Pay and the gender wage gap in health and social care

Report of EPSU Study on pay in the care sector in relation to overall pay levels and the gender pay gap in different countries in the European Union

2010

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Contents

Foreword

EPSU commissioned this report before the current global financial crisis knocked on our doors and swept in across all sectors of the economy including public services. Indeed, as the report goes to press, public sector workers across Europe are fighting reductions in pay and services. A large number of these workers, often already underpaid, are women paying the cost of a failing financial and economic system that has been geared towards the few rather than the many.

The report is the result of prior discussions in the EPSU Social services working group, Health and Social Services and Gender Equality committees.

It examines the pay levels in health care, child, elderly and other dependant care (home or residential) in 8 EU countries compared to national average wages in the public and private sectors, the extent of the gender pay gap, and the relationship with the overall national gender pay gap.

The results are alarming.

In the countries surveyed, workers in health and social care earn below national average earnings (with the exceptions of Estonian nurses and carers for the elderly in some regions of Germany). Earnings of unqualified or lower skilled workers are often at minimum or basic wage levels or not much higher; whereas qualified and professional staff earn salaries below those in comparable jobs in other sectors of the economy. In addition to low pay and low status, precarious contracts, irregular working hours and few career opportunities complete the picture.

Even though staff shortages and the demand for care workers are expected to grow exponentially in an ageing Europe, governments fail to improve the attractivity of this sector.

The gender dimension is self-evident. In the European Union, at least 80% of employees in the health and care sector are women. Many of them are migrants which brings the question of ethnic discrimination to the fore.

The report brings alive what we mean by a persistent undervaluation of women's work as the key cause of inequalities based on gender. It brings us at the heart of why women earn on average in the EU 17% less than men.

EU governments and the Commission regularly state their good intention to close the gender pay gap. But they fail to recognise that improving the wages of women-dominated jobs and sectors, as called for by the EPSU congress last June, is part of the answer.

Yet it does not take much arithmetic to work out that improving wages and working conditions in the care sector will reduce the average gender pay gap. It will give incentives to attract more men and thus help reverse the so-called gender segregation of our economies. Gender segregation is seen by the Commission and governments as one of the main causes of the gender pay gap. However, why improving women's wages in this sector is not part of the equation? Cost? But then, what is the longer term cost of having underpaid staff that provide care and treatment to our children, parents, friends and ourselves?

The report also shows that the age profile of home carers means many will retire in the next ten years. Unless we take steps to encourage young people into the profession, by giving them a clear career structure and scope for development, we will be turning the current recruitment difficulties we've got now into a full-blown crisis.

The report highlights the problems of organising and funding services in the current climate of reductions in funding and restructuring, including the privatisation and contracting out of services.

Current reforms and restructuring in this sector have to be gauged against their effects on quality working conditions especially decent pay levels and their contribution to gender equality, not against public deficit reductions. Ensuring that the pay levels of services that are contracted out are equivalent to rates in the public sector must be underpinned by EU regulations, including a revised equal pay directive.

This report is an alarm bell for actions to improve public care services, which are critical to any serious strategy aiming at closing the gender pay gap and getting the right balance between work and family life.

It offers examples on how our affiliates are tackling the question.

We are grateful to Jane Pillinger for this report and useful recommendations addressed to EPSU, our affiliates and EU decision-makers. We also thank our affiliates who have helped provide the data.

Comparing wages between countries and within different sectors can be complicated in the absence of much comparable data available. This report contributes to this difficult exercise which is essential for basic trade union work and for getting a better deal for women. While further research will be needed, the findings are clear.

A pay rise for Europe's care professionals is long overdue.

Carola Fischbach-Pyttel,

EPSU General Secretary

Brussels, 12 February 2010

Section 1: Overview of European data on pay and the gender wage gap in health and social care

1.1 Introduction

This report presents the findings of a study on the pay of health and social care workers in relation to the overall pay levels in public and private sectors, and the gender pay gap. The study has the objective to inform the debate on the gender wage gap in the care sector within EPSU and also to raise awareness across Europe about the pay situation in the care sector, including providing an evidence base upon which EPSU can make submissions to the European Commission on the gender pay gap, work-life balance and social services of general interest.

Evidence has been collated from a selection of countries covering data on the wages of male and female workers in different professions and different sub-sectors. Subsectors include care of older people and disabled people, child care, social services, community care, psychiatric care and general hospitals. Professions identified for coverage included amongst others care assistants, nurses, social educators, social workers and doctors.

Objectives of the study

- To compare data on wages in the care sector with the pay situation and the gender pay gap in the selected countries.
- To provide an analysis of pay inequalities in the EU based on the case of care workers.
- To provide an overview of demonstrated good practices and obstacles for improvement of wages in the care sector.

The information presented in the study was collected through a survey, based on a short questionnaire, telephone interviews and correspondence by email. This formed the basis for drawing up case studies on specific countries.

It is stressed that because of the different systems of data collection, and different structures of pay determination and pay levels, occupational groups, working conditions and contractual arrangements in health and social care, that it was not possible to compare health and social care data.

Health and social care are highly complex areas of public service provision. The low wages paid to workers who provide skilled care to the most vulnerable is an indication of the general low value given to work in this sector. This report shows that:

- Health and social care work is generally undervalued and low paid compared to other sectors. Despite low wage levels many care workers have a high work morale and sense of responsibility for the people they care for.
- The sector is female dominated and characterised by occupational segregation.
- Staff shortages and problems in recruiting and retaining staff, combined with new demands from an ageing population, pose significant challenges for the sector.

- Restructuring of services is having a significant impact on service provision and pay levels.
- Low value is given to care work – the lack of a care culture and a care ethic means that work in the sector is poorly valued and not funded accordingly.
- The workforce of the future that is able to provide a high quality service, will be dependent on improved salary levels.

Section 1 of the report provides an overview of and a discussion of EU level and comparable data that has already been compiled on pay rates and the gender pay gap.

Section 2 presents the findings of eight country case studies in order to highlight the pay gap in health and social care and also to draw out specific issues facing unions negotiating on behalf of health and social care workers at the national level. The objective of the case studies is to draw out different approaches, including best practices and challenges that exist, in reducing the pay gap and/or improving women's wages in health and social care at the national level.

Section 3 draws some conclusions and makes recommendations to EPSU, its affiliates and the European Commission.

1.2 Data on pay levels at the national level

Little is known of the actual employment and pay situation of health and social care workers across Europe with regards to the gender pay gap. Part of the difficulty is that there is limited comparative European data regarding the gender pay gap in the sector, and although national data is collated in a large number of countries this is not always comparable.

Earnings data, broken down in occupational groups in health and social care, exist in some countries such as the UK, Sweden, Finland, Ireland and Spain. These are countries that have undertaken national pay surveys and in some cases data has been compiled by unions as an evidence base in supporting negotiating roles. In Germany and most Eastern and Central European countries there is an absence of national and regional data on pay levels in the health and social care sectors, and where this does exist data is highly dispersed.

At the European level Eurostat data, based on the Labour Force Survey in particular, and the European Working Conditions Survey undertaken periodically by the European Foundation, provide the basis for some broad data analysis across the EU member states. However, they have limitations in the extent of micro-data relevant to this sector, and in some cases data collected does not include the health and social care sector. Some useful data does exist, however, on the gender wage gap and gender trends in wages across Europe.

1.3 Social and healthcare care in Europe: a low value, low status sector –

Employment in health and social care is predominantly female and the sector has been faced by labour shortages, a poor image and job insecurity. For the large part the undervaluation of predominantly female work in health and social care and occupation segregation has meant that the gender pay gap is substantial in this sector. Given the large number of women employed in this sector, this has also strong repercussions for the gender pay gap across the economy.

Previous research by EPSU and the PSI on the gender pay gap has shown the added value of trade union membership to workers in the public sector, with a narrower gender pay gap being noted in unionised as compared to non-unionised sectors (EPSU 2004; EPSU/PSI 2004). Evidence from other surveys across Europe has shown that the care workforce is overwhelmingly female, often with low pay and underdeveloped career structures (Rubery et al 2005). As many European countries have faced challenges in recruiting staff to this sector it is argued that more favourable working conditions and pay will contribute to the attractiveness of the sector (European Foundation 2006).

Health and social care is provided in a variety of organisational and institutional settings across Europe, in the public, voluntary and non-profit, and private sectors. There have been significant changes in policy and organisational structures, including decentralisation, contracting out, public-private partnerships and privatisation, particularly the new member states of the EU. These factors along with reductions in public expenditure on health and social care affect the earnings of women and men in the health and social care sectors.

According to the European Foundation's (2006) report on employment in the social care sector, the sector is faced with an ageing population and workforce and the need to improve the quantity and quality of care. However, this is made difficult because of low pay and high turnover in the sector:

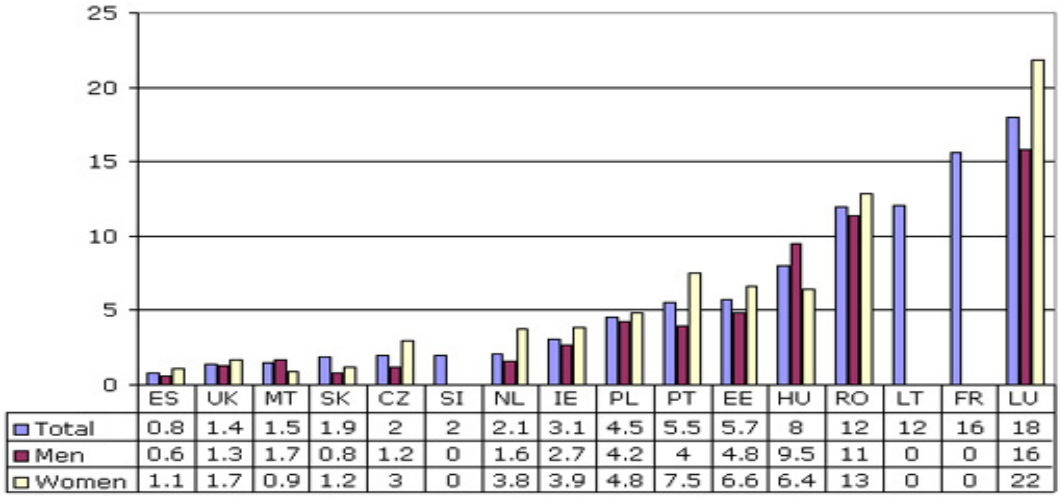
> "Low pay, low status, and high rates of turnover and burnout make it difficult to attract workers to the care sector and to keep them in their jobs. Meanwhile, given the enormous change in the structure and role of the family, demand for formal care services is on the increase: care work traditionally performed in the home must now be undertaken by the community" (2006: 1).

In some countries the problems of recruiting and retaining staff in the health and social care sectors has been a result of low pay, the perceived lack of career opportunities and the lack of attractiveness of work in the sector. The length of time needed to gain recognised social care qualifications, combined with the perceptions about limited career opportunities, has resulted in some local authorities fast tracking training and offering pay incentives to enable new graduates to training more quickly and gain qualifications while being paid (European Foundation 2006).

1.4 Low pay

The gender pay gap and the right to receive a fair wage have been important principles underpinning the European Social Model. Equal pay for work of an equal value had been a fundamental social right of the EU, dating back to Article 119 of the Treaty of Rome and the subsequent Equal Pay Directive. In 1989 the European Commission referred to fair pay in the 1989 Charter of the Fundamental Social Rights of Workers which stated that “all employment shall be fairly remunerated”, based on having “a wage sufficient to enable them to have a decent standard of living”. The definition of what is considered to be an equitable wage varies across Europe, as do levels of minimum wages. However the most commonly defined definition is that of the Council of Europe’s which defines a minimum equitable wage as two-thirds median wage of the average national wage.

Table 1: Full-time workers on minimum wages, by sex (%)



	ES	UK	MT	SK	CZ	SI	NL	IE	PL	PT	EE	HU	RO	LT	FR	LU
Total	0.8	1.4	1.5	1.9	2	2	2.1	3.1	4.5	5.5	5.7	8	12	12	16	18
Men	0.6	1.3	1.7	0.8	1.2	0	1.6	2.7	4.2	4	4.8	9.5	11	0	0	16
Women	1.1	1.7	0.9	1.2	3	0	3.8	3.9	4.8	7.5	6.6	6.4	13	0	0	22

Source: Eurostat, 2006

Table 1 shows that in those countries where the number of full-time workers on minimum wages is broken down by sex, women are more likely than men to be working on minimum wages. This data is limited to full-time workers and it is likely that the numbers of women working on minimum wages would rise if the data were to take account of part-time work.

Wage Indicator data shows that in many European countries between 10 and 20 per cent of employees earn wages that do not meet the two-thirds median wage threshold (Van Klaveren et al 2007). Women and in particular part-time workers are likely to fall below the two-thirds threshold, many of whom work in the health and social care sectors. Data from the European Foundation (2006) finds that women predominate in low paid jobs in Denmark at 10.7 per cent, compared to 6.4 men; in Germany 29.6 per cent, compared to 12.6 per cent of men; in the Netherlands 21 per cent, compared to 13.6 per cent of men; in the UK 26.6 per cent, compared to 15.1 per cent of men; and in France 17 per cent, compared to 8 per cent of men.

Substantial numbers of low paid women can be found in the health and social care sector. The Wage Indicator datasets from 2005, shown in Table 1 show that health care is positioned in the lower ranks of occupations classified by pay levels. For example, in Belgium 20 per cent of health care workers are low paid, Finland this is 7 per cent, Netherlands 19 per cent, Poland 44 per cent, and the UK 18 per cent (Van Klaveren et al 2007).

Table 1: Incidence of low pay for men and women, in the public sector and in health care, 2005, percentages

	BE	**DK**	**FI**	**GE**	**NL**	**PL**	**UK**
Male	12	9	4	9	16	23	12
Female	26	12	7	18	31	30	21
Public sector	19	-	1	8	10	39	11
Health care	20	-	7	15	19	44	18

Source: Data of hourly earnings from national Wage Indicator datasets compiled by Van Klaveren et al (2007)

1.5 The gender imbalance in care work

As the previous sections showed the care workforce is overwhelmingly female, often with low pay and underdeveloped career structures. An examination of the European care sector from a supply perspective, carried out by the European Foundation (2006) suggests that there are a number of weaknesses in the social care sector, including relatively few young labour-market entrants and the intensifying levels of staff turnover (often due to the lack of career prospects and poor working conditions). The research highlights problems in the sector which are affected by the continuing poor perception of social care as offering low rates of pay in part-time or short-term employment contracts. Cancedda (2001) also finds that in some countries labour supply factors are more important than those affecting demand. For example, in the UK, labour shortages in the home care sector arise because of the occupation's low salaries and poor working conditions. These were also seen to be affected by improved opportunities for finding alternative work in the local labour market.

