



Sick Leave—A Signal of Unequal Work Organizations?

Gender perspectives on work environment and work organizations in the health care sector: a knowledge review

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ABSTRACT

The background to this article review is governmental interest in finding reasons why a majority of the employees in Sweden who are on sick leave are women. In order to find answers to these questions three issues will be discussed from a meso-level: (i) recent changes in the Swedish health care sector's working organization and their effects on gender; (ii) what research says about work health and gender in the health care sector; and (iii) the meaning of gender at work. The aim is to first discuss these three issues to give a picture of what gender research says concerning work organization and work health, and second to examine the theories behind the issue. In this article the female-dominated health care sector is in focus. This sector strives for efficiency relating to invisible job tasks and emotional work performed by women. In contemporary work organizations gender segregation has a tendency to take on new and subtler forms. One reason for this is today's de-hierarchized and flexible organizations. A burning question connected to this is whether new constructions of masculinities and femininities really are ways of relating to the prevailing norm in a profession or are ways of deconstructing the gender order. To gain a deeper understanding of working life we need multidisciplinary research projects where gender-critical knowledge is interwoven into research not only on organizations, but also into research concerning the physical work environment, in order to be able to develop good and sustainable work environments, in this case in the health care sector.

KEY WORDS

Development processes / doing gender / gender / interdisciplinary research / work health / sustainable working life / work environment / work organization

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Introduction

The winds of change affect the structures of working life in the Swedish health care sector

The background to this article is governmental interest in finding reasons why a majority of the employees in Sweden who are on sick leave are women. A sector dominated by women that is interesting to look closer at in relation to this question is health care. From an overall perspective there has been a privatization trend in Swedish health care, with instability and changes to the ownership structures as a consequence, which has erased the borderlines between public and private sectors and affected the work conditions (Kamp et al. 2013). On top of this economic recession and the associated demand for efficient, streamlined organizations have led to a constantly increasing pace of working, and in its pursuit of efficiency, the sector has turned to the manufacturing industry's established management concepts such as Lean production (Brännmark and Holden 2012, McCann et al. 2015, Sederblad 2013). Health care is also a professional sector with clear hierarchies and a significant gender order (Lindgren 1999). Well known is that groups on the work market that have low-status positions, as many women in health care have, are more often than those who have high-status positions negatively affected by organizational changes (Härenstam et al. 2004). Consequently many women in the Swedish health care industry are exposed to negative changes in their working conditions due to privatization and/or new public management (NPM) strategies such as Lean thinking (Kamp et al. 2013). In the late 1990s Landsbergis et al. (1999) published an article on what impact Lean has on workers' health, and have also presented health issues such as stress and musculoskeletal diseases (MSDs). Health problems that we know come with demands on more effective work at the same time as the individual's control over the job is unchanged and the interactions with the management remain the same or even decreased (Ganster and Rosen 2013, Koukoulaki 2014).

The main employment sector for women in the EU is health care and social work (EU-OSHA 2013). When it comes to work health the most common diagnoses in Europe for sick leave are just MSDs and stress-related diseases (EU-OSHA 2013). Health care and social work are also the fourth most exposed work group when it comes to serious accidents at work in the EU member states (Eurostat 2013). At the same time health care and social work are the jobs that have the highest sickness absence in Europe (EU-OSHA 2013). In Sweden women employed in the health care sector and who are on sick leave (for 14 days or more) have the same kind of diagnosis, that is, MSD and mental illnesses (Försäkringskassan 2011).

The overall question to answer with the help of this review article on work environment and/or work organization is consequently why a majority of the workers who are on sick leave in Sweden are women and to be found in health care and social work (Försäkringskassan 2011). The review was originally a commission from the Swedish Work Environment Agency and a special project initiated since the sick absence in Sweden is dominated by women, in all diagnoses except accidents at work and heart-related diseases (Försäkringskassan 2011). Three issues will be discussed in the following sections from a meso-level: (i) recent changes in the Swedish health care sector's working organizations and their effects on gender, (ii) what research says about work health and gender in the health care sector, and (iii) the meaning of gender at work in the health

care sector. The aim is to first discuss these three issues to give a picture of what gender research says concerning work organization and work health, and second to examine the theories behind the issues. The main focus is on the Swedish health care sector.

