Women, work and compensation: a different and changing experience

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Tables:

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I. INTRODUCTION

Women form a growing part of the Canadian labour force and the injuries they experience constitute an increasing proportion of Workers' Compensation Board (WCB) claims. This paper documents these trends (sections 2 & 3) and addresses associated issues (sections 4 & 5). This approach is in keeping with the growing recognition of the importance of gender-based analyses for public policy (Morris, 1997). Although much of the data necessary for a full gender-based analysis remains uncollected or unanalyzed, we can nonetheless describe situations in which women have different experiences of work-related injury or illness than men do. In this paper, we refer to "gender" rather than "sex", recognizing the importance of social conditions and social behaviour (rather than only biological factors) in explaining the different experiences of women and men (Doyal, 1995; Messing *et al*, 1991, 1998). We focus more on analysis of women's situation in the context of comparative analysis. This leads us to challenge the "gender-neutral policy" approach, which assumes that policies, programs and legislation affect everyone in the same way regardless of gender (Status of Women Canada, 1996) and which has historically been the norm in the field of workers' compensation. We argue that movement towards information systems, policies and programs which are sensitive to gender issues would be an important step towards more equitable treatment of women by the workers' compensation system.

2. GENDER DIFFERENCES IN THE LABOUR MARKET

The different roles women and men have played in the waged workforce is an important factor in understanding gender differences in work and health relationships. Women's labor force participation in Canada increased dramatically between 1975 and 1997, from 44.4% to 57.4%, while men's participation rate declined from 78.4% to 72.5%. Women now make up just less than half of total employment (figure 1).

[Place figure 1 about here]

Age was associated with gender differences in labour force participation rates. In 1997, women's and men's rates for those aged 20-24 were 71.9% vs 79.3% respectively, 77.7% vs 91.4% for those 25-34, and 78.8% vs 92.6% for those 35-44[1]. The increasingly large gender differences in labour force participation seemed to be associated with pregnancy and women's family responsibilities, particularly in the most intensive years of child bearing and child rearing. This is corroborated by the fact that women made up almost 99% of recipients of maternity and parental benefits in 1993 (Statistic Canada, 1994). Further, women were more likely to be part-timers, with about 29% of employed women working part-time in 1997, compared to only 10.5% of men[2].

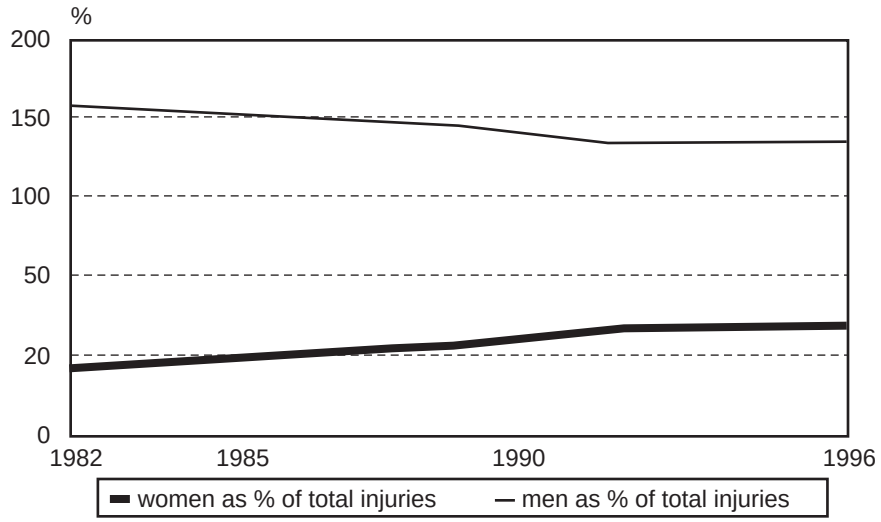
Significant changes have occurred in the pattern of employment of Canadian workers by industrial sector. The proportion of workers employed in the service industry increased from 45.2% to 77% between 1975 and 1997[3]. In 1995, 86% of employed women and 63% of employed men were in the

[1] Statistics Canada (1997) Labour force characteristics by age and sex. CANSIM, Matrix 3472, http://WWW.StatCan.CA/english/Pgdb/People/Labour/labor20a.htm. [1998, February 18]

[2] Statistics Canada (1997). Full-time and part-time employment. CANSIM, Matrix 3472, http://WWW.StatCan.CA/english/Pgdb/People/Labour/labor12.htm. [1998, Feb 18]

[3] For 1975 data, see Statistics Canada (1994). *Women in the Labour Force*. Catalogue 75-507E Occasional, Ottawa. 1997 data came from Statistics of Canada (1997), Distribution of employed people by industry. CANSIM, Matrices 3472-3482.http://WWW.StatCan.CA/english/Pgdb/People/Labour/labor21a.htm. [1998, March 25]

Figure 1.
Women's and men's proportion of accepted lost-time injuries in Canada. 1982 -1996



Note: These percentages exclude 'unknown' and not-coded injuries
Source; Association of Workers' compensation Boards of Canada (AWCBC)

service industry[4]. The top three industrial sectors for women were services, trade and manufacturing (51.2%,17.0% and 9.6% respectively) and for men services, manufacturing and trade (25.8%, 20.0%, 17.2%). Women exceeded men only in the service sector and the finance, insurance and real estate sector.

Women and men tend to cluster in certain occupations. In 1996, women constituted 79% of people in health occupations, 72% in business, finance and administrative occupations and 40% in occupations designated as social science, education, government service and religion[5]. Representation of men was greatest in trades, transport and equipment operators and related occupations (94%), occupations in primary industry (79%) and in processing, manufacturing and utilities (71%). More specific occupational categories (Table 1) suggest little change for women in the previous three decades in Canada (Fox, 1987), although the gap between women's and men's earning capacity narrowed between 1967 and 1994[6]. Thus gender segregation in the labor force implies that the range of overall occupational exposures at work will be different for women and men.