Research in the UK has also shown the importance of understanding the role that the gender pay gap has on lifetime earnings. The income gap is on average 27 per cent, but this rises to 47 per cent on retirement. This means that women on average are likely to earn £250,000 (€371,073.68) less than men over a lifetime. The gender pay gap rises if women work part-time and there is an equal pay penalty attached to part-time work, with almost two-thirds are working below their potential (Grant, Yeandle and Buckner 2005). Evidence also shows that girls are outperforming boys at school and that the achievement gap continues into higher education – but they still earn less and are rewarded less for their work (Grimshaw and Rubery 2007) .

The undervaluing of women's social care and health jobs relates to wider norms and attitudes in society, where women's skills are often less visible than men's and often they are skills that are hard to quantify especially when linked to productivity – women are stereotyped as being naturally good at the job and are thought to be prepared to trade lower pay for job reward. Across Europe the majority of the lowest-paid occupations are dominated by women – research from the UK shows that simply being in a female-dominated occupation can reduce your pay by as much as 9 per cent (Forth and Milward 2000).

Research by Coomans (2002) has also shown that labour shortages will continue to exist in the care sector, in part as a result of the ageing population and an increased demand in care services, as well as a result of the ageing of the workforce. He states that any occupation recruiting 'lowly qualified women around the age of 30 years' will need to significantly improve the quality of jobs offered, in order to make them more attractive to workers".

The European Foundation's research (2006) suggests that a number of issues need to be addressed in order to enhance the attractiveness of social care employment in all Member States. Improving pay levels is an obvious means by which to do so, as is the importance of making the sector attractive to new employees by developing clearly defined career progression routes, addressing the physical and emotional strains and stresses, irregular working hours, heavy reliance on part-time and short-terms contracts, and geographical and professional isolation. The European Foundation study suggests that encouraging a more gender-balanced social care workforce could increase the overall supply of workers and enhance the value of the work. For example, in the UK, the aim is to increase the proportion of male workers in childcare to 6 per cent, while in Norway a target of 20 per cent has been set. It concludes that:

> "More favourable working conditions and pay will contribute to the attractiveness of the sector. Pay levels for carers in some of the countries studied is close to the minimum wage, despite the skills required for working in the care sector. Such pay levels contribute to the poor image of the care sector. Moreover, many employees perceive care work as a totally unattractive form of work". (2006: 65)

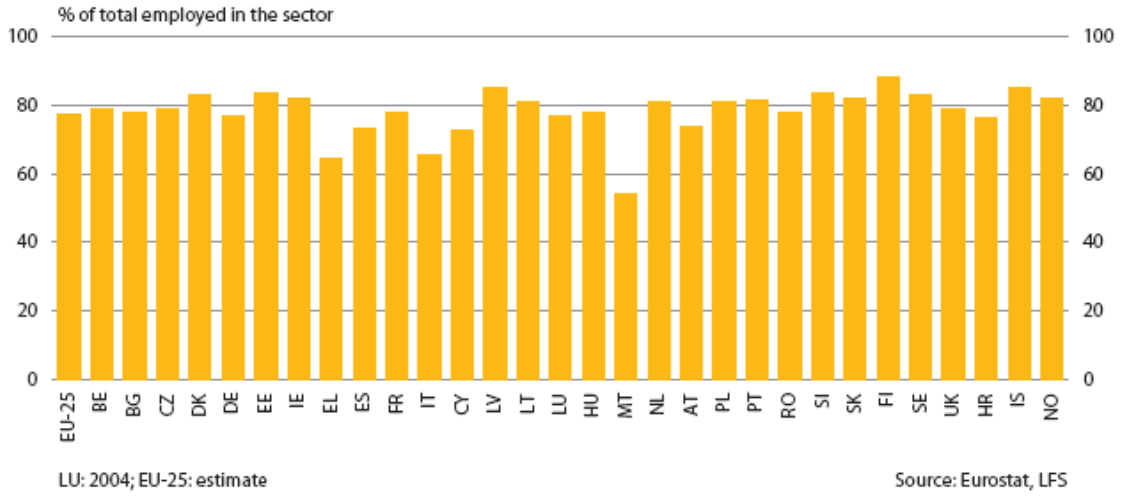
The gender imbalance in the social care workforce and the perception that skills associated with care provision are largely restricted to women influences the pay offered by the sector. As Perrons (2003) argues that because women disproportionately carry out care services and because caring skills are perceived as being female in nature, the skills associated with care work tend to be undervalued and underpaid, whereas Cacedda (2001) argues that this factor is less important in relation to better qualified workers.

1.6 Employment rates and occupation segregation

There are high rates of employment of women in the health and social care sector. Occupational segregation is one of the most significant factors affecting the gender pay gap in health and social care.

As Table 2 shows women make up almost 80 per cent of those employed in health and social work, with variations between countries.

Table 2: Women as a share of total employed in health and social work, 2005 (Eurostat, 2008)



Eurostat (2008) data also shows that in twelve of the EU Member States, health and social work was the largest employer of women in 2005, as it was also in Iceland and Norway. In three Nordic Member States and the Netherlands, it accounted for between 28 per cent and 32 per cent of all women in employment. Moreover, there are larger differences between the occupations and jobs that women and men hold, and these differences tend to be wider than those that exist between the sectors in which they are employed. This means that in health and social care, as in other sectors, the degree of concentration in a limited number of occupations is much higher among women than among men.

The Fourth European Working Conditions Survey (European Foundation 2005) found that European labour markets are highly segregated. Around half of the female workforce was found to be in two main sectors of education and health (34 per cent). The survey also examined the distribution of low, medium and high pay across the genders and sectors. In the area of education and health more men than women occupied the higher paying brackets.

Across the economy employment rates for women remain substantially below those for men in most of the EU Member States. Despite the continuing reduction in the disparity between male and female employment rates, large gender differences of around 20 percentage points and more still remain in Cyprus, Greece, Ireland, Italy and Spain, while in Malta the gap is almost 40 percentage points, reflecting the fact that only one in three women of working age is in employment. Only Bulgaria, Denmark, Estonia, Finland, Latvia, Lithuania, Slovenia and Sweden show a gender disparity of less than 10 percentage points (European Commission (2007).

Another important factor that has to be taken into account in understanding the pay levels of health and social care workers is that many more women in employment than men work part-time hours. In the EU as a whole, almost 94 per cent of men usually worked 35 hours or more a week in 2005 compared with 64 per cent of women. Almost 9 per cent of women worked 'long part-time' hours (30–34 a week), around 20 per cent worked 15 and 29 hours a week and just over 6 per cent, less than 15 hours a week. However, patterns of working time vary between Member States. In the Netherlands and Germany, 14–15 per cent of women worked under 15 hours a week, compared to women in Ireland, Austria and the UK where 6–8 per cent of women worked under 15 hours a week, whereas 5 per cent of women in the remainder of the Member States worked under 15 hours a week (Eurostat 2008, reporting on data for 2005). According to the Fourth European Working Conditions Survey (European Foundation 2005) there is an overrepresentation of women part-time workers in low paid jobs; the survey found that between 70 and 80 per cent of part-time workers are in the lower pay brackets.

1.7 The gender pay gap

The gender pay gap refers to the relative difference in average gross hourly earnings of women and men. It is one of the structural indicators drawn up by the EU to monitor the implementation of the European Strategy for Jobs and Growth. Addressing the gender pay gap has also been established as a priority for the European Commission in the Roadmap for Gender Equality, 2006-2010. In 2007 the Commission issued a Communication on *Tackling the pay gap between men and women,* which set out a number of recommendations, including a call to the social partners "to continue to implement their framework of actions on gender equality, in particular as regards the priority given to reducing the pay gap" (European Commission 2007: 10).

There is no one single cause of the pay gap. The pay gap is related to a number of factors including individual differences, such as age, education level and experience, the type of job and the sector within which the job is located. When account is taken of these differences between women and men, discrimination still accounts for a small percentage of the gender pay gap. However, the gender pay gap needs to be understood in the context of economic, social and legal factors, so that account is taken of the position of women in society. In this context women are likely to work in jobs that undervalue their skills and training. In particular,

where there is a clustering of women in specific occupations rates of pay are likely to be lower than in those where men predominate.

Occupational segregation a major factor affecting the pay rates of women and men. Across Europe around 40 per cent of women work in health, education and public administration, compared to 20 per cent of men. Within these occupations women are more likely to be found in lower skilled and lower paid positions. Childcare responsibilities and difficulties in balancing work and family life mean that nearly one-third of women across Europe work part-time, compared to 8 per cent of men.

Across the EU as a whole, average gross hourly earnings of women were, on average, 15 per cent below those of men in 2005[1]. The gender pay gap exists in all Member States and in 2005 there were only eight countries out of the 27 where the pay gap was less than 10 per cent, while six countries (Germany, Estonia, Cyprus, Slovakia, Finland and the UK) had a pay gap of 20 per cent or more.

The European Working Conditions Survey 2005 found an unequal income distribution between men and women (based on net monthly income and used to match the distribution of earnings collected in the European Structure of Earnings survey). Differences in income distribution show that, with the exception of Romania and Bulgaria, almost 50 per cent of women are in the lower pay brackets; and only 20 per cent of women fall into the upper pay brackets. Half of the female workforce is clustered into the two sectors of education and health. In education and health 30 per cent of women are in low income brackets (compared to 15 per cent of men) and just over 20 per cent of those in higher pay sectors.

More detailed data on the pay gap is available from the Structure of Earnings Survey (SES) carried out in 2002. However, it excludes public administration, education, health and agriculture. As a result the data differs from the estimates made for the whole economy from the 2005 Labour Force Survey presented above. As Table 3 shows the gap shown by the SES is wider for all countries than that shown by the 2005 estimates. Despite these limitations, the SES enables the wage gap between women and men to be examined by age, education level, occupation and length of service. These are all aspects which affect earnings and which provide some explanation for the gender wage gap. What the SES shows is that educational background, experience, length of time in a job and working hours all impact on women's lower earnings compared to men. However, they do not account for the full gender wage gap, which infers that the undervaluing of women's work and gender discrimination in pay systems continues to underpin the gender wage gap. As Table 4 shows age is a factor in understanding the gender wage gap, with older women experiencing a wide gender pay gap than younger women. This is a particularly important factor in the health and social care sector, which has a profile of an older workforce.

[1] Based on women aged between 16 and 64 years of age working 15 hours a week or more.

Table 3: The pay gap between women and men, 2005

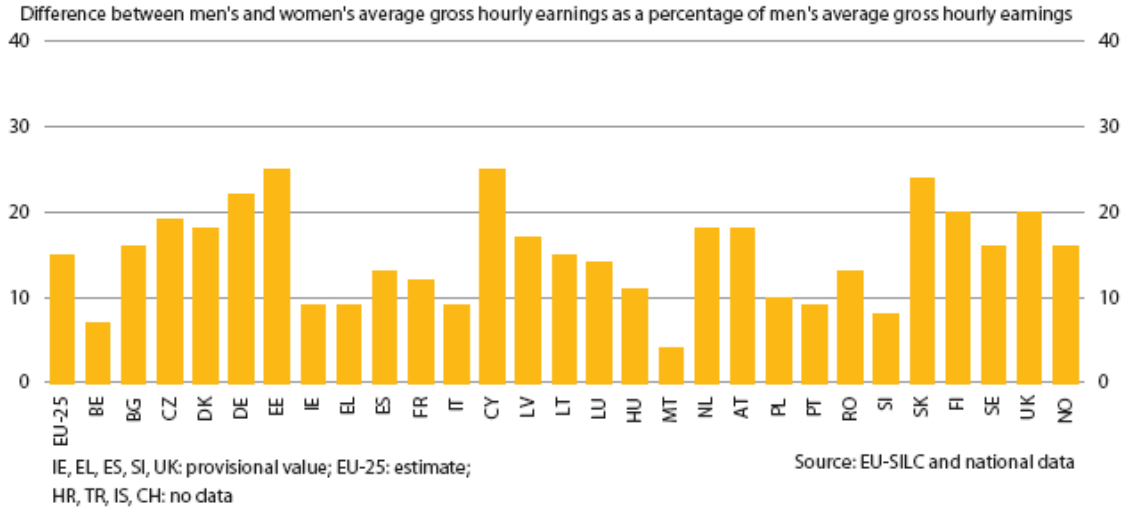
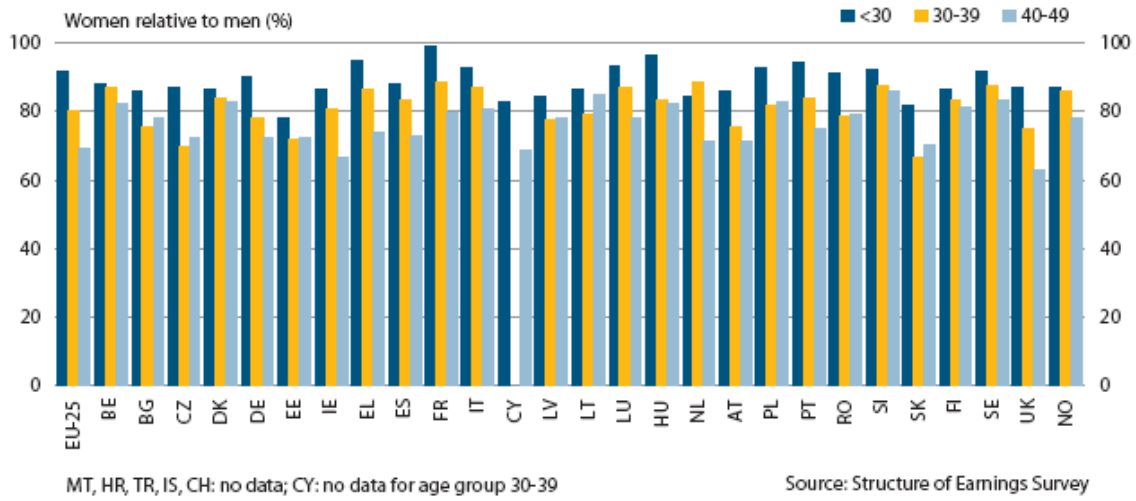


Table 4: Average hourly earnings by age group, women relative to men, per cent, 2002



Section 2: National case studies

Introduction

In this section case studies of the pay of workers in health and social care have been drawn up from the following eight countries:

- Belgium
- Estonia
- Finland
- Germany
- Ireland
- Latvia
- Sweden
- UK

Case Study 1: Belgium

Summary

- Workers in health and social care are predominantly female, in particular home care workers have jobs are low paid.
- Female dominated jobs in health and social care are devalued and lower paid than jobs with comparable levels of education and training.
- Pay scales in health an social care vary across different sectors and regions, which causes problems for trade union negotiations.

