EMPLOYMENT, WORK AND HEALTH INEQUALITIES: A GLOBAL PERSPECTIVE

Joan Benach and Carles Muntaner
with Orielle Solar, Vilma Santana and Michael Quinlan
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Joan Benach and Carles Muntaner
with Orielle Solar, Vilma Santana and Michael Quinlan
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Preface

"The problem of what man is is always posed as the problem of so-called 'human nature', or of 'man in general', the attempt to create a science of man - a philosophy - whose point of departure is primarily based on a 'unitary idea', on an abstraction designed to contain all that is 'human'. But is 'humanity', as a reality and as an idea, a point of departure - or a point of arrival?"

Antonio Gramsci

From The Modern Prince, and Other Writings.
The doctor is a popular hero: you have only to consider how frequently and easily he is presented as such on television. If his training were not so long and expensive, every mother would be happy for her son to become a doctor. It is the most idealised of all the professions. Yet it is idealised abstractly. Some of the young who decide to become doctors are at first influenced by this ideal. But I would suggest that one of the fundamental reasons why many doctors become cynical and disillusioned is precisely because, when the abstract idealism has worn thin, they are uncertain about the value of the actual lives of the patients they are treating. This is not because they are callous or personally inhuman: it is because they live in and accept a society which is incapable of knowing what a human life is worth.

It cannot afford to. If it did, it would either have to dismiss this knowledge and with it dismiss its pretences to democracy and become totalitarian: or it would have to take account of this knowledge and revolutionise itself. Either way it would be transformed.

I do not claim to know what a human life is worth. There can be no final or personal answer. The question is social. An individual cannot answer it for himself. The answer resides within the totality of relations which can exist within a certain social structure at a certain time. Finally man's worth to himself is expressed by his treatment of himself.

But since social development is dialectical and there is often a contradiction between the existing social relations and what is becoming possible, one can sometimes perceive that the existing answer is inadequate.

This book challenges us to find another answer to the question: What is a human life worth? And this, I believe, can only be done by envisaging and actively claiming a future very different from the one being prepared.

John Berger

Drawings by Yves Berger
Prologue

Global inequalities in employment and work constitute some of the most serious issues of our time. The growth of unemployment, the spread of precarious arrangements, slavery or indentured servitude, and the other hazardous employment- and work-related inequalities broadly and precisely portrayed in this book are powerfully associated with serious injuries and illnesses affecting global workers, their families, and their communities. The tragedy of the 150,000 suicides among Indian farmers, one of the more than one hundred case studies included in this book, is a powerful reminder of the fact that globalisation, gender inequities, food sovereignty, and population health are tied together.

Health inequalities are a most compelling global social justice problem and provide one of the best available sources of evidence for describing and explaining how wellbeing and justice are unequally distributed globally. Employment-related health inequalities also point to where we should centre our egalitarian efforts if we want to reach a more just and democratic world.

The history of employment relations relates to the unequal power and perennial conflict between labour and capital, which is now exemplified by the struggle between powerful corporations in wealthy countries and the rural poor in poor countries, thanks to globalisation. Thousands of millions of people have only their labour power to sell, and thus work (or do not) at the behest of those who own the material conditions of labour. Today, in an increasingly globalised capitalist economic system, a small number of corporations, international organisations, and their associated governments (mostly in rich countries) have the power to make decisions which affect the daily lives of millions of workers living on the edge of survival. They determine which kind of labour standards, which occupational health and safety regulations, and whether or not union protections are or can be put in place. They take decisions, such as those regarding access to seeds, or water and land, decisively, affecting the health and quality of life of the majority of the world’s population.
Contrary to mainstream views, the authors of this book believe that the genesis of employment and work-related health inequalities is not a technocratic, value-free process, but rather a practice that is deeply influenced by political values and the conflict of interests between owners, management, government, and workers. Since the roots are social, so must also be the solutions. Although important and necessary to some extent, technological solutions are limited. The degree of power and the level of participation that workers have is not only a key factor for promoting a more egalitarian decision-making process in and out of firms, but also an essential “protective factor” of workers’ health. We need a more equitable balance of power in employment relations. We need fair and sustainable employment. We need fair employment relations within an ecological democracy. We need to reduce current dramatic health inequalities.

The instruments to carry out an economic-ecological reconversion are out there, but we require the political power capable of instituting new rules for the game, as well as new criteria for regulating economic-ecological-social activity. As it does not seem reasonable to expect a resolution of the crisis from the institutional framework and economic agents that provoked it, the current crisis is a key opportunity to change the course of globalisation, to change work in a more ecologically equitable and fair direction which will improve health for all and reduce health inequalities.

Vandana Shiva
Introduction

"You need to have your eyes wide open to see things as they are; even wider open to see them differently from the way they are; and wider still to see them as better than they are."

Antonio Machado
Work is the means through which most people provide for their daily sustenance. People work in or out of their homes, with or without labour contracts, and in either safe or hazardous working conditions. Factors related to working conditions have received a great deal of attention and are recognised as a key social determinant of health and health inequalities, but this has not often been the case for employment conditions. Some of the reasons for this neglect are found in the confusion between the concepts of work and employment, and the lack of clarity and development of indicators and data related with employment. Yet, labour markets and social policies determine employment conditions such as precarious or informal jobs, child labour or slavery, or problems such as having high insecurity, low paid jobs, or working in hazardous conditions, all of which heavily influence health inequalities. In sum, these types of employment and working conditions have different implications for the health of populations and the social inequalities in health among social classes, genders or ethnic minorities. To reveal the different ways that employment relations, employment conditions, and working conditions affect the health of populations we need to define what those concepts mean. Then, we must use these concepts and meanings to understand both how society structures labour relations, labour/capital agreements, labour or employment contracts, and what the social processes of production are that affect the health of workers.

To begin with, employment relations, employment conditions and working conditions are different yet interrelated concepts. The first term, employment relations, constitutes the relations between buyers (employers who hire workers who perform labour to sell a profitable good or service) and sellers of labour (employees who contribute with labour to the enterprise, usually in return for payment of wages), as well as the practices, outcomes and institutions that emanate from or affect the employment relationship. Two important components of employment relations are the power relations between employers and employees and the level of social protection that employees can count on. In wealthy countries, employment relations are often subject to the provisions of the law or a hiring contract. In these societies, the government is often the largest single employer although most of the work force is employed in small and medium businesses in the private sector. In middle income and poor countries however, most employment agreements are not explicitly subject to any formal contract, and a high proportion of total employment is in the informal economy.

Given this vast spectrum across which types of employment relations can range, both within and between countries, we concern
ourselves with six specific kinds of employment relations, which we call employment conditions. This term refers to the conditions or circumstances in which a person carries out their job or occupation. It frequently presupposes the existence of an agreement or relationship between an owner who hires workers and an employee who sells his or her labour (see Glossary in section 1 of the Appendices). These conditions, with a global scope, include full-time permanent or standard employment, unemployment, precarious employment, informal employment and informal jobs, child labour, and slavery/bonded labour.

Focusing more directly upon the workers themselves, working conditions involve exposures in the workplace and the way work is organised. Working conditions can be divided into physical, chemical, biological and social exposures. Simply put, material working conditions involve the physical, chemical, biological, and ergonomic work environments, while the organisation of work involves psychosocial environment, management and control, the tasks performed by workers, and the technology being used. Working conditions also include workplace hierarchy and power relations, worker participation in decision-making, and social and occupational discrimination.

To distinguish between these concepts, it is necessary to point out that two people can perform the same job in the same enterprise, sharing the same working conditions, yet nevertheless be labouring under different employment conditions. The first worker may be a permanent and direct employee of the enterprise, while the second is a temporary worker contracted by an external employer. In this case, there are three potential differences in employment conditions. First, the first worker has a permanent contract while the second has either a short-term contract or none at all. Second, the first worker may be covered by the social security system while the second receives partial or zero coverage. Finally, the first worker may be part of a trade union while the second is not eligible.

The ways in which any society approaches inequalities in health is a political issue. On the one hand the inequalities may be accepted as the inevitable result of individual differences in genetic determinants, individual behaviours, or the market. On the other hand, they can be seen as a social product that needs to be remedied. Underpinning these different approaches to health inequalities are not only divergent views of what is scientifically or economically possible but also differing political and ideological beliefs about what is desirable (Bambra, Fox, & Scott-Samuel, 2005).
Thus, the reduction of health inequalities, especially attempts carried out at the level of social policy, will largely depend on the distribution of power among key political actors and the role of the state. While political and social scientists debate the structure, function and power of the state, this discussion has yet to penetrate the public health arena despite the state’s crucial influence on all health activities. We follow here a theory of power resources that identifies labour organisations and political parties as the key determinants of differences in the impact of the welfare state across countries and over time (Korpi & Palme, 2003).

In spite of growing scientific evidence regarding the effects of employment conditions on health, almost no conceptual models have been proposed to explain these effects. In general, there is a great lack of research concerning the impact, pathways and mechanisms that connect employment conditions with health inequalities. There is abundant literature, however, about the effect of employment conditions on health, yet it rarely focuses directly on the important role they play as a social determinant in shaping health inequalities.

The social determinants of health and employment relations and conditions have been particularly neglected for a number of reasons. First, there is a lack of public health research in poor countries, the places where precisely the most worrisome employment conditions such as slavery or child labour are found. A second reason is the scarcity of data in many countries, especially in low-income countries. A third factor is the lack of sociological training of many epidemiologists and public health researchers, which would help them understand how employment relations and conditions can lead to health inequalities. Fourth, researchers interested in controversial topics such as health inequalities, the politics of health care, or other class-based approaches, may have more difficulty obtaining research funds compared with other mainstream biomedical or clinical approaches. Finally, there is a notable lack of attention paid to theories of development in the disciplines of epidemiology and public health research.

The scarcity of research and data coming from middle income and poor countries creates a real challenge in terms of avoiding taking only the perspective of wealthy countries concerning labour markets and employment conditions. This is a critical trap to avoid because the historical legacy of production, employment, and work varies considerably across different parts of the world. For example, the labour reforms implemented in Europe during the nineteenth and twentieth centuries concerning minimum wages and hours of work did not migrate to former colonies in Asia, Africa, and Latin America.
Bearing these different paths in mind, this book strikes a balance that captures global reality, actively seeking out examples and lessons from the South. In order to deal effectively with such a diverse context, we identify common features and trends among countries while avoiding “one size fits all” descriptions or recommendations.

Origins, aims and organisation of this book

In May 2004, the World Health Organization (WHO) created the Commission on Social Determinants of Health (CSDH) with the goal of strengthening states’ comprehensive approaches to health inequities. Some specific aims of the Commission included the collection of evidence on the linkages between social determinants and health inequalities, the compilation of successful interventions and policies to address key social determinants, and advocacy for the implementation of policies that address social determinants of health. To that end, the CSDH created nine Knowledge Networks on globalisation, early child development, health systems, urban settings, measurement and evidence, women and gender equity, social exclusion, priority public health conditions, and employment conditions.

This book is based on the Report prepared in August 2007 by the Employment Conditions Network (EMCONET) as part of the work developed for the CSDH. While the structure and contents of this book are similar to the previous EMCONET report, its content has been greatly expanded to include extensive information on case studies, the impact of employment-related conditions on health inequalities, and its policy conclusions and recommendations, among other issues.

This book offers an in-depth investigation of how employment relations affect workers’ health in different ways, and from many countries. Armed with this knowledge, we identify and suggest institutional changes and effective policies capable of reducing health inequalities. The specific aims of this book are the following:

1. To provide a comprehensive description of key employment conditions. We aim to classify the types of employment conditions as they exist across countries, regions, and geographic areas. We categorise them along our six dimensions of full-time standard employment, unemployment, precarious employment, informal employment, child labour, and slavery and bonded labour. In addition, it is important to consider that while this grouping provides a convenient way to organise a complicated issue, we
must also consider cross-cutting issues, or "axes," such as social class, gender, age, ethnicity and migrant status.

2. To understand the main links between employment and health inequalities. This book explores the paths through which employment conditions and health inequalities interact. In other words, we identify not only how employment conditions affect health inequalities, but also how strong this impact really is.

3. To gather evidence of employment-related policies that effectively reduce health inequalities. With a global categorisation of employment conditions and a thorough understanding of the health-related effects of employment policy, we then take stock of those policies around the world that actually diminish health inequalities. We focus strongly on those programmes designed according to the principles of democratic participation.

4. To translate this knowledge into health policy recommendations. We will furthermore disseminate the results and collaborate in the implementation of these recommendations. This requires, of course, that this issue first be introduced into the political agendas of the relevant social actors.

This book is intended for three audiences at once. The first audience includes general readers who have no previous specialist knowledge. A second audience consists of those specialists in public health, health inequalities, social or political sciences, and labour studies, who want a deeper understanding of the situation, causes and policies linking employment, work, and health inequalities. Finally, this text is also written for activists and members of unions and social movements who are interested in a global and technical understanding of this topic. This book is organised into eleven main chapters, references, and appendices.

In this Chapter 1 we have described the contexts and concepts underlying this study, setting forth the main objectives of the study. Chapter 2 presents the concept of fair employment, the main employment conditions, and the cross-cutting axes used in this book. Chapter 3 identifies the methods, strategies, and the main sources of information that have been used. Chapter 4 presents a theoretical model with two frameworks that integrate the factors linking employment conditions and health inequalities, at the macro and micro levels respectively. Chapter 5 presents a historical and political review that provides the social context for the whole book. Chapter 6 discusses labour markets and welfare states from a country-level perspective, including selected country case
studies. Chapter 7 contains a descriptive perspective on key employment relations, including information on power relations, labour regulations and industrial relations, and a more detailed account of employment conditions and working conditions in a global context. Chapter 8 presents an analytical view of the pathways and mechanisms that drive the links between employment dimensions and health inequalities. Chapter 9 shows main findings concerning policies, including a brief description of four key policy entry points for implementing policy changes to reduce health inequalities. When EMCONET presented its Final Report to the CSDH in 2007 the first inklings of a major economic upheaval were barely apparent. In Chapter 10 we present the relevance of the global economic crisis for this book, and the need to implement a new policy agenda. Chapter 11 summarises the main conclusions and recommendations of the book. Finally, we include the references used in each chapter and several appendices with other related information of interest.
A Bozo fisherman at the break of day, removing the nets laid out the day before in the Niger River basin (Timbuktu, Mali). Catches are dwindling as a result of the river’s salinization and contamination.

Source: Gabriel Brau (2005)
Fair employment, employment conditions, and social inequality axes

"We must pay attention to the meaning of words we use, ensuring that we use only words whose meaning we understand, and, so far as possible, words whose meaning others understand."

George W. Pickering
The term fair employment encompasses a public health perspective in which employment relations need to be understood as a key factor in the quality of workers' health. For example, most workplaces are organised hierarchically, reflecting the distribution of power and control over production. Power inequalities, therefore, will have a profound influence on employees and ultimately on health, as power determines what can be considered acceptable levels of exposure to significant risk factors. Fair employment complements the International Labour Organisation's (ILO’s) concept of “decent work”, implying a just relationship between employers and employees.

Much of the history of employment relations has been characterised by unequal power and conflict between labour and capital, with the former often represented by unions demanding higher wages, shorter hours, and better working conditions through strikes, and the latter resisting those demands through firings, lockouts, or court injunctions.

Fair employment requires that certain features be present: (1) freedom from coercion, which excludes all forms of forced-labour such as bonded labour, slave labour, or child labour, as well as work arrangements that are so unbalanced that workers are unable or afraid to assert their rights; (2) job security in terms of contracts and safe employment conditions; (3) fair income, that is, income sufficient to guarantee an adequate livelihood relative to the needs of society; (4) job protection and the availability of social benefits, including provisions that allow harmony between working life and family life, as well as retirement income; (5) respect and dignity at work, so that workers are not discriminated against because of their gender, ethnicity, race, or social class; (6) workplace participation, a dimension that allows workers to have their own representatives and negotiate their employment and working conditions collectively within a regulated framework; and (7) enrichment and lack of alienation, where work is not just a means of sustenance but, to the extent possible, an integral part of human existence that does not stifle the productive and creative capacities of human beings. Depending on the degree to which it endorses each of these characteristics, employment could be placed in a continuum ranging from the complete lack of these positive features (e.g., slavery and bonded labour) to an “ideal job”, with high levels in all of them.

With the intention of basing this book on standards accepted and shared by the scientific community and the general public, the definitions of employment conditions that follow are the product of an extensive review of specialised epidemiology and public health
journals, among other sources. To this extent, these definitions reflect discussions among the EMCONET core members and civil society groups that have elucidated a consensus on a long list of concepts, and even uncovered some new ones. We only include here the main definitions of the key employment conditions used in this book, while many other related concepts can be found in the glossary in the Appendices.

**Full-time permanent employment.** Traditionally this term means a "regular job". In general, the so-called standard employment relationship has been defined as a full-time job, year-round, with unlimited duration, and benefits, the basic conditions of which (working time, pay, social transfers) are regulated to a minimum level by collective agreement or by labour and/or social security law. The full-time nature of the job, its stability, and the social standards linked with permanent full-time work are the key elements in this definition. Typically, a full-time employee is someone who is scheduled to work at least 35 hours per week: work lasts about eight hours a day, five days a week and forty-eight weeks of the year with four weeks of paid leave. Often, welfare and retirement plans will restrict eligibility based on the number of working hours and full- or part-time status (Bosch, 2004).

**Unemployment.** The meaning of this important dimension of employment varies by country. In the UK, for example, there have been many definitions, changed over time to suit the political purposes of successive governments. Roughly speaking, the unemployment rate amounts to the proportion of all those of working age in a given area who do not have a job and are actively seeking one. It often leaves out large numbers of people who would like to work but are prevented from even looking for work, as is the case for many people with long-term illness who could work if working conditions were better suited to their needs, or parents who could work if child care services were adequate (Bartley & Ferrie, 2001).

**Precarious employment.** This term has been used to signify employment forms that might reduce social security and stability for workers. Precarious forms of work have a range, with the standard of social security provided by a standard (full-time, year-round, unlimited duration, with benefits) employment contract at one end and a high degree of precariousness at the other. Precarious employment might also be considered a multidimensional construct defined according to dimensions such as temporality, powerlessness, lack of benefits, and low income (Hadden, Muntaner, Benach, Gimeno, & Benavides, 2007). Historically, precarious
Employment was once common but declined in rich economies with increased government regulation and the political influence of labour, and with changes in technology that favour more stable work relations. Currently, precarious employment is becoming more common in wealthy countries and is widespread in middle/poor income countries (Benach & Muntaner, 2007).

**Informal employment.** This term refers to non-regulated placement in the labour market, which usually involves an informal arrangement between employee and employer (informal employment) or “self-employment” (which doesn’t involve a market exchange of labour force, but only of products or services). Informal employment prevails in the informal economy but non-formal job contracts may also occur in legal, registered firms. In several countries, the worker entitlement to social benefits such as paid retirement, sick or maternity leave, or access to health care, requires a formal job contract. There are also employment guarantees for formally employed workers, such as work-time legal limits, compensations at firing, and so on, that are not available for informal workers. It is clear that employees should not be discriminated against based only on the formal nature of their job contracts, which usually constitute a mechanism to avoid tax payment by employers. Besides a lack of social benefits, workers holding informal employment have lower salaries, high turnover, lack of security, non-defined work-time, and limited unionisation (Harding & Jenkins, 1989; Santana & Loomis, 2004; Williams & Windebank, 1998).

**Child labour.** International organisations share a common understanding of a child as any person under 18 years of age. There is no consensus, however, about the definition of child labour. For instance, according to the United Nations Children’s Fund (UNICEF) (2006), child labour refers to children below 12 years of age working in any type of economic activity, or those from 12 to 14 years of age engaged in occupational duties not considered “light work”. For the ILO, child labour is defined according to its effects, that is, work activities that are mentally, physically, socially, or morally harmful and that affect schooling. In 1999, the ILO Convention No. 182, and Recommendation No. 190, defined the worst forms of child labour as those involving slavery or compulsory labour, prostitution, pornography, human trafficking, war, drug dealing or trafficking, or any illicit activity. There are also recommendations concerning hazardous occupations for children, such as those involving toxic chemicals or carrying or lifting heavy loads, among others (ILO, 2008; United States Fund for UNICEF, 2008).
Slavery and bonded labour. Millions of women, men and children around the world are forced to live as slaves. Although this exploitation is often not called slavery, the conditions are the same. People are sold like objects, forced to work for little or no pay, and are at the mercy of their “employers”. According to Anti-slavery International, a slave is someone who is forced to work through mental or physical threat, owned or controlled by an “employer”, usually through mental or physical abuse or threatened abuse, dehumanised, treated as a commodity or bought and sold as “property”, or is physically constrained or has restrictions placed on his/her freedom of movement. Examples of slavery include bonded labour, early and forced marriage, forced labour, slavery by descent, trafficking, and the worst forms of child labour.

Debt bondage was first defined in Article 1 (a) of the United Nations (UN) Supplementary Convention on the Abolition of Slavery, the Slave Trade and Institutions and Practices Similar to Slavery (1956) as: “the status or condition arising from a pledge by a debtor of his personal services or those of a person under his control as security for a debt, if the value of those services as reasonably assessed is not applied towards the liquidation of the debt or the length and nature of those services are not respectively limited and defined”. The 1956 Supplementary Convention specifies that debt bondage is a practice similar to slavery. The Convention’s definition clearly distinguishes bonded labour from a normal situation in which a worker accepts credit for whatever reason and then repays the amount by working. In the latter situation the repayment terms are fixed and the capital sum borrowed is only subject to reasonable interest rates. In bonded labour cases, these safeguards do not exist, as terms and conditions are either unspecified or not followed, leaving the bonded labourer at the mercy of the employer or creditor. In these circumstances, bonded labourers can be forced to work very long hours for little or no wages. The employer may also adjust interest rates or simply add interest; impose high charges for food, accommodation, transportation, or tools; and charge workers for days lost through sickness. In such cases workers may not have been told in advance that they will have to repay these expenses. Bonded labourers may take additional loans to pay for medicines, food, funerals, or weddings, resulting in further debt (Anti-Slavery International, 2008; Anti-Slavery International & International Confederation of Free Trade Unions [ICFTU], 2001).
In this book, various cross-cutting axes (i.e., social class, gender, age, ethnicity/race, and migrant status) are employed as the key relational mechanisms that explain why different types of employment conditions are linked to multiple disease outcomes through multiple risk-factor mechanisms (see Figure 1).

The definitions of the cross-cutting axes that follow are also the product of an extensive review of specialised epidemiology and public health journals, among other sources.

**Figure 1. Employment conditions and key cross-cutting axes used in this book.**

Social Class. Most research on employment conditions and population health does not include any analysis of social class, a concept that is defined in terms of employment relations (Krieger, Williams, & Moss, 1997). Nevertheless, social class positions defined by employment relations [e.g., workers, managers, employers, owners] are powerful determinants of population health via exposure to proximal risk and protective factors such as control over work, job demands, access to social and health services, workplace hazards or income (Muntaner & Parsons, 1996; Borrell, Muntaner, Benach, & Artazcoz, 2004). In social epidemiology, the effects of social class have been shown to predict health outcomes even when conventional “gradient” measures such as education and occupation are taken into account (Muntaner & Parsons, 1996; Wolflarth, 1997; Wohlfarth & Van den Brink, 1998; Muntaner, Eaton, Diala, Kessler, & Sorlie, 1998; Muntaner, Borrell, Benach, Pasarín, & Fernández, 2003).

Yet, in spite of this promising evidence, most research uses only traditional “gradient” indicators (education, occupation and income;
Marmot, 2004). A new impetus in social class research within epidemiology has been given by the adoption of a class measure in the UK census of populations (Chandola, Head, & Bartley, 2004). Gradient indicators usually refer to the ranking of individuals along a continuum of economic attributes such as income or years of education (Marmot, 2004). These rankings are known as "simple gradational measures" of socio-economic position (SEP) (Muntaner, Eaton, Miech, & O’Campo, 2004). Gradient measures are important predictors of patterns of mortality and morbidity (Lynch & Kaplan, 2000; Marmot, 2004). However, despite their usefulness in predicting health outcomes, these measures do not reveal the social mechanisms that explain how individuals come to accumulate different levels of economic, power and cultural resources, thus calling for explanations of health inequalities (Muntaner & Lynch, 1999).

Social class, on the other hand, has a strong theoretical background in economic and power relations at work (Wright, 2000). Indicators of social class represent relations of ownership or control over productive resources (i.e., physical, financial, and organisational). Social class has important consequences for the lives of individuals. For example, the extent of an individual’s legal right and power to control productive assets determines an individual’s abilities to acquire income, and, to a great extent, income determines the individual’s standard of living. Thus, the class position of “business owner” compels one to hire “workers” and extract labour from them, while the “worker” class position compels one to find employment and perform labour for somebody else. Social class provides an explicit, employment-based, relational, social mechanism [property, management] that explains how economic inequalities are generated and how they may affect health. Therefore, social class is a construct that involves social relations (being an owner or a worker) and hierarchies (whether a person is a large or a small employer) that have important implications for health.

Gender. This is a key cross-cutting social axis that is essential for understanding why, how, and to what extent different types of employment conditions are linked to multiple health effects through multiple risk-factor mechanisms. Gender-based inequity is found across nations, cultures, religions, and regions of the world at all levels of society, and explains why women and men come to accumulate different
levels of wealth, cultural resources, political power, and decision-making in economic and social affairs (Social Watch, 2008). It influences responsibilities, benefits and vulnerability, and conditions the types of workplace exposure with their consequent health impact and health inequalities (World Health Organization [WHO], 2006).

Women - relative to men - have been restricted in their access to jobs. In many regions of the world women are still self-employed, work in the informal sector of the economy or in the domestic sphere, and usually take primary responsibility for family wellbeing (Cedeno & Barten, 2002; Lyenda, 2001; Messing & Elabidi, 2003). Work is often “invisible” or carried out under bad, hazardous working conditions. It often entails no direct payment and is excluded from social protection (Acevedo, 2002; Social Watch, 2007). From 1960 onwards, and in particular over the last three decades, women have reportedly increased their participation in the world of remunerated employment (Social Watch, 2008; United Nations Research Institute for Social Development [UNRISD], 2005; Wamala & Kawachi, 2007; World Bank [WB], 2001). It is worthwhile to note that these employment gains are often precarious and have occurred in a context of neoliberal policy, structural adjustment, increased migration and overall reduced social protection (Arroyo Aguilar, Ynonan, & Yupanqui, 2005; Cedeno & Barten, 2002). Also, the organisation of paid labour, equipment, tools and spaces have historically been designed for men, and occupational health and safety standards have often been developed using male models (Chatigny, Seifert, & Messing, 1995; WHO, 2006). To some extent, these expanded employment opportunities have contributed to enhancing women’s economic autonomy (Arroyo Aguilar et al., 2005; Wamala & Kawachi, 2007). Economic migration from low-income to high-income countries may enhance women’s earning power, but it often increases exposure to exploitation and discrimination, and has negative implications for their family-life (Ehrenreich & Hochschild, 2003). Increased participation in the labour market has not implied an elimination of the wide pay gap, as women continue to earn considerably less than men (Social Watch, 2007). Currently, women’s wage and job discrimination - relative to men- is a “comparative advantage” and has made them, in many countries, an attractive source of labour for many foreign firms because of their lower wages (Fontana, Joekes, & Masika, 1998). Also, women continue to fill lower hierarchical positions than men and this gendered division of labour is found within the domestic sphere as well as in paid employment (Acevedo, 2002; Valls-Llobet, Borrás, Doyal, & Torns, 1999).
As a group, women suffer more from competitive pressures and are usually the first to be laid off when labour-intensive manufacturing jobs move to even lower-wage countries (Fussel, 2000; Joekes, 1995). They often have limited possibilities for skill acquisition or advancement, and have inadequate security coverage in terms of old-age pensions, even though their work as carers of family-members often continues into old age (ILO, 2002; Social Watch, 2007). In some rapidly industrialising economies or export-processing zones (EPZ), women’s share of employment has fallen and apparently no sustained improvement in labour market status has been achieved (Berik, 2000; Fontana et al., 1998; Jomo, 2001). Women tend also to be less organised into unions and women’s multiple and changing roles often have contributed to more conflicts in the domestic sphere as well as at work (Kolk, Bekker, & Van Vliet, 1999; WHO, 2006).

Age. Age represents an important axis for any analysis of the health effects of employment conditions, particularly in the context of the labour market changes described in this book. For example, the resilience of child labour in poor countries and its re-emergence within wealthy countries poses a serious challenge to health, due not only to the physical and psychological burden it places (with strong historical parallels), but also its impact on educational and other opportunities. Children and young workers also constitute a significant proportion of various forms of slave or bonded labour in Asia, and the same applies to workers in the informal sector (such as street vendors and scavengers) in South America and Africa. There is also a critical age bifurcation in the labour market within the formal sector (see for example Louie et al., 2006). Young workers (i.e. those under 25 years of age) make up a disproportionate share of those holding temporary jobs and this has continued to match growth in these types of employment.

At the other end, older workers (those of 55 years or more) are disproportionately represented amongst some categories of self-employment, although older workers are also increasingly found in temporary jobs. Age bifurcation in terms of precarious employment means that both young and older workers are disproportionately exposed to the additional health risks associated with these employment arrangements (and the more limited avenues for articulating their concerns).

Ethnicity. The concept of ethnicity is multidimensional, as it includes diverse social constructs such as origin or ancestry, identity, language and religion. It also includes social activities such as the arts, norms, beliefs, and even practices such as dressing and
cooking. Ethnicity has become a major source of economic, political and cultural conflict in both wealthy and poor societies and its origin often represents the dominance of one ethnic group over others, which may result in labour market discrimination such as unequal treatment or differential opportunities available for individuals or groups (Krieger, 2001). Thus, ethnic background often results in job discrimination and restrictions of access to labour markets with high levels of unionization, bargaining power, social security and social protection (Arrow, 1998). Occupational segregation can be a form of ethnic discrimination in the labour market in which dominated ethnic groups without work are more likely to accept jobs with worse compensation and working conditions than dominant ethnic groups. For example, in Ecuador, Afro-Ecuadorian workers experience higher levels of unemployment (70% in Esmeraldas) and precarious work (men mainly working in the informal economy and women as domestic workers and sex workers) (Valenzuela & Rangel, 2004).

A distinction is usually drawn between horizontal and vertical job segregation. Horizontal segregation arises when groups do different types of work. In the US for example, there is a higher proportion of African American and Hispanic women in cleaning services (Blackwell, 2003). Vertical segregation arises when some ethnic groups are overrepresented in certain occupations with low wages and prestige while other privileged groups are concentrated in the higher-status occupations. Occupational health inequalities are often found between different ethnic populations. In the US, African-American and Hispanic workers are disproportionately employed in some of the most dangerous occupations, and African-American workers experience additional stress caused by a discriminatory and racist work climate (Chung-Bridges et al., 2008). Almost 40% of African Americans feel that race and gender discrimination is widely accepted at their workplace (Daniels, 2004).

Migrant status. Migration is a very relevant cross-cutting social axis, essential to understanding how different types of employment and working conditions are linked to health inequalities (Benach, Muntaner, Chung, & Benavides, 2010). Migration has been given various definitions. Foreign migrant workers are foreigners that perform an economic activity remunerated from within the receiving country. Having an immigrant status implies long-term continuous residence (at least a year) so that the country of destination effectively becomes the new country of usual residence. Seasonal
migrant workers, i.e., persons employed by a country other than their own for only part of a year, are a subcategory of foreign migrant workers. Foreign visitors, tourists, or retired foreign residents are not considered immigrants.

Over the last few decades, capitalist globalisation has expanded migration, transforming the lives of hundreds of millions of people around the globe. The number of international migrants has more than doubled since 1975, with most of them living in Europe (56 million), Asia (50 million), and North America (41 million). Nowadays, 3% of the world population resides in a country other than where they were born (United Nations Department of Economic and Social Affairs [UNDESA], 2006). The main reasons for migration include war conflicts and economic factors such as poverty or unemployment, among others (Global Commission on International Migration [GCIM], 2005). Globalisation has challenged farming and agricultural sectors, which constitute the major means of livelihood in poor regions. Large numbers of people are forced to migrate from rural to urban areas and into situations of terrible vulnerability when subsistence agriculture is replaced by cash crop economies under corporate pressure linked to neoliberal governments, when corrupt governments militarise and force people out of their land, or when ethnic groups and indigenous people are evicted from their territories (Acharya & Marjit, 2000; Bhattacherjee, 2000).

Workers migrate away from their families and communities to serve as a labour force in rich countries, often filling jobs that national workers are reluctant to take. Immigrant workers are often appointed as cheap labourers with precarious arrangements in which they often cannot find adequate support for their families. In most countries the majority of migrant workers are found in the agriculture, food processing, or construction sectors, in semi-skilled or unskilled manufacturing jobs, domestic work, and in low service jobs. An example is the labourers from Eastern Europe and central Asia working in agriculture and janitorial work in the UK (Anderson & Rogaly, 2004). Migrant women and low skilled workers are those who tend to experience more serious abuse and exploitation, and are those who are disproportionately represented in hazardous occupations and industries. In addition, the precarious legal status of millions of irregular migrant workers makes them even more vulnerable to coercion.
A group of women carrying cotton after a harvest in the fields of Tiankoura (Burkina Faso). Although wages are miserable and profits are mostly enjoyed by large international companies, for the people of this region this work provides extra earnings for their ailing economy.

Source: Gabriel Brau (2005)
"In reality there are not economic, sociological, or psychological problems, but simply problems, and as a rule they are complex... We will have to master the complex problems that exist in reality by whatever tools are available."

Gunnar Myrdal
3.1. METHODS AND STRATEGIES

In this book our aim is to use methods that are suitable for the reality upon which we focus, which is complex and dynamic. In order to avoid reductive assumptions, we make a conscious effort to take a global perspective, be accurate, and avoid narrow perspectives based on the employment standards typically used in wealthy Western societies.

The challenge of studying a neglected global reality

The dominant trend in today’s occupational health research is to focus on how employment and work conditions influence health. Our study, however, delves deeper into the strikingly under-studied links between the conditions of employment and work in relation to health inequalities. A reflection upon current research uncovers three important shortcomings.

First, only a very small minority of existing studies include data from middle income and poor countries. This limitation is worrisome, as there are important differences in working and employment conditions between wealthy and middle or poor income nations. The examples are many. While non-standard forms of employment have increased in the past decades in wealthy countries, poor countries have been characterised by a large variety of hidden or less well-known, informal forms of employment as well as by extremely hazardous and unhealthy employment relations including bonded labour, child labour, and forced sex work. At the same time as employment in agriculture has sharply declined in wealthy countries, in mid- and low-income countries a large proportion of workers still engage in agricultural employment, a labour sector where the inherent threats to health are very different from those that characterise the industrial and service sectors of wealthy countries. Classical welfare state measures, including universal public health policies, have rarely taken hold in most poor countries. Finally, the links between employment and health benefits must take into account the development of local health systems, which differ amongst mid and low-income countries. In some, where precarious and informal forms of employment dominate, workers do not necessarily receive access to health services as part of employment benefits. On the other hand, in some mid to low-income countries (such as Sri Lanka, Cuba, Brazil, Chile, and Costa Rica), everybody enjoys universal access to health care regardless of their employment status.

Second, investigations into the interaction between health and employment and working conditions do not focus on the impact of health inequalities and their underlying causes.
The third and final shortcoming is that, while it is important to examine the best practices and examples of policy successes in lessening health inequalities, knowledge in this area is still very limited. To identify what works and what has worked across different historical and political contexts is a matter of utmost urgency, as policy-makers face difficult political choices in addressing enduring health inequalities.

**Systematic review approach: features and limitations**

Having identified the major objectives we want to accomplish in this study and the primary obstacles we face, we now describe our approach to tackling this complicated question. Common scientific wisdom holds that the best way to study a complex reality is by "systematic reviews" of published scientific literature combined with the collection of empirical data. The systematic review approach differs from traditional reviews and commentaries produced by "content experts" in that it uses a replicable, and transparent approach designed to minimise bias (Glanville & Sowden, 2001). By identifying, critically appraising, and summarising the results of otherwise unmanageable quantities of research, a systematic review would -at least in theory- cover the research objectives of this book.

Despite this, mainstream systematic reviews have a number of potential limitations that can lead to anomalous results (Glasziou, Vandenbrouke, & Chalmers, 2004; Asthana & Halliday, 2006; Killoran, Swann, & Kelly, 2006). First, this approach creates a strong tendency to select studies on the basis of the quality of the methods rather than the theories and concepts used. Second, this approach typically privileges particular types of research design, such as randomized controlled trials, undermining other qualitative or "soft" studies. Third, the importance of context is usually not sufficiently appreciated. This is of central importance when considering the social roots of many health issues. In the case of interventions, for example, "a fundamental problem lies in the notion that methods found to be effective in one setting could be assumed to be effective in another... In answering the question 'does this intervention work?' it is always necessary to consider not only the intervention, the outcome and the link between the two but also the context" (Kemm, 2006). Finally, the lack of studies covering a particular subject will also create bias. In this study we treat employment-related health inequalities as a global social affliction, and this is a situation in which an approach based on mainstream systematic reviews and standard evidence gathering is of limited utility.
Developing an alternative approach

The bulk of the evidence generated by academic inquiry confers essential rigour to the generation of knowledge. The interpretation of this evidence, on the other hand, is far from a value-free process. Rather, it is perennially influenced by the lens through which the interpreter views the evidence. Given the complexity of the subject at hand, the lack of scientific information available, and the limitations of the systematic review approach, here we provide an alternative.

In our approach, we overcome the major limitations of systematic reviews by beginning from a realist perspective with a two-pronged focus on theory building and transdisciplinary knowledge. First, a focus on theory allows us to clarify the book’s major concepts and to create a theoretical model (see Chapter 4) to trace complicated processes. We show the pathways along which key employment relations and conditions, social mechanisms, and health inequalities interact in a multi-level context. While some parts of this model have been addressed in various scientific studies, results have not always been consistent. Additionally, the scope of these studies has been limited, leaving many gaps in our knowledge. Therefore, interpretation of findings needs to be undertaken from a perspective that takes into account the whole theoretical model rather than a judgment on whether or not a specific employment condition generates health inequalities. Our approach recognises the fact that reaching a comprehensive understanding of global employment conditions associated with health inequalities is a complex undertaking that requires a transdisciplinary approach (Gibbons et al., 1994; Somerville & Rapport, 2000).

Employing a wide range of strategies of inquiry, a variety of methods, and multiple sources of data and evidence (including quantitative analyses, qualitative data, and narrative knowledge), we synthesise the inputs of several disciplines. Therefore, the book is not just informed by social and public health sciences such as epidemiology, sociology, and political science. Rather, we also gather information from different social actors and institutions with a wide range of global civil society experiences. This provides a way to include evidence from Non-Governmental Organisations (NGOs), social movements, and other groups or communities from specific social contexts that have been passed over in traditional scientific research reports. While sometimes very subjective in nature, this information also provides important pieces of hidden, or at least less well known, relevant knowledge.
The results of this two-pronged investigation are greater than the sum of their parts. They have qualitatively different features. They represent an amalgamation of approaches and their respective insights, the combination of which is as close to a picture of reality as we could possibly paint. A helpful analogy is to think of this process of knowledge-generation as a gigantic photo-mosaic portrait made out of many tiny pictures, which, when arranged properly, create the general image of a face. Since obtaining all the pieces of the face in detail [in our case, worldwide employment relations and conditions related to health inequalities] is truly impossible, the essence of this approach is to obtain at least the most appropriate pieces of information to approximate its key features. In our view this approach provides the most comprehensive understanding in order to identify and suggest solutions to a number of important research and policy needs: first, the need for a historical perspective on employment relations, recognising the dynamic, conflict-ridden nature of the political systems that influence people’s employment; second, the need to identify the political actors and government decisions crucial to the development of labour market and welfare state policies leading to specific employment dimensions; third, the need to make a systematic assessment of employment-related policies and interventions leading to health inequalities; fourth, the need to study these conditions in different labour market situations; fifth, the need to identify and analyse the different pathways, impacts, and mechanisms leading from employment conditions to a variety of health outcomes, including health inequalities; sixth, the need to take into account all the axes of key social differences including social class, ethnicity, race, gender, age, and migrant status to ensure that information is sensitive to this range of crucial cross-cutting inequalities; and seventh, the need to understand that some policies and interventions may work in certain political contexts and for certain groups of people and not for others. Therefore, it is important to distinguish between potentially generalisable and conditionally successful interventions and to find contextual features that turn potential into successful outcomes; finally, the need to identify a variety of sources of information as well as to allow the participation of stakeholders in research.

