



Uncovering the UK's Hidden Crisis in Women's Workplace Health

A report by the British Occupational Hygiene Society, the
Chartered Society for Worker Health Protection

August 2023



More women are getting ill because of work.



There is evidence that there is significant under-reporting of work-induced illness among women.



Not enough is being done to monitor, measure and report the scale of the problem



Women are carrying more of the burden of occupational disease than men.



Much of this is entirely preventable and would save business, the economy and society a great deal of money.



We must address the silent and growing crisis damaging women's health.

BOHS is calling for all those involved in Occupational Health protection to develop a focus on the impact of the workplace on women's health.

Introduction

How badly is women's health being impacted by work? If you look for it in the headline Health and Safety Executive (HSE) statistics, in research papers for Parliament, in the literature from many Health and Safety bodies and in Trade Union materials, with some notable exceptions, you won't find the answer.

According to the Office for National Statistics (ONS), **long-term sickness has risen more for women than for men (209,000 vs 148,000)**. In Wales, for example, 7% of men are economically inactive for occupation-related health issues, but the figure for women is almost double at 13%. The problem is acknowledged in Scotland's Health and Work Strategy, but there are no clear next steps. IOSH highlighted critical issues in response to the England's Women's Health Strategy consultation, but these vital issues did not get acknowledged in the Strategy itself.

Indeed, buried in HSE's 2022 Labour Force Survey tables is the startling truth: 918,000 women are estimated to have had their health made worse as a result of work, compared with 778,000 men. That means, **5.8% of women workers, compared to 4.7% of males** have had their health affected by work. HSE headline statistics have not included a highlight on gender and workplace health to date, we are advised that this is being reviewed for the future. It is, however, an indicator of a deep-seated assumption that men are more at risk at work than women.

Silence on this growing issue is a problem in itself. More than a decade ago, HSE reported that men were 16% less likely to suffer from work-related ill-health than females in work. However, women are more likely than men to report instead that they have left the labour market to look after the family and home. **Three quarters of women, according to a major government health survey, stated that they were unlikely to raise health issues at work.** However, in the same survey, when asked if a health condition or disability had impacted their experience in the workplace, 3 in 5 answered 'yes' (62%).

Some impacts on women's health are simply off the radar. It's hard to find, but the largest number of new occupational cancer registrations after asbestos that HSE predicts are the projected **3,900 breast cancer cases expected to be associated with shift work.** This scarcely gets a mention in literature. Outside of

the construction and related industries, the highest risk of asbestos-related death is amongst female nurses and teachers, but this is masked by the way we calculate asbestos mortality rates.

While there is a welcome recognition of the importance of workplaces appreciating the significance of women's health, there is still no acceptance of the growing responsibility of workplaces for actively contributing to women's ill-health.

In any other area of public policy or public health, such inequalities would be the subject of national concern. What is more frustrating is that the workplace is the one largely human-controlled environment and therefore a place where we can directly and consciously engineer good health outcomes, unlike the home or in private lives.

This report aims to start what should be a national discussion of a national crisis. It examines instances of how **the relationship between work and society is failing women in workplace health protection.** We ask for the impact of the workplace on women's health to be a measure of national equality policy, health and safety impact and social sustainability.

Women's work in the home and in the workplace

Much of the work done by women that contributes towards society is not in the context of economic activity.

Although a matter of disagreement (as evidenced by a YouGov poll in 2021), it appears that the data from the last census, which saw the average woman doing almost double the amount of household chores and/or childcare, compared to the average man.

Whether or not women are classed as economically inactive, that does not mean they are not working for the good of society. Consideration of the boundaries between working in the home and paid employment is a fundamental issue of social justice and health equality and needs to be re-examined from a gender perspective.

The London School of Economics (LSE) published experience of the pandemic which examined the impact of the first pandemic lockdown on household work. It highlighted the continuation of gendered differences in care and housework. Typically working in the home is not viewed as a matter of concern for the health and safety professional. Of course, post-pandemic, the shift to home working blurs the boundaries a little further. Home is not just a place of domestic work for women but, increasingly, their place of paid work as well. As the LSE's work implies, that may not have lessened the burden on women.

Many of the women most at risk of illness or disease within their paid workplace work are undertaking activities which are closely allied to the work they undertake within the home. Cleaning, health and social care can expose women, in a paid context, to the same physical, chemical and biological exposures as they are exposed to in the home.

If we take the census data on reports of work done within the home (13 hours of house and 23 hours of care) we can see that this is the case for someone undertaking cleaning, ONS figures last month showed that in main and second job, the average number of paid hours for women was increasing, while for men it was decreasing. Women currently make up 46% of the UK workforce — around 13.6 million workers. In 2021 in the UK, working-age women on average did 1.5 fewer hours of paid work and 1.8 more hours of unpaid work per day than men, according to the Institute for Fiscal Studies.

