterised by low levels of intensity and low levels of autonomy. The risk of stress is low in these jobs, but there are risks of frustration and low motivation because the jobs are not very challenging and workers have little control over what they do in their job and how they do it.

Men over 50 in micro, small or medium-sized enterprises (SEs) in human health are predominantly in ‘low strain’ jobs, characterised by low levels of work intensity and high levels of job autonomy. Again, these jobs pose a low risk of stress, but workers are less likely to suffer from frustration and loss of motivation than those in passive jobs.

The top right quadrant contains the averages for men in the sector above the age of 35 in large workplaces and under the age of 35 in SEs. These men tend to be in ‘active’ jobs with high levels of work intensity and high levels of job autonomy. Although their jobs can be very demanding, they have enough control over the way they do their job and can develop coping strategies through active learning.

Finally, the most problematic category is ‘job strain’ in the bottom right quadrant which contains the averages

for all age groups of women in SEs, for male workers aged 35–49 in SEs and for male workers under 35 in large workplaces. Their jobs are characterised by high levels of intensity and low levels of autonomy, posing the risk of unhealthy stress levels and consequently a range of stress-related illnesses such as cardiovascular disease and mental health problems.

Social environment

A good social environment is characterised by the existence of social support and the lack of abuse at work. Social support can help workers deal with high levels of work intensity. Workers in human health are close to the EU28 average on this indicator (Figure 15).

Figure 15: Index of good social environment (EU28 = 100), by gender and workplace size

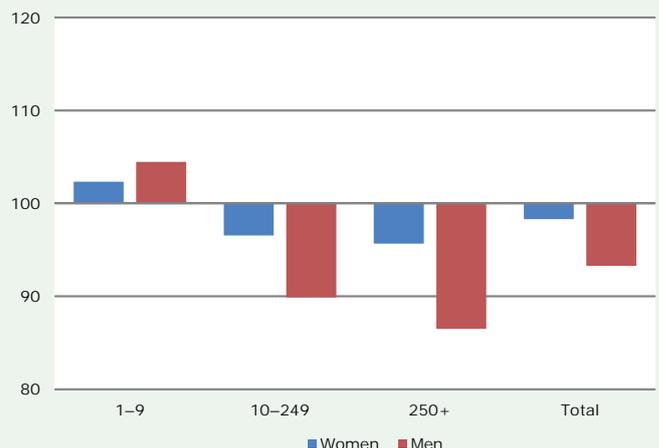
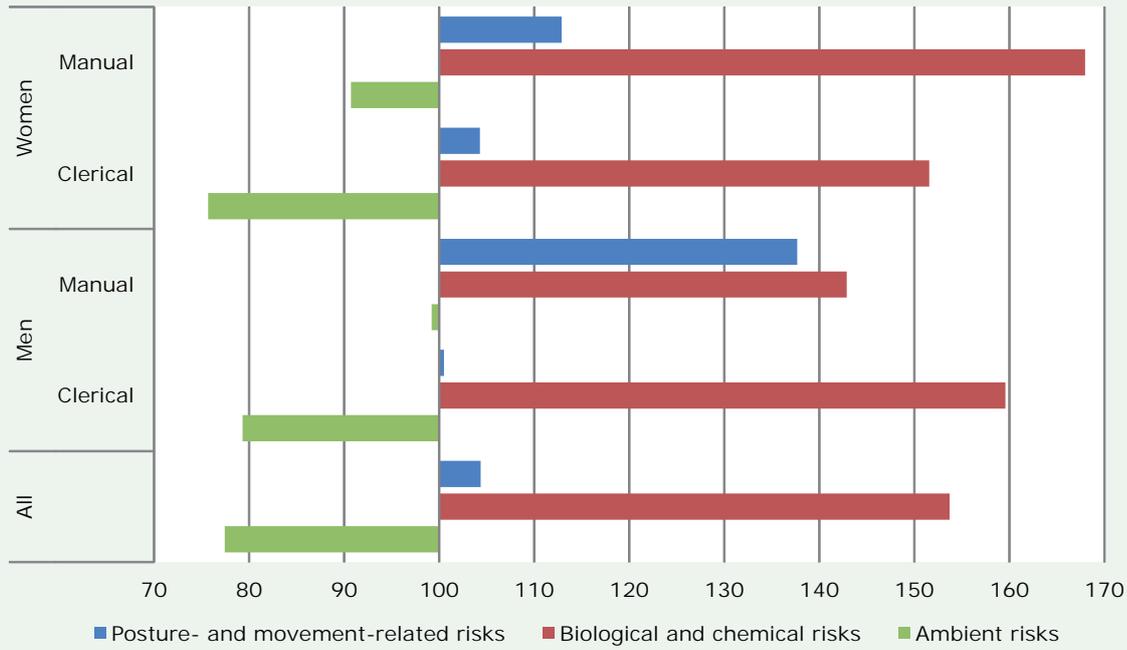


