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GENDER DIFFERENCES IN EMPLOYEE HEALTH IN SLOVENIA: THE ROLE OF WORK INTENSITY, ORGANISATIONAL COMMITMENT AND MOBBING

ABSTRACT

We aim to examine differences in the effect of work intensity, organisational commitment and mobbing on the health of working women and men in Slovenia. A subsample of employee data (n=589) included in a Slovenian Public Opinion research study on a representative sample of Slovenian inhabitants is statistically analysed. This study reveals that men have better self-reported health and are less absent from work. However, women's health is significantly negatively correlated with work intensity and men's health with mobbing. Affective organisational commitment is positively connected to the health of both genders while the normative one is negatively correlated only with women's health. Our study contributes to the theory of gender and health with evidence of health being not only a biological but also a social phenomenon which cannot be generalised, but must be interpreted in a specific time and social context.

KEY WORDS: gender, health, work intensity, organisational commitment, mobbing

Razlike med spoloma v zdravju zaposlenih v Sloveniji: vloga intenzitete dela, organizacijske zavezanosti in mobinga

IZVLEČEK

Namen študije je raziskati razlike v učinkovanju intenzitete dela, organizacijske zavezanosti in mobinga na zdravje zaposlenih žensk in moških v Sloveniji. Statistično analiziramo podatke na podvzorcu delavcev (n = 589) iz na reprezentativnem

vzorcu prebivalcev Slovenije izvedene raziskave Slovensko javno mnenje. Študija ugotavlja, da imajo moški boljšo samooceno lastnega zdravja in nižjo stopnjo absentizma kot ženske. Zdravje žensk je signifikantno negativno povezano z intenziteto dela, zdravje moških pa z mobingom. Čustvena organizacijska zavezanost je pozitivno povezana z zdravjem vseh, normativna pa negativno le z zdravjem žensk. Raziskava prispeva k teoriji spola in zdravja. Zdravje obravnava kot biološki in tudi družbeni fenomen, ki ga ne smemo posploševati, temveč ga moramo interpretirati v časovnem in družbenem kontekstu.

KLJUČNE BESEDE: spol, zdravje, intenziteta dela, organizacijska zavezanost, mobing

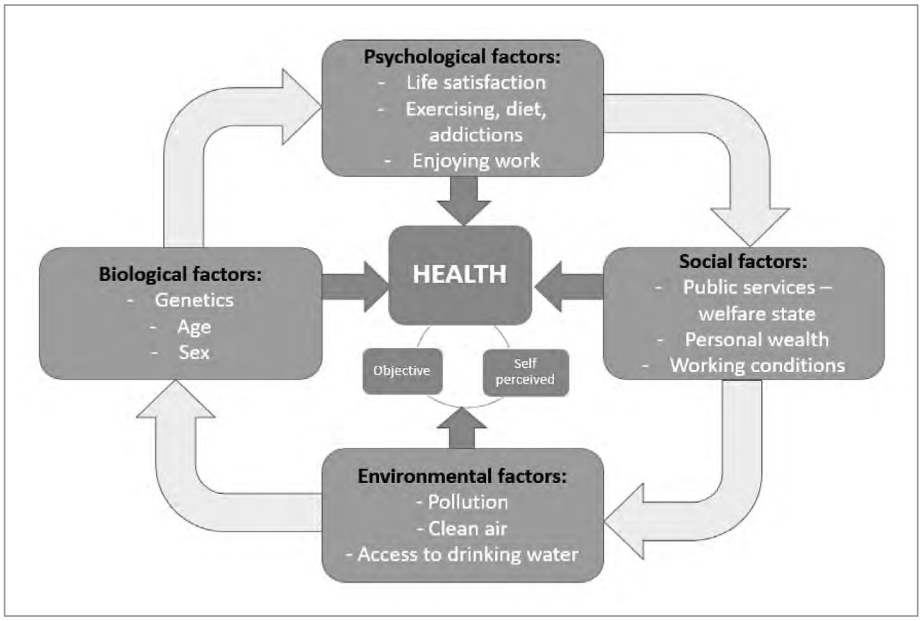
1 Introduction

Gender inequalities in health have been examined in several studies which identified biological differences and social factors as a source of inequality. Yet these studies have arrived at very different conclusions while one of the most common beliefs that 'men die earlier but women are sicker' is questioned.