**Key strategies of a synthetic comprehensive participatory approach**

In order to create a clear theoretical framework and integrate the information gathered from a variety of sources, we undertook a number of tasks: clarification of the main concepts and developing the
theoretical frameworks linking the key constructs involved at both macro and micro levels; synthesis of quantitative, qualitative, and narrative data from historical, epidemiological, sociological, and anthropological evidence as well as natural policy experiments; undertaking an explicitly comparative analysis to contextualise and classify the circumstances of different countries into a typology of global labour markets; analysis of single-country case studies through the systematic assessment of a common set of structures and institutional arrangements as identified by the theory-based approach; active search for information, examples, and lessons in the grey literature drawn mainly from the large part of the world that does not conform to the paradigm of labour relations typical of western societies; and elaboration of a diverse array of case studies with a proper quality threshold that illustrates a variety of experiences with the help of organizations, labour unions, civil society, or study participants themselves. While there is no fixed or simple formula, it is important to attempt to select studies based on the following criteria: the suitability of the study design; the quality of its methods, data, and analysis; whether the context of the study was considered in the analysis and interpretation of the findings; and the overall credibility, and relevance of the study. The geographic locations of the case studies included in this book are shown in Map 1.

Map 1. Geographical location represented in the country case studies and specific case studies.

Note: There are 19 broad “global case studies” not represented in this map.

Source: Prepared by the authors
The data gathered in this book has resulted from the participation of a multitude of scholars and experts, coordinated to build a global inventory of scientific evidence, knowledge and case studies. There were two primary means by which this took place: first, through a high degree of time-intensive involvement by the EMCONET core group members and, second, by input from a large number of participants from diverse networks of experts, researchers, activists, and other participants from governments, international organisations, civil society groups, social movements, labour unions, and non-governmental organisations. Civil society groups were encouraged not only to participate throughout the process but also to provide input and a critical review of findings.

3.2. SOURCES OF INFORMATION

This section provides an overview of the information and resources used for the study of employment and working conditions as determinants of health inequalities.

Scientific literature

The objective of this review was to undertake an exhaustive search of scientific studies that have investigated employment and working conditions in relation to health inequalities. Digital bibliographic databases explored include Medline, PsycInfo, Sociological Abstracts, Social Sciences Abstracts, EconLit, American Business Inform, Business Abstracts, Public Administration Abstracts, Political Science, and Worldwide Political Science Abstracts.

Search strategies and key words were identified after a series of tests and qualitative evaluations of each one of the listings obtained. Results were compared with the listings of other reviews, always seeking a balance between comprehensiveness and specificity. All searches were limited by year of publication, from 1985 to 2010. The bibliographical search was made independently for each of our five employment dimensions in several languages (i.e., English, French, Spanish, Italian, and Portuguese).

Grey literature

A review of grey literature, i.e., books, reports, and other documents concerning the theme of employment, work, and health inequalities not published through scientific venues, was also conducted for the years 2000-2010. Two main strategies were used to identify and select on-line documents. These strategies were explicitly intended to assure a balanced geographical and regional distribution of
sources as well as a varied and diverse presence of social actors and institutions. First, we employed a direct strategy in which a search was carried out focusing on certain places or sites where we assumed we were likely to find valuable information on each of the themes of interest. Exhaustive lists of websites based on subject were compiled with regard to international and non-governmental organisations as well as those representing workers. Second, we exercised an indirect strategy in which a list was made of the more important search engines on the Internet according to their topics. In addition, a number of "metasearchers" that allow users to obtain the maximum number of resources available on-line were selected. Five of the eleven metasearchers identified were selected as the most efficient and appropriate: IXQUICK, IPSELON, METACRAWLER, SEARCH.COM, and KARTOO. To test their efficiency, the same search words were compared with results obtained through normal searchers such as Google, Yahoo, Altavista, and Prodigy/msn. A large number of potentially useful documents were identified and selected.

Other complementary sources of information

Other relevant sources of information included an inventory of case studies, interviews, formal and informal contacts with key informants, and information provided from a variety of narrative sources not published through conventional channels. Knowledge network members covered an array of backgrounds and disciplines and were able to draw on the resources of their own networks. The ultimate goal of compiling an inventory of case studies was to select interesting but otherwise not very well-known examples or experiences to be included. In doing so, we drafted a standardised document that was widely distributed through our networks to collect case studies. This approach provided a valuable opportunity to gather information from grassroots and civil society groups as well as from community experiences.
"Because it is not the reality, the value of the model depends upon its utility, and utility depends upon the purpose for which the model is used."

Reuel A. Stallones
The first step in our alternative approach to this investigation is the development of a theoretical model which delineates the causal pathways we describe in this book. Given the complexity of the phenomenon treated, the use of theoretical models helps us organise and explain large quantities of scientific data in several ways (Muntaner, 1999). First, these models help us understand the complex links between employment relations, employment conditions and the health of workers. Additionally, they suggest further observation and testing of hypothetical causal pathways not covered in this review. Finally, theoretical frameworks help identify the main “entry-points” (i.e., exogenous factors) through which to implement policies and interventions to reduce health inequalities.

Towards this end, we have developed two frameworks based on a single overarching theoretical model. The resulting graphs and flow charts serve two key purposes. First, they show the origins and consequences of different employment relations. Second, they trace the connection between employment relations and economic and political factors, working conditions, and health inequalities. Put simply, they are a way of visualising in context the many factors that contribute to inequalities in health. The macro-structural framework traces the effects of political power struggles on health inequalities through the important mediating role of the welfare state and labour market policies. The micro-structural framework traces the effects of employment and working conditions on health inequalities.

Some methodological caution needs to be exerted. First, the main focus of both frameworks is on factors related to employment relations and conditions, not on social determinants of health in general or other public health factors. Second, neither framework pretends to be a fully-pledged confirmed theory. Rather, they are heuristic devices used to help simplify a complicated set of relationships and point out the most important pathways. Finally, it is also necessary to mention that both frameworks are “static” and should also be considered from a historical point-of-view as well as from a dynamic life-course perspective.

4.1. MACRO STRUCTURAL FRAMEWORK
The macro-structural framework (Figure 2) situates employment relations in their larger institutional context, which is determined by social institutions and relations that ultimately respond to a global division of production and the situation of each country into the world-system (Wallerstein, 1974). This framework explains the
effects of the distribution of political power (called “power relations”) on health inequalities through intermediary forces.

The model begins with the interaction between political power relations and policy-making. The idea is that a redistribution of political power relations creates new policies concerning the labour market and the welfare state. These new policies are a form of economic redistribution, since they change the way the labour market functions, which in turn affects employment conditions. For example, when a new political party gains power, its members may implement different public policies that have different public health outcomes [Navarro & Shi, 2001; Navarro et al., 2006]. Political power relations, therefore, are critical to the redistribution of economic resources and thus to the level of equality present in society.

The main actors in the realm of political power relations, however, do not only redistribute resources and change policy, thus affecting social stratification; they also have an impact on the life experiences of different social groups through their influence over access to healthcare, social services, and working conditions including exposure to hazards. Social inequalities in health are therefore fundamentally the result of what might be called a “political economy of health” [Navarro & Muntaner, 2004; Navarro, 2002].

The key causal force here is the power that government and civil society have over the labour market and welfare state policies. Their influence over the labour market is broad-ranging, with jurisdiction extending across labour regulations, collective bargaining and the power of trade unions. With respect to the welfare state, political power-holders determine the level of distribution to be achieved by social policy. Control over both institutions is fundamental to understanding employment relations, given that workers’ welfare depends on both the functioning of the labour market and the social protection policies implemented by the state. Both serve to modify social stratification and therefore social inequalities.

In our framework, labour regulation refers both to the specific regulation of the labour market (employment protection legislation) and to welfare state benefits related to a salaried relationship, such as health care benefits for those involuntarily leaving the labour market, or income security measures for the unemployed. Collective bargaining refers to one of the ways in which labour/capital relations can be conducted [see Section 6.1]. Several studies have found that the most important factor in explaining pay dispersion is the level of wage-setting, i.e., whether wages are set at the level of the individual, the plant, the industry, or the entire private sector. The concentration of unions and the share of the labour force covered by
collective bargaining agreements also matter. It has been shown, for example, that a far more severe decline in the unionisation rate in the United States than in Canada accounts for two-thirds of the differential growth in wage inequality between the two countries.

Figure 2. Macro-structural framework of employment relations and health inequalities.

The next part of the model concerns the balance between the welfare state and the labour market. These two institutions are so deeply intertwined that it is not possible to understand the labour market without considering the welfare state institutions that surround it (Esping-Andersen & Regini, 2001). The more protection people receive from the welfare state, the higher the level of "decommodification." Decommodification is the extent to which workers are able to maintain their livelihood when they find themselves out of a job (Esping-Andersen, 1990). The state’s welfare policies protect the work force from the labour market’s notorious insecurities.

Examples of welfare state social protection policies are those related to family, children, and people with disabilities. In the EU, for example, a significant proportion of social provisions in most member states consists of benefits designed to replace or supplement earnings which individuals cannot find in the labour market. Income replacement schemes usually take the form of three distinct kinds of
provisions: unemployment benefits (based upon previous earnings),
unemployment assistance, and guaranteed minimum schemes. Other
schemes include disability, employment injury and occupational
disease (workers’ compensation), maternity leave, and pension
benefits. The various welfare state schemes across the world often
rely on a unique combination of these same practices.

Although we acknowledge the difficulties inherent in establishing an
overall framework that fits the entire world, its broad scope allows
sufficient generality to be applied at different levels of aggregation
(national, regional, local). This theoretical macro framework, its concepts
and indicators are contingent upon specific historical contexts and
processes (i.e., informal work may mean a situation of precariousness in
wealthy countries but a situation of extreme poverty in poor countries).

4.2. MICRO FRAMEWORK

The micro framework in Figure 3 helps trace the links between
employment and working conditions and health inequalities through three
different pathways: behavioural, psychosocial, and physiopathological.

At the level of work organisation, potential exposures, hazards and risk
factors are classified into five main categories: physical, chemical,
biological, ergonomic, and psychosocial. They include factors such as
exposure to physical or chemical hazards, repetitive movements, work
intensification, hard physical labour, shift-work, or lack of control. To these
factors we also add work-related injuries (i.e., occupational “accidents”).

Figure 3. Micro-theoretical framework of employment and working conditions and health inequalities.
While each risk factor may lead to different health outcomes through various mechanisms, some main points need to be emphasised here. First, axes such as social class, gender, and ethnicity/race are key relational mechanisms that explain why workers, and often their families, are exposed to multiple risks. For example, there is a growing body of scientific evidence showing that workers are more exposed to physical and chemical hazards compared to owners or managers. Second, three of the key specific social mechanisms underlying class, gender, and ethnicity/race are exploitation, domination, and discrimination (Muntaner, 1999; Muntaner, Benach, Hadden, Gimeno, & Benavides, 2006; Krieger, 2000). And third, those cross-cutting axes (i.e., social class, gender, and ethnicity/race but also other related aspects such as age, migrant status, or geographical location) may be linked to multiple disease outcomes through different risk-factor mechanisms. These key axes generating work-related health inequalities can influence disease even though the profile of risk factors may vary dramatically (Link & Phelan, 1996).

Material deprivation and economic inequalities (e.g., nutrition, poverty, housing, income, etc.), exposures which are closely related to employment conditions, may also have an important effect on chronic diseases and mental health via several life-style behaviours, physio-pathological changes, and health-related outcomes. For example, the length of time children have been working may have an effect on growth and academic performance, probably caused by a lack of adequate nutrition (Hawamdeh & Spencer, 2003). In addition to the key role played by these material factors, proponents of psychosocial theories have emphasised the central importance played by one’s position in a hierarchy, that is, where one stands in relation to others. There are two models that analyse the role of the psychosocial work environment in explaining health inequalities. The first is the popular demand-control model (Karasek, 1979) based on the balance between quantitative demand and low control (i.e., limited decision latitude and lack of skill discretion). The second is the effort-reward imbalance model, which claims that high efforts spent at work that are not met by adequate rewards (money, esteem, promotion prospects, job security) elicit recurrent stressful experiences (Siegrist & Theorell, 2006).

Nevertheless, although discussion of material versus psychosocial factors may be important for research purposes as well as for the type of interventions to be considered, it has been argued that the dichotomy between both theories has been overblown (Muntaner, 2004; Macleod & Smith, 2003). The
terminology of the debate is confusing, since all exposures are material (they all belong to a material world). Thus, “neomaterial” refers in fact to physical, chemical and biological exposures, while “psychosocial” refers to socio-psychosocial exposures (Muntaner, 2004). Furthermore, there is enough evidence that all these exposures can affect health. Thus, most of these processes are intertwined and ideally should be integrated into a comprehensive framework. For example, sustained job insecurity due to precarious labour market position is also linked with poor health behaviours by way of declines in specific coping mechanisms.

Finally, it is worth mentioning that we have explicitly avoided the issue of genetic susceptibility in this framework for three reasons: first, because we focus mainly on factors that are currently amenable to policy change and social action; second, although genetic factors are important in the aetiology of many diseases, it is clear that genetic factors play a minor role in explaining the major links and impact that employment has in creating health inequalities; and finally, genetic factors are not social determinants of health and deserve their own specialised analysis.
The adobe house construction has been replacing the tents in refugee camps.
Saharawi refugee camp of Smara (Algeria).
Source: Antonio Rosa (2004)
An historical perspective on labour markets

"The only relevant question is: who benefits?"

Immanuel Wallerstein
Labour markets are historical social subsystems, hence they are dynamic. Therefore, we want to emphasise that a “one size fits all” approach to understanding and meliorating their health effects is bound to fail. Labour markets reflect the history of uneven economic and political development around the globe, and, most importantly, the pattern of colonisation and post-colonial relations between wealthy and middle or low income countries in the last centuries. This is why in this section we briefly describe the social evolution of labour markets in wealthy and middle or low income countries separately, emphasising their interdependency.

5.1. WEALTHY COUNTRIES

Although it is difficult to capture a period of rapid structural change with a single sentence, it is widely held that the apogee of certain forms of industrial production (Taylorism-Fordism), social provision (welfare states), and public economic intervention (Keynesianism) moulded the socio-economic order of the so called “Golden Age of welfare capitalism” of the second half of the XX century. Within these shared patterns of industrial production and state intervention, wealthy countries pursued similar development goals through a variety of means.

As the literature on welfare state regimes and varieties of capitalism has stressed, historical market-state interactions varied in every country, creating a diversity of labour markets (Esping-Andersen, 1990; Hall & Soskice, 2001). Such divergence among capitalist economies has been explained by a variety of driving forces, such as: (1) the bargaining power associated with social relations of production, (2) the way in which industrialisation developed as the result of different areas of specialisation, privileging some economic sectors over others, (3) the adoption of different strategies for coordinating firms with other socio-economic actors in order to prosper, and (4) the differences in the degree of citizens’ dependency upon market vs. state resources (Esping-Andersen, 1990).

The expression “Mid-Century Compromise” has been used to describe the socio-economic order that took hold in Europe from the implementation of the Marshall Plan after WWII (late ‘40s, early ‘50s) until the oil crises of the ‘70s. With high aggregate demand and sustained productivity growth, workers could benefit from relatively abundant and stable jobs with acceptable wages and social benefits for a large portion of the labour force, including low-skilled workers (Esping-Andersen & Regini, 2001). In this context, employers sought to create a loyal and attached labour force. The goal of the labour unions during this period was to protect wages and jobs (Sengenberger, 1981). These overlapping interests between the male labour force and the owners of capital facilitated labour legislation, entrenching the prevalence of secure full-
time employment among men. Meanwhile, working women mostly held “feminised” job positions which were marginalised from this negotiation process.

Public spending not only improved the skills of the labour force through educational policies but also provided the out-of-work population (the unemployed and pensioners) with benefits and some purchasing power, which stimulated consumption and production, thus conferring political legitimacy to the Mid-Century Compromise. The situation of unemployed women and female pensioners was quite different than that of men, since social provisions and even access to rights of citizenship were based on the “male breadwinner” model, which situates men as the source of social provisions for their spouses.

The family unit also played a critical role in production relations during this period. The relationship between employment and social protection reinforced a family model centred on the male breadwinner. In other words, while it was certainly not the first time in history, this period saw a normalisation of the “model in which the husband is the sole agent operating within the market sector, deploying his labour in order to secure the funds necessary to support a dependent wife and children. In exchange, the wife assumes responsibility for the unpaid labour required for the everyday reproduction of her husband’s work, such as cooking, cleaning, and laundering” (Janssens, 1997). This is important because in many respects, the labour market was dominated by workers both demanding and receiving a wage that was sufficient to support the entire family. As the overlapping interests of organised labour and the controllers of capital began to diverge, labour market wage levels began to fall.

By 1973, even before the Arab-Israeli War and the Organization of the Petroleum Exporting Countries (OPEC) oil embargo, the Bretton Woods system that had regulated international economic relations had dissolved and there were many signs of a serious crisis of capital accumulation (Harvey, 2006). The oil crises of 1973-74 and 1978-79 sparked a period of economic adjustment that realigned dominant economic and political interests, challenging the trends of steady economic growth and abundant stable employment. The decline in real growth rates of the Gross Domestic Product (GDP) and the increase in public deficit and inflation, together with a slowdown in productivity and profits and an increase in unemployment, gave way to a period of economic uncertainty that transformed the socio-economic order which had prevailed since the Mid-Century Compromise. During the 1980s a strong neo-liberal ideological offensive challenged the views and legitimacy upon which welfare states had previously developed and labour markets were subjected to regulatory reforms. These social changes produced the so-called “Washington Consensus” of the mid 1990s (Fine, 2001; Harvey, 2006) (see Section 9.2. Macro policies and health: a historical perspective).
The very high OPEC oil price that came with the oil embargo of 1973 placed vast amounts of financial power at the disposal of states such as Saudi Arabia or Kuwait. While the US was actively preparing to invade these countries to restore the flow of oil and bring down oil prices, the Saudis agreed, presumably under military pressure if not open threat from the US, to recycle all of their petrodollars through New York investment banks and then throughout the world. New York investment banks became even more active internationally, focusing less on direct investment, an issue which required a strategy of liberalisation of international credit and financial markets. Large corporations became more and more financial in their orientation, even when they were engaged in production. The interests of owners and managers were fused by paying the latter in stock options. Stock values, rather than production, became the guiding light of economic activity, and financial interests gained the upper hand within the ruling classes. Neoliberalism meant the “financialisation of everything” and the relocation of the power centre of capital accumulation to owners and their financial institutions at the expense of other factions of capital (see Case study 1). The support of financial institutions and the integrity of the financial system became then the central concern of neo-liberal states (such as the G7) that increasingly dominated global politics (Harvey, 2005).

Case Study 1. Globalisation, financial markets and employment. - Ted Schrecker

“Financialisation” is among the dominant characteristics of today’s global economic system (Epstein, 2005). While the total value of foreign direct investment (to build new production facilities and acquire ownership of existing assets) in 2006 was US$1.2 trillion, the daily value of “traditional” foreign exchange transactions on the world’s financial markets is now estimated at US$3.2 trillion, not including a variety of financial derivatives, the market for which is growing even more rapidly.

Financial crises resulting from large outflows of hypermobile short-term capital can reduce the value of a country’s currency by 50 percent or more and result in economic contractions that push millions of people into poverty and economic insecurity. This is what happened in Mexico in 1994-95, several south Asian countries in 1997-98, and Argentina in 2001-2002. The damage done by financial crises in terms of lost GDP and employment can be substantial. For example, Griffith-Jones and Gottschalk (2006) estimate the cost of the Asian financial crisis to the affected economies at US$917 billion over the period 1997-2002. Effects of the economically vulnerable are compounded by public sector revenue losses and austerity measures often demanded by financial markets or the International Monetary Fund (IMF) as the price of restoring “investor confidence.” Furthermore, a comparison of financial crises in 10 countries (Van der Hoeven & Lübker, 2005) showed that employment tends to recover much more slowly than GDP in the aftermath. Following the collapse of the Mexican peso, the then-managing director of the IMF described the underlying power dynamic in terms of “market perceptions: whether the country’s policies are deemed basically sound and its economic future, promising. The corollary is that shifts in the market’s perception of these underlying fundamentals can be quite swift, brutal, and destabilising” (Camdessus, 1995).

Even governments committed to reducing economic privation and stimulating employment often hesitate to displease financial markets. For example, investor concern about policies that might be adopted by the Workers’ Party in Brazil (in advance of the 2002 elections) and the African National Congress in South Africa (after democratisation) reduced the value of the country’s currency by roughly 40 per cent in each case. At least temporarily, the governments in question accepted high unemployment and limited social expenditure -- in the Brazilian case, in the form of a program of reforms dictated by the IMF -- rather than risk further depreciation of their currencies (Evans, 2005; Koelle & Lipuma, 2006). In South Africa, the result was “dismal development and excellent macroeconomic outcomes” (Streak, 2004) with the former including negative employment growth in every year between 1996 and 2000 and an official unemployment rate of over 30 per cent, unofficial unemployment rates, using a broader measure, were and are considerably higher (Kingdon & Knight, 2005).

Even high-income countries are affected by the need to maintain “credibility” with financial markets. In contrast to the managed exchange rate environment that permitted expansionary full employment policies in the 1960s, “[t]he demands of credibility ... imposed broadly deflationary macroeconomic strategies on the G7,” at least through the early 1990s (Eatwell, 1995: 297). Writing about the OECD as a whole, Eatwell argues that neither technological change nor competition from newly industrialising countries provide
sufficient explanations for rising unemployment. Rather, financial deregulation and the subsequent creation of a global financial marketplace “resulted in a significant increase in risk aversion in the public sector and in the private sector. This, in turn, is the major source of deflationary pressures and persistent unemployment throughout the world” (Eatwell, 2000: 349). Subsequent reductions in unemployment in some OECD countries seem to limit the value of these observations. However, unemployment often fell in a context of “flexibilised” employment relations, a retreat from social provision, and rapidly growing inequality in labour market incomes.

The markets’ are an abstraction. Their verdict on a country’s policies is simply the resource-weighted outcome of choices made not only by asset owners and managers in London, New York and Geneva, but also by a growing number of rich households in low- and middle-income countries. Public policy, including the priority attached to expanding employment and improving wages and working conditions, is therefore constrained by the prospect of capital flight: the process in which the wealthy shift their assets abroad in order to avoid “social control” (such as taxation) or risks of devaluation (Ndikumana & Boyce, 1998: 199; see also Beja, 2006: 265). The resource flows in question are substantial. Ndikumana and Boyce (2003) estimated the value of capital flight between 1970 and 1996 from Sub-Saharan Africa, where many of the world’s poorest countries are located, at US$186.8 billion [in 1996 dollars], noting that during the period “roughly 80 cents on every dollar that flowed into the region from foreign loans flowed back out as capital flight in the same year” (p. 122). They have calculated that the accumulated value of flight capital from 25 African countries between 1970 and 1996, plus imputed interest earnings, was considerably higher than the entire value of the combined external debt of those 25 countries in 1996 (Boyce & Ndikumana, 2001). Thus, public debt essentially subsidised the accumulation of private assets. Using a similar methodology, Beja (2006) estimates the accumulated value of flight capital from Indonesia, Malaysia, the Philippines and Thailand over the period 1970-2000 at US$1 trillion.

These examples lend abundant support to Sassen’s argument that owners of mobile assets traded in financial markets “can now exercise the accountability functions associated with citizenship: they can vote governments’ economic policies in or out, they can force governments to take certain measures and not others” (Sassen, 2003: 70). This argument can be taken too far: the importance of this constraint depends both on domestic political institutions and on a country’s or a region’s recent economic history and position in the world economic system. However, domestic strategies of resistance are likely to be compromised by the expanding political influence of elites for whom globalisation offers rapid increases in income and wealth, through both labour and financial markets, even as it contributes to the immiserisation of their fellow citizens.

References


The need to maintain profitability under more restrictive economic conditions and to optimise conditions for capital accumulation led employers to focus on achieving productivity gains, expanding their markets, and engaging in organisational decentralisation no matter what the consequences for employment or social well-being. Neo-liberalism arose as a restoration of class power among the upper classes whose power was seriously threatened before the 1970s (Harvey, 2006). These aims made it necessary for business and employers to push for wider and more intensive processes of deregulation and employment flexibility that profoundly altered the previous labour scenario (Castells, 1996). Thus, a new managerial strategy emerged, defined as the “flexible firm”, dividing the labour force into a multi-skilled and functionally flexible protected core and a disposable periphery with fewer labour rights. This resulted in a segmentation of the labour market (Atkinson & Meaguer, 1986; Atkinson, 1987). The acceptance of the overriding need for flexible markets as a key to creating employment in competitive contexts thus legitimated the use of part-time jobs, temporary work, and self-employment. The “overprotection” associated with permanent full-time employment was blamed as the factor responsible for the persistence of high unemployment rates, while employment flexibility in the context of uncertain product markets and short-term fluctuations in demand was invoked as the only way out. In addition to meeting the ebb and flow of this consumption-sensitive production model, part time workers were a convenient solution that could be disposed of when market conditions forced firms to cut costs. These workers were considered a better means of tying paid time to work time, shorter shifts being the solution to unproductive time on the job (Delsen, 1993; Smith, Fagan, & Rubery, 1998).

Case Study 2. Changes to employment conditions and an ageing workforce. - Philip Bohle and Michael Quinlan

The population and workforce of most developed countries and a number of developing countries (such as China) are ageing. While there is growing recognition that an ageing workforce has implications for occupational health, little consideration has been given to the combined effect of workforce ageing and changes in employment conditions identified in this report, notably the growth of precarious and informal employment (for an exception see Wegman & McGee, 2004). Nonetheless, there is reason to believe these effects are likely to be profound.

There is evidence that the health and well-being of older workers is more adversely affected by downsizing (Gallo et al., 2004). Furthermore, those losing their jobs are more likely than younger workers to remain unemployed for longer periods (or permanently), and thus suffer the well-documented adverse health affects associated with joblessness. If they do obtain jobs, they are more likely to be markedly inferior in working conditions to their previous employment (with the increased possibility of being insecure jobs that will result in further intermittent bouts of work and unemployment), and again with adverse health effects including psychological adjustment problems.

As precarious employment has increased, so, it should be noted, has an age bifurcation (see for example Louie et al., 2006). Young workers (i.e., less than 25 years of age) and older workers (over 45 years of age) both hold a disproportionate share of part-time and temporary jobs while older workers are also increasingly likely to be self-employed. This means that both young and older workers are also disproportionately exposed to the additional health risks associated with these employment arrangements (and the more limited avenues for articulating their concerns). Insecurity can impact on the emotional and physical well-being of older workers in complex ways (Clarke, Lewchuk, Wolff, & King, 2007). While conventional wisdom often cites the inexperience of younger workers as putting them at risk for job loss, a recent Canadian
study found short job tenure was a risk factor for all workers and was actually highest for older workers [Breslin & Smith, 2006].

While part-time or temporary work and self-employment is often described as a way for older workers to extend their working careers or to transition into retirement, there is no compelling evidence that this is the norm, or that flexible work arrangements have been designed to achieve this outcome. The growth of multiple job-holding suggests a mismatch rather than an accommodation. Older workers holding insecure or temporary jobs, may experience immediate financial stress due to family and other commitments [Aronsson, Dallner, Lindh, & Goransson, 2005] and will find it difficult to plan or budget for their retirement. Poorer health and discriminatory attitudes are liable to inhibit prospects of older workers in a labour market more dominated by short-term engagements. Furthermore, when they are engaged on a temporary basis, older workers who suffer an injury or disease at work are in a more vulnerable position when it comes to rehabilitation or returning to work.

**References**


Furthermore, self-employment can be seen as a pragmatic option for the unemployed when changes in the labour market prompt mass unemployment [Staber & Bogenhold, 1991]. Yet there are doubts about the positive effects of this kind of job creation. The business cycle may encourage inactive members of the population to participate in the labour market, but this does not necessarily imply decreasing unemployment. When unemployment rapidly increases, workers may be more willing to accept part-time jobs to compensate for reductions in family income rather than pursue self-employment. In countries with low female labour market participation it is further likely that part-time jobs encourage women to enter the labour market and thus do little to reduce recorded levels of unemployment. Moreover, the emergence of a new “sub-contracting” culture that stimulates the growth of self-employment suggests that certain forms of self-employment do not represent an additional source of work but rather a substitution of dependent employment for that of the own-account type. An Organization for Economic Co-operation and Development (OECD) study, for example, found no clear connection between levels of unemployment and the growth of self-employment, refuting other perspectives that identify self-employment with employment invigoration in times of mass unemployment [OECD, 1996].

In advanced economies, imports from countries specialised in low-skilled manufacturing and the spread of knowledge
Technologies have resulted in declining demand for low-skilled labour, thus forcing further structural adjustment (Howell, 2002). Low-skilled workers are now a highly vulnerable group whose wages are more likely to fall to the floor set by minimum wage regulations. Unfortunately, regulations to guarantee higher earnings increase the cost of labour, constricting the demand for labour and increasing the rate of unemployment, especially among the low-skilled (Nickell, 1997).

The labour market in industrialised countries began to move away from an overlapping interest between labour representatives and employers in the 1970s, pitting them against each other in the struggle to balance workers’ rights with the need to increase profitability. This ended the trend of steady economic growth and abundant, stable employment, ushering in the period of structural adjustment that frames employment conditions in wealthy countries today.

5.2. MIDDLE AND LOW INCOME COUNTRIES

While most Western economies achieved high living standards and continued growth, the rest of the world, trying to catch up in terms of economic development, was confronted with two rather antagonistic development paradigms: modernisation and dependency. In evolutionist theory, which heavily influenced modernisation principles, economic development is a process involving several successive stages. Industrialisation is the driving force of modernisation and, by extension, the root cause of development, whereas the welfare state is the logical corollary of this process of industrialisation and increasing economic growth. Since developed economies represented a more advanced phase of this development, those economies in the earlier stages tried to emulate the socio-economic order of the Western world (Rostow, 1960). Yet in the context of already developed countries, these efforts often led to low value exports, a preponderance of unskilled and informal labour, and a trend of poor employment relations and hazardous working conditions.

Yet, other authors saw that affluence in advanced economies came at the cost of poverty in the rest of the world. The periphery of this world system (Wallerstein, 1979) is thus exploited and kept in a state of backwardness by a core of dominant countries that profit from poor countries’ lack of sufficient skilled labour and industries to process raw materials locally. Peripheries are obliged to rely heavily on exporting a single cheap commodity to accumulate foreign currency, frequently in the hands of Western multinational corporations. In this world economic system, poor countries are producers of raw materials and cheap labour.
and importers of expensive value-added products from developed economies. This unbalanced pattern of exchange and trade is consequently thought to impede the development of the peripheral countries. Between the two extremes lie the semi-peripheries. These areas represent either core regions in decline or peripheries attempting to improve their relative position in the world economic system.

The oil crisis affected the periphery in a more heterogeneous way than those countries at the core. While some OPEC countries in North Africa and the Middle East enhanced GDP growth, some did not invest oil revenues in reforming their economic structures. Moreover, the poorest countries, heavily dependent on oil imports and external aid, were very affected by the crisis. These oil-importing developing and poor countries turned to private financial markets to pay for imports and cover deficits on their current account balances. The result was an emerging debt crisis that came to a head from 1972-1974. In this period, total long-term debt service increased by 29.4% on average (World Bank, 2007). Since the end of the 70’s oil crisis, the world’s economic situation has changed dramatically, affecting labour standards throughout the world.

Some trends might suggest that developing poor countries have been catching up in recent decades. For example, the developing economies’ share of world exports has significantly increased in the past fifteen years. In 1990, high-income countries represented 83 per cent of global exports, whereas fifteen years later that percentage was significantly lower (72 per cent). Moreover, there are some signs of a reduction in poverty and working poverty. Extreme working poverty has significantly decreased in recent decades, shifting from 40.3 per cent in 1980 to 19.7 per cent in 2003. Working poverty has also decreased, from 59.8 per cent in 1980 to 47.4 per cent in 2003 (ILO, 2007). But these changes are due mostly to economic growth in China and India, the two most populated countries. Can we thus conclude from these figures that developing economies are profiting from the new economic order?

Case study 3. Economic growth is not translated into decent job growth. - Shengli Niu

The number of unemployed people worldwide remained at a historical high in 2006 despite strong global economic growth. Even though more people are working globally than ever before, the number of unemployed remained at an all-time high of 195.2 million in 2006 or at a global rate of 6.3 per cent. There weren’t enough decent and productive jobs to raise the world’s 1.37 billion working poor and their families above the US$2 poverty line. Growth has failed to reduce global unemployment and, even with continued strong global economic growth in 2007, there is serious concern about the prospects for decent job creation and further reduction of working poverty.

For the past decade, economic growth has been reflected more in rising levels of productivity and less in growing employment. While world productivity increased by 26 per cent, the global number of those in employment rose by only 16.6 per cent. Creation of decent and productive jobs, not just any jobs, is a prerequisite for reducing unemployment and slashing the number of families working but still living in poverty. This in turn is a precondition for future development and economic growth. The strong economic growth of the past half decade has had only a slight impact on the reduction of the number of
Indeed, there is no such thing as a global integration of economies, but rather a process of regional integration. While East Asia has seen its share of exports grow significantly (representing 4 per cent of total exports in 1990 and 11 per cent in 2004), other world regions have hardly increased their export participation or have not increased it at all ("Sub"-Saharan Africa, South Asia, the Middle East, and North Africa). The G-7 (high income economies), which represents 11.5 per cent of the world’s population, produces 74 per cent of total GDP, whereas East Asia and the Pacific, representing 29.2 per cent of the total population, produce less than 7 per cent, and Latin America and the Caribbean only 5.4 per cent. Furthermore, although the reduction of poverty is perceptible in aggregated terms, it has been particularly

workers who live with their families in poverty and this was true in only a handful of countries. In 2006, the employment share of the service sector in total global employment progressed from 39.5 per cent to 40 per cent and, for the first time, overtook the share of agriculture. Unemployment hit young people (aged 15 to 24) the hardest, with 86.3 million young people representing 44 per cent of the world’s total unemployed in 2006. The employment gap between women and men persists. In 2006, only 48.9 per cent of women aged 15+ were employed compared with 49.6 per cent in 1996. The comparable male employment-to-population ratios were 75.7 in 1996 and 74.0 in 2006.

In most regions, unemployment rates did not change markedly between 2005 and 2006. The largest decrease occurred in the region of the developed economies and the European Union, where the unemployment rate declined by 0.6 percentage points between 2005 and 2006 to reach 6.2 per cent. East Asia’s unemployment rate was 3.6 per cent, thereby remaining the lowest in the world. South Asia’s unemployment rate was 5.2 per cent and Southeast Asia and the Pacific’s was 6.6 per cent.

The Middle East and North Africa remained the regions with the highest unemployment rate in the world at 12.2 per cent in 2006. Sub-Saharan Africa’s rate stood at 9.8 per cent, the second highest in the world. The region also had the highest share in working poverty, with 8 out of 10 women and men living on less than $2 a day with their families.

This underscores that tackling the decent work deficit in Africa is a regional and global priority. Employment-to-population ratios, i.e. the share of people employed within the working age population, varied between regions. The Middle East and North Africa had the lowest ratio, at 47.3 per cent in 2006. East Asia had the highest ratio with 71.6 per cent in 2006, but its ratio has dropped by 3.5 percentage points over the past ten years. If caused by an increase in educational participation, as is the case in East Asia, a decrease of the employment-to-population ratio is a good thing. In Latin America the ratio gained 1.8 percentage points, rising to 60.3 per cent of people employed within its working-age population in 2006. However, in this region non-agricultural employment is concentrated in low-productivity, low-wage sectors of the economy, with insufficient levels of social protection and exceptionally high levels of income inequality. Indeed, in Latin America, income inequality goes hand in hand with unequal access to education, health, and political power, and it involves widespread poverty.

In all regions, the total number of working poor at the US$1 level declined between 2001 and 2006, except in Sub-Saharan Africa where it increased by another 14 million, and in Latin America, the Middle East and North Africa where it stayed more or less unchanged. Over the same period, the total number of US$2-a-day working poor declined in Central and Eastern Europe (non-EU) and the Commonwealth of Independent States (CIS), and most significantly in East Asia by 65 million. On the other hand, it increased in Southeast Asia and the Pacific, South Asia, the Middle East and North Africa, with the biggest increase (26 million people) occurring in Sub-Saharan Africa.

Young people have more difficulties in labour markets than adults; women do not get the same opportunities as men; the lack of decent work is still high; and the potential a population has to offer is not always used because of a lack of human capital development or a mismatch between the supply and the demand side of labour markets. Nowadays the widespread conviction is that decent work is the only sustainable way to reduce poverty, which is why the target of "full, productive and decent employment" will be a new target within the Millennium Development Goals in 2007. Governments and the international community must make sure that the favourable economic conditions in most parts of the world will be translated into decent job growth.

Source
significant in East Asia, which shows an outstanding improvement in the reduction of working poverty, together with an increase in labour productivity. It is predominantly China and India that have contributed significantly to this trend (ILO, 2006).

The situation in "Sub"-Saharan Africa and South Asia is particularly alarming, with 89 per cent of the employed population earning less than US$2 per day. Moreover, "Sub"-Saharan Africa is the only region where working poverty has increased. In the same vein, inequality has been growing worldwide since the 1980s, both within regions and within countries. The sharpest rise has occurred in Eastern Europe, which was the region with the lowest inequality level until the mid-nineties. Inequality has continued to grow in regions that already had high inequality indexes, such as Latin America and Asia.

Indeed, major structural barriers persist for a significant improvement in the position of poor countries relative to wealthy countries in terms of a decrease in poverty and “catching up" economically in the near future. One of these barriers lies in the agricultural sector, which remains a crucial sector in many developing and poor countries. While its contribution to GDP is decreasing in other sectors (especially the services sector), it is still the main productive activity of the working population in many regions of the world. According to the UN Population Division, the rural population still comprised 59.5 per cent of the total population in less developed regions in 2000 (with an estimate of 56.8 per cent for 2005) and in the least developed economies the share was even higher at 74.8 per cent in 2000 and 72.3 per cent in 2005. Its output, however, represents only 16 per cent of GDP.

In addition, poor countries struggle to cope with other important shortages and deficiencies: specialisation in low value-added sectors in which low-skilled jobs predominate continues to be prevalent, and the informal economy is highly present. While in wealthy countries the informal sector represents 15 per cent of total GDP and 20 per cent of the labour force, in low-income countries it represents more than 50 per cent of GDP and about 47 per cent of the workforce. There are also important gaps in labour standards, such as in collective bargaining coverage rates. Child labour is a matter of further concern, given that in some "Sub"-Saharan countries more than 50 per cent of children (5 to 14 years old) are workers (Togo, Niger, Guinea-Bissau, Cameroon, Central African Republic, and Chad). Figures above 30 per cent are common in other African and Asian economies and it remains high in some Latin-American countries. Moreover, working time in many countries approaches 47 to 50 hours per week. This is the case in Peru, with
Employment, work, and health inequalities - A Global Perspective

an average working time of 49.8 hours per week (2000), Hong-Kong (China) with an average of 48 hours per week (2005), and the Philippines (about 45 hours per week in 2005) (ILO, 2005).

Despite some improvement in the reduction of poverty and the levels of working poor, low income countries are still locked into the difficult position of choosing between development and dependency. Years after the oil crises of the 1970s, most of the periphery and semi-periphery is still plagued by an over-reliance on agricultural exports and expensive imports, in addition to a labour market characterised by a pervasive informal sector and nearly universal poor working conditions and employment relations. Changes in global production systems have expanded economic migration, with millions of workers from poor countries serving as a source of cheap labour in wealthy countries, since they meet the demand for flexible labour. Economic migrants meet the demand for flexible labour. In core countries, local labour markets often leave out workers who are unwilling to conform to pressures for flexibility, mobility, and precarious employment conditions with long working hours for low pay.

Case study 4. Globalisation, economic migration, and precarious work. - Denise Gastaldo

Globalisation: João was 14 when he got his first job in a Brazilian bank. At the time, he was attending 7th grade in the morning and working in the afternoon. His job consisted of running errands for the bank office. By 19 he was finishing a high school program which offered a technical degree in foreign trade and was working as an assistant to the board of directors of a multinational bank [the Brazilian bank had been bought by a Spanish bank]. The salary for this part-time job was R$400.00 per month (CDN$150.00 dollars) and João used the money to pay his school fees. When a full-time position opened in the trade sector, João applied for the position but was denied the right to be transferred. The argument presented was that it was difficult to replace a trusted staff member; he was needed in this particular position. At 20, he started university and with the same salary he attempted to pay R$420.00 university monthly fees plus part of his living expenses. Like so many working class youth in Brazil, he had to attend a private university which offered evening classes to continue working during the day. After the first university semester and his second failed attempt to be transferred to the trade sector, João volunteered to be laid off as part of a downsizing program, cancelled university, and came to Canada to study English. He had come to the conclusion that he could not afford to attend university while working at the bank and that better English would increase his chances of getting a job in trading.

Economic Migration: Going to Canada was part of João’s plan to move beyond the difficult life of the Brazilian working class. After arriving to Canada, João realised everything was more expensive than originally anticipated. So, he got a series of short-term jobs to support his English training. Even though he was on a tourist visa, he would apply for jobs and no questions were raised. What all these jobs had in common was that they were very poorly paid (average CDN$8.00 per hour), the working conditions varied a lot and they were casual jobs. Among the jobs encountered were: carpet installer, office assistant in a bilingual company, and general labour in construction. At the latter, João perceived a good economic opportunity - to become a bricklayer and move into a well-paid occupation for undocumented workers.