Methods

The article is based on literature found using the Royal Institute of Technology's (KTH's) library search engine KTHB Primo, which provides access to the university's online subscriptions and includes scholarly journal articles, print journals and e-journals, print books and ebooks, conference proceedings, doctoral theses and dissertations, as well as bibliographic databases. Further searches were conducted using EndNote and the Social Sciences Citation Index at Web of Science (ISI), as well as the Swedish search engines LIBRIS (<http://libris.kb.se/>) and KVINNSAM (<http://www.ub.gu.se/kvinn/kvinnsam/>). The included literature is from the mid-1980s until 2014, with a timeline emphasizing the end of 1990s until today. The searches in LIBRIS and KVINNSAM resulted primarily in the research that is presented here, and that are from the 1980s and the 1990s. Later research is mainly from the scientific search engines presented above.

In order to narrow down the focus in this article, intersections such as class and ethnicity have been excluded. For the same reason the literature covers to a great extent Swedish organizations and its contexts. However, above all, British and North American research is also included. This means that the Anglosphere traditions and organizational cultures are represented and reflected in the article.

The most frequently used search terms were *work organization, organization, work, sex, gender, women, men, femininities, masculinities, health, work health, sick leave, work environment, psychosocial work environment*, and their Swedish equivalents. The terms were searched for separately as well as in different combinations. In some cases the journals have recommended similar articles on their web sites; these are included if they are in the scope of the theme presented in this article. The searches were mainly applied during 2011–2012, and supplemented to a certain degree during 2014.

Represented journals are among others *Gender, Work and Organization, Women's Studies, The American Journal of Psychiatry, Journal of Organizational Change Management, Journal of Health and Social Behavior, Human Relations, Journal of Sociology*, and *Journal of Epidemiology and Community Health*. There are also some Swedish government commissioned investigations concerning gender equality and power, as well as books by publishers specializing in science and academia. The latter is a result of the fact that the tradition of publishing varies between the scientific areas and also over time.

In addition to the report for the Swedish Work Environment Agency a bibliometric study was conducted by Sandström (2013). The aim was to find patterns when it comes to research on working life and work health, and to what extent this research includes gender differences and gender-critical perspectives. The bibliometric is divided into two parts: (i) work health and work environment in medicine, natural sciences, and technical sciences and (ii) work and gender in social sciences (Sandström 2013). A threefold strategy was used by Sandström (2013) in order to grasp relevant scientific journals: a) the starting point was well-known journals in the scope of this study, b) thereafter relevant scientific journals cited in the previously chosen journals were identified, c) finally



all indexed journals from steps (a) and (b) were checked according to citing context and additional journals not identified in (a) and (b) were included.

Results

Changes to the Swedish model (when it comes to the relations between labor market parties (Magnusson 2006)) and the ongoing trend during the first two decades of 2000 toward privatization of the public sector have a strong, multifaceted impact on the organizations within health care. In this section the three main areas that are in the scope of this article will be presented.

Recent changes in the Swedish health care sector's working organizations and their effects on gender

The Swedish labor market model has its roots in the 1930s and an agreement on work life regulations between The Swedish Trade Union Confederation and The Swedish Employer's Confederation (Magnusson 2006). The model can be characterized by concepts such as participation, learning organizations, and close collaboration between employers and employee organizations (Ekman 2011). However, today's trend toward greater efficiency, with its focus on results, means that work organizations increasingly rely on the emotional and invisible work of the individual in order to function satisfactorily (Hochschild 2001), and by this parts of the Swedish model are sidelined. These trends are manifested in the health care sector, with the concept Lean health care (Brandao de Souza 2009) as a leading star, and in practice the characteristics of the Swedish model (as learning and participation) have to give way to other priorities.

Canadian researchers have argued that organizational changes that aim to improve efficiency, which is a topical issue in the Swedish health care context, involve an increase in the invisible work performed by women (Kosny and MacEachen 2010, Messing 1998). Invisible work is often taken for granted and, due to its very nature, not formalized as a value when it comes to job qualifications, with the result that wages are not set accordingly. In addition to the question of formalizing work tasks, invisible care work brings with it work environment risks that are not necessarily visible to the naked eye (Kosny and MacEachen 2010, Messing and de Grosbois 2001). One criticism expressed in research is that the invisible work, which is usually carried out by women, has historically been considered safe and without risk because these tasks fall within the realm of the nonvisual (Kosny and MacEachen 2010).

