This article is the thirteenth of a series of articles looking at medical issues in Europe

Equal opportunities: progress so far

Peter Forster

According to Docksey, "equality policy is one of the few relatively successful and advanced employment policies at community level."¹ Indeed, gender equality is enshrined in article 119 of the Treaty of Rome. But despite a considerable number of initiatives and the substantial increase of women in the labour force, the European Commission reported in 1989 that progress in achieving equality has been slow, with women remaining largely confined to traditional occupations, relatively low level jobs, and atypical forms of work which do not provide the same levels of protection and benefits as traditional types of work.²

Coordinating unit

In the European Community equal opportunity matters are coordinated by the commission's equal opportunities unit in directorate general V, which ensures the application of directives and draft proposals, encourages positive action, and monitors the application of action programmes. It also runs a women's information service, which produces regular information bulletins and runs seminars.

The problem is that, though aimed at achieving equality between the sexes, most of the initiatives and policies adopted at an EC level deal mainly with the unequal treatment of women at the workplace—for example, dismissal, maintenance of rights in pregnancy, and training.

The commitment to equal opportunities enshrined in the Treaty of Rome has been extended by five equality directives and agreed by all member states, and despite protestations by Britain the directives have been incorporated into national laws as part of an EC wide social action programme.

The equal pay directive sought to "facilitate the practical application of the principle of equality" as outlined in the Treaty of Rome. It included the idea that equal pay should apply to work of "equal value" and not just to identical work. The obligations imposed on the United Kingdom by the directive are included in the Equal Pay (Amendment) Regulations 1983.

The equal treatment directive of 1976 provided for the equal treatment of men and women in conditions and in access to employment, vocational training, and promotion. The directive prohibited all gender based discrimination at work, both direct and indirect. In the United Kingdom the Employment Act 1989 amended the sex discrimination legislation and statutory redundancy scheme in order to comply with the directive.

The first social security directive of 1986 established the right to equal treatment in both statutory and supplementary social security schemes.

The second social security directive of 1986 implemented the principle of equal treatment for men and women in occupational social security schemes (covering employed and self employed people). The directive allowed for the deferment of the equalisation of pension age and survivors' benefits until statutory equalisation was achieved. This is being considered by the United Kingdom government.

The self employed directive of 1986 aimed to extend protection against sex discrimination to all self

Women in Europe

Women account for over one third of the western European workforce and just under one third of the medical workforce, yet the participation of women is below that in the United States and eastern Europe. There are still 21 million women between the ages of 25 and 49 "economically inactive" in the community, and average pay is still only 80% of the average pay for men.

In the United Kingdom women make up a higher proportion of the workforce than in any other EC country, except Denmark, but the earnings gap is wider than in any other country. On average, full time women workers in Britain earn 77% of the earnings of men. They fare worse in terms of maternity rights, access to child care—there are places available for only 2% of under 5s at state and private nurseries combined—training opportunities, and promotion to senior positions.³

employed people as well as to those whose employment status was unclear. It covers financial support for established business, social security, and temporary replacement services during maternity.

Equal opportunities action programmes

The first equal opportunities action programme, which covered the period 1982-5, set out to ensure the observance of the principle of equal treatment by the development of community legal action and to promote equal opportunity in practice through positive action programmes.

The second equal opportunities action programme (1986-90) aimed to consolidate steps already taken so that "equal opportunities become an accepted part of everyday life for all community citizens." Seven areas were specifically targeted:

- Improved application of existing equal treatment provisions
- Education and training
- Employment (including more positive action programmes)
- New technology
- Social protection and social security
- Sharing of family and occupational responsibility through awareness raising, child care facilities, and flexibility of working patterns
- Changing traditional male and female attitudes.

Progress under this programme has included legal measures in the form of draft directives proposing, among other things, the equalisation of retirement ages and ending the discrimination in pension rights against women who have interrupted their employment. Another important directive which failed to be adopted (on account of the United Kingdom veto) proposed shifting the burden of proof in equal treatment cases to the employer—that is, discrimination would be presumed until the employer could prove otherwise.

The commission's third equal opportunities action programme, launched in 1991, covers the period 1991-5

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and seeks to "promote women's full participation in, and to revalue their contribution to economic and social life." The programme covers proposals on the financing of child care facilities, the adoption of a recommendation on child care services, and a code of good conduct on the protection of pregnancy and maternity.