Precarious Work: After working for one year as a construction worker, João was a forklift driver for another year, and during this time he learned to do bricklaying. By then the Canadian dollar was 2.4 times the value of the Brazilian real. This situation served as an incentive for him to remain in Canada, especially because his pay had increased to CDN$29.00 per hour. Construction work usually starts at 7am at the site, which means taking the company van at 6.00 am. During the one-hour ride (and back), 5 workers and the driver would consume tobacco through environmental smoking or real smoking. During the day, a steady and sometimes fast pace has to be kept with planning to avoid wasting materials, keeping the site relatively clean (for the sake of accident prevention), and responding to other workers’ schedules.

Everyday work: In reality, the job should be called “blocklaying”, given that most of the work is done with blocks [cement squares which weight approximately 5 kilos]. A minimum of 250 blocks are laid per day per worker, but at times
when the company has to meet a deadline, anywhere between 500 and 900 blocks may be laid by a single worker in a ten-hour shift. The lack of control over one’s own work is a common feature in construction work. If materials did not arrive on time, if the work in a site was finished ahead of schedule, or if co-workers did not show up, among many other reasons, workers had to work for hours and not be paid for all the hours they were at the job but were not laying blocks. During the day, there are 2 coffee breaks of 15 minutes each paid by the company but lunch time (30 minutes) is unpaid. The workload varies considerably according to the seasons. Twelve-hour shifts, 6 days a week in the summer are not unusual, but many days without work due to rain or snow storms are also a reality in the spring or winter. This makes income fluctuate, especially from December to April in Canada. Also related to the seasons is the fact that workers are out in the open during the whole year with temperatures of up to 40 C in the summer, with plenty of sun exposure, as well as -30 C and cold burns during winter months. Some companies enforce a strict safety code and the ministry occasionally supervises sites, but in the companies where João has worked, helmets were optional due to heat during the summer and scaffolds fell a few times, though luckily no one was injured. Every year, for the last three years, João has missed around 2 weeks of work due to back pain. When this happens, he informs his supervisor he will stay at home until his back no longer hurts (he also takes over-the-counter anti-inflammatory medication). Apparently, this is a common issue for “blocklayers”.

Managing an “illegal” life: The workers’ lack of status is known by their employers and in several ways they benefit from it (not declaring taxes, not offering a benefit plan, etc). On one occasion, João was not paid for a week of work and the employer told him he would hand him over to immigration. Another time, he was paid half of the agreed amount and again was powerless to complain. When a colleague broke his leg, his co-workers used another worker’s health insurance card to get him hospital care. Some employers are known for taking responsibility for health care bills, while others may abandon their employees. This is rarely a topic of discussion and the most skilled in the job try to work for “good bosses” in the hope that they will be rescued in the case of a work accident. João has been in Canada for 7 years now. He used all the money he has saved to buy a lot and build a house for his mother and himself in Brazil. He has tried to become a permanent resident in Canada, but the lack of a university degree makes him ineligible to apply as a skilled worker. Paradoxically, the same skills that kept him employed for several years are not considered sufficient to support an immigration application.

In summary, economic migrants without work status in Canada are self-sufficient and financially responsible for others, they experience income insecurity, fear, lack of political, health and educational rights, and face abuse, discrimination, and social isolation. The construction sector is highly dependent on non-status migrants in Canada. During the last 7 years João has helped build several schools, two hospitals, the airport, and countless houses. Thus, affordable housing and services as well as a nouveau riche group in Canadian society depend on the continuing exploitation of economic migrants.
Labour markets and welfare states: a country perspective

"The improvement of medicine will extend human life, but the improvement of social conditions will permit to reach this result quicker and more successfully... [Those conditions] can be summarised as follows: full and unlimited democracy."

Rudolf Virchow
In this chapter, we paint a picture of world labour markets and welfare states in order to better understand global health. We begin with an empirical typology of countries based on employment relations. This typology helps us portray the state of labour market regulations around the world and their impact on health. Then, we present selected country case studies to illustrate the typology's different “country clusters”. These case studies also focus on the characteristics of the labour market.

6.1. COUNTRY TYPOLgy OF EMPLOYMENT RELATIONs

While empirical studies of the social determinants of health have generated frameworks and explanations that include economic indicators (Wilkinson, 2005), few scholars have investigated related structural pathways (Muntaner & Chung, 2005). To meet this need, a new research program has emerged which focuses on two political determinants of health (Chung & Muntaner 2006; 2007; Muntaner & Lynch, 1999; Muntaner et al., 2002; Muntaner et al., 2006; Navarro & Shi, 2001; Navarro et al., 2003; Navarro & Muntaner 2004; Navarro et al., 2006). The first determinant is the combination of political processes in the labour market, which forms the basis of social class. The second determinant involves subsequent welfare state policies.

In this model, employment relations are at the core of a country’s welfare regime (Korpi, 1983; Locke, Kochan, & Piore, 1995). With this in mind, we present a typology based on the role played by inequality in employment relations as a social determinant of health. This global typology creates the background for a comparison of empirical cases across the globe. In addition, Figure 4 presents a model relating employment relations and population health. It represents this relation at the national level and can be generalised to the global level.

Employment relations are a centrepiece of West European welfare states (Esping-Andersen, 1990). They are the result of a “social pact” that cements the power relationship between organised labour (trade unions and collective bargaining), government (especially Social Democratic parties), and business associations. The power of labour, usually measured by union density or collective bargaining power, varies consistently according to the type of welfare state regime (Chung, 2006), providing an effective means of classifying the type of employment relations.

Employment relations are therefore closely associated with welfare services. De-commodification of labour, that is, the degree to which individuals or families can maintain a socially acceptable
standard of living independent of labour market participation (Esping-Andersen, 1990), allows workers to exit from the labour market at need, and in turn allows them to avoid hazardous work environments. In other words, higher de-commodification means more bargaining power for workers. Therefore, the key to understanding employment relations and their impact on workers’ health is to understand the workers’ bargaining power, which gives them leverage to push for a stronger welfare state and healthier working conditions.

**Figure 4.** Model showing the main relations between workers’ bargaining power, welfare state, employment relations and health.

This process takes place along two different pathways. The first is related to the physical conditions of the workplace, which has traditionally been the scope of industrial medicine and occupational health. The second pathway is an outcome of the labour process that affects workers’ lives outside the workplace, namely wages and benefits (vacations, pensions, worker’s compensation). Together, we can see how these two outcomes of employment relations, their ensuing physical and psychosocial hazards, and the various associated forms of economic compensation affect the health status of workers. These two pathways are modified by government-provided welfare services, defining in large part the health status of the working population.

**Extrapolating the welfare state typology and employment relations**

This notion of workers’ bargaining power becomes problematic when we look for indicators (i.e., union density, collective bargaining coverage) in middle and low-income countries. The most notable difference is related to the high percentage of workers in the informal sectors of low- to middle-income countries. Although the existence of an informal sector is not only found there (Gërxbani,
2004; Portes & Sassen-Koob, 1987], the typically dire working conditions that characterise it, including child labour, slave labour, and work at lower-than-subsistence compensation levels, are exacerbated in low- to middle-income countries.

In addition, in both wealthy and middle/low-income countries, precarious employment relations have reduced the proportion of unionised workers, especially since the 1980s. These developments limit the possibility of using indicators such as union density and collective bargaining coverage to classify labour markets. Therefore, when the majority of workers cannot rely on collective bargaining, alternative indicators are needed.

Figure 5 contains a diagram of types of employment relations in a hypothetical labour market. The labour market is made up of a formal sector and an informal sector. In the formal sector, there are two types of workers: full-time regular workers and irregular workers in precarious jobs, the latter having been on the rise over recent decades. This sector is characterised by different rules and regulations than the informal sector, and the limit of their reach serves as a rough boundary between the two sectors, marking the beginning of a new set of employment relations.

While the popular notion of an informal economy connotes a uniform, para-legal "underground" economy with appalling working conditions and no social security, several empirical studies have shown that there are at least two unique class positions in the informal sector: small entrepreneurs and informal wage earners (Portes & Schauffler, 1993). Since the income inequality between these two is larger than the difference between the two dominant positions of the formal sector, it seems logical that the health implications of working in the informal sector would reflect this disparity. Therefore, as there are many more workers than employers, we can predict that the informal sector's average level of health will be worse than in the formal sector.

In other words, we expect employment relations and working conditions in the informal sector to be more hazardous than in the formal sector. Exacerbating this prediction is the fact that compensation factors serve to ease the impact of employment relations on population health. These compensation factors typically include social security benefits, universal access to health care or anti-poverty cash supplements. Thus, low wages and weak unemployment insurance mediate the negative impact of employment conditions on health.
We now proceed to develop a global typology of employment relations. Countries are divided into groups according to their position in the world system (core, semi-periphery, and periphery) (Arrighi & Drangel, 1986; Babones, 2005). Three types of employment relations are generated by each position. The aim here is to outline the macro-political and economic roots of employment relations and their relationship with population health at the global level. A macro-social approach to labour markets provides a deeper understanding of how employment relations vary on a global scale.

**Developing a global typology of countries**

Using the analytical tool provided in Babones (2005), we divided countries into three groups by their position in the world system. We compiled country data into three groups for analysis according to each country's global position (based on global income distribution). Using data from the Key Indicators of the Labour Market (KILM) from the ILO (2007) and the WHO (2000, 2004 and 2006), we conducted a series of cluster analyses of middle- and low-income countries in an effort to understand the relation between labour market conditions and health. For core countries, we used OECD data (1999) to generate labour market clusters. The final typology of countries classified by their position in the world system level and labour market characteristics is presented in Table 1 and Map 2. Specific methodological details of these analyses are provided in the Appendices (Section 2).
The clustering of countries according to labour market characteristics varies greatly between periphery and semi-periphery, on one hand, and OECD countries on the other. The labour markets of semi-peripheral countries are characterised by growing informality but maintain some degree of stability and rule of law, approximating them to wealthier OECD countries. Some, such as Chile, have even developed their own forms of emerging welfare state institutions. Countries on the global periphery, however, represent another level of labour-market instability altogether. Plagued by a heavy reliance on informal work, they face severe insecurity in their labour markets. In these countries war, political instability, authoritarian regimes, and foreign interventions threaten the rule of law and the protection of workers, and only aggravate their labour market problems (Stubbs & Underhill, 2006).

This categorisation of countries reveals two very important distinctions. First, it highlights the difference between labour institutions and informal labour markets. Labour institutions are closely related to the strength of the welfare state (Huber & Stephens, 2001).

### Table 1. Cluster of countries based on labour market inequalities.

<table>
<thead>
<tr>
<th>More Equal</th>
<th>Less Equal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CORE</strong></td>
<td></td>
</tr>
<tr>
<td>Social Democratic Labour Institutions</td>
<td>Corporatist Conservative Labour Institutions</td>
</tr>
<tr>
<td>Belgium, Denmark, Finland, Italy, Norway, <strong>Sweden</strong></td>
<td>Austria, Germany, France, Greece, Japan, Netherlands, Portugal, <strong>Spain</strong></td>
</tr>
<tr>
<td><strong>SEMI-PERIPHERY</strong></td>
<td></td>
</tr>
<tr>
<td>Residual Labour Institutions</td>
<td>Emerging Labour Institutions</td>
</tr>
<tr>
<td>The Bahamas, Croatia, Czech Rep, Hong Kong, Hungary, Jamaica, <strong>South Korea</strong>, Latvia, Lithuania, Poland, Russia, Singapore, Slovak Rep, Slovenia, Thailand, Uruguay</td>
<td><strong>Argentina</strong>, Brazil, Chile, Colombia, Costa Rica, Ecuador, Fiji, Kuwait, Malaysia, Mexico, Panama, Paraguay, Peru, South Africa, Trinidad and Tobago, <strong>Venezuela</strong></td>
</tr>
<tr>
<td><strong>PERIPHERY</strong></td>
<td></td>
</tr>
<tr>
<td>Post-Communist Labour Market</td>
<td>Less Successful Informal Labour Market</td>
</tr>
<tr>
<td>Albania, Armenia, Belarus, <strong>Bolivia</strong>, Bulgaria, Cambodia, China, Ghana, Indonesia, Moldova, Mongolia, Papua New Guinea, Philippines, Romania, Tajikistan, Ukraine, Uzbekistan, Viet Nam</td>
<td>Algeria, Cape Verde, Cote d’Ivoire, Dominican Rep, Egypt, Equatorial Guinea, Guatemala, Guyana, Honduras, <strong>India</strong>, Iran, Jordan, Mauritania, Morocco, Nicaragua, <strong>Nigeria</strong>, Pakistan, Sri Lanka, Sudan, Swaziland, Syrian Arab Rep, Yemen Rep</td>
</tr>
</tbody>
</table>

Source: Prepared by the authors
In other words, labour institutions are the means by which the state regulates the labour market (e.g., provisions for collective bargaining). Informal labour markets, on the other hand, emerge in the absence of state regulation of the labour market (Majid, 2001). Equality in the labour market typically increases as state intervention erodes the de facto authority of the informal labour markets, replacing it with a regulating, legitimate authority.

Map 2. Countries of different labour market clusters.

In the labour markets of peripheral countries however, this process is difficult, as the majority of workers are in the informal sector (Majid, 2001). Across the board, very low wages force workers to sell their labour for less-than-subsistence income. Moreover, insufficient family wages force children to venture into the labour market at extremely young ages. The result is a vast proportion of the population that is not only underpaid but is also excluded from social security benefits. While labour institution characteristics (such as union density) are scarcely recorded thanks to the informality of labour, low- and middle-income countries indicate a large informal sector. The deteriorating working conditions that this implies were corroborated by our and others’ empirical investigations. This implies that social security factors and income level should be taken into account in order to predict population health status with more accuracy in analytical studies.

A second conclusion pertains to the labour markets in semi-peripheral countries. Union density and coverage are still important in those countries, as some have emergent or residual welfare states (e.g., Eastern block), but their effects could not be analysed due to the small sample size.
Third, the labour institutions of wealthy countries confirm previous studies (Chung & Muntaner, 2006; 2007). Labour institutions, measured through union density and collective bargaining coverage, correlate closely with welfare state regime types in wealthy countries. Nevertheless, an integration of “flexicurity” and other active labour market initiatives in Scandinavian countries with varieties of welfare state initiatives could yield more refined labour institution typologies (Hall & Solskice, 2001).

6.2. SELECTED COUNTRY CASE STUDIES

In this section we present examples of countries that illustrate the labour market and health variation captured by our empirical global typology of countries. In selecting specific countries, we used several criteria (see countries marked in red in table 1). These included how well a country represents the ideal type of its cluster (e.g., Sweden and United States for the social democratic and liberal labour market clusters, El Salvador and Turkey for informal labour market clusters and Nigeria and Ethiopia for less successful informal labour market and insecure labour market, respectively); size of the country’s population and “emergence” of its economy (Brazil, Russia, India, China); labour market inequality (e.g., the large proportion of precarious workers in South Korea and of working poor in Haiti); and country’s political economy (socialist and social-democratic in Cuba, Venezuela and Bolivia).

Sweden - Mona Backhans and Bo Burström

Sweden is an example of the Nordic social democratic welfare regime, included in the “more equal” cluster among the rich or core countries. In Sweden, social policy is characterised by universality and a relative lack of targeting, and generous benefit levels with a high degree of income replacement. Although there have been some changes made by the new liberal-right wing government regarding benefit levels for the long-term unemployed since 2007, this general description still holds. Welfare services are almost solely produced within the public sector, with a small share of private actors (Statens Offentliga Utredningar, 2004:19). In 2007, 78 per cent of men and 73 per cent of women aged 16-64 were employed (Statistics Sweden, 2007). Unemployment was 4.6 per cent among men and 4.7 per cent among women. Among young people (16-24), the total figure is 11.7 per cent.

Since 1974, Sweden has had strong employment protection. In practice, this has meant that dismissals other than those based on
redundancies are very rare. The period of notice (with full pay) is between 2-6 months depending on years of service. In the 1974 regulations, rules regarding the use of temporary employees were very strict. However, temporary or substitute employment for a limited period or for a specific task was made possible. So, in 1982 the rules regarding temporary employment were relaxed by the social democratic government. Temporary employment was made possible for a number of circumstances, including seasonal work and temporary peaks in production. In 2007, all types of temporary employment were replaced by "general temporary employment" which can be used “at will” but for no more than 24 months over 5 years for a particular employee. After that, the contract is automatically made permanent.

Along with the other Nordic countries, Sweden has traditionally had a strong union movement, and still enjoys a high membership rate in all occupational groups, albeit lower among the privately employed. There is a long tradition of collective agreements, instead of legal regulations, regarding minimum wage, hours of work and the use of temporary employment, which has contributed to a strong union influence [Kjellberg, 2003]. Between 90 and 95 per cent of all Swedish employees are covered by collective agreements. In 1990, overall unionisation was 81 per cent compared with 80 per cent in 2002, having peaked at 85 per cent in 1993. Unionisation figures have plummeted, however, since new rules were introduced in 2007 regarding fees for unemployment insurance. These were changed in order to finance a larger part of insurance costs, and fees were raised drastically for many groups. As a result, many decided to leave unions to avoid paying membership fees. For some unions, membership figures declined by as much as 20 per cent in one year. Through its long history of cooperation between the parties in the labour market, as well as its well-organised unions, Sweden still provides good opportunities for unions to influence employment policy.

Temporary employment increased from 9.4 per cent in 1990 to 15.4 per cent in 2007. The increase was steepest during the 1990s. The proportion in temporary employment is larger for women (18.5%) than for men (12.6%) [Statistics Sweden, 2007]. In Sweden, 12 per cent of the resident population is foreign-born. The proportion in temporary employment is about 5 per cent higher in this group, both among men and women. Temporary contracts are especially common among young (age 16-24) working class women (42% compared to 26% of men in the same situation) [Nelander & Goding, 2006]. Since 1980, part-time employment has slowly increased among men (from 6 to 10%) while it decreased among women (from
Underemployment is most prevalent among young working class women. While women born abroad work part-time slightly less often than Swedish born women, the proportion is 5 per cent higher for foreign-born men, most of which is likely to be involuntary (Nelander & Goding, 2006). One union-led study of construction work sites in southern Sweden estimated that 1/3 of workplaces hire illegal labour (Byggnads, 2004). The phenomenon of illegal labour may be increased by the fact that asylum seekers cannot obtain work permits until they receive temporary or permanent residency. Child labour is a non-existing problem but there have been a number of much publicised cases of trafficking in young women, often from the Baltic countries or Russia, who are forced into prostitution under slave-like conditions.

Swedish research has shown that people who “work on demand” - mostly young women and unskilled workers - have an elevated risk of reporting psychosomatic symptoms (Aronsson, 1999; Aronsson, Gustafsson, & Dallner, 2000). It is common to experience economic stress and those that do have economic problems often have poor mental health (Aronsson, Dallner, & Lindh, 2000). However, not all studies show health differences between temporary and permanent employees (Bäckman & Edling, 2000). When the outcome is work-related health problems, this might be because these are highly related to time in employment. Temporary employees are also heterogeneous when it comes to the degree of precariousness (Håkansson, 2001). Analyses of the relationship between flexible employment, working conditions and health in the Level of Living Survey (ULF) in 1999-2000 showed that in the cluster with the highest proportion of temporary (37%) and involuntary part-time (16%), two-thirds were unskilled workers and 83 per cent were women (own analyses). Twenty per cent had irregular working hours and 10 per cent worked nights. Twenty-two per cent reported less than good health, compared to 9 per cent in the group with the best health.

Labour market policy in Sweden is part of the general economic policy and its main goals are to contribute to sustainable growth, increased employment and a competitive trade and industry (Sibbmark, 2007). Groups targeted by active unemployment policies (labour market programs) include disabled people, immigrants, young people, and the long-term unemployed, e.g., those who have special difficulties in finding a job. This means, for example, that people under 25 have the right to participate in a labour market
program [which may be education or work placement] after 100 days
of open unemployment (Arbetsformedlingen, 2008). Another
example is a range of special programmes designed for people with
different kinds of disabilities, such as supporting part of employers’
costs when hiring a disabled person.

**Germany - Wolfram Metzger and Michael Kronawitter**

Germany is a parliamentary, representative democratic republic
with 16 federal states. Among the core welfare countries, Germany
is an example of a corporatist conservative labour market. Its GDP is
the largest in Europe and the fourth largest in the world, behind
the United States and Japan. With a population of nearly 82 million,
Germany is the most populous nation of the European Union. Nearly
a fifth (19.8%) of the population are over 65 years old (median age 43)
and the population growth rate is negative (-0.033%); these are
demographic features of an over-aged and shrinking population,
which is recognised as a national problem. In 2006, 51.5% of the total
population was defined as economically active. Of these, 7.2% were
jobless according to the International Labour Organization’s criteria,
whereas registered unemployment was 9.2 per cent. Those
employed were divided in 88.7 per cent wage-holders and 11.3 per
cent self-employed. Immigrants represent 8.2 per cent of the
German population (6.7 million), mainly from Turkey (1.76 million),
followed by Italy, former Yugoslavia, Poland, and Greece.

Employment conditions are significantly different in “old” and “new”
German states. In the ten states belonging to former West Germany, an
average of 7.8 per cent of the civil labour force is registered as
unemployed, whereas in the five states belonging to former East
Germany the average unemployment rate is 15.9%. Part-time work in
Germany exists in higher proportion among female workers than in
male workers. In 2005, nearly a third (30.4%) of women were working
fewer than 21 hours a week, while only 6% of men were doing so. On the
other hand, 43.1% of men were working 40-44 hours a week, compared
to 24.3% of women (sources for the above paragraphs: Statistisches
Bundesamt, 2006a; 2006b; 2006c; 2007; Central Intelligence Agency
[CIA], 2007; Bundesagentur für Arbeit, 2007).

The average income per capita was 1564 Euros/month and was
20% higher in old states than in new states. Interestingly, the Gini
coefficient for property increased from 1993 to 2003 (0.625 to 0.675)
in old states and decreased in the same period in new states (0.718 to
0.671) (Bundesregierung der Bundesrepublik Deutschland, 2005).
Salary disparities between men and women are relatively high in
Germany: when persons in full-time jobs, of equal education, equal age, and in similar companies are compared, men earn 12% more than women (Hinz & Gartner, 2005).

Overall, 1.3 million working persons received additional social benefits because their salaries fell below the cut-off level for social welfare. This number includes nearly 500,000 with full-time jobs. It is estimated that 1.9 million are working in underpaid jobs and do not ask for additional social benefits because they feel ashamed or do not know how to apply. With them live about one million children (Becker, 2006).

The percentage of employees organised in trade unions decreased from 1991 to 2001 from 47.1 per cent to 36.1 per cent for men and from 31.8 per cent to 19.8 per cent for women (Gesellschaft Sozialwissenschaftlicher Strukturinrichtungen, 2007). The percentage of labour contracts in obligatory collective tariff agreements is steadily decreasing (from 69% to 57% in old states, and from 56% to 41% in new states). Other contracts are either "aligned" with collective labour agreements or the result of free negotiation (Institut für Arbeitsmarkt und Berufsforschung, 2007).

Unemployment insurance is mandatory for all employees in Germany. Contributions are 6.5 per cent of the gross monthly salary, split between employee and employer. Any unemployed person who has paid into the unemployment insurance for at least twelve months is entitled to a monthly allowance (known as "unemployment benefit I," or ALG1) which equals 60-67 per cent of the last net income, and is generally discontinued after twelve months (Bundesministerium für Arbeit und Soziales, 2006). After that period, persons still without a source of subsistence can apply for the social benefit known as "unemployment benefit II" (ALG2-as mentioned above, also paid to low-wage workers). ALG2 is financed by taxes, and pay-out is assessed according to a minimal basket of commodities (347 Euros for basic needs plus contributions for rent and insurance). Since 2005, recipients of social benefits can be required to accept state 1-Euro jobs [state work-creation schemes] (Bundesministerium der Justiz, 2007).

Statutory health insurance in Germany covered nearly 88 per cent of the population in 2003. It is based on the "principle of solidarity" where the claim for benefits is based on need and not on the individual deposit. Membership is compulsory for all low- to middle-income employees, which provides the insurance with a stable financing scheme. Only persons exceeding a salary threshold of 3,975 Euros/month are free to choose a private insurance.

Institutions for statutory accident insurance and prevention assume liability for the consequences of occupational accidents,
commuting accidents and occupational diseases. These non-profit organizations are solely funded by employer contributions, and contributions are calculated by a formula called the "adjustable contribution procedure." Within the last 30 years, contributions have decreased from 1.51% to 1.42% (Hauptverband der gewerblichen Berufsgenossenschaften, 2006).

The majority of the German population is protected from absolute or extreme poverty, defined as not being able to meet basic needs like water, food, clothing, shelter, and basic health care. The only exceptions are homeless and drug-addicted persons who cannot be reached by social security systems. Charity organizations estimate 860,000 homeless persons (1 in 100) (See Wuppertal). Relative poverty is expressed in the term of "risk for poverty," currently considered the part of the population with less than 60% of the average income (938 Euros per month). The number of people living below this threshold has increased steadily since 1983. Within the five years between 1998 and 2003, it rose from 12.1 per cent to 13.5 per cent (11% to 12.2% in old states, 17.1% to 19.3% in new states). Nevertheless, Germany, together with Denmark and Sweden, are the countries with the lowest risk for poverty in Europe (Bundesregierung der Bundesrepublik Deutschland, 2005).

The correlation between unemployment and increased mortality has been demonstrated repeatedly in scientific literature in recent years. A model shows that in a control group of continuously employed persons in Germany, 277 of 100,000 would be expected to die in the next three years. This number increases to 463 for persons with 1-2 years unemployment, and 965 for persons with more than 2 years unemployment (adjustments made for sex and age). Thus, mortality is 3.5 times higher for those unemployed for more than two years than for continuously employed people (Robert Koch-Institut, 2003).

Avoidable deaths due to heart disease, hypertension, and cerebrovascular illness differ enormously by social status and immigration status. When women living in low-indexed areas are compared to women living in high-indexed areas, the former's risk of death from one of these afflictions is doubled.

Investigations have shown that the gap between rich and poor is widening in Germany. The proportion of people living under risk of poverty has increased. Job loss is the greatest predictor of risk of poverty. Only a few branches of the German economy fall under regulations for minimum wage. However, the debate about minimum wage has intensified in recent years, given the reports of the working poor (see above). German unions are lobbying for a minimum hourly wage of 7.50 Euros (See Deutscher Gewerkschaftsbund).
Spain - Pere Jódar

Spain is an example of a core country included in the corporatist conservative labour institutions category in the typology of countries used by this book. After almost four decades of fascist dictatorship (1939-1977), a number of differential political, economic, and social trends took place in Spain, quite different from those that took place in other wealthy EU countries. A political transition started in 1978 which enacted a monarchy, a democratic constitution, and a political process of decentralisation which created 17 autonomous regions and two Northern African autonomous cities, with their own political institutions and varying degrees of legislative and executive powers. In the 80s, the country faced a sharp economic crisis, with an intense change in the economy, and the transition from an industrial to a service economy. Since then, the labour market has been characterised by low rates of activity and occupation, high levels of unemployment, a progressive worsening in the quality of employment, and the steady growth of female labour force participation (Statistical Office of the European Communities [EUROSTAT], 2008: Employment). With regard to social policies, there has been a process to build a welfare state at the same time as other EU countries have gone through a process of questioning some aspects of it. Similarly, industrial relations have been characterised by labour laws that emerged much later than in other developed EU countries. An example is the right of free union’s association, collective bargaining, and the right to strike that did not appear in the Spanish legislation until the 1978 Constitution.

The Spanish population grew strongly in the second half of the 20th century mainly due to the spectacular demographic boom of the 60’s and early 70’s, together with a large-scale internal migration from the rural interior to the industrial cities (Country Studies, 1988). The birth rate plunged by the 80’s and Spain’s population became stalled, showing one of the lowest fertility rates in the world, a figure linked to the lack of family planning policies. More recently, population has experienced a steady increase (from 40.3 million in 2000 to 45.2 in 2007) due to large-scale immigration. In 2007, about 4.5 million inhabitants were foreign residents representing 11.3 per cent of the population (1.7 million from the EU-27, 1.4 million from South America and 800,000 people from Africa). This growing trend is far from being closed; in 2008 the immigrant population increased by 700,000 people (Instituto Nacional de Estadística, 2008).

According to the EU standards, in 2006 the poverty rate was at 20 per cent, that is approximately between 8 and 9 million people living in poverty, and concentrated up to 48 per cent among older people.
living alone [EUROSTAT, 2008: Social inclusion]. Minimum monthly income has grown steadily from 409€ in 1998 to 541€ in 2006, but this is still much lower than in most countries of the EU-15, where it is higher than 1,000€. Inequality of income distribution (i.e., the ratio of total income of the 20% highest income population compared to the lowest 20%) is 5.3 in Spain (2006) as compared to 4.7 in the UE-15, or 4.8 in the UE-25. Moreover, regional inequalities are pronounced with the per capita income of the most affluent communities being almost twice that of the most disadvantaged. Similar inequalities are evident regarding unemployment, education, and other socioeconomic and labour market indicators.

The employment rate is 65.6 per cent (2007), similar to the EU average. Female labour market participation has significantly increased, with the highest growth rate in the EU in recent years (from 34.6% in 1997 to 54.7% in 2007), however clear job segregation by gender still exists, and equality at work is far from being achieved. Percentages of salaried workers were 82.1 per cent in 2006, while part-time workers are 11.2 per cent, quite below the EU’s average. However, this figure rises up to 22.8 per cent for women [EUROSTAT, 2008: Population and social conditions].

Since the mid 1980s, unemployment has been consistently above that of the EU-15, being over 15 per cent in the 90s, and one of the period’s most serious social problems. While initiatives to create employment substantially reduced unemployment rates since 2003, in 2006 the country was still severely hit by unemployment (8.6%), especially women (13.6%), and youth aged less than 25 years (22.9%); following a global economic crisis, by the beginning of 2008 unemployment was again growing at an alarming rate. Precarious work arrangements (i.e., fixed-term contracts and temporary work associated with low job security, lack of benefits and lower pay) are by far the highest among European countries (32%), more than twice that of the EU average (15%) [EUROSTAT, 2008: Population and social conditions]. Moreover, unemployment and non-standard work arrangements are unevenly distributed by gender, age, and education, the percentages being higher among women, youth, and low skilled workers.

Similarly to other Southern European countries, trade unions in Spain are weaker than in other areas of the EU. In 2004, union density was still about 16%, though the amount of people affiliated to unions changed from 1 million in 1985 to over 2 million in 2003 [European Foundation for the Improvement of Living and Working Conditions [Eurofound], 2007], with the highest figures in the industrial sector, and the lowest in the construction sector. Although only a relatively small
number of workers were union members, in 2004 collective bargaining agreements covered about 60 per cent of salaried workers [Eurofound, 2005]. Traditionally, the main concerns of Spanish trade unions have been wages, earnings and employment issues. And, more recently, working conditions, welfare policies and some occupational health issues have been on their agenda. However, with few exceptions, employment-related health inequalities have not been specifically addressed by the Spanish trade unions.

During the 80s and early 90s, a number of important macro-level policies were implemented including the reform of the social security system, an increase of public funds for social protection, the implementation of more progressive taxation policies, and the implementation of a National Health System, with almost universal coverage and free access. Today, however, the degree of social protection is still substantially lower than the EU average (20.8% of the GDP vs. 27.8% in the UE-15 and 27.4% in the UE-25 in 2005). While the share of social protection devoted to unemployment, old age, and health care and disability is relatively high, percentages are very low with regard to family/children, housing and social exclusion. Public funds for social protection, the pensions paid by the Social Security System and the benefits for illness and unemployment are the main lines of social protection accounting for about 75 per cent of the total amount of social expenditures. Social security spending is half of the EU average, and the social protection system’s coverage (16–64 years) has moved from 53.9 per cent in 1994 to 63.8 per cent in 2005.

The Prevention of Occupational Hazards Act (1995) established a modern and general framework on occupational health that regulated the general obligations of employers, employees and the manufacturers and suppliers of machinery and equipment with regard to the prevention of risk, as well as the consultation and participation rights of workers and employee representatives. This law and its corresponding regulations led to the theoretically almost universal legal protection of health at work and the integration of prevention into the management structures of companies. The implementation of this legislation, however, took place in a situation where companies and the Spanish government sought more flexible forms of labour market organization. Thus, a deep-reaching reform of labour legislation took place in 1994, followed by other successive reforms seeking the amendment of many of the precepts of the major labour laws (e.g., the Workers’ Statute, the Labour Procedure Act or the Labour Offenses and Sanctions Act), including the adoption of a number of new laws such as an act on temporary employment agencies, and the revision of regulations on
temporary/fixed term contracts, training contracts and redundancy procedures, which established the foundations for a revised regulation of the collective bargaining system. Some of the major aspects of this reform included a lifting of the public monopoly on job placement, allowing the operation of private employment agencies and temporary employment agencies, and the reduction of the costs of individual dismissal, through a restriction of the cases in which back pay awards after dismissal appeal hearings are to be paid by employers. Under these conditions, often previously illegal situations hurting workers were made legal, and there was a progressive segmentation of the labour force, with a core of permanent workers and a group of precarious workers with greater employment insecurity (Benach et al., 2007).

Work-related health problems in Spain imply an enormous health and economic cost to workers and their families, companies and society as a whole (Benavides, 2007). The high level of occupational injuries, for example, reflects important deficiencies in the prevention systems that a developed country should not have. Norms and regulations for the prevention of occupational hazards have been only partially applied, occupational health interventions have not been suitable and budgets were limited. Moreover, many interventions targeting traditional occupational hazards were designed to be implemented for permanent job holders working for medium-to-large-size firms, and are unlikely to meet the demands of the new flexible work environment.

Although research on work-related inequalities in health is still limited, a notable increase in the number of studies has been achieved since the 90s. The Spanish Black Report (1996) extensively reviewed class, gender and geographical inequalities in Spain, documenting large and consistent health inequalities (Navarro & Benach, 1996), and the first study on occupational health inequalities was published as part of the first Catalanian Black Report (Artazcoz, Cortès, Benach, & Benavides, 2003). Research shows that there are considerable differences with regard to exposures to damaging working conditions, occupational hazards and health outcomes between social classes, genders, and types of contracts. For example, physical risks, musculoskeletal problems, and psychosocial factors such as job control show much worse indicators among manual workers and women (Benach et al., 2007). Prevalence rates for all occupational risk factors are higher among temporary workers. For example, having control over job breaks rates are 26.5 per cent and 39 per cent for permanent and temporary workers, respectively. Working class women have less access to employment, are more often unemployed, and they have high family...
demands that require taking care of children and elderly dependents in a context of few public services. A study in Catalonia, for example, has shown that poor self-perceived health was 3 times more common among working class female cleaners than among non-manual employees (Artazcoz et al., 2003). The type of contract is a key factor associated with a higher incidence of occupational injuries, temporary workers showing between 2 and 3 times higher risk than permanent workers (Artazcoz et al., 2003). Although there are not systematic registries to verify the accuracy of occupational disease, available data on work-related diseases by occupational social class and severity of illness show much higher incidences among manual than non-manual workers for both minor and serious illnesses (Benavides, 2007).

Currently, policies or interventions to reduce employment and work-related health inequalities have not been formulated as one of the main goals of the national and regional health strategies, and the health of the working population has yet to become a top priority of the Spanish policy agenda. Labour-based political organizations, social movements, and national and regional governments have the responsibility of defining and being accountable for employment and occupational health policies that enforce legislation and firm compliance, leading to occupational health for all.

Canada - Toba Bryant

Canada is an example of a core country included in the liberal labour institutions category. Since the 1980s, the Canadian labour market has undergone significant restructuring. This restructuring has had implications for many Canadians with respect to the nature of their employment, and income and job security.

During the early 1980s and early 1990s, Canada endured deep recessions that led to high levels of unemployment (Jackson, 2005). Although the national unemployment rate fell below 7% for the first time since the 1980s, economic growth has produced more jobs with little security and increased income inequality in Canada. Some argue that the unemployment rate is closer to 12% (Swartz, 2003).

Canada has one of the highest participation rates among advanced industrialized economies. Approximately eight in ten (78%) people aged 15 to 64 years participate in the paid labour force (Jackson, 2005). In 2004, 58 per cent of all women aged 15 years and older were in the paid labour force. This represents an increase of 42 per cent since 1976 (Statistics Canada, 2006). The proportion of men who were employed fell from 73 per cent to 68 per cent. Women comprised 47 per cent of the paid workforce in 2004. By 2004, 65 per
Women are more likely than men to work part-time (Jackson, 2005; Statistics Canada, 2006) and in 2004 roughly seven in 10 of all part-time employees were women. There is continued occupational and industrial segregation between men and women (Jackson, 2005; Statistics Canada, 2006) as they continue to be concentrated in public and social services as opposed to the business sector. In 2004, 67% of all employed women were in teaching, nursing and related health occupations, clerical or other administrative occupations, and sales and services.

Moreover, the types of jobs women have tend to be more precarious and insecure compared to those of men (Jackson, 2005). Precarious jobs, also called ‘non-standard jobs’ in Canada, are insecure jobs that have a high risk of unemployment and/or low pay and offer limited access to benefits such as pensions and drugs or dental plans. They also usually entail limited control of hours and working conditions. While some women choose part-time employment to accommodate educational pursuits or child care responsibilities, approximately one in three women who work part-time would work full-time if they could (Jackson, 2004). In 2004, 26 per cent of female part-time employees reported that they worked part-time because they were unable to find full-time employment (Statistics Canada, 2006).

The 2001 Census shows that 13.4% of the Canadian population belongs to a visible minority group (Galabuzi, 2005; Jackson, 2005). Between 1996 and 2001, the visible minority male population grew by 28.7 per cent and the population of visible minority women rose by 32.3 per cent. The research literature identifies these populations as ‘racialised’ in the literature to recognise race as a social and cultural construct. In spite of their significant contribution to the Canadian economy, reward for the labour of racialised minorities fell behind compared to the rest of the Canadian population. Indeed, income data shows a 24 per cent gap in average before-tax income and a 20 per cent gap in after-tax income.

Sectoral occupation, unemployment and income data reveal a racialised labour market as a feature of the Canadian economy (Galabuzi, 2005). Racialised workers, particularly minority women, are disproportionately represented in low-end service sector jobs and precarious and unregulated temporary employment. Moreover, this gap persists among those with low and high educational attainment, including among those with less than high school education and among those with post-secondary education.

Further, the demands for flexibility in the labour market in a predominantly urban globalised economy have contributed to the
over-representation of racialised groups in precarious occupations; that is, contract, temporary, part-time and shift work with little or no job security, poor and frequently unsafe working conditions, intensive labour, long work hours, low wages, and no benefits. Many racialised groups work in textile and garment-making industries, light manufacturing industries, and in the service sector.

In 2003, 32.4% of all Canadian workers were covered by a collective agreement. According to the OECD, union density in Canada is 28.1%, one of the lowest among the 16 OECD countries (OECD, 2006). Unionisation has helped reduce the wage gap between men and women (Jackson, 2005). The union advantage is greater for women than for men. The pay gap between union men and union women is a little over $2 per hour, compared to more than $4 for non-union men and non-union women. Racialised workers who were covered by a collective agreement earned an average annual income of $33,525 in 1999, compared to $7,724 for racialised workers who were not covered by collective agreements.

In recent years, Canadian governments have opted for deregulating many aspects of work. Canadian governments object to labour market regulation to protect workers in precarious employment on the grounds that such policies will harm those they are intended to help. Jackson attributes this belief to an orthodoxy that has emerged to defend neo-liberal policies that are believed to perpetuate precarious and insecure employment (Jackson, 2005).

In 1996, the Liberal federal government tightened eligibility requirements, which makes it more difficult for part-time workers - many of whom are women - to collect their EI contributions (Black & Shillington, 2005).

A recent study by the Work Network of the Canadian Policy Research Networks found that education and training opportunities
are more readily available to already highly educated Canadian adults than to adults with low initial education and skills (Myers & De Broucker, 2006). The study found that a significant segment of the Canadian adult population is unable to participate in the new knowledge-based society with its orientation towards projects and short-term employment. For example, the authors note that 5.8 million Canadians aged 25 years and over lack a high school education or higher credentials; a high drop-out rate from high school - 200,000 young people, particularly young men - fail to finish high school in several provinces; and 9 million Canadians between 16 and 65 years of age do not have literacy skills deemed necessary to live and work in the knowledge-based economy.

Among countries in the OECD, Canada has the highest percentage of low-pay jobs. In the mid-1990s, approximately one in four full-time workers in Canada, or 23.7 per cent, was low paid. Low pay is defined as earning less than two-thirds of the median national full-time wage.

These developments have material implications for the lowest income groups in the Canadian population in terms of their health status and well-being. Research has established this important relationship (Auger, Raynault, Lessard, & Choinière, 2004; Pantazis, Gordon, & Levitas, 2006; Wilkins, Berthelot, & Ng, 2002)

**United States - Katherine Chung-Bridges and Lora E. Fleming**

The United States belongs to the cluster of core liberal countries with a more unequal social structure. Traditionally, market forces, rather than state regulation, determine the allocation of labour resources. Although historically income distribution has varied somewhat, in recent decades the trend has been toward higher income inequality. By one measure of income inequality, the Gini Index, its level was rising in the United States from the 1960s to the 1990s, where it then levelled off (Moss, 2000). From 1995-2005, the Gini Index then further increased by 4 per cent, indicating another rise in income inequality (DeNavas-Walt, Proctor, & Lee, 2006). Furthermore, in the United States the top 1 per cent of the population accounts for 40 per cent of the nation’s wealth (Moss, 2000). The reasons for this include the role of unions, the minimum wage, and how race and gender affect income.