Pay data

In Belgium employment in heath and social care tends to be female dominated. Lower rates of pay for women in this sector, when compared to other sectors, arise because of occupation segregation and the under-valuing of women's skills.

Research in Belgium funded through the EU's Proxima programme, shows that almost all home care workers (99 per cent) are women (EIRO 2007). They tend to be low-skilled and are around 40 years old with 12 years' experience in the job. Although low-skilled, most of the workers followed a specific certified vocational training programme to perform their job. The most important reasons given by women for choosing this career path are their desire to help people, the human relations element of the job, the degree of job autonomy and increased options for better work–life balance.

Data provided for Belgium (Wallonie) by the CSC public service union shows that different pay scales have been established in local public services (municipalities, communal social services, provinces and intermunicipal) in the Walloon Region. These scales may be different in the Flemish Region and Brussels Region and in the private sector, although the pay scales are the same regardless of the sectors in local government. Other aspects of salaries overtime, extra for Saturday, Sunday and public holidays and nights are not included in the pay scales. The data covers public sector workers, but not doctors who are very rarely employed because they have an independent status.

The difficulty faced by unions is that negotiations must be carried out for each level of government: Federal (hospitals and rest homes), Regional (three regions), and Local / Communal level.

Table 5 shows the percentage of workers by gender in selected areas of the public sector. Women are overwhelmingly those providing nursing and social care.

Table 5: Percentage of workers by gender, selected areas of public sector

Sector	Women	Men
Nurses and carers	88.7	11.3
Care of children / home help	98.8	1.2
Assistants and social workers	76.9	23.1
Disabled sector	68.8	31.2
Employee public administration	60.5	39.5
Technicians	9.9	90.1

On 1st February 2008 salaries were increased by 4 per cent, following two indexations. However, as the following two tables (Tables 6 and 7) show women working in predominantly female jobs are paid at lower levels than those in positions with comparable education and training.

Table 6 shows comparisons of salaries between graduates in nursing, administrative and technical positions. It shows that social workers and educators have a salary higher than the administrative staff, but lower than the technical staff of equivalent training. Table 7 shows that family and child care workers are devalued in relation to technical and administrative occupations that have the same levels of education and trainings.

Chart 6: Comparison of salaries between social workers and educators, and staff in comparable administrative and technical positions

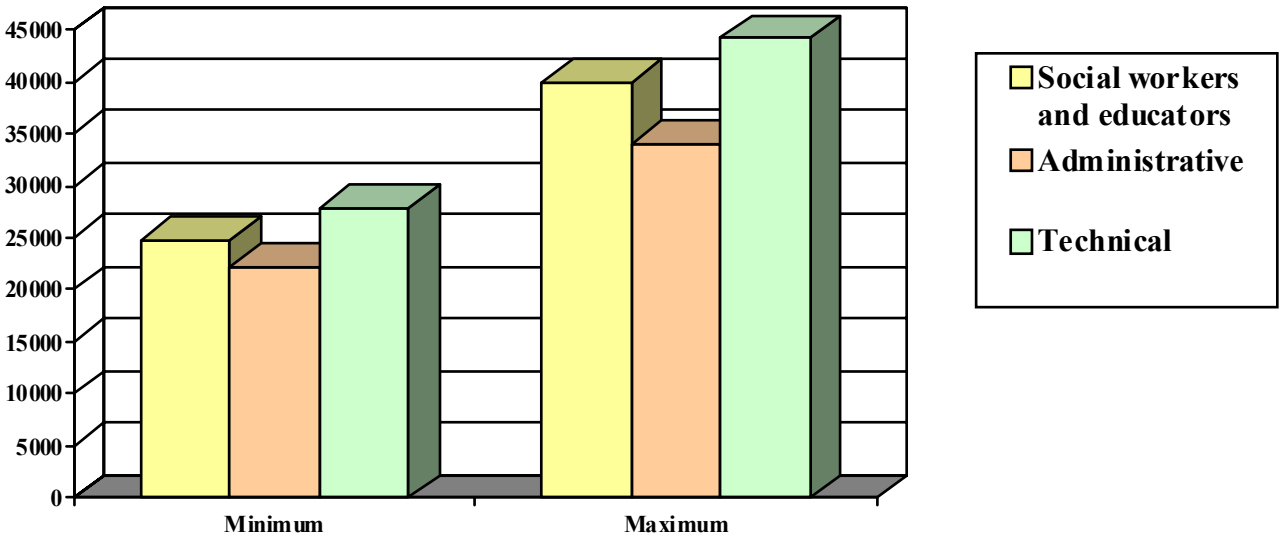
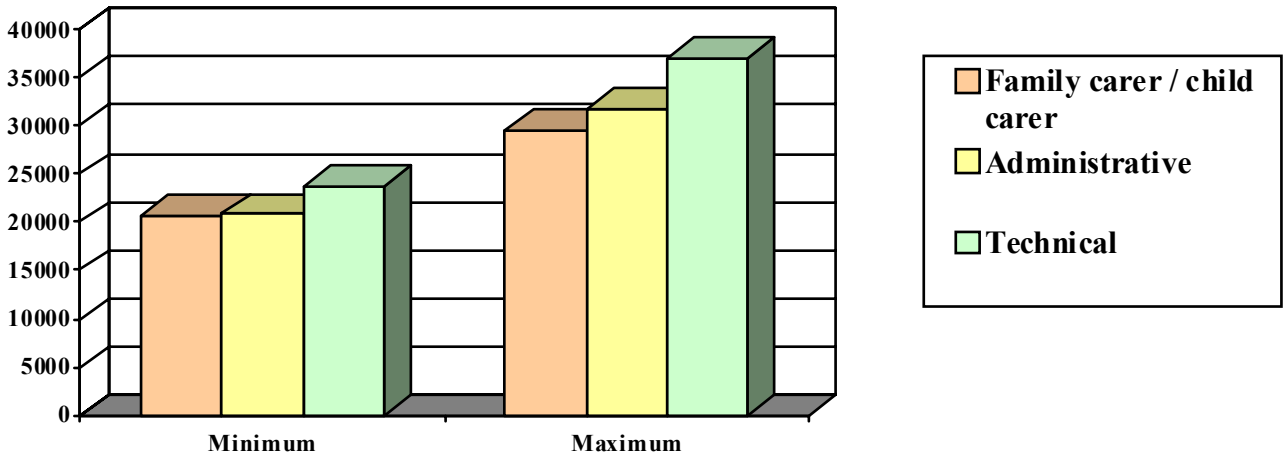


Chart 7: Salary comparisons between family and child carers, administrative and technical staff with comparable secondary level qualifications



Case Study 2: Estonia

Summary

- Estonia has a widening gender pay gap.
- Health and social care is underfunded and this has resulted in staff shortages and long working hours.
- The sector is characterised by occupational segregation and low wages.
- Women are over-represented in low paying jobs in health and social care.
- A new wage agreement in health and social care was signed in 2006

Gender pay gap

In 2005 the gender wage gap in Estonia was 25.4 per cent, this represented a widening of the pay gap and the largest pay gap since 1999 (Statistics Estonia 2006). This is surprising given that women in Estonia have higher levels of education than men and participate in the labour market in large numbers. This data was collated by Statistics Estonia from several national surveys. Average hourly earnings in 2006 were EEK 47.42 (€3.03) per hour, made up of an average of EEK 55.22 (€3.53) earned by men and EEK 41.22 (€2.63) earned by women.

There are a number of explanations given for the gender pay gap in health and social care in Estonia. One explanation is related to the fact that women workers predominate in the health and social care sectors at all levels. In 2005, nearly half of all working women worked in sectors that were deemed to have wages that were lower than the average wages; of whom 11 per cent worked in health and social care. In contrast a larger proportion of men worked in sectors where pay was higher than the average pay. Another explanation given of the gender pay gap is the difference in hourly wages earned by full-time and part-time workers. Twice as many women as men work part-time in Estonia and in 2005 part-time workers earned 20.7 per cent less than full-time workers. In some areas of health and social care wages are very low, often below minimum wage levels.

Pay levels

Table 8 shows the results of a survey of salaries in the Estonian health care sector carried out by the Ministry of Social Affairs. The survey shows that there are very low wages in the sector, with 75 per cent of doctors receive an hourly gross wage ranging from EEK 69 (€4.41) up to EEK 86 (€5.50); nurses receive between EEK 37 (€2.36) and EEK 50 (€3.20) per hour; and caregivers are paid between EEK 21 (€1.34) and EEK 27 (€1.73) per hour.

The majority of healthcare professionals work unsocial hours and receive different monthly bonuses, depending on factors such as qualifications, language proficiency or length of employment. Bonuses raised the average hourly wage by approximately 20 per cent in 2006: 25 per cent for doctors, 16 per cent for nurses and 18 per cent for caregivers.

Table 8 Average hourly wages in the Estonian healthcare sector

	Average hourly wage in 2006	Increase in average hourly wages compared with 2005 (EEK/€)
Doctors	EEK 82 (€5.24)	EEK 5 (€0.32)
Nurses	EEK 43 (€2.75)	EEK 2 (€0.13)
Caregivers	EEK 24 (€1.53)	EEK 2 (€0.13)

Source: Ministry of Social Affairs

In practice, the salaries of doctors are about 1.5 times higher than the average wages in Estonia, while the salaries of nurses are at the average wage level, and the salaries of caregivers are almost half the average wage level. The more detailed data below exemplifies the low pay of workers in the residential care sector in Estonia, based on average monthly salaries for different groups of health and social care staff.

Adults care in residential care
(except adult people with psychical special needs), average salary per month)

EUR	2005	2006
Assistant teacher	233.-	629.-
Custodian, nurse	259.-	307.-
Physiotherapist	322.-	369.-
Activity therapist or assistant	306.-	344.-
Director of extracurricular activities	301.-	279.-
Activity instructor	275.-	291.-
Doctor	290.-	290.-
Nurse	321.-	392.-
Social worker	327.-	375.-
Others	264.-	315.-

Residential care for orphans and children who are without parental Attendance (average salary per month)

EUR	2005	2006
Senior teacher	499.-	540.-
Teacher	385.-	423.-
Assistant teacher	285.-	285.-
In all (teachers)	353.-	381.-
Speech therapist, special pedagogue	364.-	392.-
Psychologist, vocational adviser	460.-	563.-
Physiotherapist	353.-	400.-
Doctor	565.-	743.-
Nurse	267.-	377.-
Social worker	471.-	310.-
Others	317.-	371.-

Care services for adults with physical disabilities (average salary per month)

EUR	2005	2006
Custodian, nurse	258.-	285.-
Speech therapist, special pedagogue	466.-	513.-
Psychologist, Vocational adviser	320.-	368.-
Physiotherapist	281.-	333.-
Activity therapist or assistant	337.-	429.-
Director of extracurricular activities	298.-	372.-

Activity instructor	281.-	321.-
Doctor	602.-	742.-
Nurse	362.-	427.-
Social worker	336.-	458.-
Others	314.-	417.-

Source: Data compiled by Rotal, Estonia

Legislation and government programmes

Equal pay first became a policy issue after Estonia joined the EU. Since then the Ministry of Social Affairs has been responsible for promoting gender equality, on the basis of the 2004 Gender Equality Act. An inter-ministerial committee for promoting gender equality and a national development plan for gender equality (2004-2008) has been in place.

Union negotiations

The public service unions representing workers in health and social care have lobbied for improved pay levels and the ending of low pay. Some of this has been argued for at the level of national agreements with the government, while in other cases it has resulted in agreements for specific sectors. For example, in 2005 the public service union Rotal concluded a minimum salary agreement with the Ministry of Social Affairs and social care staff working in residential care for children (orphanages). In this sector social care staff had been working below minimum wage levels.

Healthcare unions set out their demands for a pay increase of approximately 30 per cent in 2007/8. This can be seen in Table 9.

Table 9: Minimum hourly wages and wage demands in the Estonian healthcare sector

	2006	**Proposal for 2007 and 2008**	**per cent increase**
Doctors	EEK 75 (€4.79)	EEK 110 (€7.03)	32 per cent
Nurses	EEK 39 (€2.49)	EEK 60 (€3.83)	35 per cent
Caregivers	EEK 23 (€1.47)	EEK 32 (€2.05)	28 per cent

Source: EIRO (2006) Negotiations over new wage agreement in health care

Healthcare professionals and the unions have proposed that there should be a larger national budget for healthcare based on an increase from 5.3 per cent of GDP to 6.3 per cent of GDP. Currently spending on health care in Estonia is one of the lowest in Europe; such an increase would require an additional EEK 1.4 billion (approximately €89.4 million) funding for the healthcare sector.

Another problem is that there is a lack of nurses and doctors in Estonia, many of whom are migrating to work abroad. The Estonian Nurses' Union has estimated that around one third of nurses regularly work overtime, often in several hospitals. A recent study by the Estonian Migration Foundation found that around 600 positions (around 2 per cent of all positions) were vacant in 2005. It is estimated that in order to raise the minimum salaries of all healthcare professionals by only EEK 1 (€0.06) per hour, health care expenditure would need to be increased by EEK 45 million (about €2.9 million). The Estonian Health Insurance Fund has estimated that healthcare professionals could expect to receive a maximum hourly wage increase of EEK 8 (€0.51) in 2007, EEK 5 (€0.32) in 2008 and EEK 4 (€0.26) in 2009.