Figure 16: Indices of exposure to physical risks (EU28 = 100), by gender and occupation



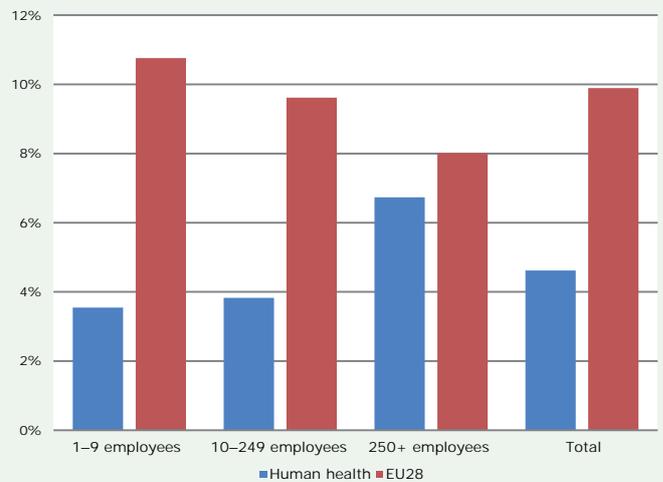
Men in the sector tend to report worse social environment scores than women, with the exception of men in micro-workplaces. There is also a general trend for workers in larger workplaces to report a worse social environment than those in smaller workplaces.

Physical risks

Exposure to biological and chemical risks is the most prevalent of the physical risks in the sector, followed by posture and movement-related risks (Figure 16). Ambient risks, on the other hand, are less common in the sector than in the EU28. Biological and chemical risks are much above the EU28 average for all categories of workers. Posture and movement-related risks are especially prevalent among male manual workers in the sector.

The percentage of workers in human health who report they were not very well or not at all well informed about workplace risks is much lower than in the EU28 as a whole (Figure 17). However, contrary to the trend in the EU28, the percentage of workers who are not sufficiently informed increases with workplace size.

Figure 17: Not very well or not at all well informed about health and safety risks at work, by workplace size

