Learning Objectives

After reading this chapter, you will be able to:

- Describe the ways in which the organization of work can affect workers’ health.
- Explain the link between precariousness and poor health outcomes.
- Explain how the size of an employer can lead to differential health outcomes.
- Discuss how gender and race are relevant to the issue of healthy work.
Karen Maleka is a personal support worker (sometimes called personal care attendant) in Guelph, Ontario. Personal support workers care for elderly, disabled, and sick persons in their homes by providing services such as bathing and dressing. Maleka can work up to 70 or 80 hours in a week. “I do full-time hours but I’m classified as part time. I take care of sick people and I don’t have a sick day.” As a result of her status, Maleka has no pension and her benefits are not guaranteed. “Because my employer says I’m part time I have to re-qualify for benefits every year, by working at least 1500 hours. Last year my friend found out she had cancer. She missed a lot of work because she was so sick, and she lost her benefits.” Maleka is paid $15 an hour during her time with clients, but she is not paid for her travel time. Maleka cannot afford a car so often rides the bus 35 to 40 minutes, unpaid, between appointments. She has no guaranteed hours in the week and no job security.

Maleka is a precarious worker. Precarious employment is non-standard work that lacks stability, security, and control. It can be part-time or temporary, and is under-protected by regulation. Precarious workers lack control over how or when the work is performed. Benefits are rare and usually the wages are insufficient to support a family. Women and racialized workers are more likely to be found in precarious employment. Precarious work is also linked
to increased risk of work-related injury and poorer health outcomes, including increased stress and poorer physical well-being. The precariousness of the employment relationship leads to worse OHS conditions. Further, gender and race have OHS implications because certain groups of workers are more likely to hold precarious jobs.

Precarious work is one example of how the structure of work and the employment relationship itself can be linked to ill health. This chapter will discuss how work itself can be an OHS issue. In addition to explaining the reasons precarious work leads to worse health, it will also examine work structure issues such as shift work, working for a small employer, and the health effects of different forms of work.

WORK AND HEALTH EFFECTS

OHS practitioners rarely identify work itself as an occupational hazard. Traditional approaches look at aspects of work—such as work location, tools, and processes—to identify hazards that could harm workers. Yet studying the entirety of work, and even broader effects of work that spill over into workers’ home lives, provides a fuller picture of the health effects of work. Indeed, there is a growing body of research that shows that the structure of work, the nature of the employment relationship, and the type of the employer all have measurable physical and psychological effects on workers. For that reason, it is an area demanding greater attention by OHS practitioners.

Karasek’s Job Demands-Control Model, which was introduced in Chapter 6, links high demand and low control over work to high levels of worker stress. Karasek’s model was the first to connect the nature of the employment relationship to health and safety outcomes. Yet the degree of control over one’s work is only one aspect of employment that can affect workers’ health. This section examines three other dimensions to work that have health consequences: shift work, extended work hours, and emotional labour.

**Shift work** requires workers to work outside of regular weekday hours. It may include regular evening or night work, rotating schedules, split shifts, irregular shifts, or on-call work. Shift work is a growing trend in Canada. In 2005, nearly 30% of employed Canadians did not work 9 to 5, Monday to Friday hours. The most common form of shift work is rotating schedules, where a worker cycles through a series of day, evening, and night shifts. Not surprisingly, shift work is particularly common in health care and emergency
services. It is almost as prevalent, however, in sales and service (e.g., consider the growth in 24-hour stores and restaurants).

The primary concern about shift work is its potential to disrupt a worker’s circadian rhythms. Circadian rhythms (commonly known as the biological clock) are the daily (24-hour) cycles our body follows to ensure (in humans) high activity during the day and low activity at night. Sleeping and waking, eating, adrenalin, body temperature, blood pressure, pulse, and many other bodily functions are regulated by circadian rhythms. When work occurs outside of that daily rhythm, it places strain on the body as it is forced to alter the cycle. A second concern is that shift work is associated with behavior contributing to poorer health, including smoking, poor diet, and increased alcohol consumption. Shift work also disrupts family and social activities. This disruption adds stress and reduces the support that workers can draw upon to manage stress.