Case study 3: Finland

Summary

- Data shows that pay levels in health and social care are generally lower than other sectors.
- There has been a narrowing of the gender pay gap, although women predominate in the lower paying occupations and their earnings tend to be below average earnings.
- Unions have focussed on raising the pay rates of low paid women workers, in sectors that are predominantly female.
- The government has also prioritised the reduction in the gender pay gap through the national Equal Pay Programme.

Pay data and the gender pay gap

National data on full-time workers shows that the wage gap between women and men has remained virtually unchanged since 2000. The average monthly earnings of all full-time wage and salary earners totaled €2,555 in the last quarter of 2005. Men earned €2,813 and women €2,275. In 2005, women earned 80.9 per cent, compared in 2001 to 80.2 per cent of men's earnings. In 2005, ten per cent of all full-time wage and salary earners earned more than €3,741 and, respectively, ten per cent of them earned less than €1,656. In the last quarter of 2007 average earnings for all employees was €2,731. Men earned €3,015 and women €2,451. The level of earnings for women was 81 per cent of men's earnings. Wages and salaries in 2007 rose by 4.1 per cent overall, whereas real earnings were 2.4 per cent higher than the previous year.

The difference in earnings between the highest and the lowest decile increased by 1.3 percentage points from 2004. The difference in total earnings between the deciles went up most (by 2.5 percentage points) in the local government sector. In the private employer sector the pay differential grew by 1.3 percentage points, whereas in the central government sector the pay differentials between wage and salary earners narrowed by 3.6 percentage points from the year before. Most of the development in earnings between the sectors is explained by different sizes of collectively bargained pay increases and by changes in the structure of wage and salary earners, such as exit to retirement, outsourcing of tasks or increased employment among full-time wage and salary earners in certain wage and salary earner groups.

Earnings data is broken down by employer sector in the private sector, municipality and the state sectors. For full time employees, Table 10 shows that overall women earned less than men in all sectors of the economy.

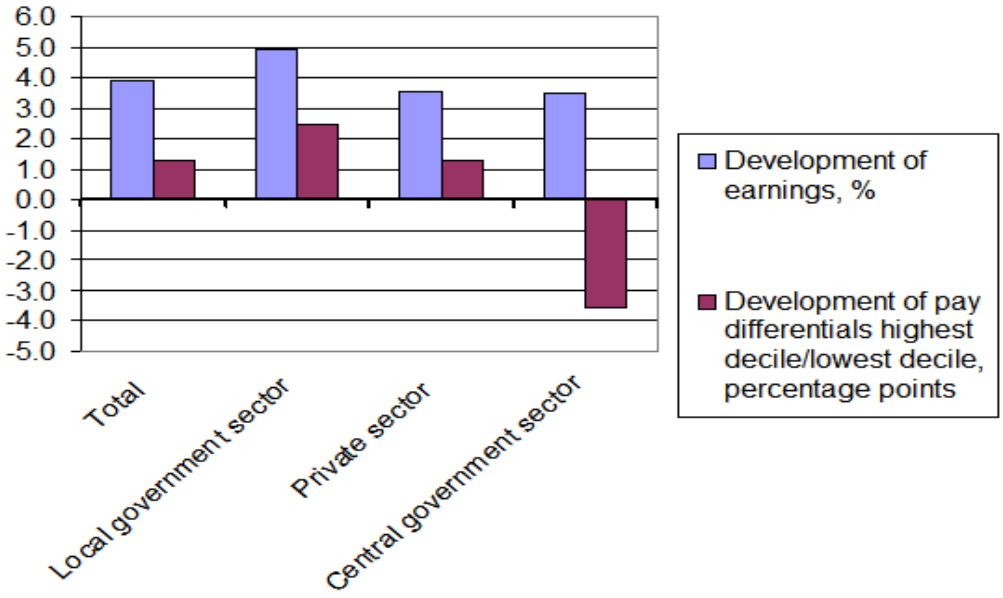
Table 10: Total earnings by employer sector and gender (€), 2006

Employer sector	Full-time employees			
	Number	Monthly earnings, €		
		Total	Men	Women
Private	924 260	2 696	2 907	2 363
- primary production	594	2 767	2 837	2 237
- manufacturing	415 221	2 757	2 855	2 443
- services	508 445	2 646	2 973	2 332
Municipality	372 663	2 419	2 875	2 287
State	108 042	2 844	3 141	2 519
Total	1 404 965	2 634	2 922	2 343

Source: Statistics Finland, Wage and Salary Statistics

Table 11 shows that change in monthly earnings and pay differentials in different employer sectors between 2004 and 2005.

Table 11: Change in monthly earnings and pay differentials in different employer sectors 2004-2005



Source: Structure of Earnings 2005. Statistics Finland

According to Statistics Finland's Structure of Earnings statistics, the average monthly earnings of all full-time wage and salary earners were €2,634 in the last quarter of 2006 and the median earnings[1] were €2,344. The difference between average monthly earnings and median earnings was greatest for wage and salary earners in the local government sector, at 13 per cent. In the private sector the difference was 12 per cent and in the central government sector 11 per cent. Women's average earnings were 80.2 per cent of men's average earnings in 2006. Measured with median earnings, the gender wage differential was

80.9 per cent. The relationship between average and median earnings is caused by the different wage / salary earner structures in different sectors.

In 2006, ten per cent of all full-time wage and salary earners earned more than €3,880 and, correspondingly, ten per cent of them earned less than €1,693. The difference in earnings between the top and bottom deciles grew by 3 percentage points from 2005. The difference in earnings between deciles grew most, by 5 percentage points, in the private sector. The differences in earnings of wage and salary earners in the central government sector grew by 3 percentage points from the year before, while in the local government sector the difference in earnings between deciles remained nearly unchanged. Most of the differences in the development in earnings are explained by different sizes of collectively bargained pay increases, the stage of the economic cycle as well as changes in the structure of wage and salary earners. There have been some small changes in the distribution of income levels between women and men. Table 12 shows the income levels of wage and salary earners in central government, local government and the private sector between 2003 and 2007.

Table 12: Income levels of wage and salary earners

	Index of wage and salary earnings €					Annual change, per cent									
	2000 = 100					Nominal					Real				
	2003	2004	2005	2006	2007*	2003	2004	2005	2006	2007	2003	2004	2005	2006	2007*
Total	112,6	116,8	121,4	125,1	129,2	4,0	3,8	3,9	3,0	3,3	3,1	3,6	3,0	1,4	1,4
Central Government	114,0	118,6	123,0	127,1	131,6	4,3	4,0	3,7	3,4	3,6	3,4	3,8	2,8	1,8	2,0
Local Government	110,7	115,1	119,9	123,5	127,5	3,7	4,0	4,2	3,0	3,2	2,8	3,8	3,3	1,4	1,3
Private Sector	113,0	117,1	121,7	125,4	129,5	4,0	3,7	3,9	3,0	3,3	3,1	3,5	3,0	1,4	1,4
Males	112,5	116,5	120,8	124,4	128,6	3,9	3,5	3,7	3,0	3,3	3,0	3,3	2,8	1,4	1,4
Females	112,4	116,9	121,8	125,6	129,6	4,0	4,0	4,2	3,1	3,2	3,1	3,8	3,3	1,5	1,3
* preliminary data															

Source: Statistics Finland, Wage and salary statistics

Health and social care agreements

Although there is formal equal pay in the health and social care sectors in Finland, the gender pay gap arises because men predominate in senior positions and women predominate in lower skilled positions. However, as the union TEHY point out that there are so few men in this sector that many of the differences between women and men are insignificant. The issue concerning the gender pay gap for workers in health and social care is principally one of occupational segregation.

Central incomes policy agreements have helped to prevent a widening of the gender wage gap. In recent incomes policies the social partners have agreed on an 'equality allowance', an additional pay increases to be used at sector level to improve the position of women and lower-paid workers. Equal pay has also been covered in a recent agreement in the municipal sector which provides for new job evaluation procedures. For example, the 2003-4 central incomes policy agreement included an “equality increment” (0.3 per cent) to be used for improving gender wage equality.

The latest pay settlement in the health sector resulted in substantial pay rises for nurses, which had the effect of markedly reducing the pay gap between health care workers and other professions which require an equivalent level of training and education. The unions argue that this is an important element of the national programme of the Ministry of Health and Social Care to reduce the gender wage gap (discussed below). The union’s focus has not specifically been on reducing the gap in wages between occupational groups in health care, for example, between nurses and matrons, rather it has been to improve the relatively lower-paid salaries in health care. In this regard, the unions have been pressing for percentage based increases.

The gender pay gap and the national equal pay programme

In Finland unions have addressed the occupation segregation of women and men in the workforce as a means of narrowing the gender wage gap. On average women’s wages are 20 per cent lower than men’s.

The Finnish Equality Act, amended in 2005, requires that equality plans must be carried out in the workplace. The legislation is intended to improve awareness of equality measures in the workplace. Every workplace, with over 30 employees, must draw up an equality plan. This must include measures that are planned or have been implemented to promote equality and equal pay. Although equality plans have been important, the union TEHY state that the studies do not permit comparisons to be made between different collective agreements.

The government has published a policy framework for reducing the gender wage gap by 5 per cent by 2015. The Equal Pay programme, launched in February 2006, has evolved out of the programme for promoting equal pay and gender equality in working life, 2004 – 2005, established by a tripartite working group appointed by the Ministry of Social Affairs and Health. The Equal Pay Programme resulted in the appointment, by the Minister of Social Affairs and Health, of a high-level monitoring group for the period from 1 April 2006 to 31 March 2007. This tripartite monitoring group was established to monitor the implementation of the Equal Pay Programme and the related action programme. When it is obvious that the achievement of the objectives of the programme are not progressing as planned, the monitoring group undertakes measures, as necessary, to achieve the agreed objectives. The monitoring group consists of the leaders of the labour market central organisations, representatives of the Government and politicians.

The main aim of the Equal Pay Programme is to narrow the pay gap between men and women from the present 20 per cent by at least five percentage units by the year 2015, calculated on the basis of the earnings for regular hours of work. The Equal Pay Programme incorporates objectives regarding the payroll systems, segregation of the labour market and women’s career development, pay and collective agreement policies, development of statistics and statistical cooperation, family and work, corporate social responsibility and

gender equality planning. Some of the measures demand action by the Government, others require joint measures by both the Government and the labour market organisations, and some of them require measures between the labour market organisations.

The government's new Action Plan for Gender Equality, 2008-2011, covers a number of objectives including the promotion of women's careers, reducing the gender pay gap, increasing gender equality in schools and measures to reduce gender segregation in the labour market.

Case study 4: Germany

Summary

- There is an absence of comparable data in health and social care.
- Wide variations in pay and collective bargaining coverage exist between care providers.
- Health and social care is a low wage sector, marked by regional disparities, dispersed bargaining coverage and the absence of a national minimum wage.
- Union campaigns have focussed on a gender neutral approach to collective bargaining and specific campaigns against low wages in the health and social care sectors.

Pay data and the gender pay gap

Low wages in a high wage economy

Although Germany is generally considered to be a high wage economy, there exists a significant low wage sector, which is exacerbated through the absence of a statutory minimum wage. Low pay is a significant problem in the health and social care/work sector. The absence of a minimum wage covering the health and social care sectors, low levels of collectively agreed wages and salaries, and highly dispersed wage bargaining are all factors keeping wages low in Germany. Significant numbers of workers are defined as 'working poor' in Germany, many of whom are women.

In Germany there exists very little data about pay levels and it is very difficult to compare data because in the field of social care and social work there are many different collective agreements and a diversity of employers. This has resulted in substantial variations in pay rates regionally and according to different employers. There is an absence also of data broken down into occupational groups in the health and social services. The relative pay of public services workers has been declining in recent years. In 2007, pay increases in the public services were much lower than in previous years, with a rise of 0.7 per cent overall (0.5 per cent in Western Germany and 1.2 per cent in Eastern Germany, which was below the average for the whole economy of 2.3 per cent).

Gender pay gap

Between 2000-2005 the German Federal Statistical Office, reported that there had been an overall narrowing of the gender pay gap, although the gap had only decreased in Western Germany, and marginally increased in Eastern Germany. In 2000, the gender pay gap was 21.5 per cent and in 2005 it had narrowed to 20.2 per cent.
Overall the average gross monthly earnings differential between women and men narrowed, with earnings for women increasing by 2.3 per cent and earnings for men at 1.8 per cent (however these figures do not cover the service sector and public services)[2].

[2] WSI Collective Agreement

Research by the Hans Böckler Stiftung Foundation on the gender pay gap - *Social undertakings towards low wages* - identifies the gender pay gap for two groups of workers in the sector – nurses and kindergarden teachers – as being 86 per cent. The research concludes that these are female dominated sectors and consequently pay rates tend to be lower than other occupational groups.

Carers for older people: example

Carers for older people receive some of the lowest levels of wages in Germany[3]. The bulk of care givers are women (61 percent women, to 39 percent on men). Their work is considered to be highly under-valued. There are also regional variations in pay rates. This is a sector that has been starved of resources as demographic ageing requires more resources. Carers for older people work in nursing homes, senior residence homes and in community based care services. There are 2.4 million employed in the public health sector, with 286,000 employed in caring for older people. It is estimated that there will be an increase of 3.5 million older people in need of care by 2050 (Federal Statistical Office 2003).

Average annual gross salaries in 2006 in the older care sector were as follows:

Saxony	€20,600
Thuringias	€20,700
Berlin	€24,400
Schleswig-Holsteins	€27,000
Bavaria without Munich	€27,000
Hesses	€29,100
Hamburg	€29,300
Baden-Württemberg	€29,900
Ruhr Valley	€30,000
Munich	€31,800

The highest salaries are in Munich and the lowest are in paid in Saxony. These pay rates can be compared to the Federal Statistical Office's national accounts where the average gross earnings of all employees in Germany rose 0.7 per cent to €26,657 in 2006.

Trade union agreements in health and social care

Pay issues are identified as being top of the bargaining agenda for 2008. Verdi's pay increase demands in the public sector, including health and social care at local and federal level, is for an 8 per cent pay rise or a minimum increase of €200 per month. This is part of the new negotiations following the ending of sectoral agreement in December 2007 that covers 1.5 million local and federal public service workers. Negotiations for a new pay agreement for medical doctors has resulted in a demand for a 10.2 per cent pay increase[4].