[table 1 on PDF page 18]

3. GENDER DIFFERENCES IN COMPENSABLE OCCUPATIONAL INJURIES AND ILLNESSES

We now turn to gender differences in the experience of time-loss injuries (and to a lesser extent illnesses). Women accounted for 26.2% of time-loss injuries in 1996 (figure 1) with B.C. (26.1%) close to the Canadian average (Association of Workers' Compensation Boards of Canada). Consistent with changes in the gender composition of labor force (figure 2), the trend from 1982 (the earliest year national data aggregated) to 1996, is for women's percentage to increase (17.1% to 26.2%) and for men's to decline (82.9% to 73.8%[7]) (figure 1). However, women still account for disproportionately few lost-time injuries.

[Place figure 2 about here]

Sectoral breakdowns (figure 3) allow us to explore this trend. In 1996, manufacturing had most lost-time injuries (29.0%), followed by services (24.5%) and trade (17.1%). Men's greater labour force participation in manufacturing, transportation and construction, which together accounted for 46.3% of lost-time injuries (but only 28% of those employed) may be part of the reason. In contrast, those sectors in which women's participation was highest, finance and services, accounted for only 25% of lost-time injuries. In spite of these obvious sectoral differences, we note that across all industrial sectors, men

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[4] Statistics of Canada (1995). Employment, by detailed industry and sex, 1995 Catalogue no. 71F0004XCB. http://WWW.StatCan.CA/english/Pgdb/People/Labour/labor10a.htm. [1998, Feb 18]

[5] Statistics Canada (1996). Labour force 15 years and over by occupation, 1996 Census, http://WWW.StatCan.CA/english/Pgdb/People/Labour/labor45a.htm.1996 Census Nation tables [1998, March 27]

[6] Statistics Canada (1994). Average earnings by sex, Catalogue no. 13-217-XPB. http://WWW.StatCan.CA/english/Pgdb/People/Labour/labor01a.htm. [1998, Feb 18]

[7] Statistics Canada (1996) Distribution of employed people by industry, CANSIM, Matrices 3472-3482, http://WWW.StatCan.CA/english/Pgdb/People/Labour/labor21a.htm. [1998, March 25]

Figure 2.
Women's and men's proportion of total employment in Canada.
1982 - 1993

Source: Data for 1982-1993 comes from Women in the Labor Force (Statistics Canada, 1994) 1996 Statistics Canada, Catalogue No. 71F0004XCB

accounted for greater proportions of lost-time claims than their labour force participation alone might warrant.

[Place figures 3 and 4 about here]

It may appear that these differences are associated with the different occupations held by women and men in the various industrial sectors. Proportions of lost-time claims broken down according to occupational groups provide further information. In the four occupational groups accounting for most lost-time injuries in 1996 (trades and skilled transport and equipment operators; intermediate occupations in transport, equipment operators; labourers in processing, manufacturing machine operators; and processing and manufacturing machine operators), men predominate. In contrast, only three occupational groups in the top 10 had higher proportions of women (assisting occupations in support of health services; intermediate sales and service occupations; and elemental sales and service occupations).

Turning to the nature of injuries sustained (table 2), we again note a difference in patterns for men and women, and changes over recent years (figure 5). Sprains and strains (the most common injury type) constituted 29.6% of all lost-time injuries for men and 12.4%, for women in 1996. In this injury category, men dropped from 80.5% to 70.6% of injured workers between 1982 and 1996, with women's proportion increasing correspondingly (19.5% to 29.4%). Men tended to have more claims for cuts, lacerations, punctures, fractures, scratches and abrasions while women were more likely to have inflammation, irritation, non-specified and other occupational injuries. The latter is consistent with more work-related disorders of the neck and upper limb, known as repetitive strain injuries (RSI) or cumulative trauma disorders, among women. An analysis of Ontario WCB data (Ashbury, 1995) found that over the 6-year period 1986 to 1991, RSI rates and claim frequency rates were higher for women than men in each of the job categories with the highest risk and further, women's rates were increasing.

Analysis by part of body affected is consistent with this inference (table 3). Although back injuries were the most common for both genders, proportionately more of women's injuries affected the shoulder(s), arm(s), wrist(s) or multiple body areas than for men. Except when special analyses are done (such as Ashbury, 1995), we are unable to provide true gender based injury rates (numbers of those with lost-time injuries/numbers of those at risk of injury), since the requisite data has not been reported.

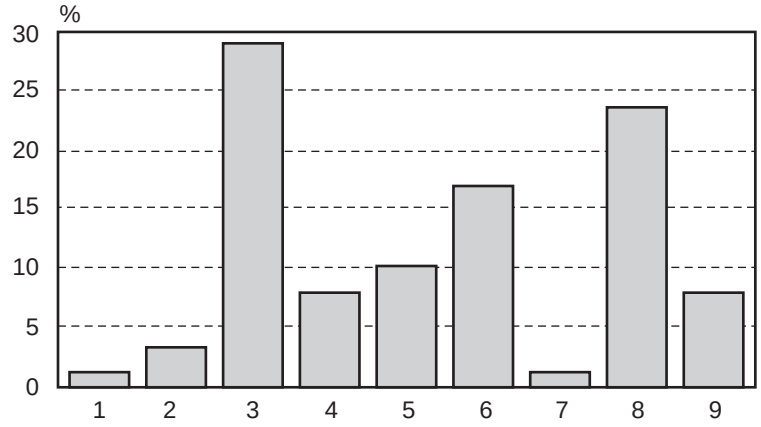
[Place table 3 about here]

Analysis of labour force and lost-time claims data (figure 4) shows that women account for proportionately fewer claims compared to their labour force participation in every industrial sector and that women report injuries consistent with their occupational exposures.