The study carried out by Kosny and MacEachen (2010) is based on empirical data from three different aid organizations (who operate with the help of employed workers). The results presented from these cases indicate different forms of invisible work: background work, empathy work, and emotional labor. Background work can according to this case (Kosny and MacEachen 2010) be described in terms of practical hands-on work that is neither included in a formal nor an informal job description. Empathy work is described as various forms of relationship-building activities. On top of these two aspects of invisible work comes the workers' ability to deal with their own emotions, in this case in relation to the care recipients/patients, that is the emotional work.

The latter is described by Hochschild (2003) as emotional management, which involves workers striving for keeping emotions under control in order to perform work in the manner that it is expected. The norm of care-related work, and thus emotional management, is affected by intersectionalities such as gender norms, social class, position within the organization, cultural aspects, as well as contextual prerequisites (Wharton 2012). This management metaphor visualizes that employees commit themselves using personal emotional individual capital outside the box of formalized paid work (Hochschild 2003, Husso and Hirvonen 2012). This praxis leads according to Hochschild and Machung (2012) to a certain lack of boundaries between paid and unpaid work, as well as between the individual's public and private identities.

The professionalization of care led in its turn to the fact that the female body became a tool for physical contact with caretakers, the very core of this work, both when using the body for example lifting patients and for tactile touch. Accordingly, these occupations possess what can be described as an inherent vulnerability (Fine 2005) consisting partly of an emotional commitment (Hochschild 2003), and partly of heavy physical labor. We also need to remember that these occupations involve physical contact with patients in intimate areas associated with certain taboos, that is, outside of what is appropriate according to social norms (Fine 2005, Husso and Hirvonen 2012).

In sum, health and social care work can thus be described as physically and mentally demanding. These kinds of demanding tasks are in turn primarily carried out by the low-status profession of nurse assistants, who most often are women. When it comes to a gender-critical perspective on the medical profession, research has pinpointed the fact that psychosocial strain is particularly high for women; this shows in one of the highest suicide rates in the labor market (Schernhammer 2004). What Schernhammer (2004) means is that women working as physicians have to relate to informal requirements, such as working more than the men to get appropriate appreciation from colleagues and employers, this also includes difficulties in getting support from the nursing staff (Lindgren 1999). However, research conducted in Canada shows that women entering the profession have led to new ways of working which include more flexibility and a more balanced work life (Jovic et al. 2006). Still 21 percentage (52 interviewed; 26 women and 26 men) of the women in this study and 3 percentage of the men felt that their family life was negatively affected by their jobs (Jovic et al. 2006). This particular case also highlights the generation differences where the interviewed women and men (who belonged to Generation X and the baby boomers) gave a picture of younger physicians as not working so hard and not putting their profession in front of their private life. A conclusion here is that even if the health care sector is female dominated the traditional gender structures and images still exist, and they affect the working lives in different ways. The gender structures show themselves in the form of clear professional hierarchies where physicians in the male-dominated field of surgery have the highest status, and where female-dominated professions such as nursery, nursing assistants, and occupational therapists have expectations to support and be the organizational lubricants (Lindgren 1999). The values of performed work tasks are in other words highly connected to a social order that includes gender, as the female-dominated professions are subordinated when it comes to hierarchal order, a holding apart of medical treatment and care as well as the professions' social status in our society (Hirdman 1988, Lindgren 1999, Riska 2001).



Being a minority in a workplace involves a visibility based on being different to the prevailing norm (Acker 1990, Gherardi 1994, Kanter 1993). The idea of difference is also a breeding ground for discrimination and sexual harassment, mechanisms that occur more frequently in predominately male environments than in mixed or predominately female ones (Wahl et al. 1998). Women are however not in a minority situation in the health care sector, but they are more often to be found in professions that are subordinated, to the ones that are male dominated. Thus we can see that the gender order (Hirdman 1988) is reproduced in this context and most likely a result of beliefs and expectations of how women and men are supposed to act and behave at work, which in turn is affected by the individual's professional status.

When it comes to gender structures in the field of medicine, Wallace (2014) shows that women working in female-dominated specialties get more formal and instrumental support than those working in male-dominated specialties (Wallace 2014). This could imply that when the group of women constitutes a critical mass the group is professionally recognized. Physicians are, however, a professional group that traditionally has power in health care; this is much due to their status in the organization and society at large, a high degree of autonomy, and higher wages than other medical and care workers (Fine 2005, Lindgren 1999). There are also power structures which show in gender segregation when it comes to different medical specialties. In the Nordic countries there are few women in surgery (10 percent) and anesthesiology (26 percent), but 58 percent in child and adolescent psychiatry as well as in geriatrics (Riska 2001). Riska (2001) highlights that women are to a higher degree to be found in medical areas that are by tradition female oriented such as child care and geriatrics, at the same time surgery is characterized by masculinity from a social constructive point of view. This segregation also affects women's possibilities to have an impact on certain parts of medicine, and further research on this topic is addressed (Riska 2001).