For a number of years Verdi has been engaged in fundamental reform of collective bargaining rights. This began in 2003-4 with the objective of introducing a uniform and gender neutral collective agreement for all workers, to be achieved through a gender neutral

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Archive 2007, see www.€ofound.€opa.eu/eiro/2007/07/articles/de0707029i.htm
[3] *Sicher, aber schlecht bezahlt, in* Stern, 5 October 2005
[4] www.€ofound.€opa.eu/eiro/2008/01/articles/de0801049i.htm

evaluation system for the grading of jobs. Since 2003, measures have been introduced to reduce gender pay inequalities seen for example in Verdi's campaign for an upgrading of 'typically female' jobs, for example, in health, care and education. In 1998 the union established an 'upgrading commission' in order to draw up concrete proposals for 'gender-fair' job evaluation within the public sector. However, little progress has been achieved and in the health and social care sectors there have been difficulties for unions negotiating and implementing gender neutral agreements since the sector is highly dispersed.

Verdi has had an impact in negotiating agreements for social care workers. For example, they have negotiated one collective agreement between with the public employers at the level of the communities; a second collective agreement was signed with the public employers Bundeslander; and a third agreement with the Federal Authority. There are also separate agreements with private companies running homes for older people and with some of the major providers of social care, including an agreement for nurses signed with the Red Cross. Some organisations, for example, Caritas, do not have a collective agreement and there is a special law exempting church providers from being covered by collective agreements.

Verdi's policy framework on gender mainstreaming means that there are specific union rules not to discriminate against women in collective agreements. This has resulted in the union changing its payment structure with public employers. This has resulted in new criteria for payment being agreed in 2005 and negotiations for a new collective agreement being put in place (although today there is no structure in place identifying the criteria for the payments). The employers have so far refused to negotiate these new criteria and the union made a decision to negotiate a new structure by December 2007.

Verdi's campaigns and negotiations are currently focussing on the so-called 'weak skills' areas, such as social care and social work. A key priority is to address the under-valuing of women's work in the new pay round for 2008. This is also a focus of Verdi campaigns including: 'Social Workers are Worth More', and the joint DGB/Verdi campaign for minimum wages – 'We Need Them'.

Particular concerns exist in the area of social care and the decline in wage levels. One example is of one social enterprise offering care for a rate of €2 per hour, which was set in cooperation with a Hungarian care company. This and other examples have raised the urgency of the need for a minimum wage. Verdi has been campaigning for minimum wage legislation for five years and recently other unions, including the DGB have joined the campaign. More recently support for a national minimum wage has been gained from the Left Party and the Social Democratic Party, after the Bundesdag refused to vote for minimum wages in 2007. One of the difficulties faced by the union is the large number of care companies where the union is not able to organise and significant competition between private companies and welfare companies to deliver the cheapest service.

Case study 5: Ireland

Summary

- Workers in health and social care are predominantly female and their earnings are below average wages.
- The sector is typified by occupational segregation and the low valuing of women's work.
- A Public Services Benchmarking Body has been established to compare wages in the public and private sectors, although this is not based on re-evaluating the wages of women and men within each sector.
- Unions have addressed the low pay of specific groups of workers in collective agreements.

Pay data

Data is collated in Ireland covering social workers, care workers, child care workers, home helps and nurses. Rates of pay are generally below the average industrial wage (which stood at €600 per week in 2007). On average men are paid €645 a week, and women €434 a week.

Workers in health and social care professional grades continued to be paid relatively lower rates of pay than other professional and industrial groups. One of the key factors that has been identified is that the sector is typified by occupational segregation and that there are poor progression opportunities for this group of workers.

Table 13 provides examples of pay levels for selected grades for professional staff in social work, Speech and Language Therapy, Social Care, Physiotherapy, Family Support and Home Helps in 2007.

In 2002 a Public Services Benchmarking Body was established to review public sector pay levels against those in the private sector. Unions had been arguing for many years that workers in the private sector had been benefitting from rising rates of pay in a booming economy, whereas this was not the case for public sector workers. The benchmarking exercise evaluated 109 grades in the public services. In 2002 pay increases were awarded for health and social care staff following an evaluation that determined that pay levels were below those in the private sector. Nurses, for example, were awarded pay increases of between 8 and 16 per cent. A second benchmarking exercise was carried out in 2007. However, the evaluation carried out limited pay increases to senior managers and senior nurses within the health and social care sector (15 of the 109 grades examined).The review body found that there were specific areas that were paid below those in comparable managerial jobs in the private sector.

IMPACT, SIPTU and the Irish Nurses Organisation have all argued that the pay of public service health and social care staff does not match that of pay in comparable positions in the private sector. Unions were critical of the methodology used in the second benchmarking process which resulted in a 'zero' outcome for public service workers in the health and social

care sectors. IMPACT has called for a genuine review of public service pay to ensure that effective methods are used for comparing jobs with private sector workers. One of the key issues the union has raised is the importance of addressing the widening gap between high and low paid workers in the health and social care sector.

One of the problems associated with the benchmarking process was that it did not identify the undervaluing of women's work as a factor determining wage differences between public and private sector rates of pay. Although based on a job evaluation to assess and score different jobs in the public and private sectors.

Table 13: Selected grades for professional staff in social work, Speech and Language Therapy, Social Care, Physiotherapy, Family Support and Home Helps 2007

Grade Description	**Pay range (€)**
Social Work Practitioner, Senor	48,781 - 63,342
Social Worker	36,215 - 52,407
Professionally Qualified Social Worker	43,611 - 57,767
Psychiatric Social Worker	43,611 - 57,767
Social Worker Senior Medical	56,634 - 66,633
Social Worker, Principal	64,966 - 79,896
Social Worker, Team Leader	56,634 – 66,633
Speech and Language Therapist	38,066 – 50,712
Speech and Language Therapist, Senior	50,815 – 60, 153
Clinical Specialist, Speech and Language Therapist	56,403 – 65,740
Speech and Language Therapist Manager	61,627 – 75,314
Speech and Language Therapist Manager in Charge III	72,622 – 79,928
Trainee Social Care Worker	27,078 – 29,778
Social Care Worker, with qualification	33,519 – 44,818
Social Care Worker, without qualification	33,519 – 43,939
Social Care Leader	44,569 – 52,376
Social Care Manager in Children's Residential Centres	54,242 – 62,326
Physiotherapy Assistant	28,474 – 33,088
Speech and Language Therapy Assistant	28,474 – 33,088
Radiography Assistant	28,474 – 33,088
CSSD Operatives	28,710 – 34,743
Medical Laboratory Aides	28,710 – 34,743
Family Support Workers	28,710 – 34,743
Family Support Workers (Non-Paypath)	30,668 – 32,261
Home Helps	27,557 – 30,638
Home Helps (Non-Paypath)	27,938 – 29,181

Union agreements and action

Public service unions have been instrumental in seeking pay rises for the lowest paid workers in health and social care and for ensuring that professional groups are paid at a level that is comparable with other professionals. This issue has been specifically raised in relation to nursing, child care and social work, both of which tend to be paid lower than other comparable occupations in the public and the private sectors. These are both female dominated professional occupations. For lower qualified staff, low rates of pay in the predominantly female care sector, has been a focus of union action. For example, IMPACCT negotiated a Home Help Service Review Agreement with the employers on the basis of evidence of the low pay of home helps, which was used as a basis for negotiating pay

increases for this group of workers. Two examples of child care workers and social workers are given below.

Social Care Workers

In this sector staff see themselves as being undervalued in a sector where work is autonomous, responsible, challenging and demanding. Occupations include therapeutic care in residential child care, child protection teams, residential centres for children and adults with intellectual and physical disabilities, services for young homeless people and young people with addiction problems. Child care workers (formerly house parents and assistant house parents) now exist in one grading structure for the care profession. A Social Care Worker earns €31,127-€41,619 per year; Social Care Leader €41,387-€48,637 per year; and a Social Care Manager earns €50,370-€57,878 per year. Although rates of pay are above the average industrial wage (€33,000), they compare badly with other comparable professional positions in the public and private sectors.

Social Workers

IMPACT has argued in its submission to the Public Service Benchmarking Body (July 2006) that Professional Qualified Social workers have a National Qualification in Social Work (which is at a level that is higher than a bachelor degree level qualification). They argue that social workers are paid at a lower level than other comparable groups such as Probation Officers and Clinical Psychologists. Given the recruitment difficulties in the profession and the legal and other responsibilities carried out by social workers, that their work is undervalued and under paid. It is no coincidence that this is a profession that is predominantly female.

For example, IMPACT cites a differential of €26,587 between the pay of professionally qualified Social Workers (who earned €53,643 in 2005) and that of Clinical Psychologists (who earned €80,230 in 2005). Entry level qualifications for social work include a relevant Graduate Honours Degree and a Postgraduate National Qualification in Social Work (NQSW); for Clinical Psychologists requirements are a relevant Graduate Honours Degree and a recognised postgraduate qualification in clinical psychology or two years practical post-graduate experience in clinical psychology. Similarly, probation officers entry requirements are for a relevant Graduate Degree, but there is no requirement for a post-graduate qualification comparable to social work, however, they earned 10.35 per cent more than social workers in 2005. IMPACT also cites the pay discrepancies between social work promotional grades and those of comparable civil servants.

Case study 6: Latvia

Summary

- Women predominate in the health and social care sector and wages are very low.
- Occupational segregation is linked to the low value of work in the sector.
- Low status and low pay has resulted in shortages of staff and migration to other European countries.
- The gender pay gap remains wide and there have been few or no government initiatives designed to close the gender pay gap.
- Unions have focussed on raising the wages of low paid workers in health and social care.

Pay data and the gender wage gap

The most recent survey carried out of salaries of women and men covering different sectors of the economy was carried out in 2003 it found that the gender wage gap widens in those sectors where the majority of employees are men. As table 1 shows women's average salaries in health and social care were 84 per cent of men's (113 LVL, compared to men's salaries of 156 LVL). Overall Table 14 shows that earnings in the health and social care sector are the lowest of all sectors in the economy.

Table 14: Average male and female salary (in LVL), by sector, 2003

Sector	Female	Male	Female salary as % of male
Manufacturing	136	169	80
Transport and Communication	182	215	85
Financial Intermediary	344	637	54
Education	155	168	92
Health and social care	113	156	84

Source: CSB, Profesiju apsekojuma rezultati Latvija, R., 2004.

In 2007 wages and salaries in the health and social care sector in Latvia were around €520 per month in the public sector and €516 per month in the private sector. These are around 2.5 per cent higher than the average gross national wage and salary of €508, but 8.9 per cent lower than the average wage in the public sector of €573 per month[5].

[5] Data is based on the Monthly Bulletin of Latvian Statistics 2006-2007, published by the Central Statistical Bureau of Latvia.

Overall, across the economy there has been a gradual reduction in the gender wage gap since 1995. In 1995 women earned 78.5 per cent of men's earnings, compared to 78.8 per cent in 2000 and 84.4 per cent in 2004 (Latvian Central Statistical Bureau). Some of this difference in 2004 can be explained by a different methodology used. In Latvia, 11.6 per cent of employed persons receive the minimum salary, and 0.4 per cent receives less than minimum salary (this data is not available by gender). At the same time there are more women than men among those receiving lower wages (less than 200 LVL). In 2005, 58 per cent women and 53 per cent of men receive wages lower 200 LVL. Men are more often among those who receive higher wages: 16.2 per cent men and 9.8 per cent women receive wages higher than 400 LVL. Low pay mainly occurs in the service sector, which is dominated by women.

The Latvian government created a new system of remuneration in 2004, the first stage of which has resulted in the establishment of salaries and wages for civil servants based on categories of qualification and levels of qualification established through job evaluation. The new salary system is based on equality principles. The government has also established regulations for setting up of a single payment system for all public sector workers.

In the health and social care sector, there are established categories of salaries which define the minimum and maximum salary for each category of worker, although it is only in the education sector that an agreement on salary increases has been agreed. In 2005 a new agreement was signed between the Ministry of Health and the trade unions on salary increases, but these have not been implemented fully in practice. In practice the health care system has for many years faced shortages of funding, typified by low wages and staff shortages. Health care workers carry out substantial amounts of overtime owing to staffing shortages, for example, doctors and nurses provide an average of the equivalent of 1.4 full-time equivalent jobs for which they are paid the equivalent of a single full-time job. Despite union strike action and a number of commitments from the government to resolve low pay and long working hours in the sector, there has been little progress in implementing improved wages in practice.

In Latvia the practice of illegal payments in the health care sector – often known as 'thank you payments' – paid by patients to medical workers as a way of fast tracking health care has been linked to low wages in the sector. Low wages in the sector has meant that the practice has been an important source of top up payment for low paid workers. A key problem that has faced the Latvian health care sector is that many qualified staff have left the country to work in other European countries, principally because of low pay in the sector. The Latvian Health Workers Union has argued that improving the salaries of health care workers is the only way to halt illegal practices. A cooperation agreement established between the union and the Ministry of Health was signed in 2007 as a step towards outlawing the practice.

Union negotiations

Latvian health care workers have been involved in campaigns and protests to improve the low wages and low status in the sector. The government has committed itself to a national programme for human resources and improving pay rates: *Development of human resources in healthcare for the years 2006-2015.* However, the Health and Social Care Workers Union has been critical of the government's failure to fully implement the national programme. The national indexation of healthcare workers salaries (based on average wages in the national

economy, as required under legislation, has not been implemented. Despite the introduction of pay rises for health care staff in January 2007, they still fell behind the actual increase in average wages. In practice, the monthly salaries of doctors were approximately €70 lower than they should have been.

The indexing of salaries of health care workers with average wages has been a priority of the Latvian Health and Social Care Workers Union. The union argues that the government has consistently failed to implement agreements on pay.

Legislation and government programmes on equality

In Latvia the Labour Law (2002) provides for equality and non-discrimination, including the guarantee of equal pay for the same work or work of an equal value. Within the frame of normal working time (40 hours per week) the employer is obliged to pay the employee at least the minimum wage or salary. The legislation states that employers must pay equal remuneration for men and women, and it is the employer's duty to establish equal pay for equal value of work. Paragraph 85 of the Labour Law provides that state and municipal enterprises and organizations must establish equal salaries for men and women, and that the salaries should be settled on the basis of collective agreement or based on agreement between the employer and employees.