Some forms of shift work disrupt the rhythms more than others. The worst forms of shifts are those that are constantly changing (irregular shifts, rotating schedules, on-call), as well as those that invert the natural rhythm (for example, permanent night shifts). Workers whose rhythms have been disrupted can experience insomnia and non-restorative sleep, as well as changes in hormone levels, which can affect cell growth. Workers rarely become habituated to shift work, even after long periods on disruptive shifts.

Research into shift work has been extensive and shows a wide range of health effects. In the short term, shift work leads to shortened and less restorative sleep and chronic tiredness and lack of alertness, as well as stomach aches, indigestion, and heartburn. Shift work is associated with increased risk of workplace incidents and injury. The risk increases as the number of days on the disruptive shift grows. It also jumps if the disrupted shift lasts longer than eight hours.

Longer-term exposure to shift work is associated with a series of illnesses and conditions. Shift workers report significantly higher rates of burnout, emotional exhaustion, stress, anxiety, depression, and other psychological distress. Shift work increases a worker’s risk of developing diabetes, and some studies have also found a greater risk of heart disease. Some studies have also suggested a link between shift work and pregnancy complications. Likely the most significant long-term risk of shift work is increased risk of cancer, in particular breast cancer. The International Agency for Research...
on Cancer (IARC) has concluded that disruptive shift work is “probably carcinogenic to humans” (Group 2A)—the second most conclusive category in the IARC.\textsuperscript{10}

Much less research has been conducted at mitigating the negative effects of shift work. Some recommendations have included:

- Restricting consecutive evening/night shifts to no more than three
- Avoiding permanent night shifts
- Using forward rotation for rotating shifts (moving from morning to evening to night) rather than the opposite
- Providing more than 11 hours’ rest time between shifts
- Limiting weekend work\textsuperscript{11}

The effectiveness of these measures has been sparsely studied and therefore their mitigating power is uncertain. At this time, the only reliable method for addressing shift work’s health effects is preventive: eliminating or minimizing shift work in the workplace. This may be particularly challenging for essential services such as health care and emergency response, given the 24-hour nature of that work. Nevertheless, considering the health risks, there is room to question the value in 24-hour restaurants, late-night convenience stores, and other all-night service industries.

Extended work hours is defined as working for long hours over a period of time. Most commonly it entails working extra hours in a day or over the course of a week. There is some disagreement whether an extended work day is defined as over 8 hours or over 12 hours. In general, extended work weeks are defined as anything over 40 hours. The most obvious consequence of extended work hours is fatigue and the increased risk of error associated with it.

One of the reasons there is disagreement over how to define extended work days is that the research is contradictory regarding the effect of working between 8 and 12 hours. Some (but not all) studies have shown that working beyond 8 hours in a day leads to increased risk of incidents and sleep disruption. When workers work more than 12 hours, the research becomes clearer that this schedule is linked to increased injury rates, more illnesses, and an overall lower level of perceived general health. Some studies have found a link between long hours and pre-term birth. Over the longer term, extended workdays are associated with weight gain, increased use of alcohol, and smoking.\textsuperscript{12}
Working extended hours over the course of a week is also associated with negative health effects. Workers who work longer than 40 hours in a week are more likely to become injured. One study found that workers who worked 64 or more hours a week were almost twice as likely to be injured than those who worked less than 40. Prolonged exposure to long workweeks leads to worsening mental health and an increase in unhealthy behaviour, including poor diet and increased alcohol consumption. Women’s mental health appears to be more negatively affected by long hours than men’s mental health.

When the two types of extended work are combined—working both long shifts and long workweeks—the effects are magnified. Other work factors, such as work pace, temperature, and mental exertion required also intensify the health and safety risks of longer working hours. Particularly concerning is the combination of long hours and shift work (common in health care and other emergency services). Extended working hours also create stress in family and social spheres as work encroaches upon those aspects of workers’ lives.

At the core of all these findings is the physical strain put on the human body by long hours of work. The worker is unable to achieve sufficient rest between periods of work to recover from the exertion of work. Complicating the picture, however, is that many workers prefer extended hours. Extended shifts often result in a compressed workweek, meaning more days with no work. Others appreciate feeling important, busy, or challenged by long hours. As with many aspects of occupational health, workers vary in their susceptibility to the negative effects of long hours.