To this discussion also comes that physicians' work is not as physically demanding as that of the nursing staff. One conclusion is that physicians do not perform the heavy and dirty aspects of care work as described above, which also means that they have a lower level of physical contact and closeness with the patients.

What does research say about work health and gender in the health care sector?

We need to discuss the term work health, and ask ourselves whether it should be measured in terms of attendances at work and statistics over sick leave, as these approaches give no indication of how the organization's coworkers really feel. The employers in the health care sector must go beyond this instrumental view and include factors that contribute to creating a good physical and psychosocial working environment. One such factor that shouldn't be underestimated is an atmosphere of open communication, which we know leads to good health (Jeding 1999). Furthermore, research into the characteristics of unhealthy work indicates factors such as sickness presenteeism, reduced efficiency, increased staff turnover, occupational injuries, and conflicts between employees (Jeding 1999, Sandkull 2008). Outcomes in practice can be burnout and physical stress, which is significant for health care staff (Piko 2006) in today's modern organizations.

Another factor that should be added to those mentioned above but is not considered so often in praxis is gender equality. However, research indicates that gender inequality and asymmetric regimes within an organization lead to psychosocial aspects, such as less support, discrimination, and harassments (Kanter 1993, Konrad et al. 2010, Welsh 1999, West and Fenstermaker 1995). In health care we can see asymmetric regimes when it comes to the professional hierarchies and the line managers, where the line manager can be a nurse who is the head over a physician who in turn is higher up than the nurse in the professional hierarchies. A gender-equal workplace with balanced power relations, on the other hand, leads to a creative environment, good work health (Alexanderson 2004), and increased productivity (Abrahamsson 2014). The latter is shown by researchers Arundel et al. (2007), who point out that on a macro-level the EU countries that have a more stable economy are characterized by democratic, learning organizations with an atmosphere of open communication and delegated responsibility.

When it comes to where work takes place, we are in today's society moving toward an increasing tempo in our work organizations, a tempo that to a certain degree is based on boundless work and flexibilities (Hochschild 2001, Hochschild and Machung 2012, Stratigaki 2004). Research in this area shows that women tend to have more open boundaries between paid and unpaid work than men (Hochschild and Machung 2012, Kvande 2009).

There is a risk that this lack of boundaries, or diffused boundaries, makes it even more difficult to set limits between what is private and what is public. This situation may result in increased psychosocial demands and less autonomy, which in turn entails a risk of stress-related reactions that could lead to a burnout in the long term (Karasek and Theorell 1990). One aspect that we know affects health and individual stress levels is the balance between the degree of demands and the degree of control a person has in their work (Karasek and Theorell 1990). Access to informal networks and social support are other factors that influence the well-being of an individual (Kanter 1993, Karasek and Theorell 1990).

In order to explain sickness absence and develop methods to reduce women's work-related health issues, the physical work environment needs to be put into context. Knowledge of how the physical work environment interacts with organizational structures and processes based on perspectives from gender theory must first be compiled, and then developed (Sandkull 2008). Today we see that research on the work environment negligibly contains a gender-critical perspective. Research on public health is according to Sandström (2013) the area where most of the gender-critical perspectives are to be found. On the other hand it is significantly weak interest in gender-critical research on work environment when it comes to medical sciences, natural sciences, and the technical sciences. In Figure 1 we can see a map over labeled clusters including perspectives such as musculoskeletal pain, sickness absence, spine pain, burnout, etc. In this bibliometric map the blue color represents gender-neutral articles and the red color includes a gender-related perspective. The articles are identified by Sandström (2013) through the process presented in this article's method section.

In order to be able to reduce the rate of sick leave we need to achieve a deeper knowledge based on gender-critical perspectives, of how organization, leadership, and ergonomics interact and influence the health of women and men in their working lives. When it comes to research into work and health, most studies up until the 1980s were based on data consisting of men, and thereafter of women and men, only women, or only

Figur 1: A visualization taken from Sandström (2013, p. 56) of the bibliometric study on work environment research (medical, natural, and technical sciences) published in identified peer-reviewed journals. The red color represents gender-related research and blue color gender-neutral research in this area.



men. Analyses of work-related factors and their effect on health based on gender theory have been rare. The empirical focus of the two predominant research areas when it comes to work health—safety at work and hygiene factors, has been on the working life of men. Men are also the group that, based on a normative assessment, take more risks than women, and therefore benefit more from the results of the first research area mentioned.