In a continuing downward trend over the past three decades, only 13 per cent of workers were unionised in 2005 (US Department of Labor, 2006a). African Americans, men, and public sector workers were more likely to be union members (US Department of Labor, 2006a). In 2005, union workers’
Median weekly income was $801, compared to $622 for non-union workers (US Department of Labor, 2006a). Until the Minimal Wage Act of 2007, the federal minimum wage had not been increased since 1996. The tension demonstrates the role of the prioritisation of the market over state regulation. Anti-poverty organisations support a higher minimum wage, while small businesses and retailers wish to keep it low (Almanac of Policy Issues, 2002). Many organisations support the introduction of a living wage, which more adequately and realistically matches the cost of living of families (Pew Partnership for Civic Change, 2006).

Yet even above the margin of the minimum wage, income is notably unequal; much of the division is along gender and racial lines. In 2005, about 25 per cent of female workers were part-time, compared to 11 per cent of male workers (US Department of Labor, 2006b). These female part-time workers are found among all different age groups, compared to male part-time workers who are more commonly younger workers. In the third quarter of 2006, full-time black male workers earned 80 per cent of what white men earned, while black female workers earned 84 per cent of what white women earned (US Department of Labor, 2006c). Hispanic salaries lagged behind those of blacks, whites, and Asians.

In addition to gender and racial inequality in income, the US has divergent levels of employment based on profession or trade. From 2003 to 2005, there were 3.8 million workers age 20 and older displaced from their jobs. Of these, 49 per cent lost their jobs due to company or work site closings, 29 per cent because their job was abolished, and 22 per cent because of insufficient work (US Department of Labor, 2006d). About 40 per cent of these displaced workers received advance written notice of the displacement (US Department of Labor, 2006d). The largest group of displaced workers in the United States has been in the manufacturing field (28%). Another diverse group of non-traditional workers consists of contingent and alternate arrangement workers. This group includes workers who do not expect their job to last, or who report that their work is temporary. However, this group is diverse in that it includes independent contractors (7.4% of those employed in 2005; largely white males, over age 35, with only 10% preferring a more traditional work status), as well as on-call workers and temporary help agency workers (0.9% of those employed in 2005; largely female, young, black, and hispanic, with 56% preferring a more traditional work status) (US Department of Labor, 2005).

Working conditions such as high demand jobs with little control or high effort jobs with low reward may be associated with poor health outcomes, particularly among black men. One factor which may provide a link between occupational segregation and health is
disparity in non-standard work shifts. Workers in highly segregated jobs with higher proportions of non-hispanic African Americans were found in one study to be more likely to work nonstandard shifts such as evenings, nights, and highly rotating shifts (Presser, 2003). Working non-standard shifts has been shown to negatively impact upon: social relationships such as family functions and marital stability; physiological outcomes such as circadian rhythms, body temperature, sleep, and hormonal levels; and health outcomes such as cardiovascular disease, gastrointestinal disease, breast cancer, and birth outcomes (Presser, 2003).

The implications of these three types of inequality (minimum wage, gender and race, and employment levels) are manifest in health care coverage. In the US, until Barack Obama’s 2010 health care reform, the critical and unique point is that healthcare has generally been contingent upon employment, being offered by the employer almost exclusively. Minimum wage jobs generally do not offer associated health care, nor do they offer a high enough wage to purchase private coverage. The racial and gender disparities in income imply an unequal means of covering the private costs associated with US health care, which are typically substantial. Finally, those whose profession is characterised by periods of temporary unemployment often do not meet minimum criteria for health insurance or employment-based pension plans (US Department of Labor, 2005).

Overall, 15 per cent of the population has no health insurance coverage [some 45 million Americans] including a growing number of workers and their families (Arheart et al., 2006), particularly in blue collar occupations. Although it seems likely that the 2010 health care reform bill will improve the situation somewhat, millions of people are likely to continue having no coverage.

South Korea - Il Ho Kim, Haejoo Chung and Carles Muntaner

South Korea belongs to the cluster of semi-periphery countries in the residual labour institutions category. South Korea is situated on the southern end of the Korean peninsula and surrounded mostly by ocean waters, with 2,413 kilometres of coast line. The total population of South Korea was estimated at 48.8 million in July of 2006. South Korea’s annual population growth rate decreased from 3 per cent to 0.44 per cent between 1960 and 2005, and is expected to further decline to 0.01 per cent by 2020. In contrast, between 1945 and 2005, the urban population has recorded an unprecedented growth, from 14.5% to 81.5% of the total population. Life expectancy at birth is estimated at 75.1 years for men and 81.9 years for women. (Figures
above supplied by the Korea National Statistical Office (KNSO)).

South Korea has achieved incredible economic growth in a short period. From 1963 to 2005, South Korea’s economy has seen a remarkable growth in per capita GNP from only $100 to $16,291 USD (WB, 2007). Except for the temporary economic crisis during 1997-1998, South Korea’s economic achievements have been remarkable; it is a major global shipbuilding country, a leader in information technology, and the world’s fifth largest car maker (Amsden, 1989; Wade & Kim, 1978). By 2006, South Korea was the third largest economy in Asia and the twelfth largest economy in the world, according to the Organisation for Economic Cooperation and Development (OECD).

The dynamic economic growth in South Korea was accompanied by several trends common to socioeconomic changes of this nature. Particularly, female participation in the labour force changed significantly from 1963 to 2006 (37% to 50%). The unemployment rate constantly decreased from 8.1 per cent in 1963 to 2.4 per cent in 2006 (2.8% for men, 2.9% for women in 2006), while the unemployment rate for young adults (age 15-29) was noticeably high at 7.8 per cent in 2006 (figures supplied by the KNSo).

In line with the challenges of globalisation and global competition, the 1997 financial crisis led to a full-scale restructuring of the South Korean labour market (Lee, 2001), marked by massive layoffs and flexible contracts of precarious employment across the nation (Grubb, Lee, & Tergeist, 2007). The number of unemployed, self-employed, and precarious workers dramatically increased. The KNSo reports that the unemployment rate reached 7.8 per cent in 1998, compared to 2.6 per cent in 1997. The proportion of precarious workers to total employed increased from 41.9 per cent in 1995 to 52.1 per cent in 2000 (40.8% men, 68.9% women in 2000) (Chang, 2001). Women in particular are concentrated in precarious or informal employment due to gender segregation and discrimination (precarious workers: 37.8% male, 60.2% female; unpaid family workers: 1.2% male, 13.5% female in 2005). Since the early 1990s, large numbers of foreign workers from relatively poor Asian countries have immigrated to work in so-called 3D (dirty, difficult, and dangerous) manual industries. The number of foreign workers was estimated by the Ministry of Labour to be approximately 425,000, including 187,000 illegal employees in December, 2006.

From 1987 to 1989, due to unequal distribution of wealth and unsafe labour environments, severe labour disputes ignited. According to the Korean Statistical Information System, nearly 1.3
million workers participated in over 3,700 labour strikes in 1987 and, as a result, national pension (1988), worker’s compensation insurance (1989), and unemployment insurance (1993) were reformed or reinforced. Basic laws regarding employment policies (1993) and employment insurance systems (1995) were effected to achieve employment stabilisation, job competency, and unemployment benefits (Lee, 2000). Against the backdrop of the 1997 economic crisis, the Korean Tripartite Commission (government, labour unions, and management) was launched in 1998, with the mission of striking a balance among labour market flexibility, labour rights, and social welfare systems. In addition, the Korea Occupational Health and Safety Act (2003) was enacted to protect workers from hazardous materials and unsafe work environments.

Several amendments to the Labour Standards Act have been ratified since it was enacted in 1953. The regulation prescribes the minimum standards for wages, working times, and other practices meant to create stable labour relations. For instance, employees are entitled to receive 60 days of pre-notification and 30 days per year of severance pay if they are fired. In 2005, the government expanded and improved employment insurance benefits to daily workers. However, precarious workers participate in the program at a significantly lower level than standard workers at 33.1 per cent vs. 83.9 per cent. The unionisation rate is low and has steadily declined from 19.8 per cent to 10.3 per cent from 1989 to 2005 [21.3% standard workers, 3.0% precarious workers] (figures supplied by the KNSO). Since Korea’s economic crisis erupted in 1997, a large gap has developed between standard and precarious workers in terms of basic rights and social welfare coverage. A Korean study found that over 80 per cent of Korean precarious workers [compared to 5.3% of standard workers] reported feeling job insecurity. In the Korean shipbuilding workforce, precarious workers suffer job strain more than standard workers by a factor of 3.7 to 1 (33.5% for precarious workers vs. 9.1% for standard workers) (Koh et al., 2004). Precarious workers more often live on minimum incomes than do standard workers: 697,000 (9.7%) in the year 2007, compared to 25,000 (0.4%) of standard workers, according to the KNSO. More recent Korean studies revealed that precarious employment is significantly associated with an increased risk of poor self-rated health, chronic conditions, mental illness and poor health behaviours (more smoking and alcohol consumption, less exercise, and fewer physical examination) (Kim 2006; Kim, Muntaner, Khang, Paek, & Cho, 2006; Son et al., 2003). Musculoskeletal disorders in particular have
increased and are now the leading cause of occupational health problems, making up 44 per cent of all occupational health problems in 2004 according to the Ministry of Labour. Another issue in the Korean labour market is that many foreign workers are injured by hazardous substances and heavy demands at work. The Ministry of Labour reported that, in 2006, 3,406 foreign workers (about 31.2%) were involved in industrial accidents, occurring mostly in manufacturing industries. Undocumented workers suffered more from salary delays, occupational injuries, and violence without any protection from labour laws because of their illegal status.

The effort to ensure more stability and protection for precarious workers came from collective bargaining and reform legislation. The Federation of Korean Trade Unions (FKTU) and Korean Confederation of Trade Unions (KCTU) were officially launched in 1961 and 1999, respectively. In 2004, the Employment Permit Act was implemented to protect migrant workers, leading to the creation of the Migrant Trade Union. These organisations are working to protect precarious workers from discrimination, unionise working women and foreign migrant workers to ensure their labour rights, and to obtain equal treatment with full-time workers in salaries, working times, holidays, and maternity rights (Korean Confederation of Trade Unions, 2007).

**Russia - Marcos Rodríguez Fazzone, Marcel Gonnet Wainmayer and Dérgica Sanhueza Cid**

Russia is a semi-peripheral country in the global economy that pertains to the residual labour institutions group used in this book’s typology. In 2006, the country’s total population was of 143.3 million, with more women (53.5%) than men (46.5%). Most of the population (73%) is concentrated in urban zones. Russia displays a negative population growth rate of -0.3 per cent. The life expectancy is significantly different for men and women: 59.9 years for men and 73.3 years for women (ILO, 2008).

The economically active population (EAP) averaged 51 per cent, or 74.6 million, for the 2003-2005 period. In 2006, 69.2 million of those economically active were employed and 5.4 million (7.2%) unemployed. The service sector made up 62.7 per cent; industry, 32.6 per cent; and agriculture 4.7 per cent of the GDP (Information & Publishing Center "Statistics of Russia", 2005). The informal sector represented 12.9 per cent of the total work force in 2001. Among informal workers, 53 per cent were men and 47 per cent women. In Russia, the informal
labour Markets and welfare states: a country perspective

The economy employs some 10 million people, and generates 22 per cent of the GDP, the source of grave problems due to illegal labour practices such as "forced debt labour".

Both the social security plan and the labour market in the Russian Federation were strongly affected by Perestroika and the transition to a market economy. Although since 1991 individual liberties have increased and great sectors of the economy have been stimulated, with the advance of privatisation and the decrease of state controls, the coverage of the social protection system has greatly declined. The universal protection of social policies began moving towards policies with regional and focused approaches. Simultaneously, more of the country’s goods and services, which were formerly public, became privatised. It is important to highlight that the social protection system of the Soviet economy was based on the requirement that all adult members of the family participate in the labour market (Foley, 1997). During the financial crisis of 1998, pension payments and other social benefits for many citizens were suspended, and programs supporting education and medical aid were cut, which increased inequality and had a negative impact on public health (Tchetvernina, Moscovskaya, Soboleva, & Stepanchikova, 2001). An ILO study of child labour in Moscow in 2001 estimated that there were 30,000 to 50,000 children working in the streets, some of them in prostitution and criminal activities. (ILO, 2002).

Migration is an important topic in Russian working life. Women emigrate out of Russia through the complex international mechanisms created in recent decades for sexual and labour exploitation. On the other hand, this workforce flow has created a deficit of semi-qualified workers, which threatens economic growth. Accordingly, policies have been put in place to encourage the immigration of workers from former neighbouring Soviet republics, and to regulate the estimated 5 to 15 million illegal immigrant workers present in Russia (ILO, 2007).

The new Labour Code, in effect since 2002, has furthered Russia’s transition from its Soviet days with its labour protection laws into a more flexible hiring system meant to create greater market mobility. Besides allowing part-time jobs and jobs for short-term periods, it has allowed employers greater freedom to dismiss workers. In addition, the Work Code allows employers to temporarily revoke benefits from workers, for reasons such as "technological or organisation changes" or "production needs". The Soviet regime regarding maternity and the raising of children has resulted in an increase of female poverty, sexual exploitation, and greatly increased migration (Serebriakova, 2007).

The most important labour organisation is the Federation of the
Independent Syndicates of Russia (FNPR), with about 28 million affiliates. One of its unusual characteristics is that, in a holdover from the Soviet tradition, the Federation’s membership includes a hierarchy of personnel from state-run companies. Because of this, many of the labour complaints translate into inter-union conflicts that are hard to resolve. There are also self-appointed “free” syndicates, which do not follow the guidelines of the FNPR. A group of Leninist union workers created the Work Protection (ZT) union in 1990, which has gained some influence in the country. Although the right to strike exists, it is restricted in some strategic areas such as energy and basic services. Several industries even establish mandatory agreement mechanisms, which in actuality render workers’ most forceful measures illegal (Ohtsu, 2001).

The disintegration of the Soviet Union brought down an entire system for labour health and safety. The responsibility for work inspection passed from labour unions to the government. Companies and factories no longer fill the role of social protector. There is no longer any protection against work-related diseases and accidents. In the last couple of years the state has tried to focus on public prevention policies to improve the health of workers, and there has been a considerable change in Russian legislation related to health and safety. In particular, sanitary standards have tightened, as have standards for professional safety regimes, industrial safety, and workforce protection. Work protection field specialists now have more authority to investigate accidents and monitor safety measures. The Russian Federation also applies the norms and directives established by the Food and Agriculture Organization (FAO), ILO and the International Organization for Migration (IOM) now.

The Russian Federation is adopting measures against forced labour, incorporating an article in its penal code relative to the trade of human beings and slave labour. In the international sphere, it has become an active member of the United Nations Convention Against Transnational Organized Crime, which seeks to convince national governments to adopt laws and programs that combat the trade of human beings and slavery.

Argentina - Marcelo Amable

Argentina belongs to the emerging labour institutions cluster within the category of semi-periphery countries. Argentina is a federal republic with 24 provincial governments and 2,247 local governments, whose authorities are democratically elected. The country has a population of approximately 40 million inhabitants, the great majority of whom (89%) live in urban areas, particularly in the Buenos Aires area (48%). One tenth of the population is
aged over 65 years, and 59% are women (Instituto Nacional de Estadística y Censos [INDEC], 2001). Around 600,000 people belong to one of the more than 30 different ethnic groups (INDEC, 2005), while 4.2 per cent of the inhabitants are foreigners: Paraguayan (21.2%), Bolivian (15.2%), Italian (14.1%), Chilean (13.8%) and Spanish (9%) (INDEC, 2001).

During the decade of the 90s, Argentina suffered under the neoliberal policies promoted by the IMF and World Bank, which after two years of continuous economic recession finally led to an enormous social crisis in 2001. For example, in 2002 unemployment (21.5%) and poverty (54.3%) were the highest in the country's history. A period of sustained economic growth began in 2003, which has slowly improved the most extreme social situations, although a regressive taxation model still persists, lacking appropriate redistributive social policies to address the huge social inequalities. By 2007, 27 per cent of the population was still living in poverty and almost 9 per cent did not have sufficient income to cover the cost of a basic weekly grocery basket (INDEC, 2006a). The distribution of poverty is highly unequal across the country: 46 per cent in the northern provinces, 25 per cent in the peripheral urban areas of Buenos Aires, and 33 per cent in the rest.

The rate of active employment among people aged over 14 years was 46 per cent in 2006, with considerable differences between sexes (45% in women, 70% in men) (INDEC, 2006a). The distribution of employments places 1.2 per cent in primary production, 14 per cent in manufacturing industries, 69.7 per cent in the services sector and 8.8 per cent in the construction industry (INDEC, 2006a). Important manufacturing industries include automobiles and transport equipment (INDEC, 2006b), while commerce (20%) and financial services (10%) stand out in the services sector (INDEC, 2006b). Finally, the construction industry has grown since 2003 and by the end of 2007 rates of employment had doubled those of the 90s (INDEC, 2008).

In Argentina, 325,000 people born in neighbouring countries aged over 14 years work in the services sector (44.8%), in domestic services (21%), construction (16.8%), industry (14.3%), and agriculture (2.2%) (INDEC, 2003). Insertion rates of Paraguayans are highest in construction (30%), while Bolivians are predominantly employed in the services (47%) and industrial sectors (20%, particularly the textile industry), and Chileans are found mainly in services (46%) (INDEC, 2003), although there are no reliable data on their unemployment rates, access to benefits, accident rates, etc. Similarly, no reliable information exists about slavery, although various organisations have denounced these practices among
groups of foreign workers. In 2006, for example, a fire in a sewing workshop led to the death of a woman (aged 25) and 5 children (aged 3-15), all illegal Bolivian immigrants [Comunidad Boliviana, 2008].

At the end of 2006, the unemployment rate was 8.7 per cent, with considerable variations between regions (from 9% in the most disadvantaged areas to 4.1% in Cuyo), between sexes (9.9% among women, 5.8% among men), and between age groups (unemployment among young people is 3.6 times higher than among people aged over 25 years) (INDEC, 2006a). Moreover, young people situated in the poorest quintile of the population have 3.5 times the probability of being unemployed, compared to the most advantaged quintile [ILO, 2007].

The proportion of wage-earners is 76.6 per cent, with considerable job precariousness: 39 per cent of workers had no social burden, and 33 per cent have no social security coverage. Moreover, 17 per cent of wage-earners report having fixed-term contracts, while 8.8 per cent do not know when their job contract will expire, and consequently 26 per cent of wage-earners may be considered to have unstable jobs. In regard to duration, 15.2 per cent of contracts are of less than 1 month, 19.8 per cent less than 3 months, and 12.6 per cent are for less than 6 months (INDEC, 2006a). Seventy-five per cent of temporary workers have no social security. Another indicator of the low quality of employment is that 11 per cent of wage-earners have more than one job, and one third of employees work over 45 hours a week (INDEC, 2006a). It is estimated that 11 per cent of wage-earners live in poverty [Beccaria, Groisman, & Monsalvo, 2006]. In 2003, 60 per cent of people earning the minimum wage belonged to a poor household (by 2005 this figure had fallen to 17 per cent) and 44 per cent of workers earning under the minimum wage were from poor households [Marshall, 2006].

Informal employment constitutes an important problem in the Argentinean labour market, the number of non-registered workers having been estimated at around 5 million (44% of all employed persons, rising to over 50% of employees in the poorest geographical regions). Informal workers receive wages that are between 40 and 45 per cent lower than formally employed workers [Beccaria et al., 2006]; whereas in the formal economy, women receive wages that are 30 per cent lower than their male counterparts, this gender-gap is even wider in the informal economy, where their wages can be as much as 40 per cent lower [Ministerio de Trabajo, Empleo y Seguridad Social, 2006].

In 2001, 6.6 per cent of adolescents (13-17 years of age) either had a job or were seeking one [INDEC, 2001]. Although there are no precise data on child labour, it is estimated that in 2004, 16.6 per
cent of children aged 5 to 17 years worked (INDEC, 2004), a total of 1.5 million children distributed throughout the country. In 2006 the rate of juvenile poverty (among those aged 15-24 years) was 36 per cent and among adolescents (15-19 years) the rate was 42 per cent (ILO, 2007).

During the liberal era, in the 90s, a series of reforms were implemented which tended to increase deregulation of the labour market, with consequent losses of rights. New forms of temporary contracts were introduced, statutes of some occupations were modified, and there was rigorous control of collective wage agreements. Other notable reforms included the implementation, after 1996, of a system of private insurance coverage for occupational risks. Near the end of 2006 19 private companies provided insurance coverage to 6,300,000 workers, representing 39% of all employees, and 98% of formally employed wage-earners. These companies did not engage in any occupational accident prevention activities. Although there are records indicating high rates of occupational accident injuries, it is impossible to analyse these figures in terms of other variables of interest, such as type of contract, or social class.

Monetary compensation and health care received by workers have become established as rights under the occupational risks insurance system. However, it is impossible to determine whether injured workers actually receive the benefits to which they are entitled, the quality of such benefits, or their accessibility, particularly in the case of workers living in remote interior provinces, etc. Nor are there any data regarding the efficacy of the system in regard to correct payment of monetary compensations, evaluations of effectiveness of job reinsertion among affected workers, or management of relapses. Participation in the field of occupational health is scarce or non-existent, and there are no plans to elect worker’s delegates specifically for occupational health.

Even though there is no union law regulating democratic representation in Argentina, wage negotiations have achieved considerable dynamism in recent years and, in 2005 for example, had repercussions in achieving an increase of the basic minimum wage. Furthermore, there is no universal unemployment benefit. In 2004, for example, only 64,000 people received an unemployment subsidy. Social policies aimed at dealing with risks due to poverty provide an allowance (of €30) to people living in poverty. In 2004 almost 2 million people received such allowances, 17 per cent of whom were aged under 25 years, 68 per cent had no occupational qualification, and 12 per cent had no previous job experience
Health policies, moreover, are characterised by enormous fragmentation and deep inequalities. The majority of workers in formal employment (15.5 million people, 39% of the population) hold some form of social security to cover health care for themselves and their families (Ministerio de Salud, 2008), although there is considerable inequality between these forms of insurance since their coverage broadens depending on the wage-earner’s purchasing power. For unemployed people, or those working informally, health care coverage is provided by the public system, financed through general taxation; 37 per cent of wage-earners report holding this form of medical insurance (INDEC, 2006a) (in 2001 this proportion was 50%). The public health care system is decentralised in provincial states, and the organisation, financing capacity, and types and quality of services provided vary enormously. The degree of public health coverage presents large inequalities between different provincial states: from 66 per cent in Formosa to 26 per cent in Buenos Aires City (Ministerio de Salud, 2008).

Given the reports about important social inequalities in regard to employment-related determinants of health, it is not surprising to find large health-related inequalities, which perhaps are even tending to increase. However, to date there are no specific studies on this topic and health information systems are not collecting the social variables necessary for such an analysis. Despite this, the public agenda is slowly beginning to include inequalities in health among its priorities.

Brazil - Elizabeth Costa Dias, Roberval Passos de Oliveira, Jorge Mesquita Huet Machado, Carlos Minayo Gómez, Marco António Gomes Pérez, Maria da Graça Luderitz Hoefel and Vilma Santana

Brazil belongs to the cluster of semi-periphery and emerging labour institutions. Brazil is the fifth largest country in the world, both in area and in population (188 million). The vast majority of this population lives in urban areas (82%). Currently the republic comprises 26 states, plus the Federal District Area, Brasilia, the seat of the government. The state of São Paulo is home to 44 per cent of the formally employed workers in the country (Instituto Brasileiro de Geografia e Estatística [IBGE], 2003). In contrast, the south region is the smallest in area and population.

Brazil has had a persistent problem with unequal income distribution for decades, one of the highest in the world. In 2002, the highest income quintile of the population owned 62.7 per cent of the
total country income, while the lowest quintile held only 3.4 per cent
(Departamento Intersindical de Estatística e Estudos Sócio-
Econômicos, 2004). Estimated income per capita was US$4,700 in 2005.

Brazil’s economically active population (EAP) was estimated to be
96 million in 2005 (IBGE, 2007). Agricultural workers accounted for 20.6
per cent of the active worker population, and of that number, 60 per
cent worked in “traditional farming.” Around one million workers were
in the mining trade, 13.5 per cent in manufacturing, 14.3 per cent in
commerce/retail, 20.2 per cent services, and 18.4 per cent in other
services (IBGE, 2003).

The current Brazilian labour market is characterised by
increasing informality in job contracts and the expansion of many
forms of precarious work, comprising many types of atypical jobs.
This is thought to be a result of the so-called “economic opening
process” and increased international market competition (Ramos &
Ferreira, 2006). Informal workers mostly have little education,
reduced professional skills, or are part of vulnerable groups such as
blacks, the young, the elderly and women (Fagundes, 1994; Barros &
Mendonça, 1996; Wanjman & Perpétuo, 1997; Dias, 2002). In the
lowest 40 per cent of the income distribution, 31.7 per cent hold
informal jobs, while in the highest 10 per cent, only 8.0 per cent of
workers have informal jobs (IBGE, 2003).

Women have been more affected by unemployment than men. In
2005, women accounted for almost 56 per cent of the total unemployed
population, with an unemployment rate of 13.6 per cent, almost twice
the proportion of men. Women also increased their presence in the
EAP (Ramos, 2007). Unemployment benefits cover formal workers who
have held a job within the previous six months, and whose dismissal
was not due to crime or misconduct (justa causa).

One of the most dramatic aspects of the deterioration of work
conditions is the persistent exploitation of child and adolescent labour,
both in rural or urban areas. According to Pesquisa Nacional por
Amostra de Domicílios, 5.5 million children from 5 to 17 years of age
have paid work. Most of these children (43.7%) are involved in the
agricultural sector (IBGE, 2003). Child labour is also common in informal
street markets and waste dumps. In Brazil, children are also engaged in
the worst forms of child labour, such as commercial sexual exploitation,
illegal drug farms and drug trafficking. Black and Indian children are
part of the workforce in farms and mining fields, but in urban areas they
work as “soldiers” and street vendors of drugs (Ministério da Saúde,
2006). To fight against child labour, the federal government launched the
Child Labour Eradication Program (PETI) in 1996 (see Case study 90).
The program assisted over 800,000 children. (Carvalho, 2004). The child
labour rate in Brazil decreased from 13.7 per cent in 1995 to 8.2 per cent in 2002 (Ministério do Trabalho e Emprego, 2005a; 2005b).

Slavery conditions persist, particularly in the agricultural and extracting (mining) industries. Twenty-five thousand workers are estimated to be living under slavelike conditions in Brazil (Ministério do Trabalho e Emprego, 2003). These workers are lured by verbal contracts and transported over long distances to work in dangerous conditions. They are induced to take out loans to pay for expenses like housing and food, and face long and exhausting work hours. Their debts continuously grow and they can never free themselves. The Ministry of Labour and Employment has been acting directly against slavelike situations through its Special Mobile Inspection Group that travels over the country to investigate slavery allegations and to apply all necessary measures to free slaves. In order to carry out more permanent actions, the Brazilian government created a National Slave Labour Eradication Plan (Ministério do Trabalho e Emprego, 2003), and responsibility is shared by various executive, legislative and judiciary powers, the Public Ministry, and civil and international groups. The plan has successfully mobilised qualified professionals to fight slavery practices and to counsel workers about their rights.

According to official data, as relates to formal workers only, in 2005, 2,700 workers died and 491,000 were out of work and received benefits from Workers Compensation Insurance due to occupational accidents and diseases. The mortality rate of work injuries among subcontracted workers was estimated at 40.4 per 100,000. This is four times higher than the estimated rate for workers hired directly [9.4 per 100,000 in the State of São Paulo in 1990]. The national incidence of nonfatal work injuries was estimated to be between 1.6% and 5.8% (Wünsch Filho, 1999; Santana & Loomis, 2004).

The creation of the Ministry of Social Development (MSD) in January of 2004 launched a significant increase in the budget for social protection. Programs for money transference, food and nutritional safety, social assistance and inclusion in the labour market have been implemented, with a substantial expansion of coverage by the social assistance network. In 2005, over 50 million poor and/or vulnerable persons were assisted by MSD programs. In May of 2006, the Family Compensation Program, the most comprehensive program of conditional income transference, had 9.2 million families enrolled, accounting for 83.2 per cent of the protected poor families in Brazil. In 2003, preexisting programs were consolidated into a broad conditional income transference program, and the Family Compensation Program was implemented (Vaitsman, Rodrigues, & Paes-Sousa, 2006).
Workers Health Referral Centers (CEREST) began to open in the 1990s, which have expanded access to specialised workers’ health care, and facilitated exchanges with social movements and labour unions. In 2003 the National Workers’ Health Care Network (RENAST) was launched as one of the key strategies of the workers’ health policy. RENAST is a hierarchical net comprising three administrative levels: federal (Ministry of Health), state (state secretariats) and municipal (municipality secretariats). It is organised according to the nature of the actions required and involves complex partnerships with various ministries and other related institutions (Dias & Hoefel, 2005). RENAST relies on societal participation: municipal councils are responsible for planning, setting priorities, and making budgetary decisions. Since 1994, worker’s health agendas at the national, state and municipal levels have been developed from proposals discussed and approved in conferences involving a multitude of concerned social actors (Dias & Hoefel, 2005).

In 2004, the Brazil National Health Council launched the 3rd National Workers’ Health Conference (3rd CNST). For the first time this conference was developed jointly by the ministries of Health, Labour and Social Security. This broad and participatory interinstitutional process aimed to develop an integrated federal policy for worker health that involved government institutions, labour unions, health professionals, social movements, grassroots organisations such as the quilombolas (communities formed by the direct descendants of black slaves who had escaped the plantations), indigenous tribes, academic representatives and other relevant stakeholders (Ministério da Saúde, 2006). The main product of the 3rd CNST was an agenda for action developed by institutions at the municipal, state and federal levels, defining priorities and guidelines over three main areas: workers’ health, sustainable development, and social participation in the planning and management of occupational health care.

Rural workers remain a segment that inflates the poor income distribution in the country. The concentration of land possession among few landowners and large areas of nonproductive farms, with only few job opportunities, leads to migration to urban areas. The Movimento dos Sem Terra (Landless People’s Movement) is a large and powerful group of displaced jobless rural workers that agitates for changes in land tenure that would allow a more equitable distribution, access to credit and technology, and more fair and efficient retail market structure [see case study 71] (Carneiro, 2007).
Chile - Magdalena Echeverría and Víctor Maturana Waidele

Chile is also a country in the cluster of semi-periphery and emerging labour institutions. Chile’s population of over 16 million people is concentrated in three large urban areas, where 85 per cent of the Chilean population live. The rural population accounts for 13 per cent of the total population, and the indigenous population is 5 per cent of the total. The population living below the poverty line is 19 per cent. Chile stands out in the Latin American region as a country that is highly participating in the global economy, and has experienced rapid economic growth in the last two decades. According to the typology of countries, Chile is a more egalitarian society compared with countries such as Turkey or El Salvador. However, since the mid-1980s, Chile has followed a free-market economic model, with scant state regulation and a focus on exploitation of natural resources: copper mining, fisheries, fruit production, and forestry.

Poverty has fallen since 1990 by 20 per cent (Ministerio de Planificación, 1990; 1993). However, there has been no improvement in the major inequalities in income distribution. Families in the top quintile account for almost 50 per cent of monthly family income, while those in the bottom quintile account for 6 per cent. The labour market participation rate has increased over the past twenty-five years, an increase which is almost exclusively due to women joining the labour force. In 2006, male participation attained 71.5 per cent while female participation was only 38 per cent, with no improvement in the type of work available for women (Instituto Nacional de Estadísticas, 2006). The wage gap with men is 30 per cent. Almost three quarters of employees are salaried workers, while self-employed workers represent 27 per cent. Since 2000, unemployment has been in single digit figures (6.6% at the end of 2006) with a 1.6% difference between men (6.1%) and women (7.7%). The level of child labour in Chile is the lowest in the Latin American region. Migrant labour is also low (1.2% of employment) although the proportion of migrant workers from bordering countries has increased.

Since the restoration of democracy in Chile, a variety of reforms have been carried out, such as the major labour reform of the early 1990’s, which was intended to rectify an unregulated labour market. However, flexibility is widespread in the Chilean labour market. The two aspects of flexibility that have been most developed are subcontracting of work and/or personnel (35% of salaried work) (Echeverría, 2006) and the lengthening of the working day beyond its customary limits (Echeverría & Jeria, 2005). In 2003, the number of hours worked in Chile annually was 25 per cent higher than in European countries, 15 per cent more than in Japan and 14 per cent higher than in the United States.

Trade union membership has declined (10% of salaried workers) and the unions are not very powerful, except among copper miners, public-
sector employees, and in a number of strategic activities such as forestry (Dirección del Trabajo, 2005). Collective bargaining in major conglomerates is also very limited and restricted to well-paid jobs, with individual, rather than collective, bargaining being the rule. Health and working conditions are not open to negotiation, partly because the military government’s labour plan excluded from negotiation any issues that might have signified workers’ participation in “the employer’s prerogative to organise the enterprise” and partly because of the predominance in the country of a trade-union culture of focusing on wage claims.

During the 1980’s social security was privatised. A long-standing public system based on solidarity and redistribution was replaced by one founded on individual capitalisation. Most of the population (72%) is affiliated to the public health system. Whether people are affiliated to the public or the private system depends on their level of income. For over two years now, a system of unemployment insurance has been operating in the country, offering temporary protection for the unemployed.

Social security protection depends almost entirely on the written contract of employment, which is also the yardstick by which the level of formality of labour relations may be measured. Workers with no contract of employment make up 24 per cent of salaried workers. They are also precarious in terms of income: in 2003, their average wage was 60 per cent lower than that of workers with a formal contract of employment. Taking into account both criteria, 40 per cent of employment is precarious on account of the lack of protection and 32 per cent of salaried work is precarious on account of its instability (Ministerio de Planificación, 2003).

Sixty per cent of all serious or fatal occupational accidents that occurred in 2004 affected workers in subcontracting firms, although only 35 per cent of all employees work for subcontractors (Dirección del Trabajo, 2004) and years ago a long-standing regulation on minimum health requirements in all workplaces was updated to include contemporary occupational risks. The list of occupational illnesses, in existence since 1967, was also updated in 2006 to include new disorders. In addition, the maximum legal length of the working week was reduced from 48 to 45 hours and compulsory rest, for which no provision had previously been made, was introduced. Both the unemployment law (2005) and the recently adopted law on subcontracting (2007) should have a favourable impact on the widespread inequity affecting conditions of employment, that is, unequal rights and benefits for workers performing the same tasks but who are nevertheless subject to different levels of job stability, pay and welfare protection. As far as occupational health is concerned, the law makes firms who use subcontractors responsible for the health and safety of all those who work on the same premises, regardless of who the employer is.
The current government has placed special emphasis on designing a system of welfare protection to foster decent working conditions during people’s working lives, as well as, at a later stage, a reform of the pensions and welfare benefits system (Ministerio de Trabajo y Previsión Social, 2007) based on a reinforcement of the solidarity component and changes in the contributory components, with a view towards universal coverage and greater equity. The actual conditions in which this is to be achieved and its outcome are yet to be determined.

**Venezuela - Sarai Vivas, María E. Martínez, Carlos H. Alvarado and Francisco Armada**

The Bolivarian Republic of Venezuela is located on the coast of the Caribbean Sea in northern South America. Venezuela is another example of a semi-periphery country in the category of emerging labour institutions. The Constitution of 1999 declares the nation to be pluralist, multilingual and multiethnic (the population is composed of an estimated 69% mestizos; 21% whites; 8% African descent; and 2% Indigenous) and declares the political regime to be a participatory democracy. The number of inhabitants is currently estimated to be around 27.5 million, and as of 2007, 90 per cent lived in urban areas, with a population density of 30 inhabitants per square kilometer. Life expectancy at birth was 73.2 years in 2005, and the total fertility rate that year was 2.7. In 2006, 69.3 per cent of the population was economically active; the employment rate was 65.6 per cent, and the unemployment rate was 9.5 per cent (8.4% in men, 11.2% in women). The youth unemployment rate reported in 2005 was 19.8 per cent. The oil sector dominates the country’s mixed economy, accounting for roughly 80 per cent of all exports (Sources for the statistics in this paragraph: Ministerio del Poder Popular para la Salud y Protección Social; Constitución de la República Bolivariana de Venezuela, 1999; Instituto Nacional de Estadística: Censo de población, 2001; Instituto Nacional de Estadística: Tasas de fecundidad, 2007; Instituto Nacional de Estadística: Fuerza laboral, 2007).

During the 1980s and 1990s Venezuela’s workplace became increasingly flexible and precarious, due to neoliberal policies that were intended to attract outside investment. Unemployment reached 14.5 per cent in 1999, and extreme poverty 20.2 per cent. The rate of informal employment among the working population was 52.4 per cent in 1999, and formal employment was 47.6 per cent. Since 1999 the Venezuelan government has taken some steps to guarantee the rights of workers, including controlling inflation and making annual adjustments to the minimum wage. By 2006 the minimum wage was US$238, ranking second in Latin America, while the informal employment rate was 44.5 per cent, and extreme poverty had fallen to 10 per cent. Since 2006 there has been no difference between the urban and rural minimum
wages. The minimum wage applies to all cases, including old age pensions which are also incremented each year.

Female participation in the workforce has risen, however several studies (Acevedo, 2005; Iranzo & Richter, 2002) have shown that women find it more difficult to get work and that on average they receive lower wages than men (figures from 2002 suggest their wages are as much as 30% lower in the private sector).

The social security system guarantees workers’ rights, as well as complete health coverage and benefits for maternity, old age, subsistence, illness, accident, handicap, death, retirement and forced unemployment. The system is administrated by the Venezuelan Social Securities Institute, whose beneficiary population has risen from 34 per cent in 1999 to 54.9 per cent in 2005 (from 21.5% to 30.6% in the economically active population).

Between 1999 and 2006 the number of unions registered by the Ministry of Labour rose from 208 per year in 1999 to 662 in 2006. A total of 5,292 new organisations had been registered by March 2007, including federations, confederations and professional associations. By 2006 the number of workers covered by general wage agreements reached 3,784,619.

The most important advances in worker protection are being incorporated into the Constitution and into laws. There are considerable differences with previous regulations, with the new laws being more universal and covering all population groups, which consequently increases the complexity of the system (Alvarado, 2005). Public expenditure on social security, as a percentage of the GDP, rose from 1.99 per cent in 1999 to 3.59 per cent in 2006, according to the Sistema de Indicadores Sociales.

The current Venezuelan approach to worker health goes beyond the traditional focus on physical risks to incorporate active participation in evaluation of and follow-up on health and safety, with an integrated outlook that considers the workplace a place for physical and mental health, for learning and personal development. A strengthened Institute for Occupational Health and Safety is leading to improvements in reporting and registration of problems as well as in appropriate actions to remedy them.

The government is pursuing a policy aimed at sustained recovery of purchasing power which includes progressive improvements in wages and control of inflation, and is currently in the process of developing a model of economic production which generates good, stable jobs. During 2006 the GDP grew by 10.3 per cent, a sustained economic growth that held over thirteen consecutive quarters, with an average of 12.9 per cent (Banco Central de Venezuela, 2007). This is in accordance with Economic Commission for Latin America and the Caribbean (ECLAC) estimates (2006), which had predicted that growth in Argentina and Venezuela would exceed 6 per cent. Social expenditures have risen from 9.45 per cent of the GDP in 1999 to 13.63 per cent in 2006.
The Venezuelan government is implementing other social policies through programs known as “social missions.” These separately financed programs aim to improve social cohesion and extend social rights (in areas such as health, education, work, and housing) to the whole population, and employ broad-based strategies that include central government, local government and community organisations. Thus whereas the ordinary budget for health rose from 1.46 per cent of the GDP in 1999 to 1.85 per cent in 2005, the program known as “misión Barrio Adentro”, whose objective is to achieve 100 per cent coverage of integrated health care, accounted for an expenditure corresponding to 2.78 per cent of the GDP. As a result, in its first two years of operation (2004 and 2005) there was an almost fourfold rise in visits to the primary health care network, which has 8,500 new neighborhood-based centers throughout the country. This new network of services gives priority to health promotion and preventive practices. By 2005 the infant mortality rate had been reduced to 15.5 per 1000 live births. Another set of social missions have notably improved access to drinking water, food and education.

Venezuelan social policies are now oriented towards structural change, and are moving towards socialising the means of production. Workers are encouraged to organise into cooperatives and co-managed enterprises. It has been shown that one of the causes of poverty is inequality in the access to assets (such as land, machinery, and technology) and in access to credit (Kliksberg, 1999), and consequently Venezuela pursues mechanisms for transferring assets to the hands of organised workers, such as firms in which the workers hold shares on equal terms with the state. In the case of cooperatives, the assets are owned collectively, with the state transferring them either directly or by means of loans. In 2004 a social mission called “Vuelvan Caras”, was set up to train, organise and activate collectively-owned production units. The units were not only aided and advised by the program, but also provided with the resources necessary to begin production, according to their community needs.