Specific and very important research in the area of gender health differences refers to work (paid and also non-paid domestic work) since a key determinant of health is the labour market. As Artazcoz et al. (2016: 165) note, in this field of research, "traditional occupational health has focused on job hazards typical of male occupations and the interest in women's occupational health has often been limited to reproductive hazards". Until recent decades there was not much comparative research. With an interest in measuring the complexity of various gender equality indicators (like the Gender Inequality Index), indices that also include health-related indicators appear together with studies concerned with the effect of gender equality at the country level on gender inequalities in health (see Palencia et al. 2014: 25–26). This is also the ambition of our study.

To properly understand the processes that produce/maintain gender inequalities in health, more studies devoted to the social and historical context of the subject are needed. Figure 1 on the next page demonstrates how four different yet interconnected factors might influence a person's health. Under each factor we list just three more specific examples, although of course there might be several of them. The labour market, family and gender policies are greatly determined by welfare state regimes (Artazcoz et al. 2016). One study of such regimes was conducted by Eikemo et al. (2008), but gender differences in health were not considered. The study reveals that the type of welfare state regime appeared to account for around half the national-level variation in health inequalities between

Figure 1: Authors' conceptual model



European countries (ibid.: 2281). Better self-perceived general health was found in countries within Scandinavian (social-democratic) and Anglo-Saxon (liberal) welfare regimes compared to Bismarckian (conservative), Southern and Eastern European welfare regimes. The last regime included Slovenia along with Czech Republic, Hungary and Poland. The "Eastern Europe" category, according to the researchers, has "limited health service provision and overall population health is relatively poor" (ibid.: 2283). However, according to the population share perceiving their health status as good or very good, Slovenia falls in the group with Bulgaria, Germany, Czech Republic and Hungary (Eurostat 2019a – data for 2016). On the other hand, regarding life expectancy at birth, Slovenia is similar to Malta, Portugal, Finland, Sweden and Austria (ibid. – data for 2016). Equating Slovenia with Eastern Europe is therefore not justified in this case.

Slovenia thus makes an interesting case study for examining gender differences in health in connection to employment conditions. In Slovenia, the gender employment gap is below the EU average (Eurostat 2019b), many more women than men complete tertiary education – Slovenia is at the very top of the EU-28 by gender gap (-24,1 percentage points) in tertiary education (ibid. – data for 2017) and the gender pay gap is much lower in Slovenia than it is in the EU-28 (ibid. – data for 2014). It may therefore be assumed that women in Slovenia enter into employment relationships on a much more equal basis than the Euro-

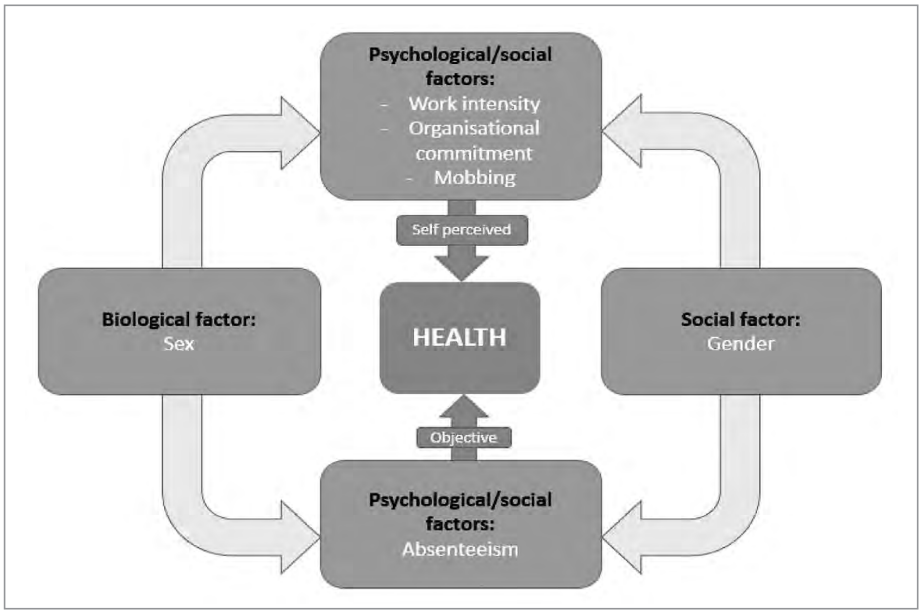
pean average and we may thus expect that the health predictors for male and female employees will also be more similar. Indeed, this is the central assumption made in this study where we focus on specific factors (self-perceived health) which might influence worker health. The subjective perception of health does not necessarily correspond to actual health problems, as demonstrated in a study by Domajnko and Pahor (2014) on a group of Slovenian elderly people. We thus also considered absence from work, which may be considered to be a more objective measure. An important body for researching absenteeism in Slovenia is the National Institute of Public Health (*Nacionalni inštitut za javno zdravje,* NIJZ), collecting data since the year 2000 (by disease, gender, age, geographical regions, economic activities and other relevant variables). Like NIJZ, a Eurofound study in 2015 also shows a bigger share of absenteeism among women than men, and that absenteeism in Slovenia is above the EU average. Still, absenteeism may not be an 'objective' health indicator as well since a person can be ill but still working because the work has to be done (see Škerjanc and Fikfak-Dodič 2014; Čehovin Zajc and Kohont 2017). Studies show that women work more often despite being sick than men (Eurofound 2015) and the share of presentism in Slovenia exceeds the EU average (Eurofound 2015). Another possibility is hypochondria, whereas a person can also be absent from work due to caregiving obligations.