As globalization increases, structural changes based on women's increased participation in the labor market and in more qualified work tasks, combined with men's increased household responsibilities, have led to a greater need for knowledge about women's work health, including ergonomic and psychosocial issues (Sandmark 2011).

Researchers argue that there are knowledge gaps when it comes to the ongoing gender segregation in the labor market (Abrahamsson and Gonäs 2014), and its consequences for work health, not least on the basis of analyses that, aside from health, include intersections such as gender, class, and ethnicity (Artazcoz et al. 2007).

In contemporary work organizations gender segregation has a tendency to take on new and subtler forms (Abrahamsson 2014). One reason for this is dehierarchized, flexible organizations, another is a well-established political correctness in the Nordic countries when it comes to issues concerning gender and discrimination (Muzio and Tomlinson 2012), where the rhetoric is to work for gender equality. Even if this rhetoric does not always turn into practice it has some effect on the workplace, as it is not correct to be openly unequal. In other words, gender and other intersections are everyday practices influencing the processes that go on in our workplaces (Acker 1990, Gherardi 1994, Karlsson 2013).

In relation to new subtler forms of discrimination, it is interesting that research implies that the more gender integrated a workplace is, the healthier the workers (Alexanderson 2004). Even if we know that gender should not matter, it does (Acker 2009, Gunnarsson et al. 2003, West and Fenstermaker 1995). This meaning takes place in two ways: first when we, more or less unconsciously, use discriminatory practices concerning gender, and second when these practices have an impact on our health at work.

The interdisciplinary research program 'Modern work and living conditions for women and men' (the MOA study), which was conducted in Sweden in the late 1990s, made an attempt to combine gender theory with work health (Härenstam 2000). The aim was to develop methods for conducting exposure assessments and analysis strategies suitable for population studies. These population studies could highlight the significance of paid work to health development and the risks associated with ill-health at the societal level, and make a contribution toward preventative health promotion (Härenstam 2004, Härenstam et al. 2003). In other words, this study had all the intentions that were sought in the international arena around ten years later.

All in all, it became evident in the MOA study that women's working situation had more time constraints and consisted of more everyday obstacles than that of the men. In addition, the women had longer commuting times and higher demands for attendance in their work. Women also had a greater responsibility for taking care of the family and home, and spent more time per week on unpaid work at home. In addition, the women had less time for leisure activities and relaxation than the men. They did, however, have a larger social network than the men, and more influence in terms of when the household work would be undertaken (Härenstam 2000, 2004).

When it came to the men in the MOA study, the results showed that they were exposed to a higher degree of work-related circulatory problems, more often had an extra job outside of their regular work, were primarily responsible for supporting their families, and had a higher heart rate increase in their spare time (Härenstam 2000). It should be pointed out that the above results are from a gender-matched selection, in which women and men were working in the same industry, in the same position, and were objectively assessed to have the same work tasks (at the same workplace in several cases).

Research that highlights these interdisciplinary aspects needs to be further developed in order to understand why these gender differences arise. Even in countries where a higher proportion of those who attend university and higher education are women, patterns arise to indicate that this group has a poorer psychosocial work environment and career development than men, and are also more frequently subject to discrimination (Artazcoz et al. 2007).

The meaning of gender and work in the Swedish health care sector

Research into what meaning gender has in our working lives and work organizations has transferred from focusing on women to include the interfaces between intersectionalities such as gender, class, and ethnicity (De los Reyes and Mulinari 2005). Research into gender and sex in working life from a social constructionist perspective and research into work environment, health, and gender from the scientific and medical perspectives have, until now, been distinct and driven forward along two different paths.



Work organization research remained gender blind for many years, and to some extent, it still is. The importance of gender in organizations and workplaces is not given, even if research and government inquiries (in Sweden) have shown for many years that it does play a role in our working lives (Acker 1990, Deutsch 2007, Korvajärvi 1998, Kvande 2003, Rasmussen 1994, SOU 1998:6, SOU 2004:43, West and Zimmerman 1987), and the health care sector is not excluded from this.