This hazard is easily controlled by reducing the number of hours worked. The reason employers don’t control this hazard is that longer shifts simplify scheduling and reduce pressure to hire more staff. These economic benefits for employers (paid for by workers in the form of ill health) ensure that long working hours and weeks remain commonplace practices.

**Emotional labour** is a term describing any aspect of a job that requires workers to regulate their emotions to meet organizationally defined rules and to display the required emotions to customers. In other words, workers engage in emotional labour when they are asked to display an emotion—empathy, happiness, friendliness—that they may not actually feel. Emotional labour is a key part of work in many occupations involving clients, patients, or customers and is required of a wide variety of workers, including nurses and doctors, store clerks, restaurant/bar servers, airline attendants, and teachers. Box 7.1 provides a more detailed discussion of emotional labour and its significance.
Box 7.1 What is emotional labour and why do we care?

Think about the last time you had to “fake” your feelings. Maybe you had to stifle your anger at your boss, or needed to pretend to be interested in a boring conversation at a party. Or you had to ignore your distress at leaving a sick child home by herself so you could come to work. Afterward, you may have felt drained, frustrated, or disconnected. This behaviour and its residual effect is emotional labour.

Now think about being a restaurant server. No matter how rude or demanding the customer is or how frustrated you might be at the moment, you are expected to remain pleasant and smile. Certain occupations require workers to respond unnaturally to difficult situations and to ignore their personal lives when they work. It is not always about hiding negative feelings and pretending to be positive. A nurse tending a dying patient needs to stifle his excitement at buying a new house or getting engaged and focus on the patient. Emotional labour is most common in occupations where the worker interacts or works in the presence of the public. That said, it can also emerge in other settings, such as when interacting with powerful individuals like supervisors or executives.

The term emotional labour was first coined in 1983 by sociologist Arlie Hochschild to describe the process of regulating emotions to create a public impression in the workplace. She observed that emotional labour is a distinct dimension of work and is an occupational requirement just as much as wearing uniforms or physical strength requirements. Hochschild recognized that humans engage in emotional regulation in many private settings (e.g., parenting, relationship management), which she called emotional work. Emotional labour is different because it occurs in the context of paid employment and the nature of the emotional regulation is in the control of employer. Emotional labour is also gendered in that women are more likely to be required to perform emotional labour because of occupational segregation.

While Hochschild considers emotional labour to be a negative aspect of work, some researchers argue that, in certain circumstances, emotional labour can be a positive experience, especially if the worker
has some autonomy over its use. Anecdotally, many workers report enjoying the exercise of emotional labour. That said, most of the studies examining the effects of emotional labour have found it lowers job satisfaction and results in psychological stress to the worker. An interesting question about emotional labour is how social expectations (e.g., a server will always be cheerful or a nurse will always be compassionate) are often seen as a universal right, regardless of the situation. Placing the burden of maintaining social demeanor on workers allows customers to escape accountability for their own behaviour.

Emotional labour is a well-established concept in the study of work but is rarely discussed in OHS. The studies that have been performed find extensive performance of emotional labour leads to higher levels of anxiety, stress, and emotional exhaustion in workers. These psychological states lead to a variety of physical and mental ailments over time, including depression.

Emotional labour can also be linked to workplace violence and harassment, in that moments of intense emotional labour are often associated with managing threatening behaviour from customers or clients. Essentially, the worker is forced (by lack of alternatives) to manage a dangerous situation by regulating her own emotions, including fear. One result is that the trauma of the event may then be compounded by the mental costs of regulating emotions under a stressful situation, leading to intensified psychological stress.

Little work has been done to examine how to mitigate the negative health effects of emotional labour, in large part because it is not widely recognized as a significant health hazard. Reducing the need for emotional labour by allowing for a greater degree of honest expression of feelings is a key aspect of reducing the consequences of emotional labour. Allowing safe spaces for “venting,” establishing zero-tolerance policies for customer misbehaviour, and revoking policies requiring workers to engage in emotional labour (e.g., smile policies) are all ways to control the health hazard of emotional labour.