The first strategic document in the field of gender equality policy: the *Concept Paper on Gender Equality Implementation* (adopted by the Cabinet of Ministers in October 2001) did not refer to equal pay for men and women or the gender pay gap. The second policy instrument to implement gender equality in Latvia: the *Programme for the implementation of Gender Equality* (2004) similarly did not prioritize measures to address the gender wage gap. Overall there have been few measures introduced either by the government or the social partners specifically to address the gender wage gap across the economy or in the health and social care sector. Nevertheless the Latvian Health and Social Care Union has placed a high priority in its actions on enhancing the value and pay levels of health and social care workers. In the health sector measures to remove low pay in nursing and social care, initiated by the union, have had a potentially important impact on reducing the gender wage gap overall. Increasing salary levels has been a focus of recent negotiations on pay levels in the health and social care sector.

Case study 7: Sweden

Summary

- Data shows that women predominate in the health and social care sectors, and that this has a direct impact on their wages.
- The government and unions have focussed on occupational segregation and the undervaluing of women's skills as factors affecting the gender wage gap.
- In recent years wage increases have benefited women workers to a larger extent than men, by focussing on low pay in female dominated sectors.
- Union negotiations have highlighted the importance of removing discrimination in pay systems, of valuing women workers and introducing specific equality awards for low paid workers in predominantly female sectors of the economy.
- The wage negotiation round 2007 (for blue collar workers) resulted in all national unions agreeing to jointly focus on women's wages.

Pay data

Swedish data on health and social care shows evidence of value discrimination with female dominated work ranked lower than male dominated work. The Swedish labour market is highly segregated, whereby the majority of employees working in health and social care are women. For example, 90 per cent of those in nursing are women, 92 per cent are midwives, and 88 per cent carry out personal care and related work. Statistics Sweden (2002) has estimated that women make up 98 percent of the employment in the area of health and social care, made up of approximately 35 percent of all employed women and 5 percent of all employed men. Average female monthly earnings in health and social care are 16 percent lower than average male earnings. Female-male wage differentials become smaller if an occupation can be divided into smaller groups. For example, in the low wage group of personal care and related workers, only 10 percent of employees are men and the female average monthly wage is 2 percent lower than the male average monthly wage.

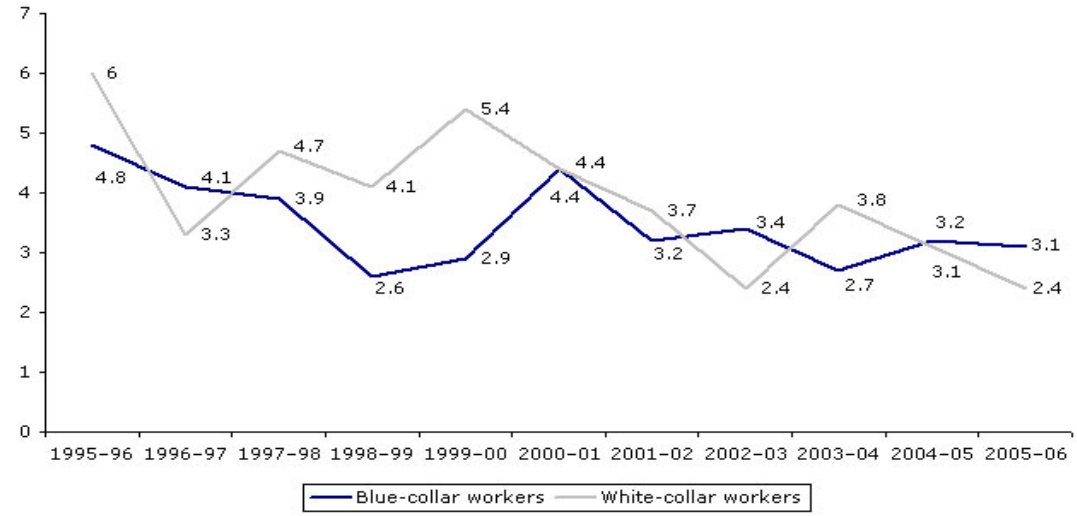
In 2006, women's wages increased more than men's in all sectors except the public sector at municipal level. While there are signs therefore of a declining gender pay gap, sectoral wage differences remain considerable. The highest wages are found in the private sector among white-collar workers, while the lowest are recorded in the public sector at municipal level.

Over the past 10 years, the annual wage increase has on average been slightly higher for white-collar workers, at 3.9 percentage points compared to almost 3.5 percentage points for blue-collar workers. However, in the past couple of years, the wage increase has been higher for blue-collar workers.

In 2006, the wage increase was between two and three percentage points for the economy as a whole. In recent years, the wage increase peaked in 1995–1996 at six percentage points for white-collar workers and 4.8 percentage points for blue-collar workers (see Table 15). The smallest increase for white-collar workers, at 2.4 percentage points, was noted in

2005–2006, while for blue-collar workers the smallest increase, at 2.6 percentage points, was reported in 1998–1999.

Table 15: Annual wage increases, by category of workers, 1995–2006 (per cent)



Source: Confederation of Swedish Enterprise (Svenskt Näringsliv), 2007

The gender pay gap

In Sweden national data shows that there is a gender pay gap, with women on average being paid less than men. Job evaluation programmes have identified value discrimination. However, evaluation studies have shown that female dominated work is generally rated lower than male dominated work, even though the demands concerning skill and responsibility are rated as the same.

The Swedish labour market is segregated with women and men usually carrying out different, and not equal, work. Evidence also shows that within the same educational categories, women have lower salaries than men, and that the clustering of women in a profession increases the risk of low pay. Men in female-dominated occupations are also affected.

The highest wages are found among white-collar workers in the private sector, while the lowest are recorded in the public sector at municipal level; the latter has an average wage corresponding to 70 per cent of the average wage of white-collar workers in the private sector.

According to a 2007 report from Statistics Sweden (Statistiska Centralbyrån, SCB) and the National Mediation Office (Medlingsinstitutet), average wages in the public sector at various levels and in the private sector compared with the overall average wage are as follows:

- Public sector at municipal level – 18 percentage points lower;
- Public sector at county council level – 0.2 percentage points lower;
- Public sector at state level – three percentage points higher;
- Private sector, white-collar workers – 14.5 percentage points higher.

In most occupational groups, men's average wage remains higher than women's. However, in 2006, women's wages increased more than men's in the private sector and in the public sector at county council and state level, thus resulting in a declining gender pay gap. The average increase in these sectors where an increase could be noted was around 0.6 percentage points greater for women compared with the increment for men.

In the public sector at municipal level, women's average wage was 92 per cent of men's in 2005 and 2006. Weighting differences in age, education, working time and occupation, women's wages represented 99 per cent of men's in this sector in 2005. The widest gender pay gap was found in the private sector among white-collar workers, where women's wages were 90 per cent of men's according to the 2005 weighted data.

Table 16 shows women's average wage as a percentage of men's in 2005 and 2006, by sector. For 2005, two sets of figures are presented, where one set has been weighted for differences in age, education, working time and occupation.

Table 16: Women's average wages as a percentage of men's

	Public sector: municipal level	Public sector: county council level	Public sector: state level	Private sector: white-collar workers	Private sector: blue-collar workers
2006	92	72	87	78	89
2005	92	71	86	77	88
2005 (weighted figures)*	99	95	93	90	94

Note: * Differences in age, education, working time and occupation have been weighted.
Source: Statistics Sweden and National Mediation Office, 2007

In 2002 study was published on working conditions and pay in the health and social care sector in Sweden *Enjoying the fruits of one's labours – facts about working conditions and wages for women and men in Health and Social Work* (Statistiska Centralbyrån 2002). It showed that in 2000, 770000 persons were employed in the sector, representing 20 per cent of all employees in Sweden. It also showed that significant numbers of women are engaged in unpaid nursing and care work in the home that is hidden, and is estimated to be larger than the amount of paid work in the health and social work sectors. The major group *Personal care and related workers* comprised 55 per cent of all employed persons within the Health and Social Work sector, and the majority of these positions (90 per cent) were in the Municipalities and County Councils. The average female monthly salary at the local government level was SEK 16200 (€1,795.20) which is 2 per cent lower than the average salary for males. The female wage dispersion was SEK 5000 (€554.07)while the male wage dispersion is SEK 6200 (€687.05). Large salary differentials between women and men in each occupational group decreases when the group is divided into unit groups, since female-male wage differentials become smaller if an occupation can be divided into smaller subgroups. Salary levels were found to be lower in the Municipality and County Council level than in the private sector.

Evidence that the gender pay gap is larger for blue collar workers than white collar can be found in Tables 17 and 18.

Table 17: Women in different sectors of the economy and the sector's average monthly salary in relation to the salary of all workers 2002[6]

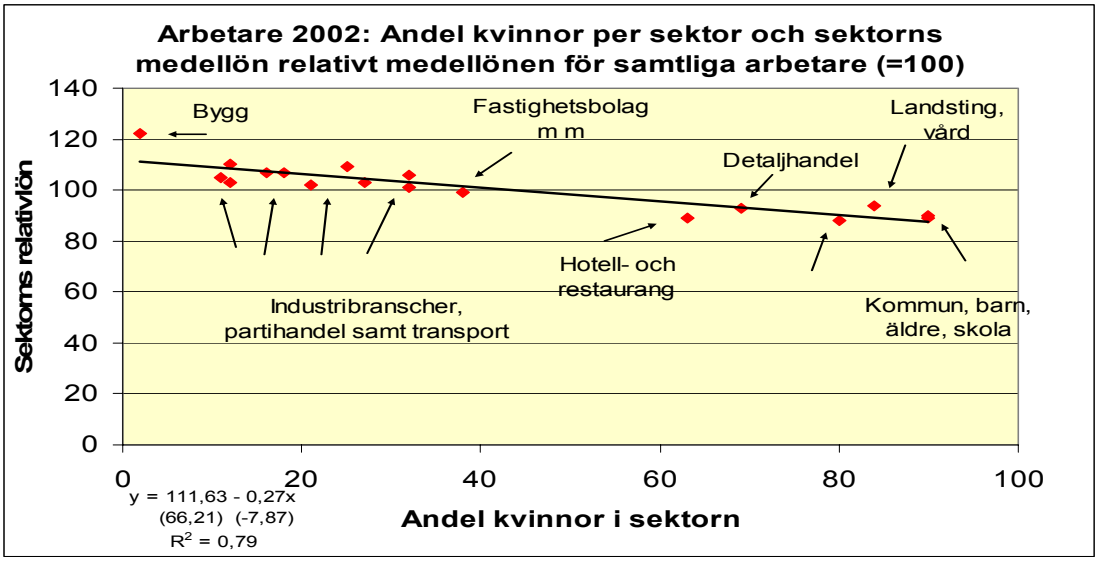
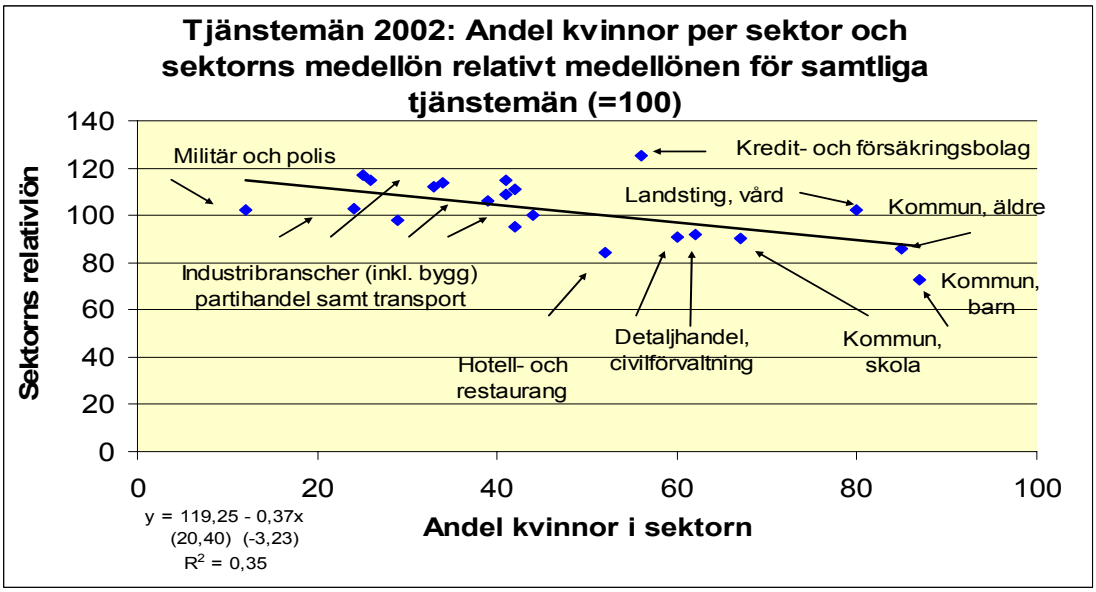


Table 18: Share of women per sector and the sectors average monthly salary in relation to the salary of all workers- white collar 2002



Tables 19, 20 and 21 present data about pay levels in different sectors of the economy. Table 19 shows that overall women are earning less than men in all sectors, with the lowest salary levels in the Municipalities (where social care is organised). The gender pay gap was largest in the County Councils (where health care is provided). When this is looked at at the level of wages in the care of older people and child care salary levels are lower than the overall data for municipalities.

[6] Sektorns realtivlön = The sectors relative wage; Andel kvinnor I sektorn = Share of women (per cent); Kommun, barn, skola, alder = Municipalities children, elderly and school; Landsting, vård = County councils health care

Table 20 shows that in 2006 women earned 18,200 SEK (€2,016.83) in care of older and disabled people, and 18,000 SEK (€1,994.67)in childcare. This is compared to an overall salary level in the municipalities of 21,100 SEK (€2,338.19). Table 21 breaks the salary levels down into different occupations in health and social care.