Apart from addressing the mentioned research gap (self-reported vs. more objective measures of health), our study explores rarely researched social and psychological factors that could be connected to workers' health: work intensity, organisational commitment, and mobbing.

2 Work intensity, organisational commitment, and mobbing in relation to health

We explore social and psychological factors that can be connected to the health of workers but previously rarely researched among genders: work intensity, organisational commitment, and mobbing, as shown in Figure 2.

Figure 2: Authors' research model



2.1 Work intensity in relation to health

Work intensity often includes different dimensions such as time demands (high working speeds, tight deadlines or insufficient time to complete a job), emotional demands (levels of job stress) and job demands (role overload) (see Burke 2009; Green 2001; Čehovin-Zajc and Kohont 2017). Several authors suggest work intensity might influence employees' health. For example, Burke et al. (2009) found that work intensity is a considerably more powerful predictor of work and health outcomes than hours worked. Boxal and Macky (2014) discovered that work intensity mainly holds negative outcomes for employees: poorer well-being in terms of fatigue, job-induced stress and work–life balance. They emphasise the importance of including work intensification in the assessment of employee well-being. Consequences of work intensity cannot affect only an individual but also their families, organization, co-workers and society (Burke et al. 2009; Boxal and Macky 2014). Work intensity factors are also significant predictors of work-to-family conflict factors (Ozutku and Altindis 2013) and the work–life balance (Boxal and Macky 2014).

Work intensity is also positively related to work outcomes and negatively related to psychological well-being (Burke et al. 2009). Studies show that work intensity (i.e. temporal, emotional and work-related demands) in Slovenia is increasing and already exceeds the EU average (see Eurofound 2015; Čehovin

Zajc and Kohont 2017). Employees who experience a higher level of work intensity suffer from worse health and, moreover, are simultaneously less likely to be able to afford the time needed for healthcare due to their work obligations (see Čehovin-Zajc and Kohont 2017).

In a society where women and men equally enjoy/suffer their jobs, and where they both equally share their necessary household work, we may assume there will be no difference in the extent to which work intensity is connected to a gender's health. On the contrary, in societies where one gender faces more work–family conflict or engages in various occupations that could enforce greater work intensity, we may expect that differences to be significant. For example, an EU survey (Burchell and Fagan 2004: 639) found that women were more vulnerable to work-related ill-health than men. Namely, although women are more concentrated in clerical jobs, which have the lowest levels of occupational illness, and men outnumber women in skilled manual jobs, which have the highest levels of occupational ill-health, within each occupational category, except for less-skilled blue-collar, men were healthier than women (ibid.: 637).

Our study will also test the extent of that work intensity is (negatively) connected to employee health and, specifically, whether any gender differences exist in the work intensity–health link. While Slovenia enjoys greater gender equality than most other countries, we will test the assumption that men are still less absent from work than women (due to childcare) and that they face greater work intensity. Therefore, work intensity might correlate with men's health more strongly than with women's health. Therefore, we pose the first research question:

- *RQ1: Does work intensity correlate differently with women's and men's health?*

2.2 Organisational commitment in relation to health

Organisational commitment, i.e. an employee's psychological attachment to the organisation, is conceptualised in various ways; for example as an attitude, identification, bond, binding force, etc. (see Klein et al. 2009). In research of organisational commitment, the three-component model developed by Meyer and Allen (1991) still dominates. In this model, organisational commitment has three dimensions (affective, normative and continuance), each characterised by a different psychological state or mindset (Meyer and Allen 1991).