Shift work, long hours, and emotional labour are linked because they all introduce a health risk into the workplace by altering how, when, or what kind of work is performed. In this way, they are distinct from other hazards discussed in previous chapters because they are associated with the nature of work itself rather than a specific task or location. Also, because they are
inextricably linked with the employment relationship, employers have been resistant to recognizing and controlling the hazards they pose.

HEALTH AND EMPLOYMENT STATUS

Work in the 21st century is becoming increasingly insecure. While the *standard employment relationship* (SER), the term for permanent, full-time, secure employment with a single employer, is still the most common form of job, its proportions are dropping. Fewer than two thirds of jobs in Canada fit the definition of SER. The fastest-growing segment of non-SER jobs is precarious employment, which now comprises 20% of jobs in the country. Precarious workers earn less and are less likely to have benefits (or may have fewer benefits) than other workers. Women, immigrants, and young workers are more likely to hold precarious jobs than other Canadians. For employers, precarious work lowers labour costs and increases flexibility, both of which lead to higher profits. While not as prevalent as in the private sector, precarious work is also present in the public and non-profit sector as these employers feel the pressure to reduce costs and emulate private sector practices.

The rise of precarious employment is concerning for a number of economic and political reasons. It reflects growing inequality in Canada and contributes to racial and gender divisions in society. Most worker advocates talk about the economic unfairness of precarious employment and the problems it creates in the labour market and in communities. Precarious employment is also a health and safety issue. The status of being a precarious worker leads to worsened health and safety outcomes.

Repeated studies with different types of precarious workers have shown that they are more likely to get injured at work and their injuries tend to be more severe. Precarious work is associated with deteriorating health and safety conditions in the workplace, and precarious workers are found to be less aware of their safety rights and have more difficulty exercising those rights. Precarious employment has direct effects on workers’ health. Precarious workers report worse mental health, including increased stress-related illness, depression, and anxiety. Evidence for decreased physical health is more mixed, but precarious work is associated with higher levels of mortality among workers.

There are two explanations for precarious work being associated with decreased health and safety outcomes. Michael Quinlan and Philip Bohle
developed the *Pressures, Disorganization and Regulatory Failure (PDR)* model to explain how precarious work leads to poor health and safety outcomes. Their model looks at three groups of factors that shape practices at precarious workplaces. First, precarious workers experience economic pressures because of income insecurity and competition for work which lead them to accept work intensification and dangerous work while making them reluctant to report injury and ill health. Second, the contingent nature of the work relationship breaks down structures that facilitate workplace safety, such as safety procedures, training, and communication. Third, the effectiveness of government safety regulations is reduced because enforcement is more difficult, some forms of work are not protected by regulation, and some workers lack knowledge of their health and safety rights. The result of these factors is workplaces that are less safe.27

The PDR model attempts to explain the increased health and safety risks through precarity’s effects on the workplace structure and practice. While this model does help us understand the workplace dynamics of precarious work, it provides an incomplete understanding of the broader effect of precarity on health. The consequences of precarious work do not restrict themselves to the workplace but spill over into the workers’ private lives, as they take stress, anxiety, and insecurity home with them.

In an attempt to build a more holistic analysis of precariousness and work, Wayne Lewchuk and his colleagues have developed the *Employment Strain Model (ESM)*. ESM looks at the employment relationship in its entirety to understand how workers’ health is affected by engaging in precarious work. The model suggests that the strain of being uncertain about employment combined with the stress of having to make extra effort to maintain and attain work are the cause of the worsened health outcomes. Box 7.2 provides a more complete explanation of the model.

**Box 7.2 Precarity and the employment strain model**

Wayne Lewchuk, Marlea Clarke, and Alice de Wolff have developed a new approach to understanding the health effects of precarious work. They began with the assertion that the reasons for the worse health experienced by precarious workers go beyond the workplace.
While it is sometimes argued that workers in less permanent relationships may be forced into accepting more physically hazardous work, or increased exposure to toxins, this is not the core of our argument. Rather, we argue that there is a limit to how much employment uncertainty and risk can be downloaded to individuals—at some point workers become stressed, and the employment relationship itself becomes toxic.  

They argue what takes place inside the workplace is only part of the picture. “Health effects are embedded in the social structuring of labour markets, and therefore begin well before workers cross the factory gates, enter their offices or begin their work tasks.”