From an international perspective, research into organization and gender became visible on the academic agenda in connection with a sociology conference in the US in the late 1980s that included the theme ‘A Feminist Critique of Bureaucracy’ (Acker 1999). In Sweden, research involving gender perspectives on work organizations came at a relatively early stage, with research already being published at the beginning of the 1980s (Gunnarsson et al. 1985, Ressner 1985). Health care research with gender-critical perspectives on the international agenda has during the last years highlighted issues such as gender, technology, and ageing in health care but also gender differences in health care staff’s emotional work (Husso and Hirvonen 2012) as well as physical, psychosocial stressors and burnout (Piko 2006). Halford et al. (2015) discuss middle management in the health care sector and how this group tackles ageing staff and new technologies at work. Conclusions here are that there are ongoing interactions between dimensions such as gender, age, and technology, and that these consequently cannot be seen as separate tracks (Halford et al. 2015). In practice this meant that the managers did try to be flexible and adjust the older nurses’ work situation, for example, when it came to scheduling work shifts (Halford et al. 2015). Another aspect of gender, technology, and care work is the rapid development of technology and its role in care giving. Gender plays a role here as technology can be said to be masculine connoted (Mellström 1999), at the same time as it is in this context going to be used for care in a female-dominated area. Nursing in today’s modern hospitals can from this point of view be said to be in transformation from a work consisting of body work and emotions to also include technical work and competence (Dahle and Isaksen 2002). Emotional work is however still an essential part of health care workers’ jobs, formally and informally. This is shown in Husso and Hirvonen’s (2012) study on care work in the public sector, where they point out that women are exposed to higher expectations of ‘delivering’ emotional work in relation to the expectations of men, at the same time as the ideologies of NPM also require high efficiency. A vulnerable situation, where women are exposed subjects, as the organizational demands on the individual are to some extent contradictory. The valuation of technical work tasks and emotional and bodily work tasks is in favor of the previous work, and it will affect future work in this sector. In this technical discourse it is important to be aware of the values that emotional work brings into health care (Dahle and Isaksen 2002), and give it space in the work organization’s formal structures and job descriptions. The interactions in praxis between different professions have been illuminated through the gender order theory, especially in research conducted by Lindgren (1985, 1992, 1999). This means that power relations concerning gender and professions have been in focus, but also in intersection with social class.

Research on masculinities has been developed into a well-established form. A pioneer within this discourse, research area, is Robert Connell (1999), who interweaves psychoanalytical and social science research in his book ‘Masculinities’ in an effort to understand both the individual and gender relationships, as well as the meaning of social

structures. These are perspectives that could help to gain a deeper understanding of above all psychosocial work environment, and in this case in health care.

If we give a description of these patterns, we find that there are ongoing processes in most workplaces in the form of hierarchization and segregation of women and men into different positions and tasks (Acker 1990). In most cases, this hierarchization is apparent in the fact that there are fewer and fewer women the higher up you look into the organizational structure (Kanter 1993).

The phenomenon of fewer women higher up in the organization is usually referred to as ‘the leaking pipeline’ (Soe 2008) or as an allocation of men. The former explanation puts the focus on women as the group that leaves the career structure voluntarily. The latter instead brings out the perspective that homosocial factors contribute to the proportion of men growing as we look further up the hierarchy.

Reproduction is a recurring theme and concept in gender research, especially when addressing the mechanisms and processes that contribute to the construction of barriers to change and integration, primarily of women and men (Abrahamsson 2000, Abrahamsson and Gonäs 2014, Bettio and Verashchagina 2009, Holt and Lewis 2011). However, Rothstein (2012) argues that explanations based on the gender order (Hirdman 1988) do not take into account the micro-activities that lead to reproduction of unequal structures in organizations and society at large.

According to Rothstein (2012), economic rationality is an example of an activity that affects the gender structures and has a role to play in the division of labor at home, as for women’s and men’s establishment on the labor market and the time they spend there. The latter is based on the fact that men are more likely to live with women who are younger, and who have therefore entered the labor market at a later date (Rothstein 2012). This situation gives men an economic head start in relation to their female partners, which keeps on growing over time, providing them with a stronger platform in working life and better salary development (Rothstein 2012). According to Rothstein (2012), the choice of which partner goes on parental leave, and takes greater responsibility for the home, is based on this economic rationality, the woman. Some questions that remain unanswered after Rothstein’s discussion on this rationality are however (i) why the man is often older in a heterosexual relationship, and (ii) why the notion of traditional motherhood is so strong in itself.

The American sociologist Hochschild (2002) has developed five different models that show how families deal with this balancing act between public and private. One of these is based on the traditional values and ideas of what is feminine and masculine in our Western culture.