Table 19: Wages in SEK (monthly salary) in Sweden in 2006 by sector and gender (conversion into € as of 31 December 2006)

-	**Municipalities**	**County council**	**Government**	**Public sector**	**Private sector**	**Total**
Women	21 100 (€2,338.19)	24 300 (€ 2,692.80)	25 000 (€ 2,770.37)	22 200 (€2,437.93)	23 300 (€2,581.99)	22 800 (€2,526.58)
Men	23 000 (€2,548.74)	33 800 (€3,745.54)	28 700 (€3,180.39)	26 600 (€2,947.68)	27 200 (€3,014.16)	27 100 (€3,003.08)
Total	21 500 (€2,382.52)	26 200 (€2,903.35)	26 900 (€2,980.92)	23 400 (€2,593.07)	25 700 (€2,847.94)	25 000 (€2,770.37)

Source: Statistics Sweden

Table 20: Wages in elderly and child care (monthly salary, SEK), 2006
(conversion into € as of 31 December 2006)

	Municipalities - care of elderly and disabled	Municipalities – childcare
Women	18 200 (€ 2,016.83)	18 000 (€ 1,994.67
Men	17 900 (€ 1,983.59	17 800 (€ 1,972.50
Total	18 200 (€ 2,016.83	18 000 (€ 1,994.67

Source: Swedish Municipal Workers Union

Table 21: Wages in different occupations in elderly and child care (monthly salary SEK)
(conversion into € as of 31 December 2006)

	Care of elderly and disabled people	Childcare
Child day-care worker		17800 (€1,972.50)
Preschool teacher- Förskollärare		21200 (€2,349.27)
Child minder		18000 (€1,994.67)
Care assistant	17300 (€1,917.10)	
Assistant nurse	18500 (€2,050.07)	
Nurse	22350 (€2,476.71)	

Source: Swedish Municipal workers union

Measures to reduce the gender pay gap

The Equal Opportunities Act of 1992 requires all employers with ten or more employees to identify and report on wage differences between women and men. The aim is to identify, remedy and prevent unwarranted wage differences and other employment terms and conditions between women and men. The survey also creates a basis for other equal opportunity measures that employers can undertake, e.g. career and skills development.

All employees, including permanent, part-time and temporary employees, have to be included in the survey. First, a survey is undertaken of types of salaries and salary procedures used at the workplace, including any fringe benefits such as a company car, bonus system etc. Any other data of relevance to the survey is also to be collected, e.g. occupational experience and education. An analysis is required for the purpose of determining the cause of a wage difference. Only then can action be taken to neutralise and counteract unwarranted pay differentials between the sexes. The question to be analysed is whether wage differences between women and men who perform equal work or work of equal value are directly or indirectly due to gender. Pay differentials occurring within a group of women and men who perform work rated as equal will be analysed. Differences between groups of employees who perform female-dominated work and groups of employees who perform work rated as being of equal value are analysed. This will clarify the manner in which groups with female-dominated work are remunerated compared with other groups who do not perform work which is, or tends to be viewed as, female-dominated.

A job is defined as female-dominated where more than 60 per cent of the employees are women, either at the time or as a rule. A structured work review is required in order to comprehensively identify the different jobs to be compared. This does not require systematic job evaluation but rather some form of structured survey detailing which demands are imposed by the job. A definition of the term “work of equal value” has been introduced into the Act, which states that an overall assessment shall be made on the basis of the main criteria of knowledge and skill, responsibility, effort and working conditions. Such a survey and analysis must be provided by all employers irrespective of the number of employees. A pay equity action plan must be drawn up by all employers with ten or more employees. The action plan must contain the results of the survey and analysis and, in addition, a costs estimate and a timetable for any pay adjustments. This must be accomplished within three years at the most. The results of the action plan will then be included in the company’s equal opportunities plan or as an appendix.

The result and success from the law varies. Many municipalities have some kind of job evaluation and there are variations in the results.

Union negotiations

The wage negotiation round 2007 (for blue collar workers) resulted in all national unions agreeing to jointly focus on women’s wages. On the 1st of December, 2006, all 15 LO affiliated unions accepted, without reservations, the joint demands drawn up within the framework of the LO coordinated wage negotiations for the year 2007. The coordination was thus very strong.

The demands covers increased real wages, with a focus on low wages, pay raises of the lowest wages, a special kitty for gender issues and improved pensions. This implies wage

increases of at least SEK 825 (€91.42) per month for full-time employees. The minimum pay raise will, however, be fixed to at least 3.9 per cent. Those with the lowest wages will thereby have the relatively highest pay increases.

The LO negotiation demands also included a kitty for special wage increases – an equality kitty of SEK 205 (€22.72) per month payable to the negotiation sectors in proportion to the number of women employed within the respective sector earning less than SEK 20,000 (€2,216.30**)** per month. As a result of the gender wage kitty the Swedish Municipal workers union has been able to negotiate higher wages for members in female dominated occupations. The union plans, in 2008, to produce wage statistics on how this has changed the pay relativities between women and men.

Kommunal, the Swedish Municipal Workers Union, has been working on gender issues in collective bargaining for many years. Their Gender Equality Programme places a high priority on equal pay. This includes the development of job evaluation schemes, getting a higher value for female dominated jobs and pressing for extra resources in health and social care. The union argues that it is necessary to continue with equality kitties in wage negotiations. They argue that this should be planned with a long term perspective and covering the whole of the labour market.

Case study 8: UK

Summary

- The gender pay gap in health and social care is primarily linked to occupational segregation
- The gender pay gap is the widest in the health and social care sectors
- An income gap exists between women and men that rises to 47 per cent on retirement
- Opportunities for progression and for enhancing wages are more limited in the health and social care sector than in other sectors in the economy
- Unions report on an overall decline in the relative pay in the public sector, compared to the private sector.

Pay data: health and social care

Data in the UK is collated on all health and social care staff working in local authorities and the National Health Service. Some national data has been collated on the gender pay gap in local government and in the private sector a new national minimum data set for skills for care has been established, although restricted to the private and voluntary care sector. In health, data is currently being compiled (but not yet available) by the National Health Service on the impact of the restructuring of the pay system in the health sector on women's wages. Overall pay levels are collated across the economy through the annual Survey of Hours and Earnings.

In 2006 the average median wage across the whole economy was £25,000 (€37,107.37) per annum (with male gross weekly earnings at £592 (€878.70) and female gross weekly earnings at £454 (€673.87)). Table 22 shows the average median wage compared to specific groups of workers in the health and social care sector. Table 23 compares average hourly earnings of different groups of workers across the economy.

Table 22: Selected median wage levels of staff in health and social care compared to average median wage, 2006

Occupation	**£ per year**
Average wage (all sectors of economy)	25,000 (€37,107.37)
Nurses midwives and health visiting staff	22,900 (€33,990.35)
Allied health professionals	28,600 (€42,450.83)
Manager in social care	21,200 (€31,467.05)

Source: ONS (2006) Annual survey of hours and earnings 2006

Table 23: Average hourly earnings of full-time employees, UK, 2006

Occupation	£ per hour
Car mechanics	9.72 (€14.43)
Child care workers	7.63 (€11.33)
Care assistants and home carers	7.61 (€11.30)
Refuse collectors	8.16 (€12.11)
Plumbers	11.51 (€17.08)
Medical secretaries	9.78 (€14.52)
Nurses	13.44 (€19.95)
Police officers	15.91 (€23.62)

Source: ONS (2006) Annual survey of hours and earnings 2006

Nurses, midwives and social workers all earn substantially less than private sector workers such as engineers, financial and accounting technicians and architects, who have commensurate qualifications. For example, a social worker earns £502.30 (€745.56) per month compared with £740.30 (€1,098.82) per month for financial and accounting technicians (based on median pay). Care assistants and home carers earn on average £7.61 (€11.30) per hour - £1 more than checkout operators £6.60 (€9.80); and less than call centre agents £8.00 (€11.87) and office assistants £8.03 (€11.92) per hour). This is compared to average earnings across all sectors of just over £11.00 (€16.33) per hour for women and £14.00 (€20.78) per hour for men. Table 23 provides a number of comparisons of health and social care staff with workers in other sectors. The conclusion from this data is occupational segregation is a major factor impacting on pay levels. In health and social care staff are working in undervalued jobs and their pay and status is accordingly at a lower level than comparable jobs carried out in sectors where men predominate. In addition, there are substantial difference between health and social care workers, with care workers located at the bottom of pay scales. Although nurses are better paid than care workers their wages are still lower than those of men's wages in comparable positions, such as police officers.

Example: care workers

The lack of opportunities for enhanced earnings in the health and social care is also an issue raised by unions. For example, in the area of social care the evidence shows that that long service and experience only results in slightly higher hourly rates of pay. The National Minimum Data Set for Social Care has highlighted the existence of basic rates of pay that 'do not value care', low pay rates and a poor pay structure in a sector where service users value a consistent relationship with their workers. Care workers working with the most vulnerable clients earn a gross median hourly rate of £5.87 (€8.71) (February 2007), which is only 19 pence above the national minimum wage. A senior care worker in the same setting earns only £6 (€8.91) per hour. Those care workers who have NVQ Level 4 or above get an extra 5 per cent more than those at entry level. This has led commentators to suggest that the pay differentials between care workers and senior staff means that it is often not worth staff taking further qualifications to gain promotion.

The National Minimum Data Set for Social Care has also highlighted the situation where social care staff can earn an additional 10 per cent in pay if they work for an agency. There are also differences between rates of pay for care workers in the voluntary and private sectors. For example, in the voluntary sector, compared to the private sector, registered

managers earn an additional 4 per cent, senior care workers an additional 25 per cent and care workers an additional 8 per cent.

Gender pay gap

The gender pay gap in the UK is primarily linked to occupational segregation. Part of the explanation of the lower pay and the undervaluing of women workers in health and social care is that 79 per cent of employees are female. In 2006 the gender wage gap in the UK was 17 per cent across all sectors and 13.8 per cent across the whole public sector. However, the gender pay gap widens substantially when this is examined in the health and social care sectors - at 32 per cent [7]. The pay gap is 25 per cent in other community, social and personal occupations.

In the UK occupational segregation is a big factor affecting the gender pay gap. In health and social work, 79 per cent of employees, or 2,638,000 in number, are female, compared to 21 per cent, or 703,000 in number that are male. This sector has the widest second widest pay gap in the UK, at 32 per cent (after banking and insurance, which has a pay gap of 41 per cent). In community, social and personal services, 52 per cent of employees are female, 48 per cent male. In this sector there is a gender pay gap of 25. For all sectors in the UK economy, 47 per cent of employees are female, 53 per cent male; across all sectors there is a gender pay gap of 17.1 per cent, with a gender pay gap in the public sector overall standing at 13.8 per cent (EOC 2006, based on ONS 2005 Labour Force Survey Spring 2005 dataset).

However, when we examine the income gap between women and men, the gap widens. This is because women work shorter daily, weekly, monthly, yearly and lifetime hours than men. For example the income gap between full-time women and men stands at 27 per cent and this rises to 47 per cent on retirement, a result of a lifetime of shorter hours, lower pay and lower levels of pension coverage than men (Women and Equality Unit (2005) Individual incomes of men and women 1996/7 to 2003/04).

Research shows that women are actually paid well below the rate that they could command because the market is not demand driven (Equal Opportunities Commission 2006). The research identifies a distorting factor, which is particularly present in the public sector, that of employers who enjoy a degree of monopolistic power in the labour market, i.e. where they have power over the purchase of labour and can keep wages and employment below the level that a freely operating labour market would achieve. This may particularly affect some public sector jobs where the state is the primary or even the sole employer of that type of labour. Other drivers such as restrictions in funding from central government across an entire sector will shape the workforce pay and investment possible within those sectors. Paradoxically, the political drive towards funding frontline services, particularly in the health and education sectors, and the drive to limit public sector pay increases, restricts the money available for rates of workforce pay, which in turn risks undermining frontline service delivery as staff turnover and vacancy rates increase. But decisions about pay, status and rewards are not only shaped by market forces, or market distortions, but are influenced by wider

[7] Based on data collected by the Office of National Statistics Spring 2005 dataset of the Labour Force Survey, and the 2005 Annual Survey of Hours and Earnings, 2005.

norms and attitudes in society – and are not entirely beyond the control of employers or policy makers.

The EOC data has shown that working in a female-dominated occupation is more detrimental to pay levels than being a woman per se. They estimate for every 10 percentage points greater the proportion of men in an occupation, hourly wage levels are boosted by 1 per cent. This link between the number of women in a sector and its low pay is illustrated by the Government's attempts to recruit more men into the childcare profession. EOC research found that promotional childcare recruitment campaigns aimed at men were of limited success because of the low pay and low status of the profession. It was only by addressing this that men would be recruited in any significant numbers. The EOC has shown that the undervaluing of women's work is compounded by the fact that women's (soft) skills tend to be less visible than men's. They are less valued and are less likely to be properly rewarded partly because their impact on productivity is hard to quantify and also because women are stereotyped as being naturally good at the job and are thought to be prepared to trade lower pay for job reward.

Single Status Agreement in Local Government

In Local Government, the Single Status Agreement, has had an impact in revaluing the low paid and undervalued work carried out by many women in the care sector. UNISON's campaign GET EQUAL, seeks to ensure that equal pay is properly implemented through the local government Single Status Agreement. The campaign comes at a time of growing concerns about the effect of privatisation and contracting out of local authority services in the UK. The new pay structures established under the Single Status Agreement provides for a single pay spine of 49 pay grades. UNISON is currently in the process of collating data of the impact of the agreement on pay levels and the gender wage gap. However, this data collection is still at an early stage and is not yet available.

UNISON's negotiations for improved wages for social care workers in local authorities have been developed through job evaluation and pay review on foot of the 1997 Single Status Agreement in local government. There has been a very slow rate of implementation by local authorities (in contrast to a similar agreement Agenda for Change in the health sector which received national funding for the implementation of evaluations and reviews). By 2007 only 20 per cent of local authorities has carried out job evaluation and implemented the new pay structure, although the deadline was set for April 2006. By 2008 this had risen to 40 per cent of local authorities. UNISON believes that in the meantime they will have had to move to increase litigation because there was little progress through negotiations.

Social care staff working in local authorities are a large female dominated group. Through the Single Status Agreement, once pay reviews have been carried out, they are generally being upgraded. There is a legal entitlement to six years back pay if equal value is demonstrated. UNISON has played a key role in negotiating for back pay and litigation. However, the union has found that as local authorities realise they have to pay more to women workers they are stepping up their outsourcing activities to avoid long term pay increases. In the past the workforce used to transfer with TUPE protection but this comes under threat after two years. Local authorities have been reducing levels of service provision in order to provide the conditions for contracting out services. The union believes this is one way of avoiding the transfer of undertakings legislation and therefore of guaranteeing increases in pay to low paid women workers. The union argues that this has gone against an important agreement

established between the government and the unions (the so-called Warwick Agreement) which stated that the pay provided by contractors would be comparable to the public sector. The union believes that as the numbers of women workers earning substantial pay rises increases, the longer term impact is that privatisation will be accelerated in order to reduce costs.