Their model is influenced by Karasek’s job strain model (introduced in Chapter 6). They define employment strain as the interaction of employment relationship uncertainty (i.e., the degree to which a worker is uncertain about his employment future) and employment relationship effort (i.e., how hard a worker works to keep a job or find new ones). This interaction creates four categories of job strain, which can be displayed as quadrants in a matrix.

The model includes a third dimension, employment relationship support, which is the degree to which the worker receives support at work.
from a union, co-workers, family members, or others. Support acts as a buffer to reduce the employment strain experienced by the worker. Precarious workers reported lower levels of support than SER workers.

This research reveals that workers who have high uncertainty, high effort, and low support were two to three times more likely to report poor health than those reporting low uncertainty, strain, and high support. Those experiencing only high uncertainty or high effort but low support also display worse outcomes. The model more accurately explains the complex interaction between ill health and precarious work.

No work has been done to determine how to reduce the ill effects of precarious work, in large part because precarity is not yet widely recognized as a health and safety hazard. Since the origins of its effect begin before work begins, it is a challenge to identify work-related solutions. The only effective method for reducing the health effects of precarity is to create jobs that are more secure and support workers more fully. This solution requires broad-scale social, political, and economic change.

Despite its seeming intractability, it is important to understand the health and safety implications of precarious work. The discussion demonstrates that workplace health extends beyond the workplace. The significance of precarious work is that it is not only the work itself that affects safety; the employment status also plays a large role in determining worker health.

HEALTH AND EMPLOYER SIZE

In Canada, 98% of all employers are small enterprises (<100 employees). Small enterprises employ two thirds of private-sector workers. Small enterprises are also common in the non-profit sector. Most of the research focusing on small and medium enterprises (SMEs) (<500 workers) has been conducted in the past 15 years and has found that workers employed by SMEs are more likely to experience work-related injury and illness. Incidents are more common in SMEs, especially those resulting in fatal or serious injuries, and SME workers are more likely to be exposed to physical and chemical hazards. That said, some studies have found that their psycho-social working
conditions are better due to the close social relationships associated with SMEs. Psycho-social conditions are, however, highly dependent upon the behaviour of the employer.33

Researchers attribute these poor outcomes to particular attributes of SMEs. The tendency of SMEs to have informal management structures, unstructured approaches to OHS, and a lack of OHS resources and knowledge are all factors that contribute to the heightened risk of injury. SME owners also tend to downplay safety risks, see safety as a relatively minor matter compared to the other challenges of running a business, and view government regulations as bureaucratic interference. They also overestimate their knowledge of OHS and, importantly, tend to push responsibility for safety down to their employees.34

These attributes of SMEs interact with other factors. For example, SMEs are more likely to provide precarious work and employ vulnerable workers such as women, immigrants, and youth. Combining inadequate OHS structures in SMEs with the vulnerable and precarious attributes of SME workers intensifies the health and safety risks to those workers.

When examining how to improve the safety climate in SMEs, attention has tended to focus on tailoring training and education approaches for an SME environment or simplifying safety management systems. Recommendations include building trust and communication, creating action-oriented education, checklists, and integrating safety goals with management goals.35 Few of these proposed methods have been rigorously evaluated to determine their level of effectiveness, and their application has been sporadic.

A broader view of the issue reveals that the current system of injury prevention, regulation, and enforcement was designed for (and by) large enterprises. Rules are detailed and written in technical and legalistic language. Hazard control efforts often require extensive knowledge, training, and investment. OHS inspectors lack the resources required to cover the large number of SME workplaces, while the close social relations in SMEs make it less likely that workers will complain for fear of being identified and ostracized. Watering down regulations for small workplaces, often the preferred solution of SME employers, would only make matters worse, as it would further relax safety requirements. Improving the safety conditions in SMEs requires reforms to the OHS system that address the dynamics specific to SMEs that place workers at risk.
In particular, the reforms need to recognize that the conflicting interests found in all workplaces are more acute in SMEs. The employer, who is likely on the worksite daily, sees the effects of safety measures on productivity and cash flow, making them more likely to resist safety improvements. Employers’ close contact with the workers makes it harder for workers to recognize and give voice to the idea that worker interests (safety) may be in conflict with employer interests (profit or cost containment). More effective training approaches do not erase that conflict.