4. WOMEN AND COMPENSABLE INJURIES

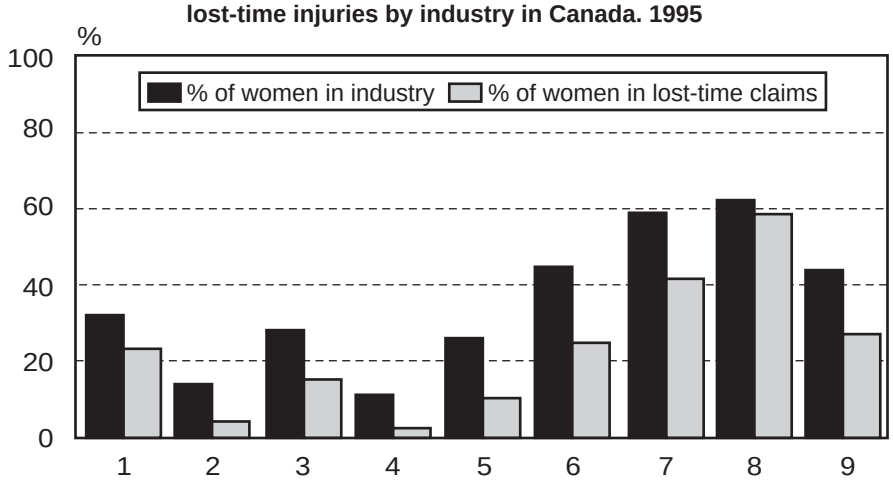
This section explores two potential reasons for women's relatively low claim rates: exclusion of some women under WC Acts and barriers women face when reporting injuries. It then goes on to explore duration of time loss associated with compensable injuries for women.

Figure 3.
Distribution of accepted time- loss injuries by industrial sector in Canada. 1996



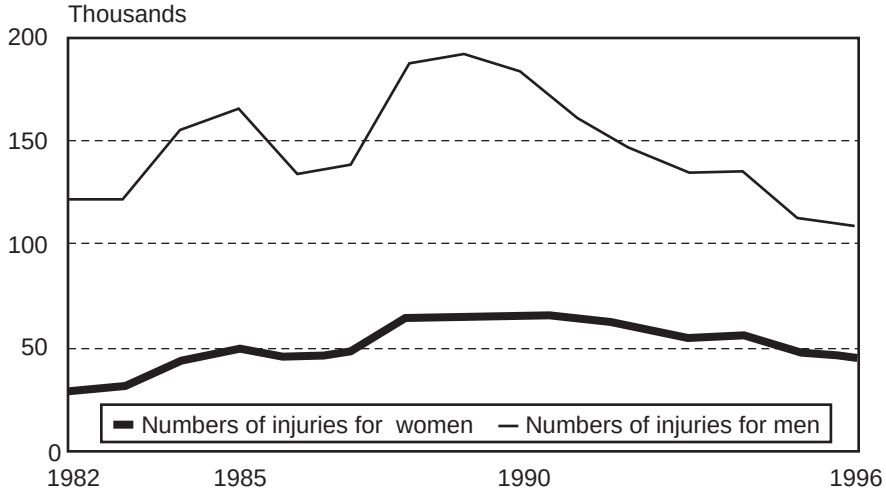
Source: 1 - Agriculture 2 - Other primary industries 3 - Manufacturing 4 - Construction 5 - Transportation, communications and other utilities 6 - Trade 7 - Finance, insurance and real estate 8 - Services 9 - Public administration.
These percentage exclude 'unknown' and 'not coded' claims.
Source: Association of Workers' Compensation Boards of Canada (AWCBC)

Figure 4.
Women's propotion in employment and in accepted lost-time injuries by industry in Canada. 1995



Note: For each industry, the first bar denotes distribution of women in the specified industry. The second bar indicates distribution of women within total time-lost injuries. 1 - Agriculture 2 - Other primary industries 3 - Manufacturing 4 - Construction 5 - Transportation, communications and other utilities 6 - Trade 7 - Finance, insurance and real estate 8 - Services 9 - Public administration.
Source: Injury data comes from AWCBC, Employment data comes from Statistics Canada, Catologue No. 71F0004XCB.

Figure 5.
Accepted lost time injuries for sprains and strains by gender in Canada. 1982-1996



Note: These percentages exclude 'unknown' and not-coded claims
Source; Association of Workers' compensation Boards of Canada (AWCBC)

4.1 Women and exclusions under Workers' Compensation Acts

As with other insurance systems, workers' compensation covers only 'eligible' employees. Definitions of eligibility differ across provinces and territories. For example, in Ontario, bank employees, independent operators, self-employed individuals - those who do not employ full- or part-time workers and who operate under a contract for service — are not automatically covered under the Act, although employers may voluntarily apply for personal coverage for the costs of compensating their injured workers (Ontario WSIB, 1997). On the other hand, B.C. coverage includes bank employees and has fewer restrictions on sectors and types of workers (WCB of B.C., 1997).

Such differences are reflected in the proportion of lost-time injuries that occur in a particular sector. For example, the finance and insurance industry sector (in which women predominate) accounted for only 0.086% of lost-time injuries in Ontario in 1996, compared to 0.49% in B.C. and 0.32% in all of Canada[8]. Coverage differs across provinces. Nevertheless, these proportions are considerably lower in both provinces than the estimated proportion of employment in this sector (4.48%). Thus women in this sector likely have low levels of coverage, yet a careful examination of coverage is reuqired to make such conclusion.