However, the important point is that for many men, the work they are undertaking

is unlikely to be the same type of work as that which they are doing in the home, and in any case, they are likely to be doing less of it. This has a direct and significant relevance in determining the impact of workplace health risks on women's health in the domestic service, childcare and cleaning sectors.

In effect the paid work that women are doing is being extended into unpaid work, often providing longer periods of continual exposure to the same hazards and risks.

Their exposure to musculoskeletal disorders (MSD), to substances that harm their skin or respiratory systems and to biological agents is going to happen over a longer duration. The degree of exposure may be up to 50% greater than that which has been risk assessed for work. It's a small example, but the starting point for seeing the lack of understanding of health risks to women workers.

Even leaving aside the confounding factor of working within the home, at a time where there is a tight labour market around health and social care, the impact of health risks on the workforce cannot be ignored. It's estimated, based on NHS figures, that 20% of health workers have left the service because of non-pregnancy, health-related issues. The situation for social care and cleaning workers is almost impossible to determine.

The workers whose health we take for granted

When we look at the working context for cleaners, childcare workers, carers and even those in the health service, the extent to which they are supported in the workplace or even supervised is likely to be limited. Even in our NHS, the explicit concept of protecting the health of the worker (as opposed to wellbeing) has been sidelined for over a decade.

In lower-skilled occupations dominated by women, many will work for agencies who will provide the worker but may not assume local responsibility for health protection. Workers such as cleaners may work at times when those who manage the health and safety of a site are not there to supervise.

The health of the people who keep our workplaces and homes safe, and who care for those who cannot care for themselves, is part of the backbone of a healthy and cohesive society. But who is protecting their health and what should employers be doing to address this and is it even their responsibility?

First, it is clear that Section 3 of the Health and Safety at Work Act places a responsibility on the undertakings of employers to ensure that they protect the health of their workers, even if they are being supplied on an agency contract by another organisation. More certainly needs to be done in having a gender perspective on workplace health risk assessments. Yet, beyond the obvious legal duties that many workplaces fail to address, there are further impacts on women's health that we have a duty to consider.

How many workplaces really think about and check on the health protection in place for the people who provide their cleaning services? Often due diligence only extends to stating that the liability and responsibility lies with someone else, like the cleaning company! Who will be assuring that the health of the women cleaning up after this exhibition is actually being protected, for example?

The majority of the UK's 1 million cleaning staff are women, according to the British Cleaning Council, and most businesses employ cleaning staff. Giving visibility and focus to the health of cleaning staff is something that employers should make sure has an equal billing with ensuring gender pay parity for managers. Ask yourself whether, in your organisation, you know hand on heart if your cleaners are working in a healthy and safe way. Indeed, see if you can find out whether

there is any real mechanism, other than a statement of contractual obligation and a Control of Substances Hazardous to Health (COSHH) sheet, that is doing anything to protect cleaning staff against MSD, dermal and respiratory health hazards.

The health of women in such occupations can't just be taken for granted. It's something that all businesses and workplaces can, should and legally must do. However, it's all too often neglected.

In areas like social care, where public bodies are the commissioners, one would expect that the health of those delivering services, often in difficult environments, such as people's homes, community care settings and specialist units, would be highlighted. However, a glance at the resources from the main regulatory and employer bodies shows that a cursory list of legislation applicable and links to generic HSE material is the sum total of the health protection advice provided.

Social care is another female-dominated area of work. It employs 1.8 million people, 82% of whom are women. If ever we needed a wake-up call to the hazards of working in close quarters care within social care, the pandemic provided it. Analysis done by the Nuffield Trust showed that social care workers were among the occupational groups at highest risk of COVID-19 mortality, with care home workers and home carers accounting for the highest proportion (76%) of COVID-19 deaths within that sector group. Social care workers were exposed as being in a sector which neither understood, nor provided for, the management of workplace health risks.

We may not be employers of social care workers now, but many of us indirectly or directly will come to be dependent on such services. Our eyes and ears and voices as a society are needed to ensure that this workforce is able to work in a healthy way.

We need to care for those who care for society

The same can be said of the National Health Service. In the first months of the pandemic, the Health Service Investigation Branch launched an inquiry into how COVID-19 was spreading. The report makes interesting reading as it becomes apparent that our National Health Service did not have a coherent approach to health risk assessment for its own employees. As an organisation employing 1.3 million people of which 67% are female, this oversight is one that was highlighted in the Health Service Investigation Branch's COVID-19 Inspection in 2020.