**RACE, GENDER, AND HEALTH**

Who you are affects your safety at work. Different groups of workers have varying safety experiences in the workplace. For example, 63% of WCB-reported injuries in Canada happen to men, even though they make up 52% of the workforce.36 While it may seem on the surface that race and gender have no impact on health and safety—hazardous workplaces affect every worker—in fact, both have a profound impact on how safe a worker is at work. Race and gender can affect health and safety in two ways. First, they can shape how much risk a worker is exposed to. Second, race and gender affect the kinds of hazard workers face.

As suggested above, men are more likely to be injured and to be more seriously injured than women. Racialized workers are also more likely to be injured among both men and women. This means that racialized men have the highest injury rates overall.37 Further, immigrants, in particular racialized immigrants, also possess disproportionately high injury rates.38 Even citizenship status can affect safety, as the lack of status of undocumented workers (i.e., workers who do not have a valid visa to work in a jurisdiction) undermines their safety at work and their ability to stand up for their rights.39

A variety of explanations have been offered for these differential safety outcomes. One explanation centres on ascribed characteristics of the workers themselves. Women are claimed to be more risk-averse than men, and thus they seek out less dangerous occupations. Racialized workers are said to be less risk-averse due to lower education levels and lower income levels. They may also be assigned more dangerous tasks because of the belief that they have poorer language skills. A second explanation critiques the assertion that workers “choose” their paths free of social and economic constraints. While some individual choice is always present, workers’ choices are often limited
by their circumstances. Economic and social vulnerability, fear of losing employment, and lack of options can lead workers to accept degrees of risk they would not otherwise choose.  

It is very important to remember that the racial and gender relations present in society do not stop at the workplace door. Attitudes, stereotypes, and behaviours about race and gender that pervade societal structures shape what happens at work. They govern what job opportunities are available to different groups of workers and they shape how work is conducted in the workplace. For example, due to stereotypes about masculinity and femininity, men are more likely to work in more physically demanding jobs (e.g., construction), which are linked to higher rates of injury. Women, in contrast, are discouraged from those occupations—both through overt discrimination and through job designs that do not accommodate the greater social reproductive responsibilities of women. While individuals do choose their career paths, we cannot understand those choices in isolation from the social forces that shape them.

In North America, there are clear power imbalances between men and women and between so-called “white” (or sometimes Anglo) workers and racialized workers. These imbalances do not work in isolation but cut across both race and gender. They are also reproduced in the workplace and thus will shape the health and safety experience of each worker. Those effects are complex but need to be integrated into our understanding of health and work. At the core, workers from groups that have less power in society will also have less power in the workplace to protect their safety. They will have less control over their choice of job. And they will have fewer options in navigating hazards in the workplace.

A second effect of gender and race is that groups of workers experience different kinds of hazards and risks. In part, this is due to occupational differences (e.g., construction entails different hazards than office work). But even workers doing the same job will experience the workplace from a different perspective, altering their health and safety. This can manifest itself in physical and psycho-social ways. As we saw in Chapter 5, women face additional chemical hazard risks (i.e., embryotoxicity and teratogenicity) due to their child-bearing abilities. Racialized workers are more vulnerable to workplace harassment (or violence) motivated by racism. Importantly, these different exposures can have significant health and safety impacts, as outlined in Box 7.3.
Box 7.3 Gender and workplace health and safety

Two recently published academic articles examine the role of socially constructed gender roles on the health and safety of men and women.

*Waitresses in “Breastaurants”*[^1]

This study examines the work health effects of women who work in restaurants that require female servers to wear revealing or body-accenting clothing. These restaurants, called “breastaurants” in the article, create environments where the servers are sexually objectified as part of their work. The sexualization occurs in the hiring selection process (picking stereotypically “attractive” women), mandated uniform requirements (tight-fitting or revealing clothing), and regulated behaviour toward customers (expectations of flirtatious friendliness). The study, a survey of 300 waitresses, finds servers in this type of restaurant experience greater rates of unwanted comments and sexual advances than workers in other restaurants. It also finds that the work environment results in negative psychological and vocational health outcomes, such as an increased incidence of depression arising from feelings of powerlessness, ambivalence, and self-blame.