“misión Madres del Barrio” is a new program that joins other governmental efforts in the fight against poverty and social exclusion. It recognises the value of work in the home, providing complete care to women and families in situations of extreme poverty, with the aim of guaranteeing access to fundamental rights: assignment of 60 per cent to 80 per cent of the minimum wage for mothers in situations of extreme poverty, training and financial support for development of productive work, organisation of neighborhood-level mothers’ committees, integral care of health needs, housing, food and education (Ministerio del Poder Popular para el Trabajo y Seguridad Social).
El Salvador - Leslie Schuld and René Guerra Salazar

El Salvador is a country in the semi-periphery, informal labour market category. It is located in Central America and has a population that is estimated at 6.9 million people. El Salvador's 1992 Peace Accords brought an end to the 60 year military dictatorship and set the base for a democratic government. The EAP is 2,591,076 (Direccion General de Estadistica y Censos, 2008). The unemployment rate is 7.2 per cent. Official statistics register 32.1 per cent of the EAP as underemployed, primarily based on level of income rather than number of hours worked (Direccion General de Estadistica y Censos, 2008). The Economic Policy Institute Global Policy Network estimates that the informal economy accounted for 69 per cent of El Salvador's total economy in 2005 (Avirgan, Bivens, & Gammage, 2005).

El Salvador has implemented neoliberal economic measures since 1989, privatising public services and recently implementing the Central American Free Trade Agreement. The economy is largely dependent on remittances from family members that have migrated to the US and other countries. According to the United Nations Development Programme [UNDP] (2003), only 17 per cent of the population is covered by social security services, reflecting the lack of formal employment.

The Constitution prohibits the employment of children under the age of 14, except with special authorisation when it is considered indispensable to the family’s subsistence. Child labour is widespread in El Salvador, especially in the informal sector. Official statistics have estimated child employment to be 1.5 per cent in children 5 to 9 years old and 13 per cent in children 10 to 14 years old (US Department of Labor, 2007). Children are employed as domestic servants, in sugar cane and coffee farming, street vending and other informal jobs. According to ILO/IPEC research in 2001, more than 222,000 children between the ages of 5 and 17 worked, with 30,000 children employed in hazardous activities. In September 2003, the Minister of Labor asserted that 67 out of 100 children were engaged in some form of work, including household work (US Department of State, 2005).

The ILO estimates that between 5,000 and 30,000 children work on the sugar plantations. Sugar harvesting is one of the most dangerous jobs of all agricultural work, requiring the wielding of a large, sharp machete. The same report also revealed that medical care was often not available on the sugarcane farms, and children frequently had to pay for the cost of their own medical treatment (Human Rights Watch, 2004). Additionally, children are employed in
other informal sectors, including selling goods in the markets and on the streets and family farming, and not protected by the law. Many of these children do not go to school; although the constitution mandates education, it is not enforced. Furthermore, since public education, transportation and other expenses are not completely covered by the government, it would be impossible for some families to send their children to school, even if they wanted to send them.

It is easy to hire and fire workers because El Salvador’s labour code allows a worker to be fired due to the employers’ “loss of confidence” in him or her (Código de Trabajo, República de El Salvador: Article 50). Workers can also be fired for such reasons as presenting false certificates, repeated negligence, revealing confidential information, grave acts of immorality, disrespectful behaviour toward the employer or employer’s family members, and absence without permission. In cases of unjustified firing, the employer is required to pay one month’s salary per year worked. Reasons deemed “unjustified” include salary reduction, deception about the conditions of employment, mistreatment of workers or family members, and worker endangerment (Article 53).

There are currently 129 active unions. Of these, 42 are industry-wide, 35 are company specific, 32 are professional unions, and 20 are unions of independent workers (Asociación de Servicios de Promoción Laboral, 2004). However, there are cases of violations of the right to organise, especially in the maquila sector. The El Salvador Labour Code itself is an obstacle to fair labour practices: Article 627 caps fines for violation of the Code at only $57.14.

Unemployment insurance does not exist in El Salvador. In cases of death on the job, dependents are entitled to 60 days of the worker’s basic salary. In cases of incapacity due to work, the employer is obligated to pay 75 per cent of the worker’s salary during the first 60 days, with social security paying the remaining 25 per cent. The employer continues to pay 40 per cent of the salary up to a maximum of 52 weeks. If the worker is injured due to work and incapacitated indefinitely, the employer is obligated to pay the equivalent of 60 per cent of the worker’s salary for life.

Employers are obligated by law to pay social security for workers. The employer and worker each pay a percentage based on the salary of the worker. Social security insurance covers 75 per cent of a worker’s salary when absent due to illness for up to three months, including a three-month maternity leave; the employer pays the remaining 25 per cent. For the 80 per cent of the population without formal jobs, medical coverage is provided by the Ministry of
Public Health. The Ministry of Public Health has hospitals in the major cities and health clinics in all 262 municipalities. However, it is in crisis, in part due to patenting laws on medicines; even the government cannot afford medicine and there is a shortage, even for insured workers. There are private hospitals for the wealthy, however the majority of them go to the United States or Cuba when necessary.

Due to the crisis in the health care system and the government’s lack of will to resolve the problem, the government has proposed privatising the health care system. This is only one of many privatisation schemes contemplated in the wake of the change to neoliberal economic policies that have a legal basis with the Central America Free Trade Agreement, although this one in particular violates the El Salvador Constitution, which guarantees the right to health care.

In many cases maquila factories deduct social security insurance from workers’ wages, but do not pay the fees to the social security administration, leaving the worker without access to health care. Also, some maquila factories have their own clinics to circumvent the public hospital. The service in these clinics is inadequate.

There is a widespread lack of potable water; many workers do not have access to water at all, or only have access to contaminated water. Dehydration and gastrointestinal illnesses are the most common illnesses in the country.

Workers are not given sufficient safety equipment to protect their health and personal safety, such as masks, rubber globes, respirators for handling chemicals, and mechanical equipment (Asociación de Servicios de Promoción Laboral, 2004).

Much of the political debate in El Salvador is focused on health care reform in general, which encompasses some of the macro issues related to employment and health conditions. This is in general a culture that has institutionalised disrespect for labour rights. Not until August 2006 did El Salvador’s Legislative Assembly ratify Convention 87 of the ILO, protecting the right of workers to organise. The ratification was a result of direct pressure from the European Union, combined with pressure from local labour organizations. Overall, the liberalisation of the labour market and other measures included in neoliberal economic agreements have diminished worker rights rather than improve them. The same neoliberal economic framework calls for the privatisation of health care services, which will only diminish access for the poor majority, as has been the case in other Latin American countries that have privatised health care.
Turkey - Yucel Demiral, Bulent Kilic and Belgin Unal

Turkey belongs to the group of semi-peripheral countries, and it is located in the informal labour market cluster. Turkey’s population is 72.6 million, with a population density of 88 people per square kilometre. 63 per cent of its population live in cities.

The service sector constitutes the biggest proportion of the Gross Domestic Product (48%), followed by industry (29%) and agriculture (11%). According to national statistics, the relative poverty rate was 20.5 per cent in 2005. The working poor population is 37.2 per cent among agricultural workers, 9.9 per cent among industry workers, and 8.9 per cent among workers in the service sector (Turkish Statistical Institute, 2006). An export-oriented industrialisation model has been implemented instead of import substitution, the development model chosen since the new constitution was approved in 1982. International Monetary Fund (IMF) and World Bank (WB) programmes, namely structural adjustment policies, have been launched. As is standard practice, like in other developing countries, it has involved free capital flows, trade liberalisation, privatisation, and deregulation of the labour market.

Labour unions have been weakened over the past twenty years and are losing their representation power while being replaced by professional associations or similar non-governmental organisations. There are no reliable data on union membership in Turkey. The available data is widely contradictory, ranging from 10 per cent to 50 per cent (Çelik & Lordoglu, 2006). Even the unions are far from presenting clear figures. The unionisation rate that includes collective bargaining, however, is presumed to be around 10 per cent. It should also be noted that civil servants do not have the right of collective bargaining.

Turkey’s social protection system is based on membership in the social security institutions. Informal labour, as it is not being registered by any social security institution, has been estimated to be 51.5 per cent in 2005. The ratio of informal employment to formal employment is 34 per cent in urban areas and as high as 76 per cent in rural areas. Some estimates have shown that formal workers earn twice as much as informal workers. There is only limited employment protection regarding dismissals in companies with thirty employees or more, which means that at least 75 per cent of the working population is not accounted for in this scheme. The current unemployment system provides benefits to merely 3 per cent of unemployed workers (Yigit, 2005).

There are several significant differences between genders in the structure of the labour force. The labour force participation rates are 25 per cent and 75 per cent for females and males, respectively. The most
prevailing reason for women to not participate in the labour force is domestic work, whereas for men it is being retired or being a student. Education is one of the important factors that determine participation in the labour force for women. It is far less among illiterates and non-school attendees (21.9%) than for higher-educated groups. Labour force participation rates increase gradually to 47.4 per cent among primary school graduates, 57.1 per cent among secondary school graduates and 79.1 per cent among higher educated people. Labour force participation rates decrease sharply by age, being 33 per cent for people 55 years old or above. The general unemployment rate is 10.3 per cent and higher in the non-agricultural sectors (13.6%). This figure increased sharply after the 2001 economic crisis, remaining higher than at any of the pre-crisis periods. Although economic growth has been about 7 per cent for the past three years, unemployment has been steady around 10 per cent, which has been referred to as “jobless-growth”. The unemployment rate among young workers (15-24 years old) is 19.3 per cent. Among the unemployed, approximately 56 per cent are long-term (more than six months). The current unemployment system covers merely 3 per cent of all unemployed workers.

Among the EU countries and middle income countries, Turkey has the highest average of working hours with 52 hours per week. Moreover, 73 per cent of male workers work more than 40 hours per week and 39 per cent of them work more than 60 hours a week. The labour law has also facilitated the flexibilisation of working time. For example, one can work 5 hours per day one week and 10 hours in the second week without extra payment.

Agricultural employment has decreased considerably during the past ten years. Currently 29.5 per cent of workers are employed in agriculture, whereas 19.4 per cent are in manufacturing, 5.3 per cent in construction and 45.8 per cent in services (Turkish Statistical Institute, 2007). The cutback of state subsidies in the agricultural sector emanating from both national and international policies has caused a dramatic decline in employment rates in this sector. Consequently, approximately 300,000 agricultural labourers have become redundant each year since the mid-90s. Since the demand for unskilled labour is low, this trend has gradually lowered the labour force participation rate. It has been estimated that 64 per cent of the working population has migrated due to unemployment or economic difficulties within the past twenty years. The rapid reduction in agricultural employment and the difficulties in generating new employment are among the most important problems challenging Turkey today.

Regarding child labour, the percentage of economically active children is 10 per cent between the ages of 6 and 17. More than half
of those children work in agriculture (58%), while 21 per cent work in industry and 20 per cent in trade and services. Approximately 52 per cent of the working children work more than 40 hours per week.

**Bolivia - Marcos Rodríguez Fazzone, Marcel Gonnet Wainmayer and Dérgica Sanhueza Cid**

Bolivia is a peripheral country in the post-communist labour market included in the typology of this book. It is located at the centre of South America. Its population is approximately 9.8 million, with 64 per cent of them concentrated in urban areas. Bolivia has an important presence of indigenous groups; ethnically the population is 30 per cent Quechua, 25 per cent Aymara, 30 per cent mixed race and 15 per cent white. Spanish, Quechua and Aymara are the official languages. Bolivia's average life expectancy at birth is 62.9 years, and the gross mortality rate in 2005 was 7.9 per thousand. The child mortality rate reached 61.2 per thousand (born in that same year), and the maternal mortality ratio was 229 per 100,000 live births. (ECLAC, 2006).

The country’s GDP for 2005 was $9.306 million USD, with 4.6 per cent annual growth. The minimum wage is 500 Bolivians ($62 USD) a month. Natural gas accounts for 38 per cent of the country’s exports, followed by minerals, oils and legumes. Important imports are petroleum products, cereals such as wheat, and machinery for agriculture and construction (ECLAC, 2006). By the end of 2005, the EAP reached 3.7 million, of which 64 per cent were male. Agriculture accounted for 32.2 per cent of jobs; industry, 21.6 per cent; and services, 46 per cent. In 2006 the unemployment rate was 9.2 per cent, according to the Continual Household Survey 2003-2004.

According to the World Bank, indigenous people represent 62 per cent of the total population. In rural areas, 72 per cent of the people speak indigenous languages, compared to 36 per cent in urban areas. Most of them are either Aymara, Quechua or Guaraní, but according to official records, almost 35 linguistically distinct ethnic groups exist in the country. Studies have shown that the obligation of workers to be fluent in Spanish has been a deciding factor in keeping indigenous people in more vulnerable and lower paying jobs. The rate of labour participation is 81 per cent for the indigenous population and 64 per cent for nonindigenous. However, a third of the indigenous EAP does not receive equal remuneration in money for their work, especially in the case of women. In 2002, 18 per cent of the nonindigenous population over 14 years of age attended school, compared to 8 per cent for indigenous people. Illiteracy is common among indigenous women (Gillette & Patrinos, 2004; WB, 2006).
Up until the mid-1980s, Bolivian law required that companies directly finance many of their workers’ health, education and housing needs. At that time, Bolivia began its transition towards an open market economy, and those labour laws were strongly criticised because of “excessive” intervention of the state. It was argued that laws discouraged investors and reduced Bolivia’s ability to compete on the world market. Since 1985, there has been a strong liberalisation of labour markets and a sharp drop in real wages. Public employment has descended 25 per cent, and the private sector was granted the right to break employment contracts unilaterally (Arze, 2001). Charges and taxes on industry were reduced also, in an attempt to attract international investment.

In 1997, more than 50 per cent of the informally employed workers were in small and medium enterprises (SMEs), mostly based in urban centres. According to the ILO, between 1994 and 2000, informal labour in Bolivia increased considerably and currently represents 67 per cent of the EAP. Most of the informal workforce is made up by women (72.1%) and self-employed workers (75%) who earn less than the average national income (Rosales, 2003). In 2004, only 34.1 per cent of employees had formal contracts, down 5 per cent from 2002. Of these, 48 per cent had an undefined contract. These statistics are more pronounced in the case of women: only 37 per cent of women had a formal contract, and 53 per cent had undefined contracts (ILO, 2005; 2006).

Bolivia has high levels of child labour. Over 300,000 children and teenagers were employed, which represents 10 per cent of the EAP in 2001. Child labour is more common in rural areas (12% of EAP) than in urban areas (9%). Child labour figures also differ between indigenous and nonindigenous children. According to the World Bank, indigenous children were employed four times more than nonindigenous children in 2002. The mining industry is responsible for one of the worst forms of child labour, denounced by the ILO and UNICEF, which exposes children to risks, accidents and degenerative diseases (ILO, 2004). Several direct action programs have been implemented by NGOs in agricultural and mining zones. Since 2001 it has been illegal to employ children for mining work, a law brought about by union cooperatives working with NGOs (Dávalos, 2002; Ledo, 2006; ILO, 2003)

Bolivia is undergoing a strong urbanisation process, with migrations towards high-income areas such as Santa Cruz, Cochabamba, Sucre and La Paz, where problems have risen due to lack of infrastructure and basic services. Because 86 per cent of the population works in agriculture, there are acute differences in
income between rural and urban workers, which triggers migration. Women’s salaries are, on average, 24 per cent lower than men’s, and several studies show that in the informal economy, the workload for women is substantially higher than for men (Valenzuela Fernández, 2004).

Informal workers have little capital to invest in safe working conditions, and since the work force is scarcely qualified, there is a high index of work-related accidents (Oursatti & Calle, 2004). Access to water, hygiene and electricity is limited, which increases the transmission of infectious diseases; Bolivia and Haiti have the highest rates of tuberculosis in the region (ECLAC, 2005). In rural areas, independent workers are more likely to die from poor living conditions and lack of access to basic services (Tennessee, 2001).

The use of health services is very unequal between rural and urban centres. In rural sectors, forced labour practices known as “debt hooks” are employed, where workers have to work to pay off debts contracted from land or business owners. Ethnicity is an important constraint on access to services. For instance, being part of an ethnic minority or not being able to speak Spanish can be a barrier to health system access. A correlation exists between poverty conditions and indigenous people; this is heightened in rural areas, and affects women and children more severely (ECLAC, 2005).

President Evo Morales’s first term (2006-2010) was characterised by the implementation of leftist nationalist and pro-indigenous policies, which have broken away from neo-liberal policies and counteracted the effects of the global economic crisis. A new constitution was approved and control over natural resources such as natural gas increased substantially, increasing revenue and international reserves. All of this allowed for increased investment in public services, coverage for services such as electricity, access to adequate sewage systems and potable water, as well as sanitation. With these increased resources, the government also initiated programmes targeting the poor, investing in the public school system, establishing care services for infants and their mothers (as part of a large-scale programme aimed at reducing infant mortality) and increasing pensions in order to prevent poverty amongst the elderly. While Bolivia is still a tremendously poor country, these policies have benefited the most under-privileged classes and reduced social inequalities.
China - Yong Li

China is a peripheral country with a post-communist labour market. Occupying most of East Asia, China is the world’s most populous country with about 1.3 billion people [National Bureau of Statistics [NBS], 2006]. Since 1978, China has changed from a centrally-planned system that was largely closed to international trade to a more market-oriented economy. The annual growth rate of real GDP has averaged 9.2 per cent over the past two decades [NBS, 2006]. In 2005, China’s total labour force was 776 million, of which 44 per cent were female and 4.2 per cent were unemployed [WB, 2007]. The majority of the labour force is still in agriculture, traditional low- and medium-technology industries, and low-skill services. The registered unemployment rate for women was 6.4 per cent in 2001, higher than men’s (4.8%), and accounted for 40 per cent of the registered unemployed population [ILO, 2004]. By official statistics, in 2002 there were about 7.7 million unemployed people in the urban areas [NBS, 2003]. According to the Chinese Ministry of Education, in 2001 the employment rate of the 1.17 million new university graduates was 70 per cent [Ya-Li, 2004]. China’s current labour market is rapidly shifting from public to private. Between 1996 and 2001, the number of urban and township workers (mainly workers in state-owned and urban collectives) fell from 149 million to 108 million, a net reduction of 28 per cent. During the same period, the employment in the urban informal private and self-employed sectors increased by 13.3 million, or 57 per cent [Zeng, 2005].

An increasing number of rural labourers are migrating to urban areas to work mostly in service activities, such as cleaning, maintenance and repair, construction, and food service. Current estimates of the number of migrant workers fluctuate between 40 and 80 million, or 6 per cent to 10 per cent of the total labour force [Zeng, 2005]. According to the survey data from the National Statistics Bureau, from 1997-2000 the share of rural migrant labour as a percentage of the total rural labour force increased from 18.1 per cent to 23.6 per cent, an average annual increase of 10.07 million, or 10.8 per cent [Zeng, 2005].

Confined by China’s household registration system, rural migrant labourers are often excluded from health care, legal and social services, and they are often working in enterprises where labour law standards are not strictly enforced. Abuses of migrant labourers have been heavy, and millions of temporary workers have faced unsafe working conditions, collusion between factory owners and local officials, and unpaid wages. The use of child labour and forced labour has been reported in recent labour scandals for
workers in brick kilns and small coal mines in Shanxi and Henan provinces in 2007 [China Daily, 2007a].

With economic reform and the increase of private sector employment, the government began to allow state and collectively-owned enterprises employment freedom. A labour law enacted in 1995 stipulates that all workers in all types of enterprises have to be employed on a contract basis [Ministry of Labor and Social Security]. In 2007, China passed a new labour law, effective in January 1, 2008, that strengthens protections for workers across its booming economy [Ministry of Labor and Social Security]. The new labour contract law requires employers to provide written contracts to their workers, restricts the use of temporary labourers, and makes it harder to lay off employees.

After 1998, the government began to adopt systems for protecting unemployment and other social welfare benefits. By 2001, the majority of people laid off by state-owned enterprises were receiving a basic living allowance, and retired personnel were receiving pensions. Since then, the newly laid-off can immediately receive unemployment compensation that has been gradually integrated with the minimum living guarantee system [Juwei, 2003]. The major problems of the current social security system are limited funding and coverage, the lack of detailed policy analyses and coordination among relevant ministries; and deficiencies in implementation. Urgently needed is an increase in funding for the minimum living guarantee system. The fiscal budget for the minimum living guarantee system only accounted for a tiny 0.1% of China’s total GDP, or less than 0.5% of total government expenditure. This is very low compared with developed countries [Zeng, 2005].

Occupation-related accidents have been very high in China [Wang & Christiani, 2003]. In 2006, the State Administration of Work Safety reported that coal mine accidents alone killed 4,746 people. The death rate in coal miners in 2005 was 2.81 for every million tons of coal mined, 70 times worse than the rate in United States and seven times higher than Russia and India [China Daily, 2007b]. The number of workers afflicted with occupational diseases in China has also been increasing. Pneumoconiosis is the most serious occupational lung disease in China, and by 2004, the country had 580,000 cases. The disease is growing at an alarming rate, estimated to be 10,000 cases per year in the future [Leung & Kwan, 2005]. Poor working conditions pose the worse threat to migrant workers. Most rural migrants often work in environments subject to high temperatures, severe dust, poisonous paint fumes, and poor air circulation, where they are often required to work overtime, sometimes without contract. Migrant workers enjoy very few of the rights, benefits and forms of protection that come with
formal employment. Medical insurance and work injury insurance provided by employers is very limited. They often lack any rights to health care, pensions, unemployment insurance, paid annual leave, paid sick leave, and public holidays. The social security status of female migrant workers is even worse. Most female flexible employees do not have maternity leave or pregnancy care wages. Once pregnant, some workers are dismissed or forced to quit. All of this means that workers in flexible employment condition have high economic insecurity.

To further improve and supplement the 1995 labour law for the expanding market-oriented economy, a new labour contract law took effect on January 1, 2008. This law adds significant protection for employees in various areas, levying penalties on employers who do not sign an employment contract with their employees, restricting the use of temporary labourers, and compensating employees for improper termination. The law also enhances the role of the Communist Party’s monopoly union and allows collective bargaining for wages and benefits.

In January of 2007, China became a signatory to the ILO’s convention on occupational health and safety. Joining the convention allows China to cooperate with international organisations to improve its occupational health and safety standards. China has established plans to close more small coal mines, upgrade coal-mining technologies, conduct more safety checks and provide miners with safety training in order to curb accidents. The country has gradually reformed and improved its unemployment insurance system since its establishment in 1986. It can be proud of a remarkable achievement: the Unemployment Insurance Regulation promulgated in 1999 gradually extended coverage from the initial state-owned enterprise workers to all urban employees. Rural migrant workers have now started to be insured.

In recent years, the economic crisis has slowed or reversed the migration from rural to urban areas and unemployment has increased.

**India - SK Sasikumar, Atanu Sarkar and Zakir Hussain**

India is a peripheral country in the cluster of less successful informal labour markets. Demographically, India is moving towards an age composition that will be among the youngest in the world. According to the projected population of 2007 (based on 2001 census data and decadal growth rate), there are a total of 217 million people of age 15 - 24 years, which comprises around 19 per cent of the total working population (Government of India [GOI], 2007), since the Government of India’s rule for the minimum age of entry into employment is 14 years. The National Sample Survey Organization (NSSO) shows that between 1993 and 2005, there has been an increase in unemployment rates in India, particularly
among this younger age group. The same study shows that in India, as
many as 6 - 8 per cent of young rural males and 12 - 14 per cent of urban
males are reported to be openly unemployed, and the situation becomes
more alarming among the age group of 15 - 19 years (20 and 30 per cent
unemployment rate among urban men and women respectively) [NSSO].

The rate of growth of the service sector has gained considerable
momentum during the period of globalisation. The Indian economy
has grown at an annual average rate of well over 6 per cent during
the post-reform period (1993-94 to 2004-05), as compared to around
5 per cent during the pre-reform period (1983-84 to 1993-94).
Another notable feature of the current growth phase is the sharp
increases registered in the rate of savings and investments in the
economy; gross domestic savings rising from around 23 per cent
during the early 1990s to 32 per cent by 2005-06; and gross domestic
capital formation increasing from 24 per cent in the early 1990s to
34 per cent by 2005-06 [GOI, 2006]. The post-economic reform
period has also witnessed a massive increase in India’s foreign
exchange reserves - from a mere US$5 billion in 1990-91 to US$167
billion by 2006-07 [GOI, 2007]. The phenomenal successes on the
macroeconomic front have not yielded the expected labour market
and employment outcomes. In fact, there is a disconnect between
growth and employment in general. This had led to a debate on
jobless growth, especially in the organised sector of the economy.
The decline in organised sector employment seems to be primarily
due to the rapid decline in public sector employment. [GOI, 2007]

The disconnect between growth and employment is also widened
by the poor quality of employment opportunities. Broadly, the
working population can be categorised into three main components:
self-employed, regular and casual. Self-employed is defined as the
persons who operate their own farm or non-farm enterprises or are
engaged independently in a profession or trade on own-account or
with one or a few partners. The essential feature of the self-
employed is that they have autonomy (i.e., how, where and when to
produce) and economic independence (i.e., market, scale of
operation and money) for carrying out their operation. Regular
salaried/wage employees are the persons who work in others’ farm
or non-farm enterprises (household and non-household) and, in
return, receive a salary or wages on a regular basis (i.e. not on the
basis of daily or periodic renewal of the work contract). This
category includes not only persons getting time wage but also
persons receiving piece wage or salary and paid apprentices, both
full- and part-time. Casual wage labourers are the persons who are
casually engaged in others’ farm or non-farm enterprises
(household and non-household) and, in return, receive wages according to the terms of the daily or periodic work contract (NSSO). Self-employment is the most dominant form of employment both in rural and urban areas. The category of self-employment is a highly diversified one, ranging from professionals like doctors and engineers to small marginal farmers and petty traders. Regular employment has more or less stagnated in both rural and urban areas. Nearly one-third of the workers in the rural areas and one-sixth of the workers in the urban areas are currently engaged as casual labourers and their earning have been abysmally low in India. Casual labourers, in both urban and rural areas, receive roughly one-third of the wages of the regularly employed, a wage that does not keep them above the poverty line. The regular/casual wage differential has widened sharply during the post-reform period. For instance, the daily wage of rural regular workers has increased from Rs 17.24 in 1983 to Rs 133.81 in 2004-2005. During the same period, for rural casual workers it has increased from Rs 6.76 to Rs 48.89. A similar trend has also been observed while comparing urban regular and casual workers (NSSO).

Such labour market trends imply that India is missing an opportunity provided by a large and growing young population because the process of economic growth is not generating enough jobs to employ them productively. The situation becomes more alarming in the context of rising informalisation in the labour market, with the proportion of poor quality employment on the increase. Informalisation in the labour market has transpired at two levels: first, informalisation has increased within the organised sector; and second, rapid growth has occurred in the informal economy. Informalisation in the organised sector is partly derived from increasing competitive pressure in the global markets, which has forced firms to minimise costs, especially labour costs, by pruning employment and also by avoiding social security commitments. Technology innovations have also played a significant role, allowing for widespread adoption of flexible labour practices such as subcontracting, outsourcing and hiring temporary and part-time workers. For instance, large industries are outsourcing their major production activities to small units (including unorganised sectors) and limiting their activities to assembly (Sasikumar, 2007).

As per the estimation made by the National Commission for Enterprises in the unorganised sectors in January 2005, the total employment (principal plus subsidiary) in the Indian economy was 458 million, of which the unorganised sector accounted for 395 million (86 per cent of total workers). Formal social security in the
form of pension and health benefits has been mostly for workers in the formal sector. For the rest of the workforce, the approach to social protection has relied mostly on promotional measures, such as the special programmes to encourage employment (self-employment as well as wage employment) among the very poor; rudimentary health-care services and education; and a system for distributing subsidised food to the public. Only about 0.4 per cent of the unorganised sector workers were receiving social security benefits like Provident Fund, and this proportion had not changed since 1999-2000. Despite successive attempts to address the problems faced by workers in the unorganised sector through legislative as well as programme-oriented measures, there has not been any significant success. This is partly due to the ignorance, illiteracy and lack of unionisation of workers, and partly due to the resource constraints of the state (National Commission for Enterprises in the Unorganized Sector [NCEUS], 2007).

However, the enactment of the National Rural Employment Guarantee Act of 2005 marks a significant step towards recognising and ensuring work as a right of the people. This act provides at least one hundred days of guaranteed wage employment every year to every household whose adult members volunteer to do unskilled manual work. It is considered the greatest initiative ever attempted in India, not only for its aggressive approach towards poverty alleviation, but also for its attempt to empower those living at the margins. This state intervention aimed at assuring employment to the rural poor is also significant in its attempt to situate employment at the centre of macroeconomic policy, rather than as a hoped-for outcome of the growth process. This ambitious rural employment guarantee programme is currently in operation in 200 districts of India and has expanded to all districts since April 2008. The Indian government has also recently introduced a bill in the parliament to provide minimum social security coverage to the unorganised sector workers, such as health insurance, old age pension and maternity benefits.

The Constitution of India has a number of acts, rules and regulations for ensuring occupational safety and health for workers. Unfortunately, these occupational safety and health laws are applicable in a fragmented manner and have been developed in a piecemeal fashion, resulting in duplication in some areas and gaps in others. There is no single, unified legislation which can address even the basic responsibilities for occupational safety and health in all the sectors. Even though the vast majority of India’s workforce is in the unorganised sectors, no authentic statistics at the national level are available on accidents and occupational diseases, with the exception of a few pilot surveys.
Nigeria - Chamberlain Diala

Nigeria belongs to the peripheral countries and it is located in the cluster of less successful informal labour markets. At the end of 2006, Nigeria’s population was estimated at 140 million, with 44 per cent of the population living in urban areas (BBC News, 2007). Nigeria has three major ethnic groups, divided among Christians and Muslims, with English as the official language.

Once a large net exporter of food, Nigeria now imports food. Nigeria is over-dependent on the capital-intensive oil sector which provides 20 per cent of GDP, 95 per cent of foreign exchange earnings, and about 65 per cent of budget revenues (WB, 2008). The largely subsistence agricultural sector has failed to keep up with rapid population growth. Nigeria’s EAP is estimated at about 57 million (68%) (ILO, 2007) with 70 per cent of the labour force working in agriculture, 10 per cent in manufacturing, and 20 per cent in the service industry. Nigeria’s major exports are petroleum and petroleum products, cocoa and rubber. Major imports include machinery, chemicals, transport equipment, manufactured goods and food.

The economically active population in Nigeria is 67.9 per cent (48.9% female and 87.5% male). Employment circumstances are heavily influenced by the relative importance of agriculture (70% of workers); female illiteracy (40%); and extensive use of child labour in the informal economy. Ascending the social strata through education does not guarantee employment or the improvement of working conditions in Nigeria. Connections to political powers and nepotism networking offer the best opportunities for employment. In 2000, Dabalen, Oni, and Adekola described employment prospects for Nigerian college graduates as bleak, based on labour statistics and interviews with managers from 55 public enterprises, private firms, professional associations and non-governmental organisations. In 1996, 17 per cent of college graduates, 51 per cent of high school graduates, 11 per cent of primary school graduates and 20 per cent of those with no schooling were unemployed (Dabalen et al., 2000).

Nigerian workers are free to join labour unions with the exception of members of the armed forces, police force or government employees. Nigeria signed and ratified the ILO convention of freedom of association, but Nigerian law authorises only a single central body, the Nigeria Labour Congress (NLC), to negotiate on behalf of labour unions. Nigerian labour law controls the admission of a union into the NLC, and requires any union to be formally registered before commencing operations. Registration is authorised only when the Registrar of Trade Unions determines that
it is expedient in that no other existing union is sufficiently representative of the interest of those workers seeking to be registered. For decades, trade unionists have accused Nigerian governments of ignoring several core labour standards, which the country is obligated to comply with by international law. The International Confederation of Free Trade Unions (ICFTU) reports "serious shortcomings in the application and enforcement of all eight core labour standards, particularly with regard to the lack of trade union rights of workers, including the right to strike, discrimination and child labour." (Afrol News, 2006). Further, trade union rights were restricted in Export Processing Zones and strikes were prohibited in such zones for a period of ten years, which is also contrary to ILO conventions. Both the ICFTU and the NLC stated that "in view of the seriousness of these problems, there is need for a much stronger commitment to social dialogue by the federal government of Nigeria in order to achieve a culture of constructive engagement of labour over policies and government issues."

Severe hazardous working conditions and high unemployment in rural Nigeria have given rise to dramatic increases in labour migration to urban settings. In turn, urban centres are experiencing shortages of housing and supporting infrastructures, making bonded labour even more prevalent in urban centres than ever before. Bonded labour consists mostly of domestic workers, although there are reports of similar employment conditions for temporary workers in private and commercial sectors. Wage and employment discrimination persist in Nigeria, anchored through an unmeritorious system of nepotism and corruption. Disproportionately fewer women are employed in the formal economy due to social discrimination in education and training. Nigeria’s Minimum Wage Act excluded many workers, particularly groups where women are significantly represented, such as part-time and seasonal agricultural workers.

Child labour is a pervasive problem in Nigeria, with severe working conditions that offer limited or no stimulation for physical or mental development. In 2003, Nigeria was estimated to have 15 million child labourers (Dabalen et al., 2000; Siddiqi & Patrinos, 2006) representing 23.9 per cent of children between the ages of 10 and 14. 40 per cent of those children are at risk of being trafficked for forced labour, prostitution and armed conflicts. Up to 6 million children do not attend school and 2 million children work more than 15 hours a day. Several child slave camps exist in the western states, as are used slaves in mining and on rubber plantations (Olori, 2003). Three main forms of child labour outside of the home are farm work, street vending, and weaving. Children as young as 6 years old trade in the streets, most of
them being between 9 and 14 years old. Studies have shown that many of them have lower haemoglobin values compared with control subjects in identical classes (Asogwa, 1986). Studies also show that children are trafficked from neighbouring countries (Niger, Benin, and Togo) to serve as domestic servants, market traders, and child beggars and prostitutes in Nigeria (Global March Against Child Labour, 2008).

The economic and political tensions in the country have remained largely under control over the past eight years but have not reduced worker vulnerabilities or improved working conditions, employment benefits, or health indices. Workplace exposures to hazards contribute to illnesses for many workers.

**Sri Lanka - Saroj Jayasinghe, Amala de Silva, Myrtle Perera and Sarath Samarage**

Sri Lanka belongs to the peripheral countries cluster with greater emphasis on informal rather than formal labour markets. However, compared to other countries in the peripheral cluster, it has healthier and more secure employment relations.

In 2006, Sri Lanka’s population was estimated at 20 million, with almost two thirds aged between 15 and 64 years. The population is expected to peak to between 20.9 and 22.2 million by 2021 (De Silva, 2007). The proportion of 15 to 59 years is expected to peak around 2026, and then begins to decline steadily as a result of the current low fertility rates.

A multi-party democracy exists with an Executive President and the parliament as the legislature. Universal franchise was granted in 1931 while the island was still a British colony. Independence was obtained 1948 and the country became a Republic in 1972. Welfarist state policies have been in place since 1931, including free education (since 1945) and free healthcare (since 1951). Since the 1980s, the country has been facing an armed terrorist conflict mainly affecting the north and east. There are four major ethnic groups: Sinhalese, Tamils, ‘Indian Tamils’ who were brought by the British in the 19th and 20th century, and Moors. The protagonists in the conflict are the Liberation Tigers of Tamil Eelam and the state of Sri Lanka. The former is banned in many countries (including the USA and the EU) as a terrorist organisation. Currently, the conflict is limited to the north of the country, though there are sporadic attacks and suicide bombings on economic and civilian targets in other areas. These events have disrupted foreign investments and tourism.

Despite the adverse climate created by violence, GDP growth has remained steady above 6 per cent over the past 3 years and per capita GDP in current USD has increased from 1,053.3 in 2004 to
1,719.8 in 2007 (WB, 2009). In the last three decades, economic policies have been geared towards creating a liberalised open economy. Poverty rates are falling and less than 20% are below the official poverty line. The country, however, is beset by a balance of payment deficit, a budget deficit and inflation. Over the years, the economy has gradually transformed from an agricultural base to one dominated by the service sector. In 2006, the service sector contributed to 59.4 per cent of GDP, industries to 28.4 per cent, and agriculture to 12.3 per cent (Department of Census and Statistics, 2006). Contribution to economic growth is also dominated by the service sector (i.e. 70%).

Sri Lanka’s total labour force in the first quarter of 2008 was estimated to be around 7.5 million (excluding the north and east of the country). The rates of unemployment have declined from 10.5 per cent in 1995 to 6.0 per cent in 2007, but with significant gender differences (4.3% for males and 9% for females). Of the 7.15 million employed, 41.8 per cent are in the service sector, 31.8 per cent in the agricultural sector, and 26.4 per cent in industry. (Department of Census and Statistics, 2008). The informal sector accounts for 59.6 per cent of employment.

The agricultural sector is the worst off. It accounts for 31.8 per cent of all employed people, where 82.2 per cent are in the informal sector as of 2008. The eighteen per cent of formally employed agricultural workers are mainly from the organised plantation sectors. These continue to be tea and rubber plantations, with the labour force having a preponderance of “Indian Tamils”. The government continues to play a dominant role in providing employment and has 813,000 employees (about 13% of the employed share), through state, provincial and semi-government sector employment (Department of Census and Statistics, 2006). The armed forces attracts youth, especially from rural areas.

The country lacks a comprehensive social security scheme. The most secure are the public servants, as they are eligible for either a pension or the Public Service Provident Fund. The Employee’s Provident Fund is available for the private sector, but only 67-69 per cent are covered (Institute of Policy Studies of Sri Lanka and ILO). The least covered are workers in the informal sector and the self-employed, e.g. the Farmer’s Pension Scheme and Fisherman’s Pensions Scheme covers only about 50-60 per cent.

Sri Lanka’s relative success in providing healthier and secure employment relations (while belonging to the “peripheral cluster”) can be traced to several factors such as a strong trade union
movement, legislation supporting workers’ rights, the role of the state sector as a source of employment, a literate population and health care provided by the state at zero charge to the user.

Workers are free to join trade unions. In 2006, there were 1,800 functioning trade unions in the country (Department of Labour). Trade unionism began during the British colonial period, when industrialisation led to the growth of a working class. In 1923, the first general strike and unions came to the forefront of the struggle for independence. Trade unionism grew further after independence in 1948. In the run-up to independence, trade unions were led by socialist parties and their representation in parliament enabled workers’ issues to be raised at the level of the legislature. Left-wing parties had less influence in the plantations, as they had a different union: the Ceylon Workers’ Congress. It gained recognition as a political party and continues to be a dominant force in politics in the plantation regions. For several decades they have had direct representation in the cabinet, the parliament and in provincial councils, yet while socio-economic conditions in these areas have improved over time, they continue to lag behind the rest of the country.

Several legislations promoted occupational health and safety standards. Initial legislations dealt with migrant workers on plantations (1880), and protection of workers in mines and factories (1896). Several subsequent legislations have dealt with the areas of health and safety of workers, including the Factories Ordinance Act. 4.5 of 1942, workmen’s compensation, maternity benefits, etc. The Factories Act was amended in 1961 and 1976. Legislation to improve health conditions of plantations has progressively enabled the public sector health services to be integrated with the services being provided by the plantation companies.

Currently, occupational health and safety comes mainly under the purview of the Ministry of Labour, with relatively little input from the health sector. There is little coordination between the Department of Labour and the preventive health services, and as a result there are some difficulties in improving standards, especially in the non-industrial sector.

Another factor that improved the working conditions of labour was the dominant role played by the state sector as an employer. About 13 per cent of employees are in the state sector. Those employed by the state enjoy basic facilities, such as a minimum wage, health insurance, pension and schemes for compensation in case of illness or injury.

Some categories need special mention, namely, child labour, workers in special industrial zones, migrant workers and domestic workers. Child labour continues to be prevalent. In 1998, 17.9 per
cent of boys and 11.9 per cent of girls were working, the majority in agriculture (71.5%). There are accusations that child soldiers are been recruited by the LTTE and other groups. The government has taken several steps to eliminate child labour (e.g. laws that state a minimum age for admission to work as 14 years, the 2006 Plan of Action for Decent Work). There are nearly 450,000 workers in Export Processing Zones, industrial parks or Export Processing Parks. They are provided with inadequate facilities. Rural females working in urban garment factories often live in overcrowded dwellings of poor quality. The country also has almost 1 million migrant workers, mainly poorly-skilled housemaids who migrate to the Middle East. They are often exploited by recruiting firms. Physical abuses in the hands of the employer are reported and they lack basic facilities for social protection, regular access to healthcare or compensation in case of injuries or illness. The state has attempted to facilitate migration through registered agencies, and has established an insurance scheme in case of accident or premature death. Poorly-paid domestic workers are a common phenomenon in the country. Though precise numbers are not available, most come from poor rural or urban households and have very little in the form of job security, retirement benefits or social protection. They are not covered by any specific legislation. More recently there is a trend towards part-time domestic workers, rather than those who live-in. There is more opportunity for exploitation of the latter category.