Low WC coverage rates in small and non-standardized workplaces can also have significant implications for women, who are over-represented in such workplaces. Smaller, non-standard workplaces are generally riskier than larger, more formal organizations (Eakin & Weir, 1995) and have historically received less attention in safety education and health promotion programs (Eakin, 1992). Recent economic restructuring, intense global competition and rapid technological change have been associated with increased numbers of small businesses in Canada, including large numbers headed by women[9]. In addition, informal workers — those who work without a formal contract, job security or benefits packages — tend to face greater health risks in labour-intensive jobs but are often excluded from legal protections and WC (Santana *et al*, 1997). Women doing domestic service[10] (particularly minority women) and volunteer work (where women are clearly the majority) would be among such informal workers.

Women's greater employment in part-time jobs may also influence their reporting of injuries. Men doing part-time work are more likely to have chosen reduced or flexible hours on the basis of the options associated with greater power in the workplace.[11] In contrast, women, particularly in the service and food sectors, often have fewer working hours than they would like. Such implied vulnerability leads us into a discussion of non-legal barriers to reporting of compensation claims.

4.2 Women and barriers to claim reporting and acceptance

Women may face barriers to reporting and acceptance because of a variety of biases and pressures among workplace parties, health professionals and WC personnel. Ideas about women's occupational injuries and illnesses, particularly those which are not associated with a single event[12] (which account

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[8] Statistics Cananda (1996) Employment in the finance and other service industries, CANSIM, Matrices 4285, 4299, 4313, 4327, 4341, 4355, 4369, 4383, 4397, 4411, 4425, 4439, and 4453. http://WWW.StatCan.CA/english/Pgdb/Economy/Finance/fin14a.htm

[9] Statistics Canada (1996). Labour force 15 years and over by class of worker, 1996 Census, http://WWW.StatCan.CA/english/Pgdb/People/Labour/labor43a.htm. [1997, March 27]

[10] Also unpaid family workers (those who worked without pay in a family farm, business or professional practice owned or operated by a related household member) should be included. 0.3% of men and 0.8% of women were in this category. Statistics Canada (1996). Labour force 15 years and over by class of worker, 1996 Census, http://WWW.StatCan.CA/english/Pgdb/People/Labour/labor43a.htm. [1997, March 27]

[11] The Globe and Mail, part-time work stats questioned A6 Wednesday, March 18, 1998

[12] Due to a lack of studies which deal with gender differences, we include studies on occupational diseases experienced mainly by women, and a few studies in which gender differences are shown.

for the majority of women's claims) may influence both the reporting and adjudication process for women's claims.

In the workplace, the majority of managers are men (Acker, 1990; Wirz, 1990). If they do not understand the nature of women's work and work-related illness or injury, this may influence the extent to which women are likely to make a WC claim. In one American study, occupational physicians saw patients at the request of their employer. They found that out of 1609 individuals with occupational health conditions affecting their wrist, hand, shoulder or back, only 25% filed any claims and that 23% of individuals who had lost seven consecutive days from work did not file a claim (EWWC 1997). The Institute for Work & Health (1998) has conducted a study of employees, the majority of whom were women, in a large, metropolitan newspaper. They found that about 60% of employees surveyed reported having some neck and upper limb pain but only 1/2 had sought any kind of health care for their complaints. Further, only 37% of symptomatic employees had reported their conditions to the workplace, and these included some with moderate or worse pain impairing their ability to perform their job duties. Fifty-four percent of symptomatic employees answered an open-ended question about reasons for not reporting their symptoms, with 23.5% reporting that they were not sufficiently severe, 11% attributing symptoms to non-work factors and 4.1% expecting the symptoms to go away. For others, workplace culture played a role: fear of layoff, harassment and unemployment (6.4%); unwanted influence or changes in jobs or tasks (4.4%); the company's negative response to those with RSI (3.9%); and fear of others' perceptions (1.7%). Other employees wanted to take care of their RSI themselves (2.8%) or were concerned about an unidentified diagnosis (2.2%). Such findings indicate that multiple barriers would have to be dealt with, both in the workplace and with health practitioners for adequate reporting to occur and permit early job modification, treatment or support to those with RSI.

The role of medical professionals in recognizing work-related of conditions is also a factor. Half of a group of U.K. doctors who were asked by the courts to report on individual cases believed that RSI was not a genuine disease entity (Diwaker & Stothard, 1995). Another study (Niemeyer 1991) showed that when women attempted to explain their RSI pains to health professionals, doctors tended to see their pains as "the outcome of thwarted urges or neglected duties of the peculiarly female kind". Such biases have a long history in physicians' characterization of occupational injuries and disease among women (Bammer & Matin, 1994; Hopkins, 1990). Women are often perceived as psychologically and/or physiologically more "frail". For example, primary care physicians and hospital interns incorrectly classified a higher proportion of non-disturbed women as "disturbed" than was the case for a similar group of men (Redman et al 1991). Women's reports of their injuries have been more likely to be regarded as "complaining", "malingering" or women-specific health behaviors than as preventable work-related conditions (Dembe, 1996).

Furthermore, when WC claims are filed, women's claims may meet more challenges and face more suspicion by WC staff. A study of 135 carpal tunnel syndrome claims filed in the U.S.A. from 1991 to 1995 found that only 19% were accepted without a problem (EWWC, 1997). The other 81% of claims were either challenged or ignored by insurers, with some of the cases taking over 1,000 days to resolve. Among women who filed claims for carpal tunnel syndromes, 40-42% did not feel that their claims were dealt with in a fair and satisfactory way. Data from the Ontario WSIB provides detailed information on accepted, rejected or pending cases by gender, from 1991-1996 (table 4). Rates of rejection for women rose from 12% in 1991 to 19% (almost one in five claims) in 1996. In every year, women's claims had higher rates of rejection than men's, with gender differences since 1994 being consistently greater than in the earlier period.