*Masculinity and Risk Taking*[^2]

This study is a review of 96 previously conducted studies examining the role of masculinity in occupational health and safety. Masculinity is the socially constructed set of practices attributed to male roles. The article argues that men are expected to follow four rules to establish masculinity: rejection of characteristics associated with femininity; quest for wealth, fame, and success; display of confidence, reliability, strength, and toughness; and willingness to break rules. They isolate five elements of masculinity that affect men’s workplace health and safety:

- Celebration of heroism, physical strength, and stoicism
- Acceptance and normalization of risk
- Acceptance and normalization of work injuries and pain
- Displays of self-reliance and resistance to assistance and authority
- Labour market forces, productivity pressures
The five factors combine to cause men to take more risks, under-report incidents, work through pain, reject assistance, and break OHS rules. The focus of both studies is not on the behaviour or employment choices of the workers but on how underlying social constructions of gender have occupational health and safety consequences. The health and safety experiences of men and women are different because their socialized roles and stereotypes shape those experiences.

The health and safety experience of a worker does not change because they happen to be male or female, Hispanic or Scottish. Rather, their OHS experience differs because the social meaning attributed to a specific gender or ethnicity alters a worker’s relationship to work, employers, co-workers, and customers. That relationship then shapes the worker’s health and safety at work (and in society). That a worker’s health and safety experience is rooted in these social relationships means the experience can be changed. If we alter our notions of masculinity and femininity and break down racial divides, gendered and racialized health and safety outcomes will be diminished. Such large-scale social change goes beyond the role of an OHS practitioner. Yet the differential health and safety experiences of women and racialized workers can be reduced if OHS practitioners become aware of the gender and race in the workplace and take action to reduce the power imbalances that arise from those dynamics.

SUMMARY

Karen Maleka is more vulnerable to occupational injury and illness, not because of the job she performs but because of the nature of her employment relationship and, possibly, her gender and race. This chapter examined various hazards that arise out of the dynamics of work itself, rather than the tasks and locations of that work. Shift work, extended work hours, and emotional labour—all aspects of the job fully within the control of the employer—have negative health effects, regardless of what other hazards may be present in the workplace. We also saw that the size of the employer can lead to worse safety outcomes, which may interact with the mounting evidence that being a precarious worker has significant health and safety
consequences. Finally, we considered how gender and race also shape workers’ experience of safety at work.

That the nature of work and the employment relationship can affect workers’ health is a new concept for OHS. It requires us to rethink what constitutes a hazard and how hazards cause health consequences, including how they interact with non-work aspects of workers’ lives. It also causes us to contemplate new ways of controlling these new types of hazard. The existing recognition, assessment, and control system is inadequate for the task of determining how to reduce hazards of this kind. What is required is a more explicit recognition that employment is a power relationship, and that power permeates all aspects of workers’ lives. Addressing the kinds of hazards discussed in this chapter requires a broader, more holistic understanding of how workplace health is shaped.

**DISCUSSION QUESTIONS**

- Practices such as shift work, extended hours, and mandatory emotional labour have become an essential part of how many occupations operate (e.g., health care, restaurant serving). Can these unhealthy practices be eliminated? How?

- What are the root causes of the negative health effects from precarious work? What can OHS professionals do to mitigate its effects?

- How are the close social relations found in SMEs a double-edged sword for safety?

- Describe how stereotypes and prevailing attitudes about race and gender impact safety in the workplace.

**EXERCISE**

Consider the working conditions at fast food franchise restaurants, including shifts, wages, job security, and job demand and control. Write 200-word responses to the following questions:

1. Identify the health effects that may arise from this work organization and recommend options for remediating the effects.
2. What are the pros and cons from the employer perspective?

Think about your work situation, or that of a person close to you. Write 200-word responses to the following questions:

1. How might dominant stereotypes about race and gender affect your experience of safety in the workplace?

2. Identify five ways in which race and gender shape workplace dynamics.

NOTES

10 Ibid.

15 Lerman et al. (2012).


28 Lewchuk et al. (2011).

29 Ibid., p. 10.

30 Ibid., p. 137.