- *Affective* commitment refers to an emotional attachment to, identification with, and involvement in the organisation. An employee who is affectively committed strongly identifies with the organisation's goals and desires to stay part of the organisation. This employee commits to the organisation because he/she 'wants to'.

- *Continuance* commitment reflects awareness of the costs associated with leaving the organisation and therefore develops from the perceived cost (benefits against losses), and requires that the employee be aware of these benefits and losses.
- *Normative* commitment is viewed as a feeling of obligation to continue one's employment and leads employees staying in the organisation due to a sense of loyalty or duty, and because they feel it is the right thing to do. Normative commitment develops out of internal pressures that stem from norms which encourage extended commitment to the organisation (Meyer and Allen 1991).

A growing body of research examines the links between organisational commitment and employee-relevant outcomes. However, studies are not fully consistent with regard to the relationship between health and organisational commitment. Mostly, organisational commitment in general or only the affective dimension was found to correlate positively with health (e.g. Nesje 2017), while continuance and normative commitment have a variable (yet generally negative) relationship with health (Meyer and Maltin 2010). Further, one can also find research showing a positive correlation with health and all dimensions of organisational commitment (e.g. Tiwari and Mishra 2008). Some researchers argue that affective commitment can buffer the negative impact of work stressors on employee health and well-being (Begley and Czajka 1993), while others suggest that committed employees might experience more negative reactions to such stressors than those who are less committed (Jackson and Rothmann 2006).

The inconsistent previous research on organisational commitment and health means there is also inconsistency regarding gender differences in organisational commitment. Some studies show that men tend to have higher levels of organisational commitment than women (Khalili and Asmawi 2012), whereas others found no significant differences in levels of organisational commitment between genders (Hussein and da Costa 2008) in the case of teachers' organisational commitment in an Islamic School according to gender). While Stewart et al. (2007) revealed that women tend to have a higher level of continuance commitment than men, an Iranian study (Khalili and Asmawi 2012) established the contrary, namely that the male participants showed a higher level of continuance commitment and affective commitment.

Since a research gap exists with respect to the connection between organisational commitment and the health of genders, we will examine it in Slovenian society. We make the assumption that men might experience only somewhat higher organisational commitment than women and that all types of organisa-

tional commitment have an equal connection to the health of both genders. To verify these assumptions, we pose the second research question:

- *RQ2: Does organisational commitment correlate differently with women's and men's health?*

2.3 Workplace mobbing in relation to health

It is clear that *mobbing* or 'workplace harassment', which may be defined as mental, hostile and unethical communication by which one or more persons terrorise another person with the aim to destroy and remove them from their workplace, dramatic affects the physical and psychological well-being of employees. A Spanish study (Carnero et al. 2010) shows that being a mobbing victim raises the probability of suffering from symptoms of poor health by 26 percentage points. Other studies found in the literature give evidence of mental and physical problems that emerge after harassment (Kostev et al. 2014). Recent studies suggest that mobbing is not a gender-neutral phenomenon, with some studies finding that women are more often victims of mobbing (Ferrari 2004) and that women and men are sensitive to different kinds of mobbing. For example, women focus on comments regarding their private life and rumours, while men are more involved in activities aimed at discrediting their work (Candura et al. 2014). Yet, there are still no studies that clearly show whether mobbing (when both genders are exposed to the same) affect women's and men's health in different ways. We may expect that, even in Slovenia, women might be victims of mobbing more frequently than men and thus in relation to mobbing women might more frequently encounter health problems than men do. Our third research question is:

- *RQ3: Does mobbing correlate differently with women's and men's health?*

3 Methods

3.1 Research description

To understand how different work-related factors (work intensity, organisational commitment and mobbing) correlate with the health of women and men, this study analyses secondary microdata taken from the research *International Social Survey Programme: Health and Health Care – ISSP 2011*[1] that in Slovenia formed part of an extended survey "*Slovenian public opinion SJM 2011/1",* which also included questions about work and family (Hafner-Fink et al. 2011). Data

1. ISSP. (2011): International Social Survey Programme: Health and Health Care. Available from: *http://zacat.gesis.org/webview/index.jsp?object=http://zacat.gesis.org/obj/fStudy/ZA5800* (Accessed 14.5.2019).

were collected on a random representative sample of adult Slovenian inhabitants (N=1082) between March and June 2011. However, respondents without recent working experience were excluded so in this paper, due to the aim of our study, 589 respondents with recent working experience were included in the analysis.