Positive action programme

The legislative initiatives have been underpinned by a positive action programme started in 1984 to "promote a better balance between the sexes in employment, eliminate the idea of a traditional division of roles in society between men and women, encourage participation of women in sectors where they are underrepresented and at high levels of responsibility."

The programme is implemented by means of a recommendation rather than a directive, and although it does not have to be incorporated into national law, it is expected that all member states will respond to it in practical terms. So far the only EC member states to give legal and financial backing to the programme have been Belgium, Italy, and the Netherlands.

Since 1990 Belgium has had a compulsory positive action programme for public sector employees plus voluntary programmes for the private sector, with financial and practical backing via specially seconded civil servants. The Netherlands has a policy of partially subsidising child care costs for working parents as well as a compulsory positive action programme in the civil service. In 1991 Italy passed its first positive action programme together with legal and financial backing. In Germany two regions have programmes for the public sector, while Spain, Denmark, and Greece have national plans of action for equal treatment of men and women. This year the Republic of Ireland has published a report by a commission on the status of women.

Provision for parental leave varies in EC countries; in the United Kingdom there is no legal right to parental leave

Underrepresentation in medicine

The NHS, which has 1.1 million employees—75% of whom are women—reflects the general position in the United Kingdom. Women are unequally represented in the different occupational groups. Isabel Allen showed that while in general women medical students were "more strongly motivated than men towards a medical career" and made good progress through medical school, house officer, and senior house officer grades, they progressed far less quickly than their male counterparts at registrar level and above.⁶

A recent study of women doctors and their careers showed that although almost equal numbers of men and women students qualify from medical school, women hold only 15% of consultant posts, only 3% of consultant posts in surgical specialties, and represent 1% of general surgeons, while they are overrepresented in the lower training grades.⁷

Parental leave

In its 1989 social action programme, which accompanied the social charter, the European Commission proposed the adoption of a draft directive on parental leave and leave for family reasons. At present there is a wide disparity among EC member states on leave available to both the mother and father—generous in Denmark, Italy, and France; poor in Ireland, the Netherlands, and the United Kingdom (the country with no legal right to parental leave). The directive proposed a minimum of three months' full time leave for each parent within two years of the birth or adoption of a child. The leave could be paid or unpaid but if paid the cost should be met by the state rather than the employer. This measure requires unanimity for adoption and is unlikely—given the United Kingdom's opposition—to make much headway at present.

Pregnancy

The Single European Act 1986 added articles 100A and 118A to the Treaty of Rome. This allowed the European institutions to sidestep the national veto, particularly the United Kingdom's. Article 118, which deals largely with health and safety at work issues, was used by the commission to advance a draft directive on the protection of pregnant women at work. The draft directive includes:

- Measures to ensure the protection of pregnant and breastfeeding women against exposure to harmful agents and processes
 - Measures requiring the reorganisation of the working conditions and hours of pregnant and nursing employees without "material disadvantage to them"
 - The right to a substantial period of paid maternity leave
 - The prohibition of dismissal on pregnancy grounds.
- These proposals require only a qualified majority for adoption by the Council of Europe.

Under existing United Kingdom legislation dealing with sex discrimination the treatment of pregnant women at work has to be compared with the treatment or expected treatment of a "comparable" male employee or partner. The European Court of Justice in the Dekker case decided that as pregnancy was a uniquely feminine condition any detriment suffered by a woman because of pregnancy was directly discriminatory.³ One of the many implications of this judgment for British employers is that the "comparable male" approach may no longer be good law. Lawyers are still untangling the legal threads of this decision, but it will

no doubt be a cause célèbre in the quest for equality in the workplace.*

United Kingdom response

The United Kingdom has been reluctant to legislate on equality issues. Opportunity 2000, which was launched by John Major in 1991, was a voluntary scheme without legal or financial teeth aimed at improving prospects for women in the United Kingdom. Prompted by the charity Business in the Community, 14 of Britain's top employers—including the NHS—have set out their own 10 year targets to improve the position of women. As a signatory to Opportunity 2000 the NHS Management Executive commissioned a report from the Office for Public Management to profile the "issues relating to the role of women in the NHS and to build on progress in providing equal opportunities for women."