[table 4 on PDF page 19]

For newly emerging disorders which are more common in women, the present lack of research evidence may be interpreted as indicating no causal relationship with work (Yassi, 1981). Yet one Canadian study (Lippel, 1995) was able to investigate other reasons for gender differences, based on a review of accepted and refused WC claims for psychological stress in Québec. Though different in nature from most injuries, it provides a glimpse of how an important work and health concern for women (see section 5) was dealt with by WC authorities in one jurisdiction. Among 97 published and unpublished decisions on WC claims for psychological stress, 51% (25 cases out of 49) of women's claims were accepted compared to 66% (36 cases out of 55) of men's. Various explanations for women's lower rate of accepted cases were advanced. Women constituted a minority of members on both the Review Board Panel (22%) and the Appeal Panels (20%). Content analysis of legal documents showed that when women occupied roles stereo-typically associated with stress, their cases were often refused on the basis that stress was 'normal' to that occupation and/or workplace. In the process of adjudication, both men and women were asked about their personal lives as part of the test of the work-relatedness of stress experienced. Yet the interpretation of similar personal stressors was different for each gender. A man breaking up with a girl friend during the period of work stress still received compensation, whereas any statements mentioning difficulties at home (mostly marital difficulties), became barriers to women receiving compensation. In the same vein, a personal trait such as perfectionism was thought to be a mark of good character for men, while the same trait prevented women from receiving compensation. The study concluded that often women's claims were refused because of male domination of decision-making roles and gender-biased perceptions about work and personal traits.

Recognition of gender biases in the workplace, among health professionals and among WC staff may result not only in less frequent or later reporting and fewer accepted claims. Prolongation of the compensation process may delay preventive efforts and slow recovery for women's claims that are recognized.

4.3 Women and recovery from occupational injuries

We have previously noted that women file relatively few WC claims. However, most WC studies indicate that once a claim is filed, women tend to remain off work for longer than do men (Bigos *et al*, 1986; Johnson *et al*, 1990). Reasons for this may lie in gender differentiated aspects of medical care, household situation, occupational role or workplace accommodation.

In previous studies not related to work issues (e.g. Cleeland *et al*, 1994; Bernard *et al*, 1993) systematic gender differences such as poorer pain management, longer hospital stay with less technologically intensive care for women have been demonstrated. Recent studies of rehabilitation programs for injured workers have suggested different response patterns for women. Results from an Ontario study indicate that women with claims for soft tissue injuries were equally likely to attend a WCB-designed physiotherapy program (Sinclair *et al*, 1997). However, upon completion of the program, they were more likely to be judged as needing continuing physical work restrictions or further assessment than were men (IWH, unpublished).

The association of marital status with duration on compensation benefits differs by gender - married women are on benefits for longer than other women, unlike married men, whose absences are shorter than those of other men (Johnson et al, 1995). The greater responsibility for domestic work assumed by married women (Statistics Canada, 1994) may be a contributing factor, as may the lesser earning potential of women which we have previously described. In general, workers in lower income groups are slower to return to work than those with higher income (IWH, unpublished).

In the same study (IWH, unpublished) both men and women in medium-sized and large firms had shorter duration on benefits after injury than did those in firms with less than 20 people, suggesting that larger firms are able to offer special arrangements to facilitate return-to-work more readily. Although it is possible that women may be less successful in return-to-work attempts because of greater workplace biases against disabled women, little research has been carried out in this area to date.

5. WOMEN'S BROADER HEALTH AND WORK EXPERIENCE

Women have broader concerns about their health and it's potential work-relatedness than are reflected in compensable injury data. As well, the hazards they face may not be clearly recognized or accepted. We review some of these here, as well as the potential implications for WC systems.

5.1 Working Women and their Primary Health Concerns

When asked about significant work-related health concerns (Walters, 1992), Canadian women cited stress, depression and anxiety. In focus groups, working women cited stress as the most important health issue, followed by RSIs, harassment and violence, and the double work day (Feldberg *et al*, 1996). Most of the focus group participants were in female-dominated occupations such as nursing, teaching and childcare. When asked to identify "the most important health problems, both physical and mental, for women who work in a job like yours", 49% indicated stress.

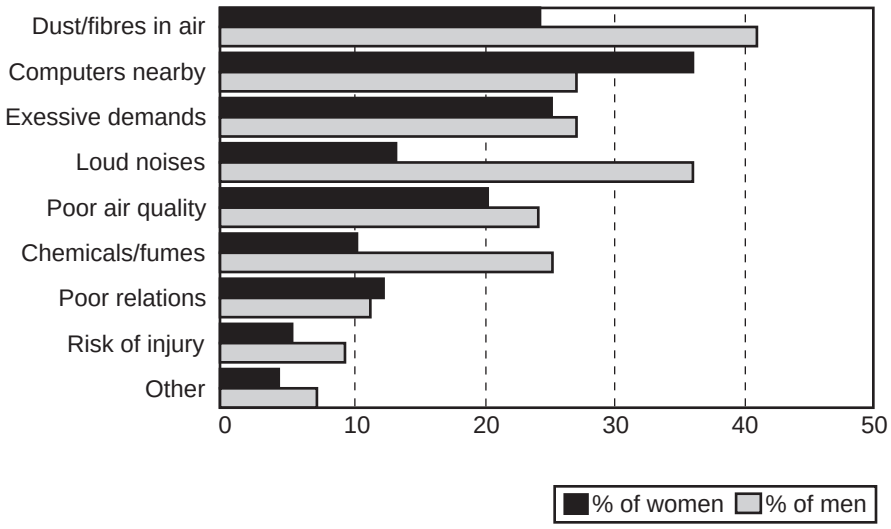
In contrast, data from the General Social Survey (Statistics Canada, 1994) involving a structured questionnaire and more traditional health/safety hazards, suggests that women and men perceived different risks differently (figure 6). For women, the most frequent responses were working in proximity to a computer screen or terminal, and excessive worry or stress due to job demands (36% and 25% of employed women respectively). For men dust/fibres in air and loud noises (more 'traditional' workplace hazards common in men's occupations) were most important (41% of employed men). Interestingly, the perceived risk of injury in the survey was under 10% for both women and men, which is in clear contrast to current WC expenditures. Differential exposure as the consequence occupational segregation by gender is certainly part of the explanation for work and health concerns.