**Ethiopia - Haile Fenta**

Ethiopia is a peripheral country in the cluster of insecure labour markets. Ethiopia is one of the oldest independent nations in the Horn of Africa and occupies an area of approximately 1.1 million square kilometres. According to the Central Statistical Authority of Ethiopia (1994) the population is estimated at 72.4 million, making it the second most populous country in Sub-Saharan Africa, after Nigeria. About 85 per cent of the population lives in the rural areas.

The annual population growth rate is estimated at 2.9 per cent. The age structure of the population is typical of many developing countries, with 43.5 per cent of the population under the age of 15 years, 51.9 per cent between the ages of 15 and 59 years, and 4.6 per cent aged 60 years and above. Life expectancy at birth is estimated at 49 years (Woldehanna, Guta, & Ferede, 2005). The literacy rate is estimated at 42.3 per cent. Ethiopia’s economy remains heavily dependent on the traditional method of agriculture, with low productivity and high vulnerability to the vagaries of nature. It
accounts for about 50 per cent of the GDP, 90 per cent of merchandise export earnings, and 85 per cent of employment [Oxford Policy Management, 2004]. Coffee is the largest export, generating almost two thirds of all export revenue (see Case study 98).

Until 1974, Ethiopia was a monarchy. In 1974, a military junta, the “Derg”, deposed the last monarch of Ethiopia, Emperor Haile Selassie, and established a socialist state. Torn by a bloody coup, uprisings, recurrent drought and refugee problems, the military regime was toppled in 1991 by a coalition of rebel forces, the Ethiopian People’s Revolutionary Democratic Front (EPDRF). A transitional government was formed and it stayed in power until 1994. Between 1995 and 2004, EPDRF assumed power through uncontested elections under the newly created Federal Democratic Republic of Ethiopia. In May of 2005, the first openly contested elections in Ethiopia’s history were held. Numerous electoral irregularities resulted in public demonstrations, which led to the loss of many lives and mass arrests of demonstrators, journalists, and opposition leaders (WB, 2009). The political climate remains characterised by a lack of trust among the parties, and the potential for further unrest remains. At the same time, the dispute between Ethiopia and Eritrea over the demarcation of their shared border remains unresolved (Abegaz, 2001).

During the Derg period (1974-90) all land, excess housing, and large and mid-sized private enterprises were nationalised without compensation. Farmers were given rights to use farmland instead of their customary command ownership rights. The economy, based on the early Soviet model, was highly regulated and controlled (Serneels, 2004). Private investment dropped and labour markets were subjected to considerable control. Job guarantees were established for all university graduates during the Derg period.

In 1990, after the collapse of the aid flow from the Soviet Union and other friendly governments, the older Soviet-style systems of the Ethiopian government became untenable. A reform plan hoped to establish a more mixed economy. In 1991, a new rebel government defeated the Derg and set out new economic reforms, though in fact, they were built largely on the economic reforms of the previous government. In 1992 the new government (EPDRF) devalued the country’s currency (the birr) and introduced further reforms leading to donor-funded structural adjustment program, with privatisation and liberalisation of the private sector and international trade. The EPDRF introduced subsequent economic reform policies, including enhanced structural adjustment and “poverty reduction and growth facility”. Foreign aid played a critical role in implementing these reform policies.
However, the economy continued to be under constant threat of political instability, war and recurrent drought, factors which have significantly retarded development (WB, 2009).

The economic reform policy increased pressure on public sector employment (which was 73% of wage employment), ending guaranteed jobs for university graduates and other restrictions on hiring in the sector (Serneels, 2004). Public expenditure generally increased during the subsequent economic reforms. Enrolment rates, especially in primary education, have grown significantly. However, the quality of schooling has gone down due to overcrowding, insufficient school supplies, crumbling school buildings and facilities, and poorly trained, demoralised and unmotivated teachers.

The other effect of the reform is seen in the health service sector. Health services are severely limited. Although health coverage has increased in the past few years, and the proportion of the population within 1 km of health facilities rose from 52 per cent to 61 per cent, the utilisation rate remained very low, and patients often bypass lower-tier health facilities because they lack the necessary staff or drugs (African Forum and Network on Debt and Development [AFRODAD], 2006).

According to the 2005 National Labour Force Survey report (Central Statistical Agency of Ethiopia, 2005), the active economic population (age 10 or older) is estimated to be 78.4 per cent (86.1% males and 71.2% females). The rates vary by place of residence (82.6% rural and 57.7% urban) and gender (86.1% males and 71.2% females).

Unemployment, accompanied by underemployment, is a serious problem in Ethiopia’s urban areas. Although the lack of reliable records and the existence of various informal types of work make reliable data hard to come by, some reports suggest that nearly 59 per cent of the urban work force is unemployed (51.1% of men and 67.3% of women). Among the urban employed, 45.6 per cent are permanent employees, 8.1 per cent are contract workers, and 46.3 per cent are casual workers.

Rural unemployment, however, is virtually nonexistent. According to a Ministry of Labour survey (2006), only 0.1% of the rural workforce was found unemployed during a twelve-month period. The rate of child involvement in economic activity in Ethiopia is also among the highest in the world. In 1999, it was estimated that 53.7 per cent of children between the ages of 10 and 14 were working (ILO, 2005). Children’s school enrolment, on the other hand, remains very low (Guarcello, Lyon, & Rosati, 2006). For instance, the labour participation rate of children aged 5-14 is 49.4% (32.9% only...
work and 16.8% work and go to school). The rate of children’s school enrolment is estimated at only 36.8 per cent (20% go only to school). Child labour is primarily a rural phenomenon in Ethiopia, and the differences by gender are large in rural areas (more males than females are in the labour force).

Ethiopian labour unions have been under a difficult situation since their formation (US Library of Congress). In 1962, the government of Ethiopia issued the Labour Relation Decree, which authorised trade unions. In 1963 the government recognised the Confederation of Ethiopian Labour Unions (CELU), representing 22 industrial labour groups. In 1973, the CELU had approximately 80,000 members. The absence of a national constituency, coupled with some other problems, such as election fraud and inadequate finance, limited the union’s activity during the monarchy period. In 1974, although the CELU supported the overthrow of Haile Selassie, it rejected the military junta. This resulted in the temporary closure of its headquarters by the military government. In 1977, it was replaced with the All-Ethiopia Trade Union (AETU), with 1,341 chapters (branch offices) and 287,000 members. Unfortunately, it fell under the control of the military government and failed to regain the activist reputation its predecessor had won in the 1970s. Even after the overthrow of the military government in 1991, its activities have remained under government control.

The government reforms that restructured public enterprises, with a view toward enhancing the efficiency of the public sector and promoting the role of the private sector, have not been welcomed by the AFRODAD. From the union’s perspective, privatisation has encouraged private employers and some government organisations to adopt a more hostile attitude toward workers and unions.

The financial benefits of privatisation have been highly emphasised by the government while the social dimension is often only superficially noted. A significant number of workers from the private sector have been laid off, some enterprises have shut down after privatisation, and bankruptcy and foreclosures have also threatened job security (AFRODAD, 2006). Sometimes neither the failed enterprises nor the government have supplied basic assistance for retrenched workers. The negative impact of reforms on the workers has been significant. Because of this and lack of transparency and consultation mechanisms, trade unions are not in favour of privatisation.

Furthermore, trade unions do not speak for most Ethiopian workers. Given the breadth of the informal economy, the overwhelming majority of workers are not covered by collective
agreement. Ethiopia has no employment benefit system and the unemployed rely mostly on the household.

Haiti - Marcos Rodríguez Fazzone, Marcel Gonnet Wainmayer and Dérgica Sanhueza Cid

Haiti is a peripheral country in the cluster of insecure labour markets. The Republic of Haiti is located in the western zone of the Island La Española, between the Caribbean Sea and the North Atlantic. Haiti is one of the least developed countries in the world, ranked 154 out of 177 countries in terms of PNAD human development in 2006. Haiti has a population of 8.5 million, with a population density of 290 inhabitants per square kilometre. The annual population growth rate is 1.4 per cent. Life expectancy at birth was 52.2 years in 2004. The mortality rate was 74 per 1000 inhabitants and the death rate for children under five was 177 for every thousand inhabitants in 2004 (ECLAC, 2006a).

In January 2010, a strong earthquake devastated the country, killing around 200,000 people and injuring over 3 million. Previously, some of Haiti’s economic indicators had been improving due to international cooperation and the arrival of manufacturing industries attracted by low worker-wages. For example, in 2005 the GDP reached 4.3 billion USD. Although the industrial sector has historically been concentrated in food processing, in the last twenty years the maquila (garment) industry has become the principal manufacturing activity in the country, employing 25,000 workers (66% of those employed in industry) in over a hundred enterprises (ECLAC, 2006b).

Haiti’s emigration rate for the 1995-2000 period was 2.6 per cent, almost three times as much as the Latin American average (0.9%). More than a million Haitians live outside the country: approximately 500,000 Haitians in the Dominican Republic; 419,317 in the United States; 120,000 in Canada; as well as other countries in the region such as Martinique, Guadalupe, Bahamas and Guyana. As in other Caribbean and Central American countries, family remittances represent as much as 23 per cent of household income.

Prior to the earthquake, an estimated 76 per cent of the population lived in poverty, and 55 per cent was indigent. This situation was even worse in rural areas, where poverty reaches 82 per cent. The distribution of wealth is very unequal, with a Gini coefficient of 0.65. Strong inequalities can be noted in education and health. In urban areas, 55 per cent of children between the ages of 6 and 12 attended school; in rural areas, the number drops to 23 per cent (Banco Interamericano de Desarrollo, 2004; WB, 2006a; 2006b).

Approximately one-third of the total population was
economically active in 2000. Men made up 55 per cent of the total employment. Most of the EAP is concentrated in rural areas: 66 per cent were employed in agriculture, 25 per cent in services, and 9 per cent in industry. The crisis in the agricultural sector (lack of investments and supplies, and an absence of educational facilities in rural areas) has resulted in increased migration to the cities. Port-au-Prince has faced increasing problems with overcrowding, underemployment, crime, and poor health and living conditions. The estimated unemployment rate is about 70 per cent, and almost two-thirds of workforce employment was of an informal or precarious nature.

In Haiti, 35 per cent of the population is under 15 years of age. Of those, 10 per cent of children between 10 and 14 are engaged in some type of economic activity. For the most part, they are the sons and daughters of poor rural families, sent to perform domestic labour for higher income families in urban areas, in exchange for room and board and access to education. In some situations, children have been exploited, subjected to moral and physical abuse, and working and living in conditions that are near servitude (Sommerfelt, 2002; ILO, 2004; UNICEF, 2006). The number of children working as domestics has been estimated as high as 300,000 (70% under 15 years of age, 70% women) (Rosenbluth, 1994).

Only 3 per cent of the population has access to some sort of social security. The informal sector (mainly women) and the agricultural sector constitute 96 per cent of the working population. Informal workers have no access to any type of social services. Haiti’s labour market is defined by three basic interlinked variables: public jobs are scarce; those that exist are distributed by nepotism or cronyism; or temporary jobs in public infrastructure and reconstruction works financed by international aid programs and NGOs.

During the past two decades, political turmoil has caused enormous changes in the traditional fabric of civil society. Several initiatives are trying to rebuild the civil and political institutions of the country. The main labour unions [the Centrale des Travailleurs Haitiens, the Fédération des Ouvriers Syndicalisés, and the Batay Ouvriye] became more active during the rule of the Lavalas party, the party of Jean-Bertrand Aristide, which was overthrown by a coup in 2004. Currently these labour unions participate in several development projects sponsored by the ILO, the AFL-CIO, Organization of Inter-American Regional Workers and other French, Canadian and German institutions (ILO, 2006).

The estimated mortality rate due to transmittable diseases is 351.2 per 100,000 inhabitants. The political crisis has undermined
the water supply and basic sanitary services. The disposal of solid waste in the urban areas is not organised and is insufficient, which helps diseases spread. Another factor is the large number of people employed in the recollection of garbage. The rate of tuberculosis is 169 per 100,000, which is the highest in Latin America and the Caribbean (ECLAC, 2005). The HIV/AIDS epidemic is at 517.2 per million, the highest for the continent (ILO, 2005; Pan American Health Organization [PAHO], 2005; ECLAC, 2005). AIDS is the main specific cause of death, according to official records.

In a situation of humanitarian emergency such as Haiti’s, there have been few advances in legislation for labour protection. Presently, labour union protests are focused on fundamental rights such as minimum wage, forms of labour exploitation and violence, and establishing ground rules with respect to foreign investments and the actions of international forces present in the country (Martino, Filippi, & Loiselle, 2003).

The foundation, in 2003, of a free trade zone on the border with the Dominican Republic marked the beginning of a series of conflicts relating to the formation of labour unions in maquila factories funded by international finance capital. These conflicts are fuelled by inflation and the readjustment of salaries. Violence against women has also been the subject of several protests by labour unions, especially in those enterprises oriented towards exportation (Martino et al., 2003).

Although wages improved during Aristide’s government, and rules against child domestic labour were introduced, pressure from investors promoting more labour flexibility caused the labour unions to confront the government. The World Bank and the IMF have demanded reforms, which has given rise to a government improvement program and a set of short-term investments in infrastructure. The limited power of the labour unions, the absence of social coverage and the reduction of state-sponsored jobs have accelerated labour flexibility (WB, 2006c). The reduction of the real minimum wage, which accumulated a 50% negative variation in the last three years due to inflation, also marks an important setback for labour concerns.

The UN Economic Commission for Latin America and the Caribbean (ECLAC) has recently called attention to the faulty implementation of the public works committed for the country, which makes job creation difficult and stops economic reactivation. The United Nations has designated $97.9 million for the UN Transitional Appeal 2006-2007 in Support of Stabilisation in Haiti, a special initiative to address the collapse of the state health and educational systems and introduce productive improvements in the country’s
agricultural system.

Cuba - Jorge Román

Given its specific characteristics, Cuba has not been included in the typology of countries. The Cuban archipelago occupies an area of 109,886 square kilometre. Its population in 2006 was 11,2 with a population density of 102.3 people per square kilometre (75.5% urban), and a demographic growth rate of -0.4 per cent. The Cuban Republic has a socialist political regime, with state property predominating in the economy. In 2006 the EAP (both sexes) reached the level of 4,847,300 (62.68% men). Of these, 4,754,600 (98.08%) were employed. The total unemployment rate was 1.9 per cent (men 1.7%, women 2.2%). The youth unemployment rates by age groups (both sexes) were: 15-16 years of age, 0.02 per cent; 17-19 years, 2.84 per cent; and 20-29 years, 17.29 per cent. The three main groups of export goods (in order of export value) in 2006 were products from mining, tobacco, and sugar industries. Medical care services provided abroad, tourism, and money sent by Cubans living abroad were also important sources of income for the country. The main imports (in order of imported value) were transport equipment and machinery, fuels, lubricants and related articles, and foodstuffs and livestock.

The principal employer in Cuba is the state, which employs 81.78 per cent of Cuba’s workers through its enterprises and centres of production and services. However, cooperatives account for 5.41 per cent of all employed people, and the private sector employs 12.81 per cent. The private sector includes people who are self-employed (3.21% of all employed). The self-employed in authorised autonomous jobs pay a tax quota fixed by law. Informal economic activity as a unique job is minimal (the source of all geographic, demographic, and economic statistics in the above paragraphs is the Oficina Nacional de Estadísticos. Other government sources of information about employment and working conditions used in this case study are the Código de Trabajo, Ley 49/1984; Constitución de la República; Leyes, decretos leyes, acuerdos, resoluciones e instrucciones relacionadas con la salud, la seguridad y el medio ambiente laboral; Ministerio de Salud Pública, Anuario estadístico).

The monthly average salary in 2006 reached 387 CUP. Cuba has two official currencies, the Cuban Peso (CUP) and the Cuban Convertible Peso (Cuban Unit Currency or CUC) [1 CUC = 24 CUP = 0.80 USD]. Many basic products are sold in CUP at low prices, while many other necessary products are sold in CUC. While, in some formal jobs, extra payments in CUC are given to stimulate the workers, and some
economic sectors provide opportunities of extra income in CUC and foreign currencies (i.e. tourism), access to strong currency (CUC) by means of formal employment is still limited. In general, the existence of two currencies and the deformations of the relationship between wages and prices determined that salaries have lost their correspondence with important aspects of peoples’ quality of life, as well as their correspondence with the amount and quality of the work done. This situation has conditioned many formal workers to participate in additional informal economic activities in order to increase their income.

Employment is guaranteed for all citizens fit to work and there is no temporary employment or precarious jobs. There is no child labour, slavery or bonded labour in Cuba. In Cuba, job vacancies are filled by candidates whose abilities are suited to the position. Termination of an employment contract by the employer must be legally justifiable (retirement, total or partial disablement with no possibility of internal transfer to another job, or being demonstrably unsuitable for the job are some legal reasons for termination). When an employee is terminated, for whatever reason, he or she is compensated and the employer may also be obligated to guarantee placement in another job. The Cuban Workers’ Union, a consortium of all unions, has legislative initiative and is also a source of material rights, since it has the right to promote changes in legislation. These and other topics are discussed at workers’ congresses. The unions’ chief responsibilities are to represent workers and to negotiate collective wage agreements.

Cuban social security is universal, providing coverage for all workers and their families against occupation-derived risks. The entire population is covered by the National Health System. All health services are free for the whole population. The social security system is made up of both long-term economic subsidies and short-term ones borne by the employer. These subsidies provide coverage for workers and their families in conditions of retirement, death of the spouse, disability and others. In 2006, social security had 1,533,230 beneficiaries and the total expenditure was 3,783 million pesos. Pensions for old-age, total disability or death accounted for 90.43 per cent of this expenditure; accident and illness subsidies for 5.56 per cent; partial disability pensions for 0.08 per cent; the category “other expenditure,” which covers maternity leave, accounted for 3.68 per cent; and “complementary expenditure,” 0.08 per cent.

Except for occupational diseases, which generally correspond to working conditions and exposure to specific risks, there is no evidence
that workers’ health problems differ substantially depending on employment status. Health inequalities at the macrosocial level may exist between urban and rural populations, and across geographic areas, and also between job sectors (services, production, public administration) and income levels. Discrimination on the basis of race, skin colour, sex, nationality, religious beliefs or any other offence to human dignity is forbidden and punishable by law (Article 42 of the Constitution of the Republic). Cuban people generally consider their Cuban identity as superseding any racial or ethnic identity, a cultural pattern that prevents discrimination in the work place or in access to health care or awareness. At the microsocial level, dangers and risks are attached to certain professions and working conditions, either environmental or organisational. Moreover, psychosocial risk has increased in the growing services sector. The repercussions of health problems are a topic of research among experts in occupational health, including repercussions for the worker’s family. Although no national surveys have been conducted on job conditions and health in the working population, studies in specific sectors and territories have suggested that between 30 per cent and 50 per cent of interviewees, and in some cases more, claim occupational stress (Román, 2003; 2007; Hernández, 2003).

The Sistema Nacional de Vigilancia de las Enfermedades Profesionales (National Occupational Diseases Surveillance System), in operation since 1998, tracks occupational disease throughout the country. The following are some data related to occupational illness and injury. In 2006, 307 cases of occupational disease were diagnosed in Cuba, representing a rate of 15.9 per 105 workers. This rate is the lowest in the last five years; the highest was 19.4 per 105 workers in 2002. Between January and September of 2007, 245 cases of occupational disease were diagnosed: 101 cases of chronic nodular laryngitis (CNL); 66 poisonings with insecticides; 26 cases of hypoacusia; 10 cases each of pneumoconiosis; and 10 cases of brucellosis. According to statistics from the “Ministerio de Salud Pública” (Ministry of Public Health), between 1998 and 2003, 841 cases of CNL were diagnosed, representing incidence rates between 11.58 and 5.60 per 103 individuals exposed. The most affected groups in terms of sex were women (92.0, with incidence rates between 15.79 and 9.57 per 103) and, with respect to occupation, primary teachers (81.68, rates between 26.8 and 11.9 per 103). CNL persists as an occupational health problem, mainly in primary and kindergarten/creche teachers, appearing at lower ages and with shorter exposure times than among people making a living using their voices (Reyes García, 2006). In 2006, according to the
"Oficina Nacional de Estadísticas" (National Office of Statistics), 5,940 cases of occupational injury were reported, 82 being fatal. The incidence rate was 1.9 injury cases per 103 workers; the frequency of injuries was 0.9 cases per 106 person-hours worked; and the death rate was 13.8 fatal accidents per 103 workers injured. Between January and September 2007 there were 61 fatal accidents with 62 deaths, of whom only one was a woman. The sectors most affected by occupational accidents were agriculture, local state administration, construction, and primary industry (statistics from the Oficina Nacional de Inspección del Trabajo).

In 2005, of a total of 48,789 workers assessed in the Comisiones Provinciales de Peritaje Médico Laboral (with an average rate of 16.9 visits per 103 workers), 6,786 were declared totally and permanently disabled, corresponding to 13.9 per cent of the population visited, a rate of 234.8 per 10,000 workers. The main causes were: cerebrovascular diseases (186.9 per 1,000 workers); osteoarticular diseases (180 per 1,000 workers); diseases of the circulatory system (152 per 1,000 workers); mental conditions (132.9 per 1,000 workers) and cancer (105.9 per 1,000 workers) (Linares, Díaz, Díaz, Rabelo, & Suárez, 2007). The national health system, through the primary health care institutions (33,221 doctors in 14,007 medical centres) offers its services for general health problems presented by the workers in the institutions of each community. The law provides the legal framework for protection of both workers and the population at large. Prevention of occupational risks and their health consequences constitute an integral part of this regulatory framework, and is the mission of occupational organisations, unions and their corresponding collective negotiation mechanisms. Improvement in job and employment conditions forms part of these aims and practices. The Ministry of Labour and Social Security, the Ministry of Public Health, and the Cuban Workers Union, constitute the main actors involved in policies for preventive health and protection of workers’ health. Local administration, unions and political organisations of each work place enforce compliance with these regulations, under the supervision of government officials.
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"Hidden behind workplace walls, they are invisible to society. Everyone knows-and suffers-their own working conditions, but is unaware of those of others. So, they are situations experienced by all but as the daily routine of the masses they escape the observer. They happen behind closed doors and are always guarded like an industrial secret."

Asa Cristina Laurell
In order to understand employment conditions, an analysis of power relations (e.g., between employers, managers or state officials and workers) is crucial. Technology and living standards can change dramatically over time but, unless these power relations are examined historically, we will not be able to fully capture the social mechanisms that make health inequalities at work so durable throughout time and place. Occupational health has been notorious for ignoring power relations (e.g., focusing typically on biological or physical hazards in the workplace) or by focusing on psychosocial factors that do not contemplate power relations (e.g., demand/control and effort-reward models). Therefore we begin our section on employment relations and health inequalities by introducing power relations and their importance to employment-related health inequalities, mainly emphasising the power of corporations and its consequences. We follow with a brief account of the consequences of these power struggles, namely the consequences of labour market regulations in the workplace, which tend to mitigate the health inequalities produced when workers do not have enough power over their employment and working conditions. Specifically, we emphasise the effects of the social and economic processes that take place among immigrants, such as those in Export Processing Zones (EPZs) in middle-income and poor countries. Finally, we follow with a detailed account of employment and working conditions as social determinants of health inequalities in populations.

7.1. POWER RELATIONS

One of the aims of this book is to analyse the "political economy of health" (Navarro & Muntaner, 2004; Navarro, 2002) as the context of employment relations created by the interaction between powerful economic entities and political institutions (see Chapter 4). It is important to understand that these actors have a significant impact on the lives of different social groups in different ways. The decisions they make create different levels of exposure to hazards in the workplace and the possibility of living a healthy life.

In an increasingly globalised, market-based economic system, the political, economic, financial and trade decisions of a handful of institutions and corporations affect the daily lives of millions of people worldwide. These decisions create labour standards, occupational health and safety regulations, and union protections, among many other things. Large corporations are particularly relevant to this process thanks not only to their
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growing power and resources but also to their pervasive influence on key economic decisions that have serious consequences in the production of health, disease, and death (Wiist, 2006) [see Case study 5].

Of the world’s 150 largest economic entities, 95 are corporations. The revenues of Wal-Mart, BP, Exxon Mobil, and Royal Dutch/Shell Group all rank above the GDP of countries such as Indonesia, Saudi Arabia, Norway or South Africa (WB, 2005). Multinational corporations manufacture many of the goods and services we consume and they contract or subcontract millions of jobs, many of which have a negative impact on employees’ health. This is because corporate behaviour and decisions may directly or indirectly promote disease in various ways: through advertising aimed at creating new customers, through public relations in order to foster a positive image of their products or activities, through litigation intended to delay, weaken, or overturn laws and regulations, through sponsored research which supports their points of view, or even using illegal strategies to advance their objectives.

In addition to those corporate decisions which relate to a single company, large companies can shape unhealthy employment relations through campaign contributions. Campaign contributions and lobbying for legislation both favour private corporate economic interests (Freudenberg, 2005). In 2002, for example, the drug industry in the United States contributed about $22 million to Republican Party representatives and almost $8 million to Democrats. In the European Union (EU), the intense political lobbying of employers concerning legislation on chemical products (REACH, or Registration, Evaluation and Authorisation of Chemicals) is much of the reason why the European Commission significantly watered down chemical regulation reform. Many other examples may be found in poor countries [see Case study 6].

Both corporations and governments often hinder the development of trade unions in an attempt to shape working conditions so that they widen profit margins, and in turn fund their lobbying activities. They may also limit involvement in work organisation and occupational health and safety matters (Hogstedt, Wegman, & Kjellstrom, 2007). The result is a workplace environment in which individual, rather than collective concerns and actions, are very often emphasised. As an illustration of these complex interrelations, we highlight the case of China [see Case study 7] and the impact of two large corporations: the largest retail company in the world [see Case study 8] and a growing global company [see Case study 9].

"Before I was injured, I had health care through Medicaid. Wal-Mart refused to pay my worker compensation benefits from my injury, and then Medicaid dropped me because the injury happened at work. Now I have no insurance coverage at all; I cannot get it through Wal-Mart or anywhere else. Wal-Mart has ignored my bills and my pain. […] I have accumulated tens of thousands of dollars in debt from medical bills, lost my apartment, my credit is ruined and I live in pain every day.”

Case Study 5. Neo-liberal agricultural policies and farmers’ suicide in India. - Atanu Sarkar and Mona Anand

About three-fifths of India’s workforce is employed in the agricultural sector, the land being the main source of livelihood for most of the over one billion Indians. Seeds are the primary means of production in agriculture. Over centuries, seeds have been evolved by farmers who have freely saved and exchanged them, and freely planted a diversity of crops in order to maintain ecosystems, meet their diverse needs and earn incomes (Shiva, 2004). However, since the 1990s, an epidemic of suicides among farmers shows that farming has become a hazardous occupation. The exact national figure of suicides is not available and the identification of farmers’ suicides is extremely difficult, but it is estimated that between 1997 and 2005, over 150,000 farmers committed suicide (Sainah, 2007). Any suicide might be viewed as an individual decision emerging from the despair caused by a complex web of tragedies. Although the linkages between that concrete personal decision and the historical context in which it takes place are difficult to make, a key public health question is to understand the economic and social determinants of this epidemic.

In the late 1980s, farmers were encouraged to shift from their traditional self-sufficient cropping (of paddy and vegetables) to more remunerative cash crops. But unlike their traditional food crops, total reliance on cash crops entailed a gamble, since fluctuations in market prices affected their earnings. Furthermore, their cultivation involved huge expenditure on inputs like fertilisers and pesticides. In 1988, the World Bank recommended a shift towards the private sector and the entry of multinational companies into the seed sector. That same year, the New Seed Policy was introduced, lifting restrictions on private sector importations of foreign germplasm, enabling larger seed producers, particularly those with foreign collaborations, to access seeds from international sources. These strong trends towards the privatisation and concentration of the seed industry and the displacement of farmer varieties increased the costs of seeds and agrochemicals for farmers, which in turn increased farmers’ debts. This new kind of corporate feudalism led by multinational corporations is capital-intensive and produces an agriculture that is socially, economically and ecologically non-sustainable. Farmers started to lease land for the production of monocultures of introduced varieties and non-sustainable practices of chemically-intensive farming. In addition, the introduction of higher-performing, more expensive genetically-modified crop seeds further increased the gap between small and large farms.

The key consequences of the neo-liberal policies driven by multinational corporations may be summarised as follows: dependence on the monopolies of seeds, dependence on supply and use of pesticides, cumulative loss of crops, under-priced crops, and cumulative debts of farmers to private money lenders (leading to even the sale of kidneys among the most desperate farmers) (Shiva, 2004). The final outcome, however, has been a growing epidemic of suicides among many smaller farmers who have been proportionally more affected by debt woes than larger ones. Today’s agricultural economy favours large producers, and small farmers have almost no ability to secure credit through conventional banks, allowing usury moneylenders to step in. High interest rates, combined with the low annual income of the small farmer, have created a vicious debt trap. Once caught in this trap, the small farmer either has to sell or mortgage his land or commit suicide as an extreme step as declared by several family members: “Now my father in law has ended his life after he failed to repay a loan to the money lender”; “my husband committed suicide two years ago after he fell ill and could not afford this treatment” (Farooq, 2004).

The epidemic of farmers’ suicides may be thought of as a barometer of the stress faced by many farmers in India, as a result of the globalisation of agriculture. This public health crisis does indeed have its roots in neo-liberal policies, which have had a disastrous and unforeseen effect, leading to farmer indebtedness, which often overwhelms the average farmer-owner.

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Case study 6. A wealthy country with poor workers: the role of power relations in the Democratic Republic of Congo. - Joan Benach

The Democratic Republic of Congo is one of the richest countries in Africa. Minerals like cobalt, copper, zinc, manganese, uranium, niobium, and cadmium are abundant, and the country has vast reserves of other strategic minerals such as cassiterite, a tin ore used in computer circuitry, and coltan (a contraction of columbium-tantalite), a heat-resistant mineral vital for making superconductors and transistors in cell phones, laptops, PlayStations, automotive electronics, and missile guided systems. In Congo, however, most people live in complete misery, many are undernourished, and the mortality rate is very high, with one in five newborn children never reaching the age of five. How a country can be so wealthy and have people living at the margins of survival is a paradox that can only be explained through a deep examination of its international power relations.

Congo’s wealth mainly serves the interests of Western governments and corporations such as Sony, Microsoft, IBM, Nokia, Motorola, Hewlett-Packard, Dell and Intel. The U.S. government, for example, has for decades spent millions of dollars in securing access to these minerals by training and arming human-rights abusers and undemocratic regimes like Mobutu’s dictatorship, while the wealth of Congo is used to enrich high-technology and mineral companies profiting from the cheap extraction and exportation of minerals (Montague & Berrigan, 2001). The exploitation of the country’s natural resources by governments and western companies has fuelled a war that has engaged various countries (Congo, Angola, Namibia, Zimbabwe, Rwanda, and Uganda), producing a frightening human catastrophe with widespread hunger, violence, malnutrition, infectious diseases, and four million deaths between 1998 and 2004, more than any other conflict since World War II (Coghlan et al., 2006). In addition, the war has spread the use of child soldiers, of child slavery in mines, a mass displacement of people, and the widespread use of rape as a weapon of war.

The working conditions of most Congolese people look grim. Most workers are in the informal sector, in subsistence agriculture with an average income that is insufficient to sustain a family. Child labour is common, and many children have to support their families instead of attending school. Child mining in coltan mines, stone crushing, and prostitution are some of the worst forms of child labour. Many studies have also reported the forced or compulsory recruitment of children as soldiers by different armed groups. Although few women actively participate in the war itself, women and girls are also victims of the conflict. Sexual violence has been used as a weapon of war by most of the forces, which are involved with large-scale rapes and abductions. Women serve as forced labourers performing domestic labour, including finding and transporting firewood, cooking, and doing laundry for the same men who held them captive and sexually assaulted them (Human Rights Watch, 2003; 2007). A 1967 Labour Code provided guidelines for labour practices, including the employment of women and children, anti-discrimination laws, and restrictions on working conditions. However, the unfair power relations portrayed above, the collapse of the economy and the corruption of the government destroyed the enforcement of such laws. Today there is a vital need for the international monitoring, regulation, and certification of natural resource extraction and sale. Such a goal, however, will only be accomplished by a mobilised public bringing pressure to bear on governments to create the necessary institutions for such a response.

References
EMPLOYMENT, WORK, AND HEALTH INEQUALITIES - A GLOBAL PERSPECTIVE

Case study 7. Privatisation, working conditions, labour movement and worker protests in China. - EMCONET*

The turn of the millennium saw a massive sell-off of state assets in China, which led to the number of private enterprises tripling from 440,000 to 1.32 million between 1996 and 2001, reaching 5 million in 2006. By the end of that year, private enterprises accounted for approximately two thirds of GDP and 70-80 per cent of economic growth. The closure and merger of hundreds of thousands of state-owned enterprises in the mid- and late-1990s has had a number of important consequences.

First, millions of laid-off workers demanded re-employment at their former company or to be granted formal retirement. Workers found it increasingly difficult to find re-employment, and those that did find jobs usually obtained low-paid, temporary employment and soon became unemployed again. This process took place in a context in which managers or local governments refused to strictly implement central government policy regarding restructuring, or reneged on promises made during restructuring, leading to workers’ protests.

Second, it initiated a rapid decline in the standard of living for a large number of workers after they were laid-off, and a widening gap between the rich and the poor. While in 1978 urban income was 2.6 times rural income, the gap expanded to 3.3 times rural income in 2006. Taking into account that rural residents basically have no social security or welfare benefits, the actual urban-rural income gap is probably six to one, in favour of urban income. From 1985 to 2002, the absolute difference in annual income between the highest and lowest income groups increased 20.6 times.

A third consequence is the growth of worker protests as a response to unemployment, low wages or the non-payment of wages, exploitation, and the violation of labour laws and regulations with regard to employment and working conditions, particularly in the case of migrant workers. In 2006, only 33.7 per cent of migrant workers had signed job contracts with their employers, 30.6 per cent had not signed contracts, and 15.7 per cent of the workers did not know what a labour contract was. Over 35 per cent of workers were only occasionally paid on time, and 15.7 per cent usually had their payment delayed. Migrant workers worked an average of 6.3 days per week, for about 9 hours per day. Only 11.9 per cent had a two-day weekend, 46 per cent had not signed a contract or agreement, 14.9 per cent were unable to obtain their wages on time, 30.1 per cent worked overtime with no overtime compensation, 57.2 per cent did not receive compensation for work-related injuries, 79.5 per cent received no paid vacation, 92.4 per cent did not receive a housing subsidy, 79.8 per cent of female migrant workers received no maternity leave, and over 70 per cent had no social security plan.

Over the last few years, China has been characterised by continued mass disputes undertaken by laid-off urban workers and, since 2002, by the protests of migrant workers caused by the violation of their rights, low wages and failure to receive wages on time, hazardous working conditions, excessive overtime, and intimidation. From 1994 to 2004, the number of collective labour dispute cases handled by labour dispute arbitration committees and the number of workers involved in such cases increased substantially year by year. Moreover, mass protests by workers such as demonstrations, sit-ins, strikes and so forth also increased greatly during the same period. It is estimated that between 1993 and 2003 the number of mass protests in China grew each year from 10,000 to 60,000, with a corresponding increase in the number of participants each year, from 730,000 to 3.1 million. For example, on 27 July 2005, over 500 employees at Dongzhi Dalian Ltd. went on strike to protest arbitrary increases in the speed of the production line and low wages. This action prompted strikes by workers at other Japanese-invested firms in the Dalian Enterprise Zone such as Mitsubishi, Toshiba, NEC Electronics, Nissin and Asahi. In total, more than 30,000 workers at a dozen companies went on strike.

In 2003, the central government introduced a number of measures designed to improve the living and working conditions of rural migrant workers in the cities. Just a few years later, however, there was little evidence that these measures had taken effect. In many cases, many local governments still adopted repressive measures, and management often used the technique of “divide and rule” to weaken disputes. The Chinese government has not addressed the root causes of social unrest, namely corruption, social injustice and income inequality, nor has it given the Chinese people more freedom of speech or the right of assembly.

Transnational companies’ codes of conduct may have helped to improve working conditions at some factories. However, much like the government’s collective contracts programme, corporate codes of conduct have largely been imposed on factories in a top-down manner and without the involvement of the workforce. Although corporate social responsibility could in theory help the development of workers’ rights in China, these practices have yet to significantly improve working conditions or relations between labour and management as a whole. Reasons for the ineffectiveness of these practices stem from the fact that they are not a genuine move towards increasing the empowerment and participation of workers.

Since the 1990s, the Chinese government and the All-China Federation of Trade Unions (ACFTU) have developed a basic legal, regulatory and administrative framework for promoting the collective labour contract system. Collective contracts can help empower workers and encourage them to stand up for their legal rights, while at the same time enhancing labour-management relations. The implementation of the new Labour Contract Law from January 2008 onwards may further strengthen the legal framework and create a generally beneficial policy environment for undertaking individual and collective contract negotiations. Thus far, however, because of the lack of genuine worker participation in contract negotiations, they have brought only limited benefit to China’s workers. Collective contracts directly negotiated by democratically-elected workers’ representatives will not only help realise the aims and objectives of corporate codes of conduct, but will also have the crucial advantage of being legally enforceable. Free collective bargaining should be introduced into the collective contracts negotiating process as a means of not only protecting workers’ rights and interests but also of improving labour-management relations. Given the widespread abuse of workers’ rights and the often severe tensions that exist between labour and management in China today, there is now an increasingly urgent need to promote greater worker involvement in this process. The challenge for China’s labour movement is to give real substance to this
process by gradually introducing collective bargaining into the process.

* This article is based on research reports and reference material published by China Labour Bulletin.

**Sources**


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**Case Study 8. Wal-Mart’s nation and its impact on labour and health. - Joan Benach and Carles Muntaner**

Founded in 1962 in Rogers, Arkansas, Wal-Mart has become a ubiquitous component of the U.S. landscape (96% of the population live within 32 km of a Wal-Mart location, expanding steadily in countries such as Mexico, Japan, Canada, the United Kingdom, and China to become one of the world’s largest “corporation nations.” Wal-Mart’s sales are bigger than the GDP of all but a few countries, having the largest labour force in the world with the exception of government employment (Zook & Graham, 2006). Wal-Mart is thus the largest retail company in the world, employing 1.8 million people across the globe, including 1.3 million in the United States (more than GM, Ford, GE, and IBM combined), with revenues accounting for more than 2 per cent of GDP. This commanding position has been achieved thanks in part to its pioneering low-price/high-volume business model, which has squeezed competitors and suppliers alike by aggressively implementing supply-chain operating efficiencies, increasing productivity in distribution, and using its market power to dictate lower prices to its suppliers (Dube, Eidlin, & Lester, 2005).

Wal-Mart has been widely criticised for its policies and labour practices by labour unions, community groups, grassroots and religious organisations and environmental groups. For example, it has been accused of wage abuse (e.g., workers at Wal-Mart earn on average a third less than their counterparts in similar jobs), bilking workers of due overtime pay, firing employees for discussing unionisation, discriminating against female staffers, and not providing appropriate health insurance (Grimm, 2003). In the United States, as recognised by the company itself, health coverage is inadequate and expensive for their employees (they spend 8% of their income on health care, nearly twice the national average), and Wal-Mart has a large percentage of employees and their children on public assistance (Greenhouse & Barbaro, 2005). Indeed, Wal-Mart encourages its low-income workers to benefit from state public assistance and social services, particularly public health care benefits, so that citizens are truly subsidising this wealthy corporation (Dube & Jacobs, 2004). Not only does the company have aggressive plans to attack growth in employee benefit expenses, but it also controls its workforce by opposing unions and fighting efforts at unionisation. When employees are hired, they are immediately shown an anti-union video. Store managers are often held accountable for the success of union organising, and they have sometimes been accused of violating labour laws to stop it (Rose, 2006). When workers at a Jonquière, Quebec, Wal-Mart voted to unionise, Wal-Mart closed the store five months later, citing weak profits (Bianco, 2006). In developing countries, the situation is often worse. In China, workers in factories are often teenage girls and young women who work in sweatshop conditions, thirteen to sixteen hours a day, with wages well below subsistence level and no enforcement of health and safety rules. In the Philippines, Wal-Mart has been accused of violating workers’ freedom of association, forcing workers to take on 24-hour shifts, and not allowing workers to drink water or go to the bathroom during work hours. Moreover, the impact of Wal-Mart on labour and health goes beyond direct employees, having an impact on indirect workers subcontracted by third-party providers and on competitors’ employees. The Wal-Mart model ensures a race to the bottom, pitting workers against each other as countries seek to keep labour costs low.