The report identified four general and pervasive barriers to equality: outmoded attitudes about the role of women; direct and indirect discrimination; the absence of proper child care provision; and inflexible structures for work and careers. It noted that dis-

*In the first test of the Dekker judgment in the United Kingdom (*Webb v EMO Air Cargo (UK) Ltd*) the Court of Appeal upheld the "comparable male" approach. Nevertheless, the possibility remains for industrial tribunals in future cases to follow the constitutional and interpretative decisions of the European Court of Justice in preference to those of the Court of Appeal or the House of Lords.

crimination could take many forms but was particularly apparent in subjective and informal selection procedures; stereotyped assumptions about the ability, character, suitability, and natural role of women; the use of insider, word of mouth, and old boys' networks; unnecessary age bars; and excessive mobility requirements.

Conclusion

Although the cause of equality enjoys a general measure of acceptance throughout the community, progress has been slow. As the commission's third action programme implies, perhaps the time is right to "pause and consider" what steps should be taken to increase public awareness of the law on equality, to monitor developments in member states, and develop a system for spreading information and legal standards in what is a most complex field.

1 Docksey C. The principle of equality between women and men as a fundamental right under community law. *Industrial Law Journal* 1991;4:258.
2 European Commission. *First annual report on employment in Europe*. Brussels: European Commission, 1989.
3 Dekker v Stichting Vormings-Centrum voor Junge Volwassen (VJV-Centrum) plus (1991). Case 177/88.
4 NHS Management Executive. *Equal opportunities for women in the NHS*. London: Department of Health, 1991.
5 Equal Opportunities Commission. *Women and men in Britain*. London: Equal Opportunities Commission, 1991.
6 Allen I. *Discussing doctors' careers*. London: Policy Studies Institute, 1989.
7 Joint Working Party. *Women doctors and their careers*. London: Department of Health, 1991.

Leading for Health: responses

Management and information

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This is the sixth in a series of articles responding to the questions raised by the BMA's document, "Leading for Health." The document looks well beyond the coming British election and raises questions about health and health care that will be on the agenda of many countries into the next century.

The questions posed by *Leading for Health: a BMA Agenda for Health* on management and information in the health service cannot be answered without considering what sort of service is required to provide health care for the nation. Management arrangements will be influenced by the structure of the NHS, and the information required should be determined by the needs of management, medical audit, and health services research.

A national health service

Public funding of health care in the United Kingdom is by no means excessive when compared with that in other countries in the Organisation of Economic Co-operation and Development (table, fig 1) but nor is it extremely frugal. The contribution by individual people from their private income to the total funding of health care remains small in relation to the other countries in the organisation, though it is growing. Publicly funded health services tend to have low costs¹ because the provision of services is controlled centrally rather than market driven and administrative costs are low, particularly if remuneration of professional staff is constrained.

The administrative costs of NHS hospitals with their global budgets were estimated to consume 6.9% of expenditure in 1984,² whereas private hospitals billing each patient spend up to 18% of total revenue on administration.³ Administrative costs are even higher when public money is spent in the private sector because of the need to regulate the use of this money. In the United States administrative costs account for over 24% of expenditure,⁴ and most would agree that

the Americans can no longer afford a market driven system,⁵ even though their public expenditure on health per capita exceeds that of the United Kingdom (table).

I therefore assume that the United Kingdom, irrespective of which political party is in power, will continue to have a broadly publicly provided as well as publicly financed health care system and that expenditure from the public purse is unlikely to

Countries in the Organisation for Economic Co-operation and Development ranked in order of public health expenditure per person in 1990 converted to American dollars by using general purchasing power parities

	Gross domestic product	Public expenditure on health
Canada	19 925	1330
Sweden	16 320	1269
Norway	17 799	1226
Iceland	16 194	1201
Luxemburg	18 175	1189
United States	20 774	1089
France	15 568	1022
Finland	15 565	964
Switzerland	18 716	951
Germany	15 943	935
Belgium	14 672	897
Italy	14 727	865
Netherlands	14 609	858
Japan	17 019	830
Denmark	15 452	811
Australia	15 363	801
Austria	14 224	792
United Kingdom	14 907	772
New Zealand	11 822	697
Spain	11 077	573
Ireland	9 858	571
Portugal	7 879	326
Greece	7 643	309
Turkey	4 941	70

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