3.2 Sample description

Among the analysed respondents, the majority (77,4 %) were full-time employed, 5,8 % were self-employed, 8,7 % were students who work, and the remaining 8,1 % were other occasional workers. They were aged between 19 and 78 years (retired people who still work occasionally), 53,5 % (315) of the analysed respondents were men and 46,5 % were women (274). On average, the women in our sample have completed a somewhat higher education level than the men (most men have a high school diploma, while women mostly have a university degree), and were also a little older than the men (M_M=39,90, M_F=40,19), which in fact reflects the national characteristics (women are more educated and live longer).

3.3 Description of the variables

Health

The respondents' health assessment was measured with four reliable (Cronbach α=0.75) indicators on a Likert scale, where 1 meant worst and 5 the best health. Respondents were asked how often (over the preceding 4 weeks) they had: a) experienced difficulties with work or household activities due to health problems; b) bodily aches or pains; c) felt they could not overcome their problems. They were also asked: d) how they would rate their self-perceived health in general. Principal axis factoring (PAF) was used to create one factor Health that consists of all four indicators, which explains 57,4 % of the variance. Confidence in using this self-assessed health factor is based on previous research (Wu et al. 2013) which demonstrates that subjective health assessments are valid health status indicators. This factor's consistency with other objective health measures in the database was further checked by using a comparison between self-assessed health and days of absenteeism from work.

Work intensity

Work intensity, defined as the rate of physical and/or mental input given to work tasks performed during the working day (see Green 2001: 56), comprising time, job and emotional demands (see Burke 2009; Boxall and Macky 2014; Čehovin-Zajc and Kohont 2017), was measured with seven indicators about work on a 5-point Likert scale, where 1 meant completely disagree, and 5 totally agree:

a) Today I work far more than I did a decade ago; b) I do not have time for work outside my primary job to improve my living standard; c) I am overburdened by the amount of work I have to do at my job – work overload; d) I am constantly under time pressure at work; e) I work in unsafe and/or unhealthy working conditions; f) I do physically demanding tasks at work; and g) My work is stressful. The indicators had an approximately normal distribution (skewness and kurtosis coefficients between -1 and +1). Due to the relatively high reliability of all seven indicators (Cronbach α = 0,743, N=7), principal axis factoring (PAF) was used to establish one common factor that consists of all seven indicators mentioned above.

Organisational commitment

Organisational commitment, a three-dimensional concept defined as an employee's psychological attachment to the organisation (Meyer and Allen 1991), was measured with nine indicators on a five-point Likert scale. Based on theoretical suggestions (ibid.), confirmatory factorial analysis was used to obtain three factors.

The first factor, *continuance commitment,* is represented by: a) too few opportunities to leave the current organisation; b) working in the current organisation out of necessity; and c) the opinion that leaving one's job would be too stressful at this time. A common feature of this factor is staying with the organisation due to certain internal or external pressure that would make exiting from the current organisation either practically or psychologically too costly.

The second factor, *affective commitment,* consists of indicators that measure job satisfaction in the organisation: a) the desire to complete one's career in the same organisation; b) happiness to come to work; and c) recommending work at this organisation to one's children. The common features of this factor are certain positive feelings and preferences for working in the organisation and it is therefore named affective commitment because it reflects the desire and satisfaction of an employee regarding their job.

The third factor, *normative commitment,* consists of: a) staying in the organisation due to moral obligation; b) finding employment elsewhere unethical; or c) a guilty conscience due to leaving one's organisation. A common feature of this factor is staying with the organisation due to a certain moral obligation.

Together, the three factors explain 61,997 % of the variance. The first factor explains 26,52 %, the second 24,95 %, and the third 10,54 % of the variance. The reliability of the indicators in each factor is acceptable (Cronbach α >0.60).

Mobbing

Mobbing or workplace harassment (see Ferrari 2004; Carnero 2010; Candura 2014) was measured with seven dichotomous indicators. The sum of positive answers to seven answers (0 to 7 scale) describes the quantity of different types of mobbing experienced in the working organisation. Respondents were asked whether in the previous 6 months in the workplace they had experienced: a) mistreatment; b) receiving abusive or hateful comments; c) being pressured not to enforce their rights; d) being humiliated or ridiculed with regard to their work; e) their mistakes always being sought; f) not being given information that affects the quality of their work; and g) the spreading of rumours about them.