**References**


7.2. LABOUR REGULATIONS AND THE LABOUR MARKET

By working on the assumption that free market globalisation and increased global competition require a continuous race to the bottom in costs, corporations and governments push labour standards down to levels of brutal economic exploitation and slavery-like practices. This is especially true in middle- and low-income countries. In other words, global economic pressures for efficiency encourage the development of employment relations that are extremely unhealthy. The globalisation of production processes and the generation of health inequalities are rather apparent in recent decades, even in the most technologically advanced industries [see Case study 10].

EPZs have become the symbol of this new global economic order and its potential effects on labour regulations, industrial relations, and workers’
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welfare. The ILO has defined the EPZ as an “industrial zone with special incentives set up to attract foreign investors, in which imported materials undergo some degree of processing before being re-exported.” (ILO, 2007). EPZs go by many names such as free trade zones, special economic zones, or maquiladoras. These zones are intended to attract foreign investment, and are thus subjected to preferential treatment as regards fiscal and financial regulations. Often, this involves exemptions from part or all of the labour code, including occupational health and safety regulations. In 2006, there were 116 countries with EPZs, adding up to a total of 3,500 EPZs. In this same year, 66 million people were working in EPZs. In China alone, there were 40 million people working in EPZs, amounting to about a third of the ten-year growth of employment in China or a third of the whole industrial manufacturing workforce. For many, then, EPZs appear to be an efficient strategy by which middle- or low-income countries can develop their economies, create employment and improve their infrastructure. However, this success typically comes at the price of creating very unhealthy working environments.

Ironically, it is the very reason that EPZs are so attractive to investors which often creates these hazardous working and employment conditions (see Case study 11). The downright dangerous work environments and the near impossibility of union formation indicate to investors that productivity is the key concern in many EPZs. Looking at the example of China, we can see that EPZs have created jobs that result in young women’s massive entry into the formal labour market (Hogstedt, Wegman, & Kjellstrom, 2007). However, workers suffer from poor work environments and practices there and around the world (see Case study 12). In these working environments, un-paid overtime work, sub-human working hours, and deficient health and safety standards are common. For example, there are factories where workers are locked into the workplace during working hours. In some cases, workers have died in fires while locked in their building. Poor ventilation, failure to provide medical attention, lack of proper accommodation and the creation of social “ghettoes” in barracks-style living quarters are other examples of EPZ employment practices. The problem is even more pervasive when considering the hostile employment relations in many EPZs. Relentless hostility towards trade unions is a constant, and is among the arguments put forward by authorities in order to attract investors (ICFTU, 2003). Threats of dismissal, physical assault or even death are used to discourage
“The government must understand that immigrants do all the jobs that people here don’t want to do, so they are not useless and they contribute enormously to the economy.”

Source: Joseph Rowntree Foundation.
People in low-paid informal work. Need not greed. Kagezy, 30, hospital porter, works on “borrowed papers” waiting for asylum.

workers from joining the unions. Several countries, moreover, prohibit strike action in EPZs.

In the last few decades, capitalist globalisation has expanded economic migration, transforming the lives of hundreds of millions of people around the globe. In many countries, economic migrants meet the demand for flexible labour. Often labour markets are unable to provide workers who are either flexible or mobile enough and prepared to accept precarious employment conditions with long hours for low pay. Fleeing poverty, war, or unemployment, workers migrate away from their families and neighbourhoods to serve as a labour force in rich countries and send capital in the form of remittances back to impoverished communities around the world (see Case study 13). Neoliberal economic policies (and agencies like the World Trade Organization, WTO) are also trying to create a new international guest worker system, guiding the flow of migrants on a global basis in order to fulfill corporate labour needs (Quinlan, Mayhew, & Bohle, 2001; Toh & Quinlan, 2009). The General Agreement on Trade in Services (GaTS) has identified four modes of trade in services. The Mode 4 proposal made by the WTO in Hong Kong in 2005 dealt with the temporary movement of persons, i.e., when independent service providers or employees of a multinational firm temporarily move to another country. Mode 4 refers to persons working abroad, but only to a very restricted category of migrants. It only covers suppliers of services and the temporary movement of workers, as GaTS excludes “natural persons seeking access to the employment market” and “measures regarding citizenship, residence or employment on a permanent basis”.

Case Study 10. How does a production sector make social inequalities in health worse? - Laurent Vogel

The growing internationalisation of production sectors has become more apparent in recent decades. Not many of the things we consume are produced entirely in one country nowadays. The organisation of production is creating wide health inequality gaps.

This is fairly common knowledge where agricultural commodities and raw materials exported to industrialised countries are concerned. Sugar has always left a bitter taste in the mouths of the generations of slaves who worked the plantations and the farm labourers who came after them. Asbestos production is a well-publicised health disaster, but its calamitous effects have differed widely by social class. It has left the well-to-do relatively unscathed and slain hundreds of thousands of miners, workers in the building trades, textiles and other sectors of the manufacturing industry. These wide class differences are even more striking when looked at on a world scale. Asbestos is now mostly used in countries where workplace health and safety standards are very low. It is currently used mostly in Asia and, to a lesser extent, Latin America and Africa, while it has almost entirely vanished from Europe, North America and Oceania.

The electronics industry has contributed significantly to the trend towards worsening global social inequalities in health. Computers and mobile phones are everywhere; what daily activities get done without the use of some electronic device? Yet the familiarity of technology that is all around us shrouds the physical reality of the production process in even greater obscurity. The devices seem so light, toylike, outside the realm of hard matter, that we perceive the work embodied in them as pure intellect or information. This illusion of dematerialised technologies masks the exploitation of the workers that produce them and the widespread health damage that results.

A network of activist researchers, trade unionists, and environmental groups has gradually coalesced since the late 1970s. From California’s Silicon Valley to Scottish semiconductor circuit assembly workers, from the maquiladoras that assemble TV sets in Mexico to the Taiwan labourers suffering chemical pollution diseases, the network links together dozens of groups and movements who have not resigned themselves to “paying the price of progress.” The pooled research of these groups is showing us how the international division of labour in the electronics production sector is converted into mass inequalities. Not all those involved in the production process are exposed to the same risks, any more than they have the same access to preventive health and health protection provision. An entire production cycle can be tracked and seen to have unequal effects between genders and countries depending on the political and social conditions and the intensity of workers’ resistance.
The plight in the electronics industry is worsened by the end-of-life cycle of products, for the organisation of production creates mountains of waste. The information technologies sector has operated on a strategy of planned obsolescence resulting in a colossal waste of resources. While there is nothing new to the history of capitalism in such a strategy, it had never been pushed to the point of scrapping most of the equipment produced after a few years, when it was physically able to operate for decades. Public opinion may have been aghast at the coffee mountains burned to solve the production glut during the 1929 crisis, but the same thing is happening every day on a much bigger scale with electronic components. In many cases, they are disposed of or recycled in atrocious working conditions in China or India, or by prisoners in United States jails.

Knowing this, it is hard to think well of billionaire electronics industry moguls when they launch charitable operations to promote health. The money put into them represents only a fractional share of the profits paid for by health disasters.

Sources

Case study 11. Flower production in Ecuador and Colombia: working conditions and implications for workers' health and the environment. - Jorge A. Palacio

Influenced by neo-liberal policies, some Latin American countries have adopted regulations meant to convert their traditional model of agricultural production into another one that is more focused on non-traditional products and characterised by single corps. One example is the flower agribusiness, characterised by low wages, extended working hours and reduced overtime pay. There are reports of women's rights violations, where in some cases women were asked to provide proofs of sterilisation before being contacted and others were fired as a result of pregnancy. Basic workers' rights are not respected in most of the flower agro-business. Numerous cases have been reported in which workers are not allowed to create trade unions, and those involved in this kind of initiative are systematically fired.

This new agricultural model of flower production in Ecuador and Colombia has led to extensive health and environmental problems. The flower agribusiness has a strong impact on workers' health. Some data established that about 40,000 and 110,000 workers are directly involved in the flower industry in Colombia and Ecuador respectively (65% of them women) and nearly 66 per cent suffer from work-related health problems [US/Labor Education in the Americas Project & International Labor Rights Fund, 2007]. Flower production is associated with altered blood pressure and blood-related markers (anaemia, leucocytes), liver disorders, asthma, neurological problems, premature births, congenital malformations, genetic instability, toxicity, malnutrition, stress and workers' high perception of risk at work. However, other not less important factors also characterise the flower industry, such as low wages, obligatory and extended overtime, women's rights violations, or child labour, although the extent of the cases is not well known and insufficiently studied.

In addition to a moderate increase in salaries and the technological modernisation of the sector, the flower agribusiness implemented in Ecuador and Colombia is also characterised by the loss of cultural and social values and its tremendous impact on the environment (Breith, 2007). At the environmental level, only a few members (no more than 20%) of those new flower agribusinesses follow the regulations set by the Flower Label Program to ensure environmental safety and good labour and market practices. As a result, there is uncontrolled use of chemicals and pesticides, with an evident impact on the hydrology surrounding those agro-industries. Moreover, there is evidence of the harmful impact of chemical use not only on the water supplies and rivers but on other fields and plantations (i.e. potatoes, onions) and, even riskier, data suggest a bioaccumulation of sub-products of DDT in cow milk (Sánchez & Mac, 2005).

The production of flowers should evolve into a fairer and more ecological agribusiness characterised by its minimal impact on the health, environmental, and social conditions of those communities where flowers are produced. Social, academic and non-governmental institutions are the most important organisations involved in this purpose, but customers should also take responsibility for environmental protection and workers' wellbeing associated with the flowers sold in the United States and European markets.

References
Case Study 12. What are the origins and consequences of maquilas? - María Menéndez and Joan Benach

Maquilas is the short form of maquiladoras, a term originally associated with the process of milling and which later became common parlance (together with the term sweatshop) to mean the industrial plants built by multinational corporations in poor countries in order to take advantage of the much lower cost of doing business there. Currently, millions of clothes, car stereos, shoes, and children’s toys are produced in these plants. This phenomenon started in the mid-1960s, when about 185,000 Mexicans returned to Mexico after the United States ended permits for “guest workers” [braceros] to work as farm workers. This scenario facilitated the creation of a so-called free trade zone, where U.S. firms set up assembly plants on the Mexican side of the border (the Border Industrialization Program). These factories were thus allowed to import components and raw materials duty-free and re-export the finished product to the United States [Williams & Homedes, 2001]. During the 1980s, maquilas spread out in Central America, mainly in Nicaragua, Honduras, Guatemala, El Salvador, Dominican Republic, and in the 1990s in the south-east of Asia and the north of Morocco, to cover the U.S. and the European markets, respectively. Today, in Mexico, Honduras, and Nicaragua, about 1.5 million workers are employed in maquilas. Local governments and multinationals claim that these factories are a source of wealth and economic development in the country, promoting the creation of jobs, technological advances, and workers’ training, which all contribute to the improvement of peoples’ living conditions. The reality, however, is quite different. While company management enjoys exceptional legislative and economic conditions, those employed in maquilas are not paid enough to support their families with dignity, as they face dangerous and exploitative conditions and often suffer from exposure to poor health and safety hazards, lack of benefits, arbitrary discipline, and sexual and moral harassment. In the life of a standard maquila worker in a “tax-free” area, work never ends. It likely starts at 4 A.M. with housework, continuing on to the bus stop at 5 A.M. to go to the factory to work in a production chain with only twenty minutes to rest during the lunch break, and it is often prolonged even after arriving home at 9 P.M. Low wages, long hours, unpaid overtime, and the lack of environmental or labour regulations are clear examples of labour rights violations, which are reinforced by the infringement of workers’ basic human rights to form independent trade unions. Unionised workers and their leaders are intimidated and repressed in what have sometimes been called “enterprises free of syndicalism.” In this context of absolute domination over labour and the absence of control of the state and worker’s organisations, employers are not concerned with the dependence on healthy worker’s labour of obtaining surplus value, because the socioeconomic context allows them to have worker turnover. The human right to health does not exist in these workplaces. As in most regions, occupational health in Central America is not a governmental priority, and work-related health problems are almost always underreported, misdiagnosed, and not recognised as such [Wesseling et al., 2002]. Furthermore, there is a lack of research on the situation of maquilas owing to the extreme difficulty of investigating often miserable employment and working conditions within non-democratically accountable firms.

References

Case study 13. Labour moves to rich countries while companies profit from migrant remittances to poor countries. - Joan Benach and Carles Muntaner

Over the last few decades, capitalist globalisation has expanded economic migration, transforming the lives of hundreds of millions of people around the globe. Millions of individuals are moving from villages to towns or from poor to rich countries in search of ways to provide for their families and escape from unemployment, poverty, war, or their lost land property. Workers migrate away from their families and communities to serve as a labour force in rich countries and send capital in the form of remittances back to impoverished communities around the world. Globally, it is estimated that migrants from poor countries send home more than US$300 billion a year, more than three times the world’s official foreign aid combined, making remittances the main source of outside money flowing to the developing world. About 10 per cent of the planet’s population directly benefit from money sent home by migrants working in other countries [DeParle, 2007a]. Most of this money is spent on food, clothing, housing, education and basic supplies. In 38 countries, remittances account for more than 10 per cent of GDP, and in countries such as Guinea-Bissau, Eritrea, Tajikistan or Laos, percentages account for 35 per cent or more [International Fund for Agricultural Development, United Nations and Inter-American Development Bank]. In Mexico, inflows from Mexicans living abroad represent the country’s second largest source of foreign income behind oil exports.

An important problem faced by immigrant communities is the high fees associated with remittance transactions. Being forced to spend billions in transfer fees to send money back home for food, urgent medical care, and education is a major economic security issue for immigrants. With five times as many locations worldwide as McDonald’s, Starbucks, Burger King and Wal-Mart combined, Western Union is the lone behemoth among hundreds of money transfer companies, with earnings from global migration accounting for nearly $1 billion a year, and critics complaining about its high fees, which can run from 4 to 20 per cent or more. The company’s lobbying for immigrant-friendly laws has raised the ire of groups who say
7.3. EMPLOYMENT CONDITIONS

Full-time permanent employment

In wealthier countries, the traditional pattern of the employment relationship, or so-called “standard employment”, has for many years been that of full-time work under an employment contract of unlimited duration, with a single employer, workers protected against dismissal, and social protection. In many of these countries, this is still the prevailing pattern of employment. However, since the early 80s there has been a decline of “standard” full-time permanent jobs, and the spread of different forms of non-standard work arrangements (such as contingent, unregulated underground work or home-based work), many of which are characterised by variable work schedules, reduced job security, lower wages, hazards in the workplace and stressful psychosocial working conditions. The growth of precarious employment has also had spillover effects on the remaining permanent jobs, including increases in work intensity, longer hours and presenteeism (Quinlan & Bohle, 2009). On the other hand, in middle- and low-income countries, labour markets are characterised by low levels of government regulation, insecure labour markets, high levels of poverty, and political instability. Permanent employment is uncommon and informal work is the norm.

References

Boycott Western Union. Retrieved from http://www.boycottwesternunion.net/
There is no single definition of permanent full-time employment. The number of hours that are regarded as being normal for full-time employees, as well as what “permanent employment” means, vary considerably according to the country concerned. According to the European Union Labour Force Survey, in the EU permanent employees are those with a “work contract of unlimited duration”. However, in South Korea, for example, full-time employment is defined as “working full-time with permanent contracts of over 3-month in duration” (Kim, Muntaner, Khang, Paek, & Cho, 2006), and in France it is centred on an employment contract of undetermined length. By and large, a distinction is also made between employees working 35 hours or more per week (full-time), and those who work fewer than 35 hours per week (part-time).

The share of the employed within the world’s working-age population (aged 15 years and older), also known as the employment-to-population ratio*, declined between 1997 and 2007. This population ratio provides information on the ability of an economy to create employment. Although a high overall ratio is often considered positive, this single indicator does not assess the level of decent work. It stood at 61.7 per cent in 2007, almost a percentage point lower than ten years earlier. The decrease has been larger among young people (aged 15 to 24 years). Within this group, the ratio decreased from 50.6 per cent in 1997 to 47.8 per cent in 2007. The gap between men and women continued, with 49.1 per cent of women of working age employed in 2007 and 74.3 per cent of men. The gender gap in labour force participation is another indication of women’s more limited chances to take part in the world of work (ILO, 2008).

In order to analyse how full-time permanent employment is distributed in the world, it is necessary to consider the lack of trustworthy data available. Although middle-income and poor countries represent the largest work force in the world, work regulations for permanent jobs are very limited, and there is often a lack of data. In those countries, perhaps one of the best available indicators is “formal work”, which can be defined as any job in which the employee has a formal contractual relationship with their employer. Although formal contracts do not guarantee access to health systems and insurance, the lack of such a contract seriously undermines workers’ rights to such services, mainly in terms of receiving health benefits following work-related illnesses or

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* The employment-to-population ratio is defined as the proportion of a country’s working-age population that is employed. A high ratio means that a large proportion of a country’s population is employed, while a low ratio means that a large share of the population is not involved directly in labour market-related activities, because they are either unemployed or (more likely) out of the labour force altogether (ILO, 2007)
injuries, but also in terms of aid for dependent family members. Similarly, regarding contributions to social insurance systems, if a contract does not involve any contributory obligations, there is far less incentive for voluntary contributions, especially when low-wage workers are expected to channel some of their current income into a system from which they may receive benefits in the future.

In middle- and low-income countries there has been an increasing informalisation of labour markets, indicated by a decline in the number of employees with formal working agreements. According to the ILO, out of every 100 workers worldwide, only 6 are fully employed, and another 16 are unable to earn enough to get their families over the poverty line of US$1 per day (ILO, 2001). In Latin America, despite the lack of information on indicators that define the quality of employment, it is still possible to describe some of the main characteristics of jobs. A small number of countries show a downward trend in hiring with formal or written contracts. In those countries which have information available from the beginning of the 1990s, formal hiring fell by four percentage points between 1990 and 2005 (ECLAC, 2007). In 2005, 12 countries in the region reported that 49 per cent of their wage workers had a formal contract with their employers, with one in four having a permanent contract (i.e., one in every eight wage workers overall) (Figure 6).

**Figure 6.** Wage workers with formal and permanent contracts in Latin America [12 countries] in 2002 and 2005.

It needs to be emphasised that the slight upturn in jobs with formal contracts was recorded mainly on the strength of temporary work contracts: only 4% of the jobs created between 2002 and 2005 came with a permanent contract. As it is shown in Figure 6, informal hiring is not the exclusive domain of low-productivity sectors. Only about 25% of wage workers have a formal contract in those low-productivity sectors, while the figure is about 54% in medium- and high-productivity sectors. Furthermore, employers are more likely to have a formal contract with their male workers (52%) than their female workers (46%). In 2002, approximately 40% of female workers with a formal contract also had a permanent contract. In 2005, this only applied to 30% of those female workers. This data shows that during the regional upturn in employment, there has been a strong decrease in permanent contracts for women. For the region as a whole, in 2005 there were 20% fewer women with permanent contracts than in 2002 (ECLAC, 2007).

In wealthy geographical regions such as the European Union, data on the spread of permanent full-time employment is available, i.e., employees who do not have fixed-term contracts of limited duration. In the EU, about 235 million people were employed in the 31 countries analysed in the IV European Survey on Working Conditions (Parent-Thirion, Fernández Macías, Hurley, & Vermeylen, 2007). Data show, however, large variations across the EU (Figure 7). Half of those workers are concentrated in just five countries (Germany, UK, France, Italy and Spain), and there are large differences in employment, the participation of women in the workforce, and in the use of part-time work. All those differences in labour market indicators may have a large impact on working conditions, health and health inequalities.

In the EU-27, 78% of employees report holding a contract of indefinite term. However, substantial differences exist between countries: twice as many respondents in Luxembourg and Belgium (90% and 89% respectively) hold indefinite contracts as in Cyprus and Malta (46% and 50% respectively). In terms of country groups, a higher-than-average proportion of respondents in continental countries (85%) hold indefinite contracts, while the lowest proportion is found in Ireland and the UK and southern European countries: 68% and 70%, respectively. In the candidate countries, the majority of employees have no employment contract (60%), while 28% of them have an indefinite-term contract (Parent-Thirion et al., 2007).
Workers with a permanent contract have more skills and credentials, more information on workplace hazards, experience less hazardous work conditions, and have better health outcomes. In the EU-15, for example, nearly 20 per cent of workers with no contract, temporary contract or those working in manual occupations are not well-informed about workplace hazards as compared to only 12 per cent among permanent and white-collar workers (Parent-Thirion, et al., 2007). Research also shows that 31.6 per cent of full-time permanent workers suffer backache, and for women this risk seemed to increase (Benach, Gimeno, & Benavides, 2002). Overall, full-time permanent workers present low levels of job dissatisfaction and health problems (i.e., fatigue, backache and muscular pains) and moderate levels of stress, but absenteeism was high (Benavides, Benach, Diez-Roux, & Roman, 2000). Many studies on permanent employment have determined that psychological health and job satisfaction may be parts of a causal chain reflecting the interplay of health and other aspects of wellbeing. People with impaired health may be more vulnerable in critical transitions in their life-course, and this, in turn, reinforces the social gradient in health. Furthermore, findings of similar associations between types of employment and health in several surveys on working conditions in the European Union suggest that these associations may be robust (Benach, Gimeno, Benavides, Martínez, & Torné, 2004).
Like countries, not all workers have the same types of contracts or exposure to occupational hazards. Existing data shows that health inequalities by social class are significantly large. Studies need to consider the key role played by the cross-cutting axes [e.g., social class, gender, race, ethnicity, and migrant status] analysed in this book. By and large, in the EU workers with a higher level of education are more likely to hold an indefinite employment contract: 83 per cent of those with a tertiary education hold an indefinite term contract, as compared to 66 per cent of those with only primary level education. Slightly more men (79%) than women (76%) hold an indefinite-term contract. Lower-than-average percentages of unskilled workers and skilled agricultural workers hold indefinite-term contracts (65% and 58% respectively) [Parent-Thirion et al., 2007]. Research has also shown that when occupational social classes have less skills and credentials, they tend to experience hazardous working conditions, including physical strain, low job control, greater noise and air pollution, shift work, a monotonous job, and a hectic work pace, as well as worse self-reported health and a large number of health outcomes [Vahtera, Virtanen, Kivimäki, & Pentti, 1999; Schrijvers, Van de Mheen, Stronks, & Mackenbach, 1998; Siegrist & Marmot, 2004].

Worldwide, more women than ever are participating in labour markets, either in work or actively looking for a job. However, during the last decade, the gender gap in the labour force participation rate [i.e., the share of working-age women who work or are seeking work] stopped closing, with many regions registering declines. The female share of total employment stayed almost unchanged at 40 per cent in 2006 [from 39.7% 10 years ago]. In 2007, only 52.5 per cent of all women of working age were either looking for work or working (ILO, 2008).

Gender segregation is a phenomenon in which women are under-represented in some occupational areas and overrepresented in others [relative to their average representation in employment overall]. Many studies have revealed that a high degree of gender segregation is a persistent feature of the structure of employment. Segregation can take place across various employment variables: occupation, sector, economic status of the firm, employment status, or employment contract and form [full-time/part-time work]. Women are more likely to work in low-productivity jobs in agriculture and services. The poorer the region, the greater the likelihood that women’s work remains uncompensated. The step from unpaid contributing
family worker or low-paid own-account worker to wage and salaried employment is a major step towards independence and self-determination for many women. Worldwide, the share of women in wage and salaried work grew during the past decade, from 42.9 per cent in 1996 to 47.9 per cent in 2006 (ILO, 2008). Alongside the "horizontal" segregation of women into different types of jobs is "vertical" segregation: the under-representation of women in higher hierarchical positions, better-paid jobs and jobs with a higher status. Additionally, in spite of the strong increase of women in the labour market in recent decades, often there are no significant changes in the distribution of domestic work, even when both partners are working (see Case study 14).

Migration for employment and its linkages with development have emerged as a global issue which affects most countries in the world. Through their labour, migrant workers contribute to growth and development in their countries of employment. Countries of origin greatly benefit from their remittances and the skills acquired during their migration experience. Many immigrant workers, however, either cannot find employment or cannot find employment that is adequate to support themselves and their families in their own countries (see Case studies 15 and 16). Migrant women and low-skilled workers are those who tend to experience more serious abuse and exploitation, and are those who disproportionately are represented in dangerous industries and in hazardous occupations.

**Case study 14. Gender inequalities in domestic work among workers: a hidden topic in occupational health.** - Lucia Artazcoz, Imma Cortès Franch and Joan Benach

Despite the dramatic increase of women in the labour market in recent decades, there has been no significant change in the distribution of domestic work, even when both partners are working. Many people want to have satisfying paid work and a happy family life. However, for many women this objective is very difficult, since they continue carrying out most family and domestic responsibilities.

In a study carried out in Catalonia (Spain), among workers under 65 years of age, married or cohabiting women worked at home an average of 22.1 hours a week, whereas the corresponding mean among men was 8.6 hours. Additionally, while among men the number of hours of domestic work did not correlate with social class, among women, time devoted to domestic tasks increased for those in less privileged social classes (see Figure). The total number of hours of paid work and domestic work was higher for women. These gender inequalities are more pronounced for older women, but they still persist among younger workers. Moreover, these gender inequalities have been related with gender inequalities in health status among workers (Waldron, Weiss, & Hughes, 1998; Artazcoz, Borrell, & Benach, 2001; Artazcoz et al., 2004).

Women are more likely than men to work part-time. Although for some groups, part-time status may permit a more effective balance between work and non-work activities, in many cases working conditions are poorer than in full-time jobs. In Europe, part-time jobs are segregated into a narrower range of occupations than full-time jobs, and are typically lower-paid, lower-status (such as sales, catering, and cleaning), more monotonous, and have fewer opportunities for advancement (Fagan & Burchell, 2002). Most studies carried out in the United States have shown that part-timers usually earn less per hour than full-timers, even after controlling for education, experience and other relevant factors (Kalleberg, 2000). Additionally, part-time work is often related to job insecurity (Quinlan, Mayhew, & Bohle, 2001). Moreover, to the extent that part-time work continues to be performed mostly by women, it contributes to perpetuating gender inequalities in society.

"I work long hours. I get up earlier than he does. I have to get up, sweep the house, go fetch water, and then go to the fields. After work I come back to cook and feed the animals. In the evening, I'm usually in bed first because each day is so tiring and hard. He goes out and visits, plays chess, and smokes."

Figure. Weekly hours of domestic work among workers, married or cohabiting, by sex and social class.

<table>
<thead>
<tr>
<th>Social Class</th>
<th>Men Weekly Hours</th>
<th>Women Weekly Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>I &amp; II</td>
<td></td>
<td></td>
</tr>
<tr>
<td>III</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IV &amp; V</td>
<td></td>
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</tr>
</tbody>
</table>

References


Case study 15. The social context of migrant farmworkers.- Toni Alterman*

Work involves more than the purchase and sale of physical and mental labour; it is also a type of social engagement within and across job categories (Krieger et al., 2006). Each worker is imbedded in her or his social context, bringing to the workplace the individual’s social position in relation to key societal dimensions such as property, power, class, gender, race, ethnicity, national, and citizenship status. The workplace is a social domain where social relationships within the society at large are reproduced. Workers are exposed not only to job-specific hazards, but also to hazards within the broader societal context in which workers live their lives and do their work. These hazards may include racial or ethnic discrimination (Krieger et al., 2006; Williams, Neighbors, & Jackson, 2003).

Although there are a number of published studies on ethnic disparities in health (Landrine, Klonoff, Corral, Fernández, & Roesch, 2006), only a few studies have examined ethnic discrimination among migrant farm workers (Holmes, 2006; Alderete, Vega, Kolody, & Aguilar-Gaxiola, 1999). Qualitative and quantitative studies have shown that migrant farm workers in the United States experience stressors such as poverty, social and geographic isolation, language barriers, dangerous working conditions, unpredictable work, substandard housing, lack of reliable transportation, educational stressors, exploitation, and feelings of instability due to constantly being uprooted (Magaña & Hovey, 2003). Additional stressors include worry about socialisation, education, daycare for children, failure to meet high expectations, and immigration status. Migrant workers’ ambivalence about leaving the family and feeling the need to migrate to provide financial support was found to be a predictor of anxiety among recent immigrant Latino farmworkers in North Carolina (Grzywacz et al., 2006).

Ethnic discrimination in Latinos has been conceptualised as a form of acculturative stress. Findings from acculturative stress studies are that perceived discrimination is uniquely related to psychological distress when other
EMPLOYMENT RELATIONS AND HEALTH INEQUALITIES: A CONCEPTUAL AND EMPIRICAL OVERVIEW

Prevalence of depressive symptomatology was found to be 20.4 per cent among migrant farmworkers in rural California, as measured by the Center for Epidemiologic Studies Depression Scale (CES-D) one week prior to interview. In a more recent qualitative study, ethnicity and citizenship were found to be related to disparities in work and housing in a group of indigenous Triqui and Mixteco Mexicans in the western U.S. and Mexico (Holmes, 2006). Participant observation and interviews were conducted with approximately 130 farmworkers and thirty clinicians, in addition to border activists and patrol officers throughout fifteen months of migration. One million indigenous Mexicans, mostly Mixtec, Zapotec, and Triqui people from the state of Oaxaca, are estimated to be living in the United States. Approximately 53 per cent of agricultural workers in the United States during 2001-2002 were born in Mexico and lacked authorisation to work in the United States, with the majority living below the poverty line. A conceptual diagram of hierarchies on the farm developed by Holmes (2006) shows that at the highest level of a hierarchy defined by health, financial security, and control over time and others’ labour are workers of Anglo-American and Japanese-American descent who are citizens, speak English, and often work indoors or sitting. Further down the hierarchy are U.S. resident Latinos, followed by Mestizo Mexicans, who speak Spanish and often perform standing work. At the lower level of the hierarchy are undocumented Triqui Mexicans who speak an indigenous language and often work outdoors and kneeling. The author suggests that inequalities are likely to be driven by larger structural forces that include social and political forces such as the “corporatisation” of U.S. agriculture and deregulation of international markets (Holmes, 2006). Researchers need to consider the international context of migration and explore the implications of racism and anti-immigrant prejudices in the development and maintenance of health disparities.

According to Williams et al. (2003), discrimination is multi-dimensional and its assessment should include comprehensive coverage of all relevant domains. They recommend using lessons learned from the stress literature to inform and structure future research in this area. Issues such as the measurement of discrimination, chronic versus acute discrimination, severity, workers’ multiple roles, and macrostressors (stressors related to large-scale systems such as economic recession) need to be considered. Investigators from Collaborative Psychiatric Epidemiologic Studies, including the National Survey of American Lives, the National Latino and Asian American Study, and the National Comorbidity Study Replication, developed an agreement that includes which variables are to be included in their analyses, how the variables should be coded, the types of analyses to be conducted, and how the analyses would be reported in the final articles. This method provides an opportunity to compare findings across multiple racial and ethnic groups (Takeuchi, Alegria, Jackson, & Williams, 2007).

Disparities in exposure and tasks due to racial or ethnic discrimination have important implications for health and prevention and should not be ignored. Both qualitative and quantitative studies are needed among various national, racial, ethnic, and occupational groups.

* The findings and conclusions of this case study are those of the author and do not necessarily represent the views of the National Institute for Occupational Safety and Health.

References

Unemployment

The growth of the world economy since the beginning of the 21st Century has so far failed to significantly reduce global levels of unemployment. It is in low-income countries, and specifically among women and youth, that unemployment hits hardest. In these countries, unemployed workers turn to the informal sector to find work, but there they face high uncertainty due to the lack of unemployment benefits or availability of social security. To illustrate the global picture of unemployment, we first discuss the definition of the term itself. After this, we use empirical data to demonstrate world trends in unemployment (before the economic crisis, see chapter 10). Finally, we discuss the impact of unemployment on both individuals and societies.
According to a consensus definition, an unemployed person is a person above a specified age who during a reference period was without work and who is currently available for work and seeking work. In other words, unemployment figures demonstrate how many people are both not working for pay but also seeking employment for pay. Therefore, it is only indirectly connected with the number of people who are actually not working at all or working without pay. This definition is a problem because it excludes those who are without paid employment because none is available or because they cannot actively search for it.

It leaves out many workers in the poor world who, having no regular jobs or income, still work and do not fall within the unemployed category. It also excludes large numbers of people who would like to work but are prevented from even looking, such as those with long-term illness who could work if working conditions were better, and parents [most often mothers] who could work if child care services were adequate. Also, this definition does not count the population incarcerated in prisons, those who are self-employed in the informal economy, involuntary early retirees, and those who work for payment for as little as one hour per week or slightly more but would like a full-time permanent job ["involuntary part-time" workers] (ILO, 1982). Given the shortcomings of the consensus definition of unemployment, it is critical to remember those who are not counted as we turn now to the global situation.

Worldwide, unemployment remained at an historical high in 2006 despite strong global economic growth. Growth failed to reduce global unemployment and, even with strong global economic growth in 2007, there was serious concern about the prospects for fair job creation and reducing working poverty further. These concerns have only grown more serious since the economic crisis that began in 2008. This is not to imply that the mere economic process of growth is beneficial for workers. Research has also shown that when the economy expands and unemployment drops, health inequalities may increase [see Case study 17].

In 2007 there were about 190 million people unemployed globally, a slightly higher figure than the year before. This represented 6 per cent of the world’s population. Overall, employment increased by about 5 million in 2008, leading to a slight increase of the unemployment rate to 6.1 per cent in 2008 (ILO, 2009). In many non-industrialised countries, estimates of unemployment are around 30 per cent, while in developed countries, unemployment is often around 4-12 per cent. We break down global unemployment first by demography and then by geography (ILO, 2006; 2007a).
Employment, work, and health inequalities - a global perspective

Women and youth are by far the largest two groups of unemployed potential workers in the world. Women are more likely to be unemployed than men (6.6% vs. 6.1% respectively). There are over 85 million unemployed youth [aged 15 to 24] around the world. They comprise nearly half of the world’s total unemployment, despite the fact that this age group makes up only 25 per cent of the working age population. Compared to adults, youth are more than three times as likely to be unemployed (ILO, 2006; 2007a).

In addition to women and youth, unemployment levels correspond to levels of education. The distribution of unemployment is more concentrated among the least educated. In 2003, a person in the developed economies with only primary education was at least three times as likely to be unemployed as a person with tertiary education. This pattern reflects the increase in demand for more highly educated and skilled workers in developed economies and the declining demand for workers with low education (ILO, 2007b). With these demographic trends in mind, we turn to the geographical distribution of unemployment.

In 2006, there were not enough decent and productive jobs to raise the world’s 1.37 billion working poor (those working but living on less than the equivalent of US$2 per person, per day) and their families above the poverty line. Available information shows a wide global dispersion of unemployment rates (see Figure 8 and Map 3). The highest levels of unemployment, however, were concentrated in countries in the regions of Central and Eastern Europe (non-EU) and the Commonwealth of Independent States (CIS) as well as Latin America and the Caribbean. Looking at the ILO-comparable unemployment estimates available, the results showed that the average unemployment rates available for the new Member States of the European Union (Czech Republic, Estonia, Latvia, Lithuania, Poland, Slovakia and Slovenia), 11.7 % for males and 12.5 % for females, were higher than the former Member States, 7.0 % for males and 7.8 % for females, in 2003 (see Table 2) (ILO, 2007a; 2007b).

Table 2. Unemployment rate and employment to population ratio by region in 1996 and 2006.

<table>
<thead>
<tr>
<th>Region</th>
<th>Unemployment rate</th>
<th>Employment-to-population ratio(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>World</td>
<td>6.1</td>
<td>6.3</td>
</tr>
<tr>
<td>Latin America and the Caribbean</td>
<td>7.9</td>
<td>8.0</td>
</tr>
<tr>
<td>East Asia</td>
<td>3.7</td>
<td>3.6</td>
</tr>
<tr>
<td>South-East Asia</td>
<td>3.7</td>
<td>6.6</td>
</tr>
<tr>
<td>South Asia</td>
<td>4.4</td>
<td>5.2</td>
</tr>
<tr>
<td>Middle East and North Africa</td>
<td>13.0</td>
<td>12.2</td>
</tr>
<tr>
<td>Sub-Saharan Africa</td>
<td>9.2</td>
<td>9.8</td>
</tr>
<tr>
<td>Industrialized economies</td>
<td>7.8</td>
<td>6.2</td>
</tr>
</tbody>
</table>

Sources:
Figure 8. Percentage of unemployed by region and level of wealth in 2003.

**Low income countries**

**Middle income countries**

**High income countries**

Outliers: 1 = Mongolia, 2 = Dominican Republic, 3 = Swaziland, 4 = Kenya, 5 = Nigeria, 6 = Zambia, 7 = Sudan, 8 = Ghana, 9 = Mali, 10 = Cameroon, 11 = Uganda, 12 = Rwanda, 13 = Romania.

Regions: EAP (East Asia and Pacific), ECA (Eastern Europe and Central Asia), LAC (Latin America and Caribbean), MENA (Middle East and North Africa), NAM (North America), SA (South Asia), SSA (Sub-Saharan Africa), WCE (Western and Central Europe).


With the empirical evidence mapped out, revealing those areas where unemployment is highest, we now take stock of the impact of unemployment. Although this problem has been studied for a long time, scientific evidence has focused on two periods: economic crisis and high unemployment. In the 30s, research focused mainly on work-loss, whereas in the 70s the focus was more on the non-economic aspects of unemployment. These periods of investigation offer various insights into the impact of unemployment. For instance, a classic study by Marie Jahoda reveals important differences in patterns of reaction to unemployment (Jahoda, Lazarsfeld, & Zeisel, 1933). On the other hand, an earlier Canadian study links unemployment to higher levels of malnutrition, malnourishment, cardiovascular disease and anxiety (Marsh, Fleming, & Blackler, 1938).

Research at the aggregate level has shown that high levels of unemployment, at both the national and local levels, are correlated with poor health and increased mortality. Evidence demonstrates that male unemployment correlates with deteriorated health for wives as well as with child abuse. As unemployment tends to hit already deprived groups (e.g., ethnic minorities and migrants), there is a need for research into the dimension of gender as well as of other power-related mechanisms, such as social class and ethnicity (Hammarström & Janlert 2005). Moreover, the influence of context should be taken into account: a positive correlation between trends of unemployment rates and suicide rates was identified in both Japan (Inoue et al., 2007) and Hong Kong (Chan, Yip, Wong, & Chen, 2007), whereas reduction in unemployment, a marker of economic growth in this case, predicted an increase in CHD mortality in the US (Ruhm, 2007).

What is clear is that the unemployed are excluded from social participation and the health benefits that it brings. In fact, a study of the EU-15 has identified unemployment as one of the ten most important contributors to the total burden of disease in the 1990s (Diderichsen, Dahlgren, & Vågerö, 1997). The problem is that it is very difficult to rely on empirical investigation to demonstrate this because, in those countries where unemployment is very high and the informal sector typically quite large, official unemployment rates are unlikely to be a true reflection of the realities of the labour market. This means that in the end, it is quite difficult to study the relationship between unemployment and health in the less developed areas of the world (Gilmore, McKee, & Rose, 2002), and more specifically in countries which have severe economic and social crises, including poverty and migratory processes (see Case study 18).
Case study 17. Do health inequalities increase when employment grows? - José A. Tapia Granados

Recent research has proved the counterintuitive fact that, for the evolution of mortality rates, periods in which the economy expands, jobs are created, and unemployment drops, are worse than economic downturns in which jobs disappear and unemployment grows. Death rates tend to increase in expansions and decrease in recessions (Gerdtham & Ruhrm, 2006; Tapia Granados, 2005; 2008; Tapia Granados & Iones, 2008; Ortega Osona & Reher, 1997; Abdala, Geldstein, & Mychaszula, 2000). In the United States, a one percentage point reduction in unemployment is predicted to increase coronary heart disease mortality by 0.75 per cent, corresponding to almost 3900 additional fatalities (Ruhm, 2007). Atmospheric pollution, consumption of harmful substances or foods, and the worsening of quality of life and working conditions when economic activity accelerates have been suggested as potential links between the economy and changes in mortality. In the United States, in the last decades of the 20th century, the death rates of females and nonwhites seem to be substantially more linked to the fluctuations of the economy than those of males and whites (Tapia Granados, 2005). Using the U.S. National Longitudinal Mortality Study it has been found that during the 1980s, low-income and low-education groups may have been disproportionately at risk during periods of increased economic activity (Edwards, 2006). Mortality increases during expansions seemed to be greater among those who were working than among those who were not, and it appeared greater in African Americans than in whites, though the increase in mortality was much smaller in the top third of family income. In general, high income seemed to be protective against rising mortality during economic expansions. Additional evidence suggesting that health inequalities may increase during economic expansions rather than during recessions is provided by a study of mortality at working ages 35-64 in Finland (Valkonen et al., 2000). During the years 1981-1995 (see Figure), which included an economic expansion (1981-1990) and a strong recession (1991-1995), the mortality of women in manual work occupations is flat, though showing a slight (not statistically significant) tendency to rise during the expansion, while the mortality of women in non-manual occupations decreased significantly in that period. During the expansionary 1980s, the manual/non-manual gap in female mortality clearly widened. During the recession, female mortality significantly dropped in both groups. Male mortality was manifestly falling throughout the whole period, but for manual occupations the decline was slow during expansion and accelerated significantly with the downturn. The mortality of men in non-manual occupations seemed to fall at a slightly faster rate during the expansionary years, than in the recessionary 1990s. Mortality overall evolved for the better during the recession than during the expansion, and if the health inequality gaps are widening in any period, it seems to be precisely during the expansion years.