The fact that our own health service has inadequate protections for its employees' own health again was highlighted through the relatively high number of deaths and sickness experienced during the pandemic. The failure to have available PPE that could fit females in a female-dominated workplace is a tragic illustration of a very basic failure to consider women in the appreciation of health risk. In fact, female nurses and female teachers are more likely to die from asbestos exposure than most other workers not working in construction or other trades.

When we look across the cleaning, social care and health sectors, which employ more than a tenth of the country's workforce, we can see that the health of workers in these female-dominated contexts, is not being looked after. It is little wonder therefore that these sectors demonstrate the highest levels of sickness absence, with a 3.7% sickness absence rate in 2021, more than double the rate for male-dominated skilled trades or that of administrative or managerial staff.

Indeed, overall while men lost 1.8% of their working hours to sickness in 2021, women lost 2.6% of their working hours. Sickness absence may not be caused by work itself, but it is likely to be a significant contributory factor. Prior to the pandemic, the largest single reason for sickness absence was MSD. Again, prior to the pandemic, adults would spend the majority of their waking lives at work and it is highly probable that work is a major contributory factor to MSD. For almost all age groups, women are more likely to suffer from MSDs. Women generally have more work-related cases of carpal tunnel syndrome and tendonitis, but also respiratory diseases, infectious diseases, and anxiety and stress disorders.

While it is not unlikely that the prevalence of MSDs among women may be partially related to the impact of having children, what becomes clear is that the duty to risk assess the susceptibility of workers to ill-health is perhaps being ignored.

Indeed, in the case of pregnant workers, Trades Union Congress (TUC) research

showed that 40% of workers had not had a health and safety risk assessment. Of those that did have a health and safety risk assessment, almost half (46%) said their employer did not take the necessary action to reduce the risks identified. 28% of low-paid pregnant women reported to the TUC that they had been forced out of the workplace on unpaid leave, sick leave or early maternity leave, with 17% of women in median to high earning jobs reporting the same. Health and social care, as well as cleaning, often require women to work irregular hours or rotating shifts, which have been demonstrated to increase the risk of miscarriage.

Women's health is undoubtedly suffering in the workplace. This will continue to place an ever-greater pressure on health and social care, as well as our national benefits bill. This has two major impacts. First, the overall cost of publicly funded health and social care will increase, while the pressure, demands and health impacts on those providing it will also increase.

The irony is that most workers at risk of their health being damaged are paid for out of public funds. Twice as many women work in the public sector than men and six times more women work in public sector jobs than in the private sector in the UK, according to research by [Birkbeck University](#). But the picture is probably even more pronounced than this, since private sector providers of social care, domestic services and the like are often delivering services that are also publicly funded.

In a perverse irony, it essentially means that publicly funded services are driving the increased demand and pressures that may be contributing to spiralling demand for health and social care and increased illness. This is because of a lack of focus on the prevention of ill-health in sectors where women are the major part of the workforce. And in these areas, the burgeoning burden on women from psychosocial risks, is the tip of the iceberg of mental illness disproportionately affecting women in the workplace.

Men's safety is prioritised over women's health

However, there is an amplifying factor in our overall approach to Health and Safety. The costs to the UK of safety incidents accounts for just over a third of the overall estimated direct costs (including personal impact and healthcare costs, but excluding benefits costs and lost tax income/other public costs like loss of skills).

The number of accidental deaths, compared to deaths arising from occupational ill-health, is almost 100:1. Men, tragically, are much more likely to die from an accident at work than women. In 2021/22, 116 (94%) of all worker fatalities were to male workers, a similar proportion to earlier years. Lessening the focus on workplace health in favour of safety inherently favours the protection of male workers over female workers.

And, indeed, the focus of most industry activity is on the prevention of accidents and on safety. HSE itself, in the calculation of “societal risk” outlined in its guidance on ALARP (reduction of exposure to be “as low as reasonably practicable”), draws a distinction between 100 people dying in an accident or 100 people dying slowly. In the HSE methodology, the former is likely to lead to public outcry and lack of confidence in the regulator, whereas the latter is not. However, the notion that there is a lesser societal risk of people dying of lingering illnesses, drawing on the resources of the state and creating the social and family agony of a slow death, is a curious one.

If we were to consider the biggest social concerns of our time in the UK, most people would identify access to health and social care as our biggest challenge. 1.8 million people are suffering from ill-health because of preventable workplace health exposures. Over 4% of workers have suffered ill-health because of work, compared to 1.7% because of accidents.