3.4 Answering the research questions

All of the mentioned factors had an approximately normal distribution, allowing us to use parametric tests to analyse the research questions. A t-test for independent samples was initially used to reveal the equality or differences in health, work intensity, organisational commitment and mobbing among men and women. To reveal bivariate correlations between health, work intensity, organisational commitment and mobbing, Pearson's r coefficient was used; specifically on a subsample of men, on a subsample of women, and on all respondents with working experience. The final analysis that helped more comprehensively answer our questions was a multivariate linear regression in which health was explained with work intensity, organisational commitment and mobbing. This multivariate regression model was conducted three times, for the subsamples of men, of women, and all respondents with work experience.

4 Results

The t-test for independent samples shows that the men rated their health significantly better than the women, and are also significantly less absent from work. However, contrary to this, they both rated their work intensity, the three types of organisational commitment (affective, normative and continuance) and mobbing, without any significant differences.

Table 1: Differences in health, absenteeism, work intensity, organisational commitment and mobbing among men and women (t-test for independent samples)

	Gender	N	Mean	SD	t-test	p
Health	Men	312	0,32	0,81	2,76**	0,006
	Women	273	0,12	0,92		
Absenteeism	Men	284	0,76	1,12	-2,47**	0,014
	Women	249	1,01	126		
Work intensity	Men	262	0,05	1,02	1,25	0,212
	Women	231	-0,06	0,98		
Continuance commitment	Men	261	-0,03	1,02	-0,72	0,472
	Women	238	0,03	0,98		
Affective commitment	Men	261	-0,06	0,96	-1,46	0,145
	Women	238	0,07	1,04		
Normative commitment	Men	261	0,04	1,03	0,89	0,372
	Women	238	-0,04	0,97		
Mobbing	Men	311	1,40	1,81	1,60	0,110
	Women	271	1,17	1,73		

****p≤0.001, **p≤0.01, *p≤0.05*

Source: authors based on database Hafner-Fink et al. 2011.

Since health holds direct consequences for absenteeism, i.e. being absent from work, a more detailed insight into absenteeism among both genders revealed the majority of men – 58,5 % (compared to less than half the women – 48.6%) were not absent from work in the previous 6 months. Absenteeism measured in days in the last 6 months was higher among women than men (see Table 2).

Table 2: Differences in absenteeism frequencies among men and women

Absenteeism (no. of days being absent from work in last 6 months)*	All		Men		Women	
	Frequency	Valid Percent	Frequency	Valid Percent	Frequency	Valid Percent
0 days	287	53,8	166	58,5	121	48,6
1–3 days	121	22,7	62	21,8	59	23,7
4–10 days	63	11,8	29	10,2	34	13,7
11–20 days	28	5,3	13	4,6	15	6,0
more than 20 days	34	6,4	14	4,9	20	8,0
Total - valid	533	100,0	284	100,0	249	100,0
Missing (DK, NA)	56		31		25	
Total	589		315		274	

** Cramer's V=0.101, p=0.023*

Source: authors based on database Hafner-Fink et al. 2011.

The bivariate Pearson r analysis shows a significant correlation between health and all analysed work-related factors (work intensity, three types of organisational commitment, mobbing). The only exception is the non-significant correlation between normative commitment and health among men and the total, while normative commitment is significantly related to health among women.

Table 3: Bivariate correlations between health, work intensity, organisational commitment and mobbing (N=430); comparison among men (n=228) and women (n=202)

	Pearson r	Health	Work intensity	Organisational commitment			Mobbing
				Continuance	Affective	Normative	
Health	All	1					
	Men	1					
	Women	1					
Work intensity	All	-0,246***	1				
	Men	-0,180**	1				
	Women	-0,337***	1				
Continuance commitment	All	-0,168***	0,277***	1			
	Men	-0,143*	0,278**	1			
	Women	-0,188**	0,280***	1			
Affective commitment	All	0,215***	-0,144**	0,021	1		
	Men	0,197**	-0,288***	0,054	1		
	Women	0,259***	0,027	-0,019	1		
Normative commitment	All	-0,059	0,208***	-0,016	-0,001	1	
	Men	0,066	0,289***	0,025	-0,022	1	
	Women	-0,181**	0,105	-0,065	-0,021	1	
Mobbing	All	-0,194***	0,209***	0,100*	-0,175***	0,051	1
	Men	-0,203**	0,209***	0,127	-0,084	0,024	1
	Women	-0,212**	0,203**	0,073	-0,270***	0,083	1

****p≤0.001, **p≤0.01, *p≤0.05*

Source: authors based on database of Hafner-Fink et al. 2011.