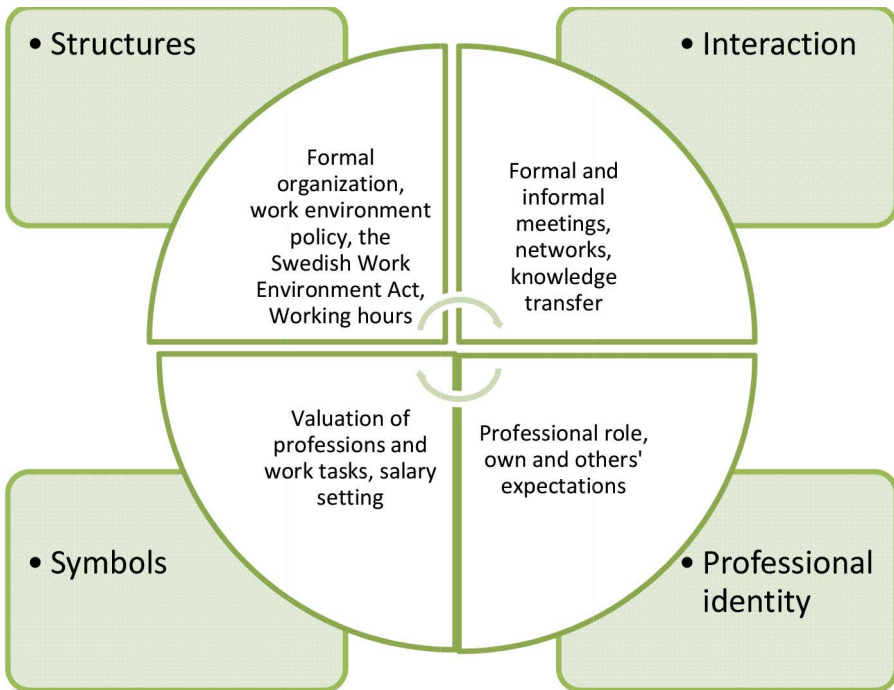
If we want to understand how these structures are created and how we can initiate a change in prevailing values, practices and actions based on theories that highlight gender-marked activities that take place in our workplaces are useful (Acker 1990, Ahrenfelt 2001, Gherardi 1994).

Organizational researcher Joan Acker (1990, 1999) has clearly shown the meaning various micro-activities have in an organization. Acker (1990, 1999) argues that organizations cannot be understood as solid and complete systems as they are made up of processes and the dynamics created through human interactions. One of these processes is the construction of gender patterns within organizations. Concrete examples of different practices that contribute to creating these patterns are the division of labor and distribution of assignments, permitted behavior and expectations on employees, as

well as hierarchies within working groups and between departments. In the health care sector we see a division of labor where a majority of the jobs that contain some form of care are female dominated, examples are nurses, assistant nurses, and physiotherapists (Socialstyrelsen 2014). The construction of symbols and images that explain and reinforce gender differences is also a process that contributes to the meaning sex/gender has in a workplace (Acker 1990). This may involve general values relating to different activities or individual notions about what can be expected from women and men. The processes revolving around symbolism (Gherardi 1994) are reflected in, for example, the valuation and expectations when it comes to women's informal competences within health care.

If we want to develop a sustainable work environment, we need to work with the above-mentioned processes in parallel. It is not enough to simply increase the proportion of women within a field through recruitment. This will not make the gender labeling of work tasks within the other areas of the organization fade away, or change values that relate to various tasks. Based on the processes highlighted by Acker (1990), we can abstract dimensions such as structures, interaction, symbols, and professional identity, which individually and together contribute to the gender-creating processes in a workplace. This is most simply described in a model of these dimensions and their mutual roles (see Figure 2).

Figur 2: Four dimensions consisting of processes that individually and together construct the importance of gender in a workplace (Acker 1990, Kvande 2003, Vänje 2005).



McDonald (2012) highlights an interesting perspective, namely that there have been few studies conducted within predominately female professions and looking at how women and men construct the meaning of gender and perform practices that aim *not* to follow the prevailing gender order (McDonald 2012). A burning question connected to this is whether new constructions of masculinities and femininities really are ways of relating to the prevailing norm or are ways of escaping the gender order and deconstructing the meaning of gender (McDonald 2012)?