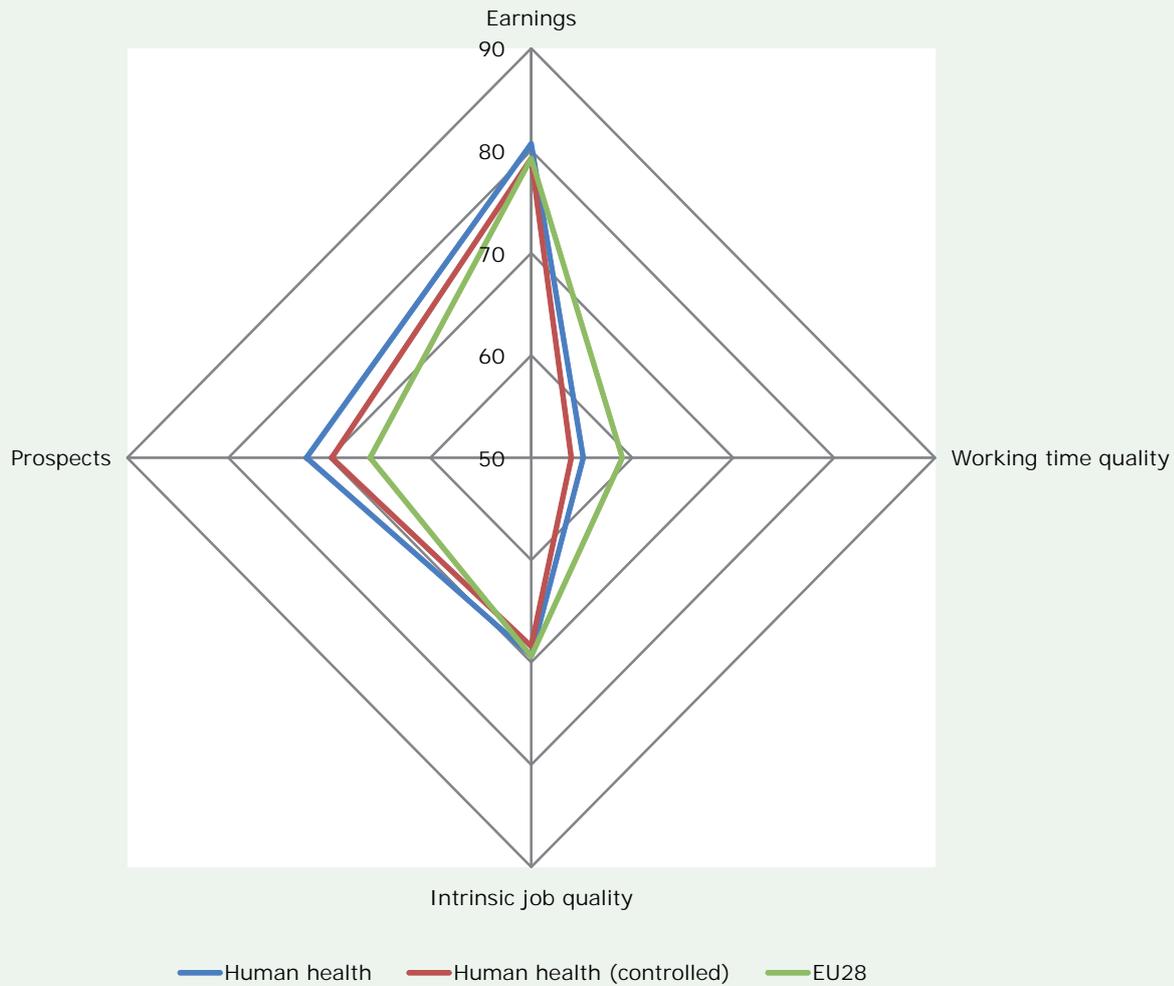


Job quality

In the report *Trends in job quality in Europe*, the authors constructed four indices of job quality: earnings, prospects, intrinsic job quality and working time quality. The indices are built using job characteristics that are unambiguously associated with workers' well-being.

Figure 18 summarises job quality in the human health sector. It shows the average score for the sector and subsectors on each of the indicators, with and without controlling for the structural characteristics of the sector's workers (age, gender, workplace size, education level and country), and for the EU28.

Figure 18: Job quality in the human health sector compared with EU28



Note: Scores on all four indicators range from 0 to 100

Job quality in the human health sector is only slightly lower than in the EU28 as a whole in terms of working time quality. On the other hand, the sector score for prospects is clearly above that in the EU28. Earnings and intrinsic job quality indicators for this sector do not differ substantially from those in the EU28 as a whole. When controlling for the structural characteristics of the sector – age, gender, education, establishment size and country distribution – the difference compared with the EU28 for working time quality becomes larger, and the favourable difference in prospects is reduced.

Health and sustainability of work

Working conditions can impact both positively and negatively on the health of workers and on the sustainability of their jobs.