[Place Figure 6 about here]

To support this argument, the health effects of adverse working conditions showed almost no gender differences in research with women and men in similar jobs with comparable working conditions (Loscocco & Spitze, 1990). The study analyzed the effects of four kinds of working conditions — job demands, job deprivations and rewards, physical environment and work-related social support. 2260 nonsupervisory employees were recurited from 27 different plants in seven manufacturing industries in southern central Indiana. The study found that all of the above-mentioned factors affect well-being of men and women, yet there are almost no gender differentes in the effects of working conditions on well-being.

Women's special concerns about RSI and stress, are supported by other evidence on gender differences in prevalence. Several studies have documented higher prevalence rates of RSI and more severe symptoms in women (Polanyi, 1997; Tanaka *et al*, 1988). In analysis of RSI among newspaper employees (IWH, 1998) gender differences in demographic, physical and psychosocial factors seemed to account for women's tendency to have more severe symptoms. More women were touch typists, spent more time on the phone, believed that a poorly designed workstation could cause RSI and tended to have less formal post-secondary education. Women who suffered from RSI also had higher levels of psychological strain and psychosocial stress (Shadbolt 1988). Women's jobs both at work and at home contribute to their RSI (Meekosha & Jakubowicz, 1986). Nevertheless, doctors, family members, coworkers and managers may not show to recognize the work-relatedness of their symptoms (Reid *et al*, 1991).

Figure 6.
Perceived exposures to workplace health hazards by gender, 1991



Source: Statistics Canada, Catalogue 11-612E, No. 8.
Reprinted in Women in the Labor Force, 1994 edition

National Population and Health Survey showed that Canadian females in all age groups over 12 years of age had a higher prevalence of depression in 1995[13]. While the survey included non-employed people, three large cross-sectional population surveys conducted in Canada and Sweden also found gender differences among employed people. These studies have used concepts of psychological work demands, job control and other psychosocial job characteristics (Karasek and Theorell 1990, 1996) to partially explain such gender differences in mental health. In Sweden, Hall (1989) documented the highest levels of control among white-collar men in male-dominated jobs, while the lowest was found among blue-collar women in male-dominated jobs. Men in jobs traditionally regarded as 'women's work' had a higher level of control than women in the same jobs. Women working in the lowest stratum of jobs and with a majority of men were likely to have the greatest work stress. In a Canadian study using survey methods (Roxburgh, 1996), women were exposed to lower substantive complexity and job control, although the lower job control did not directly lead to women's lower distress. Women were more vulnerable to the negative effects of job routinization, one dimension of psychological demands in Karasek's model. In an analysis of Canadian data from the 1994-5 National Population and Health Survey (NPHS) (Scott *et al*, 1998), women workers reported significantly less decision latitude and more psychological demands than men. Furthermore women with higher job strain (high demands and low control), greater job insecurity and higher chronic stress were significantly more likely to have poorer general health. Women who reported their main activity as working for pay or profit and caring for family reported more job strain, while job insecurity was more important for those only working for pay and profit. These findings indicate the complex interplay between work and home stressors in predicting the nature and impact of women's stress (Lowe 1989).

5.2 Hidden work-related health risks for women

Uncovering health risks involved in women's work is an ongoing challenge where the tradition has been to focus on men's occupational health concerns in jobs typically held by men. Historically, women's role in reproduction and its relation to work has been an important focus. The U.S.National Institute of Occupational Safety and Health estimated the number of workers exposed each year to nine known or suspected reproductive hazards (mostly to women) and on this basis argued that adverse reproductive outcomes should be included in the top ten occupational diseases (CDC-NIOSH 1985). Consultants to the recent Royal Commission on New Reproductive Technologies extrapolated these figures to an estimated 1.5 million Canadian workers similarly exposed to a range of biological, chemical and physical hazards each year (Royal Commission on New Reproductive Technologies, 1993). Since 1981, Quebec's health and safety law has contained a provision for physician authorized protective reassignment of pregnant or breast-feeding women to work which would not pose a risk to the woman or her (potential) child. If no such work is available, compensated time off can be authorized by the Work Health and Safety Commission (CSST). Over 80% of women compensated have been in their 2nd or 3rd trimester, and ergonomic hazards have been the main reason (62%) (Groupe de Travail "Pour une maternité sans danger", 1993). Biomechanical exposures or stressors acting on women during pregnancy have been associated with reduced gestational age and birthweight, and work scheduling, has been associated with pregnancy loss (Infante-Rivard 1993).

Such risks may also cause musculoskeletal strains but for these conditions, the extent of the risk may be perceived differently for women and men. Daycare workers lifting children, waitresses carrying heavy trays or check-out cashiers lifting bottles of milk and juice are somehow perceived as not handling manual material in the same sense truckers loading boxes are[14]. This is in spite of the fact that the total weight handled each day in each job may be very similar and may cause musculoskeletal strains in women. Even the same occupation may pose different health risks for each gender. Among employees working at poultry factories, bakeries (Dumais et al, 1993) and the cleaning industry(Messing et al,

[13] Statistics Canada (1995). Prevalence of depression, by age and sex, 1995. Http://WWW.StatCan.CA/english/Pgdb/People/Health/health35.htm. [1998, February 2]

[14] See articles in *Invisible: Issues in women's occupational health*, edited by Messing *et al* (1995)

1993), women and men have been found to occupy different roles and do different tasks, with women tending to do more repetitive work. Relying solely on a job title as a proxy for exposure, in the judgement of work-relatedness of women's health conditions may thus introduce inaccuracy and bias (Messing et al 1994). Lack of consideration of the different health risks associated with different tasks, may lead to the conservative notion of women as the 'weaker sex' rather than identifying aggravating work factors (Mergler et al, 1987).