In his article, McDonald (2012) presents what he refers to as principles that men in predominately female professions use to reinforce their masculine identity, namely to:

- distance themselves from their female colleagues,
- embody masculine values,
- attempt to reconstruct the professional role, and
- renegotiate and redefine masculine concepts (McDonald 2012)

One concrete example of the above-mentioned practices is how a man relates to his professional role as a nurse without losing his self-esteem and identity (Robertsson 2003).

One important aspect, based on this reasoning, is how easy it is to end up in a catch-22 situation if we always base social constructs in the biological categories of women and men. Detaching ourselves from the biological categorization of gender in analyses of femininities and masculinities creates the opportunity to gain an understanding outside of stereotypes and traditional perceptions (McDonald 2012).

New constructions and variations of femininities and masculinities *may be* a step toward breaking down prevailing norms relating to gender (McDonald 2012). However, expectations concerning how to act like a woman or a man make it easy to find a sense of security in continuing with the sorting and categorization.

Discussion and conclusions

What meaning does then this theoretical knowledge have when it comes to managing the health care sector? It certainly helps us to understand social processes in workplaces, but above all it provides us with tools to work with projects that aim for sustainable change. If we are able to understand the formal and informal power structures, activities, and the prevalent norms of a health care organization, we will indirectly know what aspects are central to process in order to create an improved gender-aware physical and psychosocial work environment.

Emotional work and emotional demanding work are factors considered as psychosocial risks for women working in the health care sector (EU-OSHA 2013). This means that these kinds of work practices that are not directly visible for observations have to be included in not only this sector's work environment policies and actions plans but also as factors being aware of in practical work that aims for decreasing the number of sick leaves. In this development work we also have to be aware of the fact that coworkers' emotional capital outside the formalized job descriptions (Hochschild 2003) causes a boundlessness between the individual's private and public identities (Hochschild and Machung 2012).

An aggravating circumstance is that analyses on work-related factors and their effects on the work health from gender-critical perspectives are rare. What we do



know however is that women's and men's bodies are not as different as we earlier thought, instead these differences are surrounded by myths but also affected by how we live and social constructions (Fausto-Sterling 1992). This means that development of the work environment will be useful for both women and men. In this work it is however of great importance to be conscious about the power structures in the organization and how they affect women's and men's interactions (Acker 1990, Gherardi 1994).

If the current gender inequality in the workplaces is not dealt with (Acker 1990, Göransson 2007, Holt and Lewis 2011, Kanter 1993, Leonard 2003), we will not be able to achieve a sustainable working life either (Forslin 2009). Here it means a working life that is sustainable from the perspectives of crafting employees' individual resources as well as by collaboration between employees and their managers in order to create organizational development (Rees et al. 2010).

There are several conclusions to be drawn from the research presented in this article. A crucial one is that women's higher degree of sick leave can be interpreted as a signal of unequal work organizations. A gender equal work environment paves the way for creativity, good work health, and productivity. On the contrary current research shows that with an unequal work organization and discrimination negative health aspects follow (Pavalko et al. 2003) as conflicts, harassments, and employee turnover.

In order to run an organization smoothly today's management trends such as Lean Health Care relies on individuals' emotional and private engagements in their job tasks. This leads to a certain lack of boundaries between paid and unpaid work, as well as between the individual's public and private identities (Hochschild and Machung 2012). With these kinds of work tasks that are neither formalized nor visible, work environmental risks will appear and have an effect on the work health.

Rather few studies have been conducted within predominately female professions that study how women and men perform practices that aim not to follow the prevailing gender order, that is, to undo gender (McDonald 2012). Doing research on constructions of masculinities and femininities that highlight deconstructing and reconstructing the meaning of gender in health care is therefore called for (McDonald 2012). Empirical knowledge from such studies would be valuable for the development of the work environment in the health care sector.

To gain a deeper understanding of working life we need multidisciplinary research projects on gender that include organizational as well as work environmental and medical perspectives. In other words we need to interweave gender-critical knowledge into research not only on organizations, but also into research concerning the physical work environment and work health. Also this would be valuable knowledge when developing good and sustainable work environments. The latter combines with innovations of new methods for change that lie on a gender theoretical ground, and take contextual preconditions into account.

A question to address for future research is if the gender order is reproduced in the privately owned, formerly public sector organizations, or has the change created an opening for new patterns and conditions when it comes to the working conditions of women and men? There is here a lack of research and need to investigate how the privatization of health care affects what the work involves, and what meaning the restructuring has had on employees and managers from the perspectives of gender and health.

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