Figure 19 shows that the human health sector compares favourably with the EU28 for a lower proportion of workers with poor self-reported health, and a higher proportion of workers saying they would be able to do their job at the age of 60. However, for the indicators of health at risk because of work, work affecting health negatively and presenteeism, the sector shows a less positive picture. After controlling for structural factors such as age, gender, education, establishment size and country distribution, the differences in poor self-reported health, health at risk because of work and work affecting health negatively remain statistically significant.

Figure 19: Health and sustainability of work

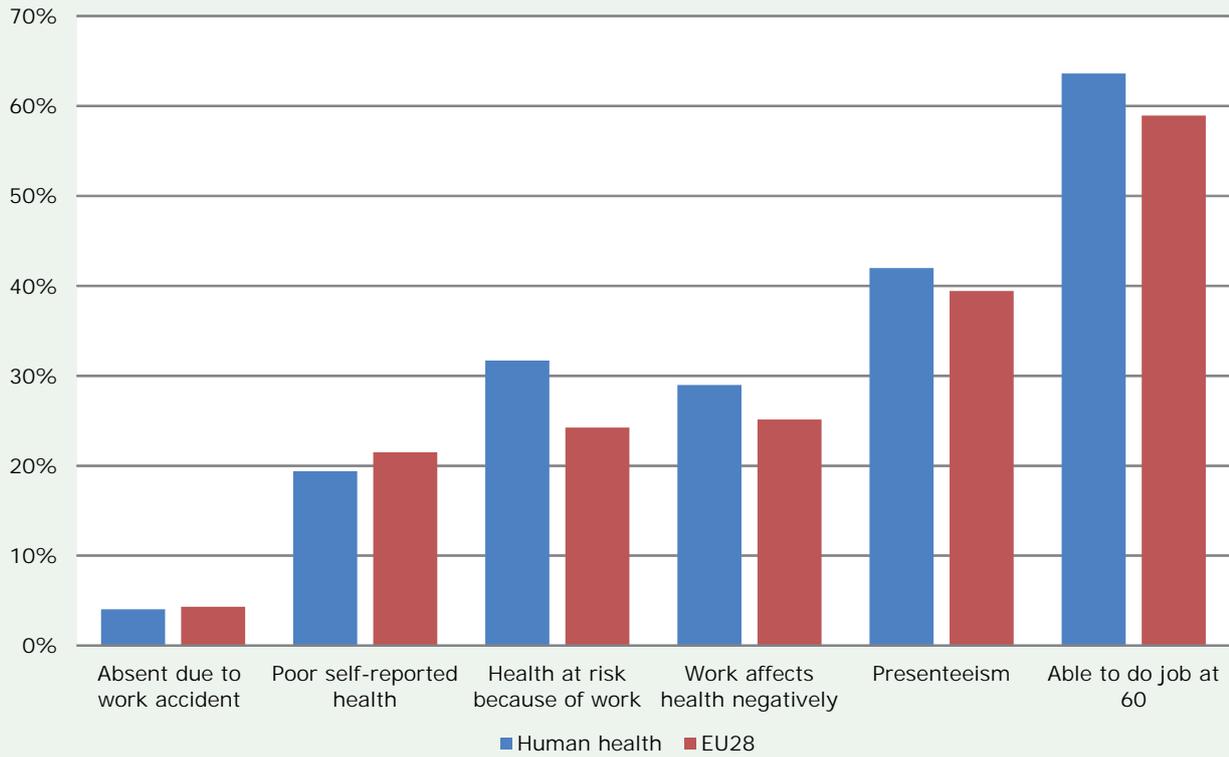
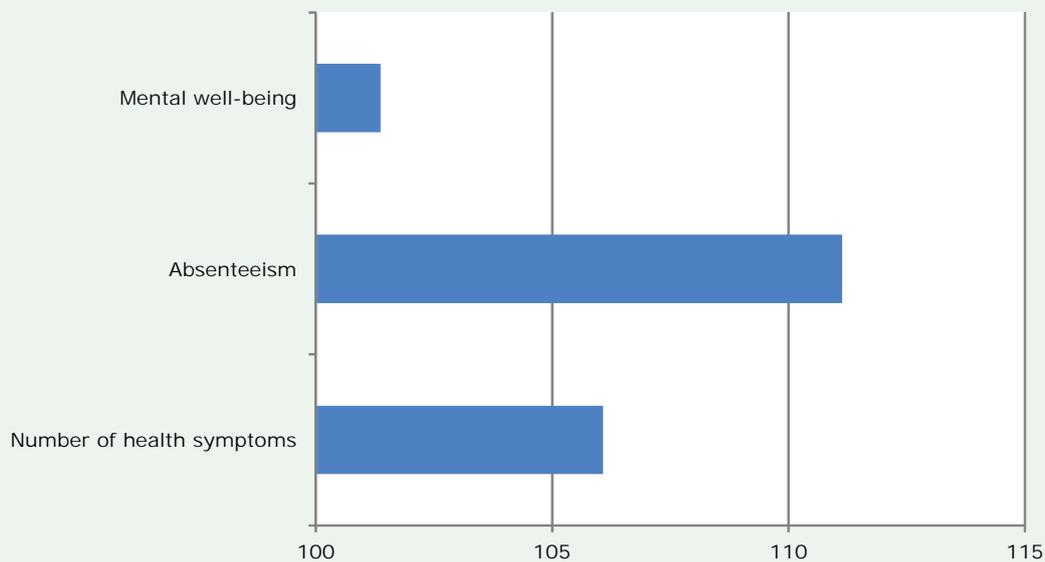