To check the concomitant impact of work-related factors (work intensity, organisational commitment and mobbing) on health, a multivariate linear regression model was used. The initial model was conducted on 430 employed respondents who had answered all the questions and shows that work intensity, continuance commitment and mobbing deteriorate an employees' health, while affective commitment improves their health. However, when analysing the same model for the subsamples of men and women, the analysis reveals important

differences. Men's health is worsened by mobbing and improved by affective commitment. Work intensity, continuance and normative commitment seem to bring no significant effect for men's health. On the other hand, women who work at a lower work intensity, have lower normative commitment and higher affective commitment to the organisation tend to have better health. Mobbing and continuance commitment do not exert a significant influence on women's health.

Table 4: Standardised regression coefficients for health predictors

Model		All		Men		Women	
Beta		p	Beta	P	Beta	p	
1	(Constant)		0,000		0,000		0,158
	Work intensity	-0,157**	0,002	-0,100	0,181	-0,275***	0,000
	Continuance commitment	-0,117*	0,014	-0,108	0,111	-0,110	0,095
	Affective commitment	0,174***	0,000	0,163*	0,016	0,241***	0,000
	Normative commitment	-0,034	0,467	0,098	0,146	-0,173**	0,007
	Mobbing	-0,121*	0,011	-0,153*	0,021	-0,097	0,149
	N	430	228			202	
	R2adj.	0,111		0,083		0,208	
	F (df)	11,677 (5)		5,097 (5)		11,579 (5)	
	p (Model)	0,000		0,000		0,000	

****p<0,001, **p<0,01, *p<0,05*

Source: authors based on database of Hafner-Fink et al. 2011.

5 Discussion

Although Slovenia is a European country in which women are employed on the most equal conditions and we thus expected only minor differences in health predictors stemming from the working environment, our research show that significant disparities continue. Still, the results of this study strongly contradict popular belief and can be only partly interpreted by pointing to the existence of some very traditional gender roles and perceptions.

Our study of a population of Slovenian workers shows that the men rated their health significantly better than the women, and are also less absent from work. This is in line with studies from other countries and also with the European working conditions survey (see Eurofound 2015) and data from the National Institute of Public Health (2019) for the same year as our study (2011) where women were almost 1/5 more frequently absent from work than men (but were 5 times more

frequently absent due to care for a family member). Another Slovenian study on health behaviour among men and women (see Zaletel-Kragelj et al. 2005) reveals that employed women were identified as being at a very high risk for frequent stress perception with at least minor difficulties in coping with such feelings, requiring that specific public health measures be introduced for this group.

We initially assumed that men face greater work intensity (working more, overburdened, work pressures ...) and thus work intensity might correlate to men's health more strongly than to women's health. However, the results of the study are just the opposite: in Slovenia, there are no differences in gender with respect to work intensity and (probably exactly due to this) work intensity negatively correlates only with women's health. Kanjuo-Mrčela and Ignjatović (2013) noted that the increasing work intensity in Slovenian organisations seen in the last decade due to the processes of privatisation, restructuring and competitive pressures in international markets has had a specific effect on women's lives because of their double burden of paid and unpaid work. Their study, conducted in 2010, also showed a weak positive correlation between greater working hours (paid and unpaid) and greater health problems for women (while there was no influence on men). They also revealed that there were more workers in Slovenia working more than 70 hours per week than in the EU-27. Concerning the number of hours of (paid/unpaid) work, there was a large gender difference in both the EU-27 and in Slovenia, but it was considerably larger in Slovenia since 17,3 % men and up to 41 % women reported working for more than 70 hours per week. In our study, only paid work was considered and, therefore, there were no significant differences. However, when the burden of unpaid domestic work (which in Slovenia is still mostly in the domain of women) is considered, it is quite understandable why work intensity has a negative correlation only with women's health.