However, with diseases that take longer to develop, it is worth comparing deaths resulting from ill-health with deaths resulting from safety. In 2022 HSE statistics document a tragic 123 safety-related work fatalities. In the same period, 12,000 work related deaths were recorded arising from long disease alone. It is hard not to question whether there is an in-built imbalance in our priorities and one which may have an increasing impact on health inequalities.

Part of the problem is that we don't know the extent of the problem in an area like lung disease, as outlined by Camp et al in 2004 research. There are indications, where the data exists, that the burden is greater for women as White et al showed in relation to occupational asthma in 2016.

In 2021, the Minister for Patient Safety, Suicide Prevention and Mental Health, said that “for generations women have lived with a healthcare system that is designed by men, for men”. She asserted that there was an in-built prejudice against women at the core of health provision. It is possible that the poor occupational health outcomes for women may be exacerbated by this. However, in the context of health protection, through prevention, such a bias is only likely to amplify the impact of health inequalities.

The same may also be true of health and safety. The majority of health and safety workers in the UK are men, as are the vast majority of the health and safety workforce. Could this have an influence on the pro-safety bias? Is this the reason why the UK has so little focus on reprotoxins (substances harmful to reproductive health)? Indeed, is the subject of the gender gap in occupational health protection another area which is too hard to handle? Although not directly relating to physical health, it remains a matter of note that the statutory reporting of serious injury, RIDDOR, as a matter of practice does not include the reporting of sexual assaults.

The Executive's guidance on RIDDOR notes:



HSE has no formal agreements with the EOC or CRE on demarcation but inspectors should refer cases of sexual or racial abuse to these bodies if it is clear that they do not result primarily from failures in health and safety management.



Neither of these bodies is designed to address the sorts of preventions that are needed to manage the health and safety implications of sexual abuse in the workplace. However, it has the effect of making violence to women something that is not dealt with under RIDDOR, whereas other forms of violence in the workplace are. BOHS is actively canvassing HSE's review of RIDDOR to address this inconsistency.

We can and must act

The workplace is one of the few wholly human constructed environments. Unlike other areas of public health activity, occupational exposures that make people ill at work are entirely a matter of choice. We choose to let people become ill at work, largely for the sake of convenience and saving money.

However, that logic certainly breaks down in the context of the major areas of female employment. Much female employment is at the cost of the taxpayer and when the employee gets ill the public purse pays the health costs, benefits and social care for that person. In many circumstances, the failure to invest in the protection of the worker results in that worker becoming a cost and demand to the system that they supported.

In more general terms, the manifest inequality in the management of women's health in the UK's workplace is a major social failure. Protecting health at work is not like battling obesity or alcohol abuse. Exposures that cause ill-health in the workplace are often hidden, insidious or hard to understand.

The causes of women's ill-health in the workplace are often not complex, but result from an absence of any real concerted effort on the part of employers to try and prevent them, and the absence of sufficient public or policy focus on this. We need to get serious about preventing women from becoming ill in the workplace with the same vigour as we have been serious about preventing accidents happening to men.

A call to action

Empowerment:

Women should be empowered through awareness, education and training to recognise workplace risks to their health, so they can act and speak out.

Accountability:

The impact of the workplace on health should be a consistent indicator of health and safety impact, from employers, through industry bodies, public project impact, academic researchers to national regulator and policy indicators.

Focus:

The UK needs a Women Workers Health Strategy to assist in tackling institutionalised inequality in the protection of women's workplace health and support the sharpening of the duties on employers to deliver non-discriminatory health outcomes.

Leadership:

Professional bodies should lead from the front by supporting their members to identify and call out risks to women's workplace health, while unions should work to better enable women's concerns about ill-health caused by work to be heard by employers.

Professor Kevin Bampton

July 2023

Kevin.bampton@bohs.org
www.bohs.org

What is BOHS and how can it help?

The British Occupational Hygiene Society and its two Faculties (the Faculty of Occupational Hygiene and the Faculty of Asbestos Assessment and Management) is a scientific charity, which is volunteer-led and funded through its own work as an awarding body, publisher and through membership subscription.

For 70 years, it has brought together scientists, academics, experts from HSE, professionals and clinicians to provide free technical guidance, training materials, free seminars/webinars and support to prevent disease in the workplace. Prior to HSE, BOHS set occupational exposure limits for substances such as asbestos. Its [Breathe Freely](#) free resources for construction health are now delivered in all major English-speaking countries of the world.

BOHS is committed to a vision where the workplace is not a significant cause of ill-health. It stands ready to support with the provision, development and delivery of materials and expertise to support women in their battle against workplace ill-health. Working in partnership with the institutions and people in the UK, we want to make a difference and believe that through greater understanding and awareness, we can help save women's lives.