Many women in Walter's study (1992), considered stress to be "part of life" rather than the result of particular workplace hazards. The conceptual shift in definition of the source of women's health problems, from general life conditions or their particular physiology (particularly reproductive) to hazardous working conditions, has required gender sensitivity. For example, researchers have documented that irregular menstrual periods can be associated with work stress and/or working in cold areas (Mergler & Vézina 1985). Review of job descriptions as part of pay equity work, raised the issues of RSI and stress for women workers at an Ontario newspaper (TARP, 1994). The 1993 Statistics Canada Violence Against Women Survey (cited in Feldberg, 1996) found that in the 12 months prior to the survey, 6% of employed women experienced sexual harassment while over their entire worklife, 23% of women reporting injuries had experienced workplace harassment at some point.

'Caring' or 'emotional' work has just begun to be recognized as an important health risk. Emotional work is defined as "the labour involved in dealing with other people's feelings, a core component of which is the regulation of emotions"(James, 1989:15, cited in Yyelland 1994). Since service workers primarily deal not with things but clients, "the facilitation and regulation of the expression of emotion in the public domain appear to be the core nature of work" (Stelling, 1994). Their frequent employment as teachers, nurses, waitresses, or public servants highlights this component of women's jobs. For example, a good bed-side manner is required in nurses. Nonetheless, nurses are often caught between structural constraints (such as downsizing and changing administrative practices) and patients' and their families' demands to provide a better quality of care (Yyelland, 1994). However, because emotional work is often perceived as consistent with the feminine character and work that women do at home, it may not be regarded as a legitimate occupational health risk. Furthermore, the interaction of demands at work and at home may be considerable, resulting in the famous "double day" of paid work and unpaid house work that can together produce fatigue, stress and anxiety (Duxbury, 1997; Hochschild, 1989, 1997; Statistics Canada, 1995).

Thus increasingly, a broad range of health conditions are being linked to work, recognizing the multiple causes that may give rise to each condition. Yet, these are work-related diseases according to definitions developed by the World Health Organization since they are "aggravated (aggravation of pre-existing conditions), accelerated, or exacerbated by workplace exposures" (WHO, 1985, cited in Jeyaratnam 1992, 5-6). Reluctance to recognize the broader scope of work-related health impacts among women in a timely fashion, may result in the growth of future 'epidemics' of claims that could have been foreseen (see section 6).

6. KEY ISSUES AND POTENTIAL AVENUES

6.1 Information for Gender-Based Analysis

Currently, information by gender is limited to numbers of claims by particular categories, i.e. numerator information. Yet to compare rates of injury or disease by gender, one needs better denominator information. At the most superficial level, this would include gender specific information on employment within each sector and occupation. Such information now comes from other sources that may not truly represent the workforce covered by WCB and must be integrated with claims information to provide rates (Hébert, 1993). Currently availability of such analyses are limited to researchers, rather than being part of the ongoing data available for monitoring equity in the WCB system.

Nevertheless, because of historical gender divisions of labour the use of sector or occupation as a proxy for exposure to hazards is often inappropriate, because men and women may do different work within the same occupational group. Such information can be obtained via periodic hazard surveys. Yet it could also be extracted from systematically organized and recorded inspection and enforcement data (including gender), currently collected by the occupational health and safety arm of the B.C. WCB. This source of more detailed information on jobs and exposures, collected in a routine manner (as per Rest & Ashford, 1992) might permit comparison of different exposures under same job title for women and men.

6.2 Range of Work Hazards

With changes in technology (e.g. increased computerization), in the mix of industrial sectors (e.g. larger service sector) and in the availability of research evidence (e.g. job demand-control and health), a wider range of work hazards are being recognized. Links between work and health go further than traditional notions of injury in occupations traditionally dominated by men (e.g. mine fatalities). Injuries prevailing among women tend to be caused not only by physical characteristics of jobs but also by psychosocial dimensions of women's work. In sectors and jobs where women predominate, slower onset, partially disabling conditions arising out of the nature of employment are increasingly being recognized (e.g. work-related musculoskeletal disorders of the neck and upper limb or RSI). In addition, women's service work requires tremendous 'emotional work', a major source of stress. Yet, stress-related disorders are rarely considered within prevention mandates are problematic areas of compensation.

Movement on an ergonomic standard which includes organization of work as well as biomechanical demands and anthropometric standards are important steps in dealing with this wider range of hazards. Workplace programs which support early reporting and intervention for work-related musculoskeletal disorders are another option. Some jurisdictions (e.g. Denmark) have developed inspection protocols for psychosocial hazards, similar to ones for physical or chemical hazards. The considerable experience with compensation of stress-related disorders in other jurisdictions (e.g. California) could be reconsidered in the refinement of guidelines for Canadian WCB systems.

6.3 Awareness of the Role of Work

Unlike acute injuries, the most prevalent conditions related to women's work tend to arise from multiple potential causes i.e. they are non-specific. Assessment of work-relatedness thus requires knowledge of work factors relevant to the condition and documentation of an occupational history, with specific inquiry as to relevant work hazards. Although ideally the woman's health care provider would do this, few have adequate training or appropriate incentives to obtain such information. Hence, conditions such as carpal tunnel syndrome, which occur more commonly among older women for a variety of reasons, may not be linked to workplace exposures, both through lack of knowledge and a general attribution of women's complaints to biological (e.g. hormonal) differences.