Our assumption regarding organisational commitment was also false. There were no significant differences between men and women in the extent to which they are committed to the organisation, and commitment does not necessarily have a positive connection to health. Organisational commitment was found to have a contradictory effect on health in previous studies (see Meyer and Maltin 2010; Tiwari and Mishra 2008, etc.), but gender differences in the extent of organisational commitment on health were not examined. Our study of gender health differences in Slovenia, a society where no differences in the level of organisational commitment among women and men were found, shows an interesting aspect of the role of organisational commitment for health. Affective commitment positively correlates with the health of both genders, yet a higher correlation is found in the female subsample. Of course, women are traditionally seen as 'more emotional' and therefore more strongly influenced by commitment

to the degree it could impact their health. However, contrary to this, normative commitment negatively correlates only with women's health. It appears that a woman who does not feel morally obliged to work in the organisation tends to have better health (in opposition to the belief that women are 'naturally' more inclined to follow instructions due to their passivity), while such a sense of obligation plays no role in men's health. There are various explanations for these results, especially because previous studies also presented completely different results on the organisational commitment of men and women. Women can also only act according to their traditional (emotional, subordinate, obedient) role. They might also be more affected by organisational commitment because they are more susceptible to these influences due to being overloaded with domestic work. There are several possibilities and, without a longitudinal study and a clear understanding of the temporal and spatial micro-conditions, we can only guess.

The connection between mobbing and health is even more surprising. Although some recent studies show that women are more frequently victims of mobbing than men (e.g. Kostev et al. 2014), our findings establish that men are a little (but insignificantly) more exposed to mobbing. We may conclude that no significant differences exist in mobbing exposure among men and women, yet mobbing is significantly (negatively) connected to men's health only. Until now, no evidence has shown and explained why women are less affected by mobbing as the results of our analyses reveal. On the contrary, as the Slovenian researcher Ule (2012) claims, mobbing and threats of dismissal affect women's health more because women mostly depend on their male superiors in their jobs and have poorer support networks. Our results also stand in contrast to research by Candura et al. (2014: 377) who discovered that women are more affected by comments regarding their private life, while men are more affected by activities aimed at discrediting their work. Only half of the questions in our study were directly connected to work. Candura et al. (ibid.) explain that another reason that women are more targeted by psychological harassment may be the more passive attitude of women (or they are more easily attacked) and the fact they rarely hold managerial positions (since bullying is mainly exercised by superiors towards subordinates). In the case of Slovenia, men are also found in the majority of managerial positions, leading to the possible conclusion that workers are more brutally attacked by members of the same sex (since mobbing has significant health consequences for men only). We might therefore use the same argumentation about the passive attitude of men, but our findings can also be explained by other possibilities. It is also possible that women do not notice mobbing and are not affected by it because they are simply 'more used to it' while on the contrary men are very quickly offended.

As Jogan (2013) notes, in Slovenian society during socialism, especially in the 1970s and 1980s, the key institutional basis for eliminating discrimination against women was established. Today, men and women in Slovenia have obvious sympathies towards the policy of equal opportunities for both genders (albeit that orientation is more typical for women). However, as Jogan also found, a deep androcentric understanding of women's inclusion in paid work as a complement to the man's income is still quite strongly present in the opinion of both genders since almost half the respondents of a study over the last decade believe that part-time work is most suitable for mothers with preschool children. This demonstrates that, despite the advanced state policy in the area of gender equality, it is much harder to overcome traditional family patterns which still permit men to not participate very much in household work and childcare. These social factors are also likely to be responsible for our research results.

6 Conclusion

Although among Slovenian workers no differences have been established among men and women in perceived work intensity, organisational commitment and mobbing at the workplace, the correlation of these factors with health reveals significant differences. Therefore, we can affirmatively answer two of our research questions; namely, whether work intensity, and mobbing correlate with women's and men's health differently. More precisely, mobbing in the workplace worsens men's health but does not have an influence on women's health. Contrary to this, work intensity does not deteriorate men's health, while it has a significant negative impact on women's health. Similarly, the normative dimension of organisational commitment was found to negatively correlate only with women's health, while it has no impact on men's health. However, no significant gender differences were found in the impact of affective and continuance commitment on health. Affective organisational commitment was established to have a significant positive impact on the health of both genders. Continuance commitment, on the other hand, does not affect either gender's health. Our study also reveals that men are self-reportedly significantly healthier and less absent from work than women. These results can partly be explained by the patriarchal patterns that are still present in Slovenian society, even though the former socialist system and the current Slovenian efforts have established a solid foundation for gender equality. The negative influence of mobbing on men's health and normative commitment on women's health, however, do not fully correspond to this interpretation. Accordingly, while our study has some limitations (as a cross-sectional study, secondary data with limited indicators, etc.), and must be interpreted in a specific temporal

(survey from 2011) and geographical (case of workers in Slovenia) context, it can still serve as inspiration for future research in this field.

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