Bargaining in improved wages in health care: Agenda for Change

In the UK, a major overhaul of the National Health Service (NHS), Agenda for Change, involves the introduction of a new pay system based on an agreement of unions and employers in 2003. The initiative has been hailed as the most ambitious attempt to reform pay and conditions ever taken in the UK. The new system involves widespread job evaluations and pay reviews which will ultimately place pay, grading, access to career development and working hours on a more equitable basis for women and men throughout the NHS.

The NHS Agenda for Change, which provides fair pay, a national skills framework and an improved system for career progression for staff, has resulted in a better system for valuing women's work. This was underpinned by a job evaluation scheme specifically designed for the NHS.

Since 2004 all NHS staff (except doctors, dentists and some senior managers) have been covered by the Agenda for Change terms and conditions of employment. The agreement has resulted in overall pay increases, particularly for female dominated work, which has been the result of job evaluation. The agreement also provides support for personal development and career progression through the NHS Knowledge and Skills Framework, which linked to annual development reviews and personal development plans. The system is designed to allow staff to progress by taking on new responsibilities, enabling jobs to be designed around patient and staff needs, while improving overall productivity and the job satisfaction. The implementation of Agenda for Change and the establishment of the Pay Review Body and the integration of Review Body for Nursing and Other Health Professions within its remit is welcomed by trade unions in creating a fair, single status, pay system in the NHS.

A detailed list of the Agenda for Change pay bands from 1 April 2006 has been published by the NHS Negotiating Council.

The staff side evidence for the 2008-2009 pay round has recommended annual pay increases based on the findings of the 2007 independent Pay Review Body. The 2007 pay round was problematic in that the 2.5 per cent pay increase recommended by the Pay Review Body was not upheld by the government, who awarded a 1.9 per cent pay increase. This compares to average pay increases across the economy of at least 3.5 per cent. An NHS staff survey carried out by Incomes Data Services (2007) found that staff were unanimous in their criticism of the staging of the 2007 pay increase, and many were of the view that this sent a strong message to staff that they are undervalued and that their hard work is not recognised. In averting industrial action by the RCN, the Secretary of State for Health agreed to talks, which resulted in an improved pay offer of 2.02 per cent in 2007. Unions consider that the loss of pay resulting from the 2007 settlement would need to be made up in the 2008 pay round.

UNITE's evidence to the National Health Service Pay Review Body (NHSPRB) highlights the importance of improved pay levels to take account of inflation for the recruitment and retention of staff. Specific recommendations are made concerning the recruitment and retention of pharmacists. In 2007 the NHS Staff Council staff side organisation also provided evidence to the Review Body on the pay of nursing staff and other health professionals.

Generally there has been trend towards pay settlements in the private sector being ahead of those in the public sector; and in the health sector the NHS settlement for 2007 was below that of other areas of the public sector (for example, where there was a 3 per cent pay increase from staff in higher education; a 3 per cent increase for the police). A study by the Office of Manpower Economics (2006) has highlighted the continued pay differential between the public and private sectors for nurses between 1993 and 2003.

Data for pay and earnings for NHSPRB staff groups show a wide variation between median pay for qualified and unqualified staff in categories identified in Table 24.

Table 24: Variations between the median pay for qualified and unqualified staff.

	Median full-time basic salary	**Qualified**	**Unqualified**
All Nurses Midwives & health visiting staff	£22,900 (€33,990.35)	£24,800 (€36,810.51)	£14,500 (€21,522.27)
Allied Health Professionals	£28,600 (€42,450.83)	£30,800 (€45,716.28)	£15,100 (€22,412.85)
ST& T Staff Other	£24,800 (€36,810.51)	£27,700 (€41,114.96)	£14,500 (€21,522.27)
London Ambulance Staff	£21,000 31,170.19)	£24,800 (€36,810.51)	£19,700 (€29,240.61)
Outside London Ambulance Staff	£19,700 (€29,240.61)	£24,800 (€36,810.51)	£16,400 (€24,342.43)

Source: Information Centre for Health & Social Care NHS Staff Earnings Estimates January to March 2007.

These figures show a large pay gap shown between the qualified and unqualified groups, particularly the first three unqualified groups. There is a £10,000 (€14,842.95) pay gap between qualified and unqualified nurses and a £15,000 (€22,264.42) pay gap between qualified and unqualified health professionals. Unions have raised concerns that this may tempt employers to fill vacancies with unqualified staff, and thereby gain a financial advantage.

This issue was raised in the Staff Side Evidence to the National Health Service Pay Review Body (2007) for the 2008-2009 pay round. In the basic pay and earnings data collected for the NHSPRB groups, by Agenda for Change band. The unions suggest that this requires careful scrutiny with regard to the ratios between qualified and unqualified staff in the future.

Table shows that the median pay for all groups in the public sector, based on the Annual Survey of Hours and Earnings (ASHE) 2006. It records the annual percentage increase for nurses of only 1.5 per cent, and for midwives there was a decline of -4.0 per cent.

In addition to the low level of increase, or indeed decline from the previous year for midwives, it can also been seen that the pay gap between nurses and police officers has widened. In the Staff Side Evidence to the National Health Service Pay Review Body submission in 2006 this gap was £223.50 (€331.74) per week, widening to £232.70 (€345.40) per week in 2007, as seen in Table 25.

Table 25: Median pay comparisons across different workers in the public services, 2005 and 2006.

Occupation	**Median Pay ASHE 2005**	**Median Pay ASHE 2006**
Nurses	£429.20 (€637.06)	£435.70 (€646.71) (+1.5 per cent)
Midwives	£485.60 (€720.77)	£466.40 (€692.28) (-3.95 per cent)
Police Officers	£652.70 (€968.80)	£668.40 (€992.20) (+2.4 per cent)
Social Workers	£487.00 (€722.85)	£502.30 (€745.56)(+3.14 per cent)
Teachers (Secondary)	£598.60 (€888.50)	£600.20 (€890.87) (+0.27 per cent)

Finally, unions have raised concerns about the issue of the low value of female dominated professions. The Staff Side of the NHS has begun to take account of the pay of other employees in the wider economy, which is possible on the basis of the Annual Survey of Hours and Earnings (ASHE). According to the NHS Staff Side (2007):

> "Staff side's argument is not that nurses are likely to become train drivers, but rather that wages reflect the value placed on employees within a society. It is the value of, for example, a midwife, or a paramedic in relation to an accounting technician that needs to be considered...these figures highlight that the earnings of the male dominated professions tend to be higher than the female dominated professions both within and outside the public sector" (2007: 44).

Section 3: Conclusions and recommendations

3.1 Summary of the main findings from the case studies

General findings regarding pay levels

In the eight countries surveyed, workers in health and social care are regularly earning below national average earnings (with the exceptions of nurses in Estonia, and carers for the elderly in some regions of Germany). Earnings of unqualified or lower skilled workers are often at minimum wage levels or not much higher; whereas qualified and professional staff earn salaries below those in comparable jobs in other sectors of the economy. There is evidence of the undervaluing of work in female dominated sectors, and that this impacts on the wages of men working in these sectors as well.

Comparing pay rates in health and social care with other sectors of the economy is not always easy to carry out because of an absence of comparable data. However, data from a number of countries does show that when compared to other occupations (with similar levels of skills, responsibility, working conditions and training) in both the public and private sectors, that workers in health and social care loose out in terms of pay and status. Even where job evaluation and benchmarking exercises have been carried out to establish pay rises, these do not always fully take account of the impact of occupational segregation and the under-valuing of women's skills. It is only when these are explicitly designed to address the predominance of women in low paid and under-valued care jobs that pay levels tend to benefit women. Where there have been job evaluations schemes designed to address value discrimination, they tend to award women higher wages. However, there have been few broad based evaluations across different sectors of the economy with workers in public and private sectors. These are key practices that will impact on the reducing the gender pay gap in the future.

Whilst there is a large variation in skills levels, occupational, professional and job grades within and between health and social care, pay levels in health and social care have generally been falling in real terms and also in relation to average wages in the economy.

Variations in pay between different public services and between private and public sector pay

The case studies also show that there exist variations within different public services with commensurate training, experience, working conditions and responsibility. For example, nursing unions in several countries have highlighted the lower pay nurses received compared to police officers, teachers, social workers and other public servants whose jobs are comparable to nurses. There have also been some landmark equal pay cases in several countries where female dominated occupational groups have been compared to male dominated occupational groups within the health care system. Successful outcomes have been achieved through job evaluation and legal action in this respect. Few unions have had the opportunity to initiate or carry out substantial job evaluation or benchmarking exercises to compare the pay of public service workers in health and social care with those in other

professions in the private sector. Where this was carried out in Ireland through the national benchmarking exercise, it failed to take account of the undervaluing of female skills and occupations.

There is substantial evidence of the gender wage gap in health and social care, including evidence that segregation and the clustering of women in female dominated sectors drags down wages. In each of the case studies there is evidence from different occupational sub-sectors of the gender pay gap, particularly as compared to other occupations and sectors where men predominate in greater numbers. All countries surveyed highlight the structural factors impacting on the gender wage gap in health and social care.

Undervaluing of work is closely linked to the undervaluing of care work generally

The low value placed on care and a lack of a care culture and care ethic, means that health and care work is never funded adequately. There is evidence to show that health and care staff feel undervalued and underpaid and that this is connected to recruitment and retention. These are particularly crucial issues given the demand for care work in the future, arising from an ageing population, and the need to recruit and retain the best staff.

Cuts in public service funding

All of the data reviewed so far show the problems of organising and funding services in the current climate of reductions in funding and restructuring, including the privatisation and contracting out of services. This also impacts on the room for manoeuvre in earmarking resources for pay increases, particularly for the lowest paid workers and in ensuring that the pay levels of services that are contracted out are equivalent rates to the public sector.

Wages are being driven down in this sector

There is also evidence to show that in some countries wages are being driven down, with pay rises at lower levels than other sectors and not keeping in line with inflation. Several of the case studies highlight the problems union face in ensuring that health and social care workers are awarded real pay rises. In Germany, for example, in the absence of a minimum wage the emergence of “one euro a day jobs” are appearing in private companies / social enterprises in health and social care sector.

3.2 Examples of different union approaches to addressing the gender pay gap in health and social care

There have been a number of union actions to address the gender pay gap in health and social care. In particular, many unions have sought to integrate issues concerning low paid workers into wage negotiations, and in particular some have introduced measures to address occupational segregation and the gender pay gap. Examples from the case studies include:

- *Specific equality-pay rises to female dominated and/or low paid sectors*. Equality kitty / equality rises have been negotiated by unions with special ring fenced funding for pay rises to address low pay in female dominated occupations. For example, this has been successfully negotiated in Sweden and Finland.

- *Gender neutral evaluation of women's jobs.* Job evaluation to address the undervaluing of women's pay built into the two agreement in the UK (Single Status Agreement in Local Government; Agenda for Change in Health)

- *Measures to address pay inequalities at workplace level* through equality audits (in Sweden this has been particularly successful because of the requirement to review and address the gender wage gap). Voluntary pay audits have initiated by unions in the UK; while equality audits required under legislation and with the social partners in Sweden, Finland, Denmark and Norway.

- *Specific initiatives to benchmark public sector pay* rates against those in the private sector, as carried out in Ireland.

These represent some good practices of different approaches that can be used to address the gender pay gap in health and social care.

3.3 Recommendations

Trade unions

- Trade unions should use best practice approaches to gender mainstreaming to ensure that collective bargaining at the national level always takes account of occupational segregation and the undervaluing of women's work and skills on pay levels.

- Specific measures should be advocated for by trade unions to address the low pay of women, particularly in areas where women predominate.

- The recruitment and retention of staff in health and social care needs to be argued for in the context of better pay, and also improved career progression, access to training, and good quality working conditions.

- Trade unions could highlight to governments and employers the key statistical indicators and data on the gender wage gap broken down by sector and occupation, that would assist comparisons between pay in health and social care and other occupations. This would help to identify the gender pay gap and also enable better comparisons between health and non-health occupations, and in evaluating the differences in job content for the purposes of job evaluation.

- Trade unions should in the future ask employers to provide data on the average pay and working hours broken down by gender. Affiliates should provide this information to EPSU or information on why the employer has refused or failed to do so.

EPSU

- EPSU should formulate recommendations stating the urgent attention that needs to be given to improving women's wages and reducing the gender pay gap in health and social care, as well as the gender pay gap in other sectors of the public serices. This should be forwarded to the European Commission, European Parliament and other relevant institutions, in order to highlight how low pay and the gender wage gap are

major barriers to the development of Social Services of General Interest in the future as well as to gender equality in general.

- EPSU policy should continue to emphasise a gender mainstreaming approach to collective bargaining so as to address the issues of discrimination in pay systems, the undervaluing of women's work and occupation segregation on pay.

- Best practice approaches in collective bargaining and in the development of equality reviews and job evaluation free from gender bias should collated by affiliates to enable EPSU to monitor and publicise this information.

- EPSU should obtain data from affiliates on the gender pay gap in their sectors and carry out an annual review of action taken to reduce the gender pay gap through collective bargaining or other means.

European Commission

- Specific attention needs to be given to the development of improved access to data and indicators on the gender pay gap in health and social care in cooperation with Eurostat and the European Gender Equality Institute. The Commission should also be providing, in cooperation with the Gender Equality Institute, more guidelines and information on how to carry out job evaluation free from gender bias.

- The European Commission should undertake a Europe-wide study and guidelines on how governments and the social partners can work together to re-evaluate work predominantly carried out by women in under-valued areas of work in health and social care.

- The European Commission should provide specific resources for the development of union expertise in the area of workplace equal pay reviews and equality reviews (as provided for under the revised Equal Treatment Directive).

- Addressing the gender pay gap and decent pay in health and social care needs to be positioned as a key element of the delivery of Social Services of General Interest, of improving the access to quality services for an ageing population, and of gender equality policy objectives, notably the closing of the overall gender pay gap and reconciliation of family and work life.

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