Figure 20 shows that mental well-being scores in human health are slightly above the EU28 average, but absenteeism and the reported number of health problems being clearly higher. However, the differences in absenteeism and a number of health symptoms are not statistically significant after controlling for gender, age, education, workplace size and country. Therefore, only the difference in mental well-being scores remains when taking into account structural features of the sector.

It is important to keep in mind that the impact of work on health is a very gradual process that can take a long time and cannot be fully captured in a cross-sectional survey. The results in this section are likely to underestimate the often negative health effects that physically and psychologically strenuous working conditions can have.

Figure 20: Indices of health symptoms, mental well-being and absenteeism (EU28 = 100)



References

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European Working Conditions Survey

Eurofound developed its European Working Conditions Survey (EWCS) in 1990 in order to provide high-quality information on living and working conditions in Europe. Five waves of the survey have been carried out to date, enabling long-term trends to be observed and analysed.

The EWCS interviews both employees and self-employed people on key issues related to their work and employment. Fieldwork for the fifth EWCS took place from January to June 2010, with almost 44,000 workers interviewed in their homes in 34 countries – EU28, Norway, the former Yugoslav Republic of Macedonia, Turkey, Albania, Montenegro and Kosovo. The 5th EWCS was implemented by Gallup Europe, who worked within a strong quality assurance framework to ensure the highest possible standards in all data collection and editing processes.

The questionnaire covered issues such as precarious employment, leadership styles and worker participation as well as the general job context, working time, work organisation, pay, work-related health risks, cognitive and psychosocial factors, work-life balance and access to training. A number of questions were included to capture the impact of the economic downturn on working conditions.

For more information on the EWCS, see <http://www.eurofound.europa.eu/surveys/ewcs/index.htm>

Sectoral analysis

The report *Working conditions and job quality: Comparing sectors in Europe* and the series of 33 sectoral information sheets aim to capture the diversity prevalent across sectors in Europe in terms of working conditions and job quality. The report pinpoints trends across sectors in areas such as working time and work-life balance, work organisation, skills and training, employee representation and the psychosocial and physical environment. It identifies sectors that score particularly well or particularly poorly in terms of job quality and sheds light on differences between sectors in terms of health and well-being.

For more information, see <http://www.eurofound.europa.eu/surveys/ewcs/2010/sectorprofiles.htm>

Further information

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