Training on the wider range of relevant hazards and increasing literature linking work and health is one response. In addition to health professionals, claims adjudicators and any consultants drawn in to judge work-relatedness should be the target of such training. Other suggestions to improve documentation of working conditions and sensitivity to women's work-health concerns include: providing specific billing incentives for careful documentation of work-relatedness (Yassi, 1981); increasing the provision of publicly funded clinical occupational health personnel knowledgeable in such matters; and promoting recruitment and advancement of women in occupational health and safety agencies (Rest and Ashford, 1992) and compensation divisions.

6.4 Supports for Recovery

We have shown that in a number of follow-up studies of compensable soft-tissue injuries, women take longer to return to work than men. Potential explanations include: greater degree of disability among women because of barriers to reporting; greater home demands which interfere with the recovery process; or less willingness on the part of employers to provide substantially modified work for women. We have suggested some ways that reporting barriers could be dealt with above. Dealing with women's disproportionate role as family caregivers and home workers is a more daunting task. Some workplaces, recognizing that workers whose family needs are respected are more productive and absent less often, have initiated family-friendly policies such as flexible working hours and part-time arrangements to reduce home-work conflicts. Perhaps further flexible return to work is required for women to promote recoevery euqity.

7. CONCLUSION

The increasing role of women in the labour force and the different mix of workplace hazards, compensated conditions, work/family roles and patterns of recovery which women experience point to the need for adjustments in current work, safety and compensation activities. A prime need is for improved informations systems so gender-based analyses can be conducted. Greater emphasis on research in the health, safety and compensation field which includes gender analyses would then be facilitated. Greater hiring of women in the workplace inspection and prevention area along with training on gender differences in hazards would be useful. Training of health care professionals and agency staff on gender issues in the health, safety and compensation field should occur. Eventually, these actitivies should support policy shifts in the recognition of the work-relatedness of conditions, their compensability and the supports for recovery which reflect women's different experiences of health and work.

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Table 1. Women's top 10 occupations in 1961 and 1996

Order	Women's top 10 occupations in 1961	Women's top 10 occupations in 1996
1	Stenographers, typists and clerk-typists	Retail sales clerk
2	Clerical occupations, n.e.s.	Office secretary
3	Sales clerks	Cashier
4	Maids and related service workers, n.e.c.	Registered nurse
5	School teachers	Accounting clerk
6	Bookkeepers and cashiers	Elementary/kindergarten teacher
7	Nurses, graduate and in-training	Waitress
8	Farm labourers	Office clerk
9	Waitress	Babysitter
10	Sewers and sewing machine operators	Receptionists

Source: 1961 data comes from Wilson (1991). 1996 data comes from 1996 census analysis by Statistics Canada (cited in The Globe and Mail, He's a trucker, she types — 1990s just like the 50s A1. Wednesday, March 18, 1998.

Table 2. Percentage of accepted lost-time injuries by nature of injury and gender in Canada, 1996
(%)

Nature of Injury	Within genders		Across genders		Total
	Women	Men	Women	Men	
Sprains, strains	46.8	40.2	12.4	29.6	42.0
Contusion, crushing, bruises	13.5	15.1	3.5	11.0	14.5
Cut, laceration, puncture	6.4	10.2	1.7	7.5	9.2
Fracture	4.1	6.4	1.1	4.7	5.8
Inflammation or irritation	7.8	4.9	2.1	3.6	5.7
Occupational injury, n.e.c.	5.5	4.5	1.5	3.3	4.8
Other occupational injury or illness	3.8	2.6	1.0	1.9	2.9
Scratches, abrasions (superficial wounds)	1.1	3.5	0.3	2.6	2.9
Others	11.0	12.6	2.9	9.3	12.2
Total	**100.0**	**100.0**	**26.5**	**73.5**	**100.0**

Note: These percentage exclude 'unknown' and 'not-coded' claims.
Source: Association of Workers' Compensation Boards of Canada (AWCBC)

Table 3. Percentage of accepted time-loss injuries by part of body and gender, 1996 (%)

Part of body	Within genders		Across genders		Total
	Women	Men	Women	Men	
Back	29.7	26.6	7.8	19.6	27.4
Finger(s)	9.3	12.5	2.5	9.2	11.7
Leg(s)	6.2	8.5	1.6	6.3	7.9
Shoulder(s)	7.9	5.6	2.1	4.1	6.2
Multiple parts	8.0	4.9	2.1	3.6	5.7
Arm(s)	5.7	4.8	1.5	3.6	5.1
Ankle(s)	4.6	5.0	1.2	3.7	4.9
Hand(s)	4.1	4.7	1.1	3.5	4.6
Wrist(s)	5.6	3.4	1.5	2.5	4.0
Foot(feet)	2.8	3.8	0.7	2.7	3.4
Others	16.1	20.2	4.3	14.8	19.1
Total	**100.0**	**100.0**	**27.3**	**76.1**	**100.0**

Note: These percentages exclude 'unknown' and 'not coded' claims
Source: Association of Workers' Compensation Boards of Canada (AWCBC)

Table 4. Percentage of claims accepted, rejected and pending by gender in Ontario, 1991-1996 (%)

Year	Men				Women			
	A	P	R	Z	A	P	R	Z
1991	86.68	0.02	11.56	1.73	86.11	0.01	12.02	1.86
1992	85.76	0.02	12.64	1.58	85.16	0.01	13	1.83
1993	84.71	0.02	13.96	1.31	83.56	0.02	14.92	1.5
1994	82.91	0.03	15.91	1.15	79.98	0.02	18.47	1.52
1995	82.84	0.04	15.89	1.23	79.58	0.05	18.84	1.53
1996	82.35	0.11	16.51	1.03	79.23	0.14	19.29	1.34

Note: A = accepted, P = pending, R = rejected, Z = amalgamated
Source: Ontario Workers' Safety and Insurance Board