Figure. Evolution of annual age-standardized mortality at ages 35-64 (per 100,000 population), by sex and social class, Finland, 1981-1995.

Straight segments are regression lines (slopes with standard errors are indicated) computed with the data corresponding to the expansion (1981-1990) or recession years (1991-1995) of the period considered.

References


Case study 18. The historical roots of the global crisis of Zimbabwe.

The Republic of Zimbabwe (formerly called Southern Rhodesia, the Republic of Rhodesia and Zimbabwe Rhodesia), is a landlocked country in the southern part of Africa. Natural resources are abundant with large reserves of metallurgical-grade chromeite, as well as other commercial mineral deposits such as coal, copper, asbestos, nickel, gold, platinum, and iron. Agriculture has for many decades been the backbone of the economy, with maize being the country’s largest crop and tobacco the largest export crop, followed by cotton. In spite of its economic richness, in recent decades there has been a collapse of the agriculture-based economy, and the country has endured rampant inflation and critical food and fuel shortages. Today, the economy of Zimbabwe has fully collapsed, with the world’s highest inflation rate (over 100,000% according official statistics in February 2008, and around 14.000.000% according independent estimates in July 2008). Power cuts are customary, the water supply is drying up and many of Zimbabwe’s factories have closed for lack of supplies. Food supplies are scarce and the fields produce only a fraction of Zimbabwe’s needs amid a shortage of seeds, fertiliser and irrigation. There is vast economic poverty and inequality: the poorest 10 per cent of Zimbabwe’s population consume only about 2 per cent of the economy, while the wealthiest 10 per cent consume over 40 per cent.

Employment conditions have worsened dramatically in the last few years. Between 1999 and 2003, more than 600,000 jobs were lost in the formal sector, and thousands of home-based businesses, which are the core of the informal sector, were eliminated, leaving thousands without sources of income. About 80 per cent of the population is unemployed. In rural areas near mineral reserves, people dig or pan for gold or diamonds, risking their lives in shallow mines which frequently collapse. But poor people feel they have little choice if they are to survive, even if they have to face police detentions, which have occurred under the campaign “Chikorokoza Chapera” (The End of Illegal Gold Dealings) following concerns over rampant smuggling of precious stones and environmental degradation in mining areas. In the cities, the streets are overcrowded with unemployed school-leavers and able-bodied men desperate to feed their families. Hundreds of thousands of Zimbabweans, including much-needed professionals, have emigrated. With the Zimbabwean economy in ruins, about 3 million people, a quarter of the population, have left the country in search of work, mainly in South Africa. Many more people will leave the country. Rural areas are already inhabited mostly by the very young who are looked after by the elderly after the intervening generation fled Zimbabwe in search of work. Zimbabwe has one of the world’s lowest life expectancies (37 years for both men and women) and infant mortality is high, with 51.12 per 1,000 live births dying of the most advanced forms of vitamin deficiency. Families in which a grandmother or a child is the head are a growing social phenomenon, often the result of the AIDS epidemic. For the one-third of the population infected with HIV, the cost of drugs has just risen 4,000 per cent to 1.3bn Zimbabwe dollars a month.

While many simple explanations have been attributed to Zimbabwe’s global crisis (i.e., a drought affecting the entire region, the HIV/AIDS epidemic, the failure of government price controls and land reforms, or the persistence of Mugabe’s regime for almost three decades), the deeper causes of the current situation need to be understood through an historical analysis which takes into account the legacy of colonisation and the political forces that have led the country.

The colonial era (1890 - 1980) had a destructive impact on the lives of Zimbabweans. Not only was their heritage stolen, but the best farmland and resources were also taken by British colonists. Decades of domination and oppressive colonial rule were fuelled by the ideas of Cecil Rhodes, an enthusiastic believer in colonialism and brutal conqueror of the region at the end of the 19th century. By 1922, two-thirds of the native Zimbabweans were confined to reserves in tribal areas, and various laws forced them to work on European farms. In the 1940s and 1950s, faced with a wave of strikes and growing political awareness among black urban workers, the British Labour government encouraged more white emigration to support the colonial regime in Rhodesia. Thus, all the managerial and privileged jobs went to whites and systematic discrimination against the African population was legally enforced.
When Britain tried to decolonise Rhodesia in the 1960s, it was opposed by the white settlers who eventually made the Unilateral Declaration of Independence (UDI) in 1965, which was unrecognised by Britain. Ian Smith, the Prime Minister of the British self-governing colony of Southern Rhodesia, insisted that the white settlers would not transfer political power to the black elite. Culminating in the Land Tenure Act of 1969, legislation was passed to divide the land up into white- and black-owned areas. The weak and divided nationalist black organisations, Zimbabwe African National Union (ZANU) and Zimbabwe African People’s Union (ZAPU), went into exile and organised limited guerrilla operations against the Smith regime. In the 1970s, influenced by the FRELIMO movement in Mozambique, ZANU moved away from carrying out limited guerrilla incursions towards building a base of support among the rural masses and stepping up the war against the white regime. Robert Mugabe came to the leadership of ZANU by using the growing popular support obtained by this radical-sounding land programme against the older, more conservative leaders. At the same time, Mugabe suppressed more radical sections of the guerrillas who opposed a deal with Britain and the Smith regime, including the murder of 300 guerrilla fighters in 1977.

By the mid 1970s, the decline of the Rhodesian economy and fear of a radicalisation of the masses forced Britain and the US to a deal with Mugabe. On April 1980, the country attained independence along with the new name of Zimbabwe with a government led by Mugabe. All the factions in Rhodesia agreed to a new constitution and free elections, and the conservative British government led by Margaret Thatcher gave full support to Mugabe. Mugabe agreed to pay off the debts built up by the Smith regime in financing the war, major pro-business decisions were made, all promises of land nationalisation were dropped and the large white farmers were guaranteed 10 years of ownership of their land if they wished to stay. The small farmers and landless got virtually nothing. Between 1980 and 2000 only 70,000 out of approximately one million farmers on the poorest Communal Area land were resettled, and nothing was done to remove the white farmers and organise land reform.

In 1991, when the rhetoric of socialism disappeared with the collapse of the Stalinist regimes, the Mugabe government adopted the IMF’s Economic and Structural Adjustment Programme. Even though Mugabe attempted to fully implement the neo-liberal economic policies, earning the praise of the World Bank in 1995 as “highly satisfactory”, the results have been disastrous. Between 1990 and 1995 per-capita spending on healthcare fell by 20 per cent, 18,000 public sector jobs were abolished and the civil service wage bill reduced from 15.3 per cent to 11.3 per cent of GDP between 1990 in 1994. Foreign exchange controls were removed and trade tariffs lowered. Liberalisation first hit the weak manufacturing sector, but by the late 1990s the crucial exporting agricultural sectors such as tobacco, together with mining, were hit by falling prices. Debt levels rose to $US4.3 billion by 2000, taking as much as 38 per cent of foreign export earnings in 1998. With the increase of unemployment and decline in real income, there was a wave of strikes and the opposition party, the Movement for Democratic Change (MDC), attracted growing support. It was only during this large crisis, when it was not possible to meet the increasing demands of the IMF without losing more support, that Mugabe resurrected the land issue. Whereas land occupations had been suppressed by the police in the 1970s, in 2000 Mugabe began backing the war veterans’ movement and encouraged the takeover of white farms. A band of unemployed youth were paid to intimidate and in some cases murder white farmers, as tens of thousands of poor farmers and landless peoples began occupying the higher-grade land. No attempt was made to nationalise the land, and while a relatively small number of small farmers gained land, the big gains were made by the elites. While Mugabe hoped that the attacks on white farmers would persuade Britain and the international bankers to make more concessions, his land programme has been entirely consistent with his bourgeois nationalist politics, and his attempt to gain popular support is completely subordinate to the interests of the black elite who have increased their personal fortunes. Indeed, Mugabe’s politics have been similar to many other African black bourgeois regimes professing Pan Africanist (or socialist) views supported by colonial powers when colonial rule ended in the 1960s. The Zimbabwean elite, most of them educated in Western universities, were used by colonial powers to maintain their economic domination of the country, either through the development of native industries through policies of import substitution and financial aid from the West, or in the form of taxes on international corporations that continue to operate. Private companies, including several hundred that are British-owned, have been left untouched.

The regime of sanctions and economic boycott imposed by neo-colonial forces and agencies has had a devastating impact on Zimbabwe. The 2008 election has been qualified as the most important since independence in 1980 but there will not be an effective and egalitarian solution to the current global crisis and the land question without taking the main core of production and finance out of the hands of the multinationals and the local elite and placing it under democratic control and ownership of the working people and poor farmers.

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Precarious employment

The rising and increasing reliance on both neoliberal policies and structural adjustment programs has changed the regimes of industrial relations around the world. The weakening of unions and labour market regulations in many countries exacerbates this transformation. The critical forces in this process are political. Decisions taken by governments, international institutions and corporations have transformed labour standards around the world, resulting in rising levels of what is known as “precarious employment” (Louie et al., 2006).

Precarious employment refers to a labour market situation in which the labour relations that underline standard employment relationships are inadequate. This means that workers in "vulnerable jobs" are more prone the fluctuations of the market; they are unprotected and increasingly unable to support themselves and their families. In this section we examine the root causes of precarious employment, to create a clear understanding of the nature of the public health problem they generate. Once this is established, we present the available global data on precarious employment, explore their implications, and illustrate the situation with several examples [see Case studies 19 and 20].

Global changes in models of production have changed the requirements of many employers. In many of today’s markets, “flexibility” is the top priority. Rapid changes in supply and demand, outsourcing, subsidies from high-income countries, capital-labour accords, and changes in employment contracts themselves have created the need for flexible labour to enable firms to quickly adapt to changing economies. Meanwhile, as labour markets become less regulated in many places, standard production models are becoming useless. With fewer legal mechanisms to dampen the practice, and increased demand for labour output that matches rapidly-fluctuating global consumption patterns, workers are expected to be much more flexible about their labour relationships.

This increased reliance on flexible workers changes the way labour markets behave and creates difficulties in the application of traditional analytical techniques. At the micro level, employers have a bigger need for employees with flexible schedules and salaries. While some amount of flexibility is required to sustain a dynamic labour market that can handle structural adjustments, when increased flexibility addresses rising unemployment numbers in low- to middle-income countries, employers begin to see it as a positive feature of a worker’s personality and even as a "state of mind" (Scott, 2004; Luttwak, 1998; Amable, 2006).
However, this behaviour changes the labour market because increasingly flexible labour means that protections formerly offered by labour laws and union agreements no longer apply. Flexible workers are not typically on a contract, nor do they form part of a union, so their income and job security are left unguarded.

These types of markets are typically referred to as "non-standard employment." However, this term is limited in capturing the reality of new labour markets for three main reasons. First, these forms of employment lack sufficient conceptual and theoretical development by scholars. Second, non-standard employment covers a range of poorly defined categories, including work arrangements that do not necessarily imply employment conditions that are worse than those of permanent jobs. And third, since these categories are not very informative, they are easily confused with possible explanations and mechanisms linking work arrangements and health outcomes.

Together, these three limitations suggest that we must move beyond a simple comparison to full-year, permanent employment. If we are to make any progress in understanding employment conditions that do not fit well into the typical labour market models of western capitalism, we must seek conceptual alternatives that are based on the social structure of work organisation, such as the sociological concept of "precarious employment."

Pecarious employment, as defined above, can be characterised along six main dimensions (Amable, 2006).

1. Employment instability: this refers to the type and duration of a working contract, indicating that short term contracts contribute to greater employment precariousness.
2. Empowerment: this refers to the way the worker’s employment conditions are negotiated, whether it is individually or with the support of a trade union by means of collective negotiations.
3. Vulnerability: this refers to the set of explicit or implicit social power relations in the workplace or the capacity to resist the discipline that the wage relation imposes (intimidation, threats of being fired, and discrimination).
4. Low wages: individuals are classified according to their wages and the sufficiency of these to cover regular and unexpected living expenses, indicating their economic dependence on employment and their potential material deprivation.
5. Workers’ rights: these include severance pay, unemployment compensation and paid vacations, among other workers’ rights that may modify or mitigate the other aspects of employment precariousness.
6. Capacity to exercise rights: this refers to the degree to which workers feel powerless in exercising their legal rights.
In fact, the term “precarious employment” actually represents a continuum of conditions. On one end there is the “standard” full-time permanent contract with the accompanying social benefits. On the other end, there are the worst conditions in each dimension that often lack social benefits in any quantifiable form (Vosko, 2006; Benach & Muntaner, 2007). Given this spectrum, we have to use the concept carefully, since in many low-income countries data are not available and there is not a single index of precarious employment to help us draw international comparisons. Furthermore, indicators of essential dimensions of precarious employment such as “powerlessness” are not yet fully developed and indicators of social benefits are not fully available.

Given these important limitations, we decided to select two accessible and quite useful indicators of key precarious employment dimensions along the lines of “job insecurity” and “low wages.” For many of the countries analysed (n=172), we use the percentage of “working poor.” Developed by the International Labour Organisation in 2000, this is defined as “those who work and at the same time belong to poor households” (Majid, 2001). For many high-income countries, though, this indicator is not very sensitive. For this reason we have selected indicators of temporary employment in OECD countries and in the European Union. Additionally, for a number of EU countries, we also use data on the percentage of employees who have both temporary contracts and low wages (OECD, 2002; Ramos Díaz, 2005). Finally, a recent study has analysed the prevalence of precarious employment in a high-income country using a multidimensional measure (see Case study 21).

Using data from the ILO (KILM), we have compared percentages of working poor in the years 1997 and 2003 by countries with different levels of wealth. Results show how the large burden of the working poor is overwhelmingly located in low-income countries and middle-income countries (see Figure 9 and Map 4). For example, low-income countries classified in the periphery according to the typology used in this report, such as Bolivia, Haiti or Nigeria, had high percentages of working poor in 2003: 16.8, 32.7 and 78.2 per cent respectively, and the highest levels were mainly located in very poor Sub-Saharan countries such as Sierra Leone (81.5%), Liberia (83.7%) or Uganda (87.8%) (ILO, 2007a; 2007b).

The working poor constitute around 25 per cent of the employed labour force in all poor countries. In other words, one in every four employed persons in poor countries belongs to a poor household. Out of the 550 million working poor in the world, an estimated 330 million, or 60 per cent, are women. Of the 1.1 billion young people aged 15 to 24 worldwide, one out of three is either seeking but unable to find work, has
given up the job search entirely, or is working but living on less than US$2 a day. In fact, in absolute worldwide numbers, the number of working people living on US$2 a day has continued to grow, reaching 1.37 billion in 2006 (ILO, 2004; 2006).

While the situation is considerably better in most OECD and EU countries, the condition of temporary employment appears as a consistent indicator of precarious employment, which gives us good means of measuring this phenomenon in the west. Temporary employment, first of all, refers to workers on fixed-term contracts and on temporary agency contracts, as well as workers with part-time positions (see Figure 10). They constitute a rather diverse group that work in a wide range of sectors and occupations, and for both public and private employers. However, temporary jobs are disproportionately held by younger workers, women, and those employed in low-skill occupations, agriculture and small firms.

Temporary labour is also typically characterised by precarious employment and working conditions. Workers are less satisfied with their jobs and more often report inflexible work schedules, monotonous work tasks and worse working conditions. Temporary jobs tend to pay less than permanent jobs and often offer less access to paid vacations, paid sick leave, unemployment insurance, pensions and other fringe benefits, as well as less access to training. Although nominally covered by virtually all public schemes and many voluntary, employer-provided schemes, the real eligibility of temporary workers appears to be substantially lower in many cases. This is because eligibility criteria for social benefits typically include minimum contribution periods. In other words, temporary employment per se rarely disqualifies workers. Since they have temporary contracts, most of these workers do not meet this minimum time requirement and are thus excluded from benefits in the end (OECD, 2002).

In the end, flexible, temporary jobs and all kinds of precarious employment can be just as dangerous for workers as unemployment. Indeed, employees in flexible jobs share many labour market characteristics (e.g., lower credentials, low income, or being women, immigrants, and non-whites) with the unemployed, while experiencing themselves bouts of unemployment, a factor strongly associated with adverse health outcomes. Therefore, even if precarious employment has only a modest impact on individual health, given the growing number of employees exposed, the magnitude of the potential impact on their overall health might be large. Moreover, the effects of precarious employment may be devastating not only to the health of the worker but also to the health and wellbeing of the family members and dependents who rely on income from the worker (Benach & Muntaner, 2007; Benach, Benavides, Platt, Diez-Roux, & Muntaner, 2000).

“Life is hard. I caught my fingers in one of the machines six months ago. The boss was furious. He had to pay fifty dollars for me to see a doctor. The pain is incredible still. He says I have to work day and night to pay him back. But what choice do I have? At least I have food and shelter. In China, I had nothing.”

**Employment, Work, and Health Inequalities - A Global Perspective**

**Figure 9.** Percentage of working poor by region and level of wealth in 2003.

<table>
<thead>
<tr>
<th>Region</th>
<th>Low income countries</th>
<th>Middle income countries</th>
<th>High income countries</th>
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<td>WCE</td>
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**Outliers:** 1 = Timor-Leste, 2 = Moldova, Rep. of, 3 = Uzbekistan, 4 = Yemen, 5 = Serbia and Montenegro

**Regions:** EAP (East Asia and Pacific), ECA (Eastern Europe and Central Asia), LAC (Latin America and Caribbean), MENA (Middle East and North Africa), NAM (North America), SA (South Asia), SSA (Sub-Saharan Africa), WCE (Western and Central Europe).


**Map 4.** Percentage of working poor by country in 2003.

<table>
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Case study 19. Kaisi metals factory in Guangzhou (China). - Charles Kernaghan and Barbara Briggs

In the Kaisi Metals Factory in Guangzhou in the South of China, between 600 and 700 workers toil under dangerous and illegal conditions, producing furniture parts for export to U.S. companies. Among those companies is the Knafe & Vogt Manufacturing Company, located in Michigan, which imported $10.4 million worth of goods from the Kaisi factory in a three-month period at the end of 2006. Every single labour law in China is routinely violated at the Kaisi factory, along with the International Labour Organization’s core worker rights standards, while the U.S. companies sourcing production there say and do nothing. Grueling, exhausting, numbing, dangerous, and poorly-paid would be the only way to describe the workday at the Kaisi Metals Factory. Kaisi workers are routinely forced to toil 14 ½ to 15 ½ hours a day, from 8:00 A.M. to 10:30 or 11:30 P.M., often seven days a week. It is not uncommon for the workers to be at the factory 100 hours a week, while toiling 80 or more hours. Workers are paid on a piece-rate basis. It is standard for management to arbitrarily set wildly excessive production goals, requiring workers to complete 7,780 to 11,830 pieces in a day, which is 640 to 980 operations an hour, or one piece every four to six seconds, for which they are paid an astounding six-hundredths of a cent per piece. The work pace is brutal, relentless, and dangerous. Workers are paid below the legal minimum wage and cheated of their overtime premium, earning less than half of what they are legally owed. Workers are paid just $24.33 for a 77-hour work week, 32 cents an hour, while they should be earning at least $52.56. The current minimum wage is 58 cents an hour. It is a dreary life for the workers at the Kaisi factory, who are housed in primitive, over-crowded company dorms located on the seventh floor of the factory. Each room measures about 3 1/3 by 7 1/3 metres and its walls are lined with double-level metal bunk beds. There is no other furniture, not even a bureau, a table, or a chair. Six to eight workers share each room. For privacy, the workers drape old sheets and plastic over the openings to their bunks. There is a tiny bathroom, which the workers say is filthy. There is no hot water and any workers who want to bathe during the winter must walk down four flights of stairs to fetch hot water in a small plastic bucket and return to their dorm room for a sponge bath. The air reeks of perspiration and sweaty feet. Married couples must live “off campus” under equally deplorable conditions, since they are able to afford only the smallest, most primitive one-room apartments. Zhu Shenghong, who lost three fingers at the Kaisi factory, lives in a single room with his wife. Their only furniture consists of a bed, which is broken, a few primitive wooden tables, and three tiny chairs Zhu made himself before he was injured, using scraps of wood he picked up on the street. The toilet is an outhouse, and the kitchen is in a hallway partitioned with some planks of wood. Zhu and his wife often cook with wood, largely subsisting on turnips. This is all that two people, both working in export factories, can afford. Much worse still is the fact that the Kaisi factory is a dangerous place to work, where scores of young people have been seriously injured, and some maimed for life. Dai Kehong was just 24 years old when both of his hands
were crushed while working on a punch press molding machine, producing furniture parts for export to U.S. companies. It happened at 9:00 P.M. when Dai was 13 hours into his routine 15 ½ hour shift. Dai’s right hand was mangled and deformed, with only the thumb and forefinger remaining, but frozen in place. His left hand was also crushed and frozen into a claw, as he is unable to bend or straighten any of his fingers. He has no ability to use either hand and will need an artificial limb. In September 2006 alone, five Kaisi factory workers were seriously injured, resulting in the loss of at least six fingers. In direct violation of China’s laws, the Kaisi factory failed to enroll its workers in the mandatory national work injury insurance program, which is China’s equivalent of worker compensation. Kaisi management also failed to report these serious work injuries to the local authorities. Management is even refusing to pay for Day Kehong’s artificial limb. Meanwhile, the U.S. companies stood by and did not say a word as scores of young workers were injured and maimed due to dangerous working conditions. Nor have the companies sourcing production at the Kaisi factory uttered a single word to protest the seven-day, 80-hour work weeks, or the fact that workers were being paid below the legal minimum wage and cheated of their overtime premium while working on their goods. Nothing has been done to bring the primitive dorm conditions up to a level of acceptable decency and fairness. In fact, the companies give every indication that they care much more about their products than about the human beings who make them.

Sources


Case study 20. Female workers in the asparagus agro-industry in Peru. - Françoise Barten

Between 1990 and 2002, female participation in labour in urban settings in Latin America increased from 37.99 per cent to 49.7 per cent. In Peru, female participation in labour was at 42.2 per cent in 1990, and by 2002 had increased to 56 per cent. It is worthwhile to note that, while female participation in the labour market started to increase during the 1980s, it grew in particular during the 1990s, within a context defined by neoliberal policies, the application of structural adjustments, increased precarious employment, and the reduction of social protection.

The implications for the health of female workers are clearly illustrated by the example of the asparagus industry in Peru. This industry has become very important in both economic and social terms. It is currently the main non-traditional agricultural export product and the 2nd most important product in terms of gross annual income (US$200 million). Also, the asparagus sector provides an important source of employment for people in the coastal zone, in particular for women, who represent 60 per cent of the workforce. In the Ica region, the industry has increased paid employment for women and induced the migration of women from the Sierra to the coastal zone. Employment is seasonal (6 months out of the year), based on short-term contracts (with a maximum of 3 months) and consequently without any social protection or security. It is also characterised by the massive involvement of women, long working-days, exposure to hazardous working conditions (e.g. extreme temperatures), pesticides and unidentified chemical substances.

Compared to male workers, women conduct specific activities both in the factories as well as in the field, and are therefore exposed to specific hazards. The exposure of female workers to pesticides has not yet been acknowledged as a health risk, as spraying continues to be a predominantly male activity. However, the spraying of pesticides is often conducted in the presence of unprotected female workers. Also, residual exposure to pesticides is substantial and explains the high prevalence of pesticide intoxication among women in the region. Still, it is important to acknowledge differences among women. The women who work in the factory are generally young, in their reproductive age, and over-qualified for this type of work, given their years of education. This type of employment represents the best opportunity in an increasingly restricted labour market. However, for the women who labour in the field, this employment provides no opportunity for improvement or promotion, as they are paid according to the number of hours that they work, while the women in the factory are paid according to the number of products made.

It is worthwhile to note that work in the asparagus industry does not enhance female workers’ organisation, and even induces “de-organisation”, due to a lack of employment opportunities at both the local and national levels, fear of losing the job, or increasing insecurity. Also, the long working shifts (many women are picked up at 3:00 P.M. to travel to the field and return home around 8 P.M.), combined with family and household responsibilities, contribute to the alienation of women from their family and community lives, limit their opportunities to develop social networks, and keep them marginalised from local and national events. On the other hand, increased female participation in productive activities has also contributed to increased autonomy and, to some extent, a redefinition of traditional gendered roles, for instance within their families.

Source

Case study 21. The prevalence of precarious employment using a new multidimensional scale: the case of Spain. -
Alejandra Vives Vergara, Marcelo Amable, Salvador Moncada i Lluís, Xavier Gimeno Torrent, Clara Llorens Serrano,
Fernando G. Benávides, Carles Muntaner and Joan Benach

Employment precariousness has been recognised as a multidimensional condition for almost two decades in
the field of sociology of work (Rodgers, 1989). Nevertheless, public health research has developed neither a
multidimensional nor a global indicator. The most frequently used indicators of employment precariousness in
public health are the subjective appraisal of “job insecurity” or the “atypical contract” forms, primarily
temporary contracts (Virtanen et al., 2005), which, among other health outcomes, have been shown to have a
clear association with occupational injury incidence (Benávides et al., 2006). Spain has shown the highest levels
of temporary contracts within the EU-15 for over two decades. Though the actual prevalence of employment
precariousness is still unknown, it is present in a wide array of employment conditions including the standard
permanent contract (Benach & Muntaner, 2007).

In response to the lack of an appropriate indicator of employment precariousness, in the late 1990s the
Health Inequalities Research Group and the Occupational Health Research Center at the Pompeu Fabra
University in Barcelona, Spain, set forth on a research program to define and analyse the public health-related
dimensions of employment precariousness. The first part of this project had three phases: interviews with
experts in public health, occupational health, and the labour market; an in-depth literature review; and focus
group interviews with temporary workers (Amable, Benach, & González, 2001). As a result, six dimensions of
employment precariousness were defined: temporality of contract; empowerment to decide on employment
conditions; vulnerability to abuse or mistreatment; wages; statutory rights; and worker capability to exercise
legal rights. Subsequently, the Employment Precariousness Scale (EPRES) was developed, providing a measure
of employment precariousness for quantitative epidemiological research. The scale encompasses these six
dimensions (26 items in all), and the validation study of EPRES demonstrated internal consistency reliability.
Cronbach’s alpha coefficients for the six dimensions were: temporality: 0.81; empowerment: 0.95; vulnerability:
0.90; wages: 0.71; rights: 0.83; and exercise of rights: 0.88 (Vives et al., 2010).

Preliminary results of the application of the EPRES to a cross-sectional representative sample of the
Spanish working population were obtained from the Psychosocial Factors Survey of Spanish workers carried
out between 2004 and 2005 by the Work, Environment and Health Union Institute of Barcelona (Instituto Sindical
de Trabajo, Ambiente y Salud) (Gimeno, Llorens, Moncada, & Navarro, 2006). The sample was composed of
workers of 15 to 65 years of age who had worked during the previous week for payment either in money or in
goods. Individuals were selected by random route sampling and interviewed at home. The sample consisted of
7,644 workers, 49 per cent women (mean age: 35.8 years) and 51 per cent men (mean age: 37.6 years). The
prevalence of precarious employment was measured by applying EPRES and dividing the resulting index of
employment precariousness, which ranges from a minimum of 0 to a maximum of 4 points, into three groups:
none or low (0<1 point); moderate (1<2); and high (2-4) precariousness.

Results for the total sample show that 42.9 per cent were exposed to moderate and 7.2 per cent to high
employment precariousness. Women (8.7% high precariousness) were more precarious than men (5.7% high
precariousness) at all ages, with a gap that was wider among older age groups. According to occupational
social class [See Figure], employment precariousness followed a social gradient for both women and men,
where workers in unskilled manual occupations were the most exposed to high precariousness (18.9% of
women, 10.5% of men). By age, employment precariousness was highest among young workers (11.8% in age
30 and under) but relatively stable after that. The accumulation of characteristics predicting precariousness
resulted in high employment precariousness among 24.5 per cent of women under 30 years of age in unskilled
manual occupations, more than three times the sample mean.

Preliminary results also showed an association between employment precariousness and self-perceived
health, which was measured with the Spanish version of the SF-36 health questionnaire. Among workers with
high precariousness, self-perceived health was worse than among workers with moderate precariousness and
these, in turn, had worse perceived health than workers with no or low employment precariousness.

The SF-36 measures self-perceived health on a scale of 0 (worst) to 100 (best). Mean values of self-
perceived health for workers with low, moderate, and high precariousness were 77.1, 73.5, and 69.9 respectively
for general health and 76.9, 70.6, and 65.2 for mental health (data not shown).

The high proportion of workers exposed to employment precariousness highlights its public health
importance as well as the need to adapt and apply new scales of employment precariousness in other
countries.
Informal employment

Over the past two decades, the informal economy in low- and middle-income countries has risen rapidly. Even before the Asian financial crisis of the late 1990s, the informal economy was a powerful segment of the labour force. In Latin America, for example, the share of the workforce involved in informal, non-agricultural work was 55 per cent, 45-85 per cent in Asia, and in Africa it was nearly 80 per cent (Charmes, 1998). By
clusters based upon degree of development, the informal economy represented 41 per cent of GDP in low income countries, 38 per cent in transition countries and 18 per cent in OECD countries (Schneider, 2002). Recent studies confirm that the informal economy is growing worldwide (Farrell, 2004). While this labour remains unregistered, the informal economy represents a substantial volume of economic production. In fact, according to the Confederation of Free Trade Unions (CFTU), a quarter of the world’s working population works informally. What is more, this labour accounts for 35 per cent of global GDP. Its presence is dramatically stronger in poor countries, where 50-75 per cent of the workforce is informal, excluding those employed in agriculture. In the EU the number is 30 per cent of workers, demonstrating that the informal sector is not just a concern for poor countries. Additionally, with two-thirds of the actively working female population in poor countries involved, women are over-represented in the informal sector (ILO, 2003a).

In the end, we must remember that the extent and overall economic contribution of labour performed in the informal economy are challenging to measure. This problem is only made worse by the fact that the informal economy involves quasi-legal businesses and illegal or criminal activities (Thomas, 2001). Despite this notoriously difficult phenomenon, there are three competing explanations for how the informal sector comes to life.

The first explanation, the old informality/dualist economic theory, was developed in the 1960s. During this time it focused on transition societies, where the lack of land reforms and rapid industrialisation caused massive migration to urban centres. This created a gap between the availability of jobs and the demand for labour, resulting in unemployment and poverty and the creation of the informal economy.

The second explanation is known as the neoclassical informality/legalist theory. This explanation holds that, far from holding a marginal position, the informal economy is a dynamic production segment of the economy. It is useful because it attracts small entrepreneurs who have limited access to credit and technology, as well as workers desiring better income, freedom from tight schedules and less subordination.

The final theory is structuralist. The structuralists argue that informality is directly linked to the formal economy (unlike the dualists) and results from the practices of formal firms (unlike the legalists). In the end, most debates today involve the legalist and structuralist interpretations of informality, which, respectively, “blame” the existence of the informal sector on informal and formal workers and firms (Portes, Castells, & Benton, 1989; Noronha, 2003; Chen, Vanek, & Carr, 2004).
EmpLOYMENT, work, AND Health INEQualiTiES - a global perspective

We follow here the approach taken by a recent International Labour Conference (Hussmanns, 2004), which used the term “informal economy” for “all economic activities by workers and economic units that are - in law or in practice - not covered or insufficiently covered by formal arrangements”. Informal sector and informal employment refer to different aspects of the “informalisation” of employment and correspond to different policy-making targets. The concept of an informal sector refers to production units, while the concept of informal employment refers to jobs. Thus, using a building-block approach the framework disaggregates total informalisation of employment according to two dimensions: type of production unit and type of job [see Table 3]. The type of production unit is defined in terms of legal organisation and other enterprise-related characteristics, while type of job is defined in terms of employment status and other job-related characteristics. Production units are classified into three groups: formal sector enterprises, informal sector enterprises, and households. Jobs are distinguished according to status-in-employment categories and according to their formal or informal nature. For employment status, the following five groups from the International Classification of Status in Employment (ICSE-93) are used: own-account workers; employers; contributing family workers; employees; and members of producers’ cooperatives.

Table 3. Conceptual framework of informal employment.

<table>
<thead>
<tr>
<th>Products on units by type</th>
<th>Jobs by status in employment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Own-account workers</td>
</tr>
<tr>
<td></td>
<td>Informal</td>
</tr>
<tr>
<td>Formal sectors enterprises</td>
<td></td>
</tr>
<tr>
<td>Informal sector enterprises (a)</td>
<td>3</td>
</tr>
<tr>
<td>Households (b)</td>
<td>9</td>
</tr>
</tbody>
</table>

(a) As defined by the 15th International Conference of Labour Statisticians (excluding households employing paid domestic workers) / (b) Households producing goods exclusively for their own final use and households employing paid domestic workers.

Note: Cells shaded in dark blue refer to jobs, which, by definition, do not exist in the type of production unit in question. Cells shaded in light blue refer to formal jobs. Un-shaded cells represent the various types of informal jobs.

Informal employment: Cells 1 to 6 and 8 to 10.
Employment in the informal sector: Cells 3 to 8.
Informal employment outside the informal sector: Cells 1, 2, 9 and 10.

The 17th International Conference of Labour Statisticians defined informal employment as the total number of informal jobs, whether carried out in formal sector enterprises, in informal sector enterprises, or households, during a given reference period. Informal employment is comprised of own-account workers and employers employed in their own informal sector enterprises; contributing family workers, irrespective of whether they work in formal or informal sector enterprises; employees holding informal jobs, whether employed by formal sector enterprises, informal sector enterprises, or as paid domestic workers by households. Employees are considered to have informal jobs if their employment relationship is, in law or in practice, not subject to national labour legislation, income taxation, social protection or entitlement to certain employment benefits for reasons such as: non-declaration of the jobs or the employees; casual jobs or jobs of limited, short duration; jobs with hours of work or wages below a specified threshold; employment by unincorporated enterprises or by persons in households; members of informal producers’ cooperatives; and own-account workers engaged in the production of goods exclusively for own final use by their household (such as subsistence farming or do-it-yourself construction of own dwellings). Additional informal employment outside the informal sector includes the following types of jobs: employees holding informal jobs in formal sector enterprises or as paid domestic workers employed by households; contributing family workers working in formal sector enterprises; and own-account workers engaged in the production of goods exclusively for own final use by their household.

We have distinguished the informal sector from underground production, illegal production, and household production for own final use. Illegal production is defined as production activities which are forbidden by law, or which become illegal when carried out by unauthorised producers. Illegal production can be considered to represent a violation of the criminal code. Underground production is defined as production activities which are legal when performed in compliance with regulations, but which are deliberately concealed from public authorities. An example is the sale of legal goods and services without tax declaration. Thus, underground production can be considered to represent a violation of the civil code. For conceptual purposes, one can however distinguish three types of production activities: (i) activities which are legal and not underground; (ii) activities which are legal, but underground; and (iii) activities which are illegal.

Being outside the legal structure, firms in the informal economy rely mostly on trust, the extent to which social norms are respected, and the strength of social ties. In rural areas, most informal economic production is concentrated in subsistence farming. In urban settings, informal production is mainly carried out on streets and by small size
firms, most of which are home-based or family-owned enterprises. In this case, workers are mostly family members or relatives, and the overlap of capital and labour functions are common [Portes et al., 1989; Daza, 2005]. The major problem is that this lack of statutory regulation means that there is no way to ensure the protection of working conditions, wages, or acceptable levels of occupational health and safety.

Workers having informal jobs are disadvantaged compared to formally-hired workers in several aspects that separately or together affect their health and safety. The most important factor is poverty, since several studies show that firms in the informal economy usually have low profits and informal workers have lower salaries than those in formal firms. Wages are a large component of family income and therefore the informal jobs are important determinants of consumption patterns. Small business owners, on the other hand, do not fare worse than their formal counterparts. Also, informal employment affects the family, as children of women working as street vendors who accompanied their mothers, compared to the general population, have an increased prevalence of acute diseases (38.0% vs. 27.3%) and injuries (5.8% vs. 3.6%).

Since firms in the informal economy are unregistered and out of state control, working conditions, which are largely dependent on the reinforcement of workers’ health and safety laws and regulation by the state, are worse than in formal firms. Large formal enterprises may keep part of their workers illegally unregistered, with only a verbal employment arrangement. Formal firms may keep informally-employed individuals in the most dangerous activities in order to avoid fines resulting from occupational injuries or diseases, or to reduce expenses from labour-related taxes, to have more flexibility for hiring and firing, or keep payments under the legal minimum wages (ILO, 2006). Occupational hazards are common. For instance, awkward postures and exposure to toxic chemicals, excessive noise, poor sanitation, high workload, pesticides, violence and sexual assault (Iriart et al., 2006) are commonly observed in informal economy settings. As a result, a high proportion of occupational injuries and diseases among informal workers have been reported in several studies. Informal workers reported receiving less training and supervision than formal workers and limited access to protective equipment. Other factors associated with the informal economy and informal jobs are a low standard of housing and sanitation and inappropriate management of waste or toxic substances that can affect the environment and health. The scientific literature on occupational health and the informal economy is scarce and most studies are descriptive, a fact which limits the generalisation of results (Da Silva,
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Fassa, & Kriebel, 2006; Fonchigong, 2005; Hernandez, Zetina, Tapia, Ortiz, & Soto, 1996; Nilvarangkul et al., 2006; Lowenson, 1998; Rongo, Barten, Msamanga, Heederick, & Dolmans, 2004; Iriart et al., 2006; Santana & Loomis, 2004, Gutberlet & Baeder, 2008). Case studies, however, are a useful approach to illustrating and understanding the social conditions, working conditions, occupational hazards and health problems faced by many of these workers around the globe (see Case studies 22, 23 and 24).

There are other, more insidious side effects of the informal economy. In addition to many who are informally employed, self-employed workers are often ineligible for wage-dependent social benefits and are rarely visible in official statistics. They do not have a formal job contract and there is no employer. In poor countries, most maintenance services, such as painting, cleaning services, and baby-sitting, are performed by informal labourers. Moreover, their income will vary according to their ability to find jobs, quality and type of service, and their social or health insurance depends on out-of-pocket payments. Because they are not associated with a firm, they are often marginalised as informal labourers (ILO, 2007).

This lack of social security coverage is largely concentrated in the informal economies of poor countries, which are generally a larger source of employment for women than for men. Work in the informal economy is characterised by low levels of skill and productivity and low or irregular incomes. In some parts of the world, the growth of a "migration industry" comprising private recruitment agents, overseas employment promoters, human resource suppliers, and a host of other legal and illegal intermediaries, has caused a spike in female labour migration (ILO, 2003a; 2003b).

According to the ILO, the global assessment of the informal economy can be made using two main types of indicators: "vulnerable employment", a global but indirect measure of informal employment, and "employment in the informal economy", a partial but more direct measure. Vulnerable employment is a new indicator that estimates the sum of own-account workers and contributing family workers as a share of total employment. Since these two groups of workers are less likely to have formal work arrangements, this indicator may help to assess the informalisation of labour markets (ILO, 2008). Globally, it is estimated that in 2007 five out of ten people who worked were either contributing family workers or own-account workers. Not even half of all those employed enjoy the possible security that wage and salaried jobs could provide (ILO, 2008).

Employment in the informal economy is defined as a percentage of total employment (i.e., the ratio of the number of persons employed in the informal economy to the total of employed persons). The information available shows wide variations in definitions and

“This body is my only asset. On days I work, I earn. When I am sick, I cannot earn. My fire stays cold those days. There is no other body, no other asset to fall back on…”

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Methodologies used in data collection, so some of them cannot be compared. In fact, strictly speaking, only six countries [Ethiopia, Georgia, India, Latvia, Russian Federation, Turkey], those that use a harmonised definition, can be compared. Ethiopia and India are the countries that present the highest levels of informal economy employment, approaching 50 per cent (ILO, 2007).

Most countries have their own definition of the informal economy and available data are scarce, with a great variety of sources. In Tables 4 and 5 we show the most updated data available for each country. With respect to the informal sector (Table 4), the highest rates (both in men and women) are in Benin, Lithuania, Nepal, Pakistan and Peru, between 56 per cent and 97 per cent. With regard to employment in small or micro-enterprises, more than a half of the countries have rates over 50 per cent, with 97 per cent. With regard to employment in small or micro-enterprises, more than a half of the countries have rates over 50 per cent, with Uganda and Bolivia standing out (Table 5).

Case study 22. The ship-breaking industry in South Asia. - Atanu Sarkar

Ship-breaking, a highly mechanised industrial operation which was carried out in the developed world in the 1970s, has been shifted to poorer Asian states due to the high cost of upholding environmental, health, and safety standards in developed countries. Nowadays, ship owners send their vessels to the scrap yards of India, Bangladesh, Pakistan, China, Turkey, the Philippines, or Vietnam, where workers are desperate for jobs and health and safety standards are virtually ignored. South Asian countries such as India, Bangladesh, and Pakistan receive the largest number of vessels and engage between 70,000 and 80,000 labourers. Ship-breaking in this region has been receiving a lot of adverse publicity in the national and international media due to the large number of accidents and deaths of workers over the past few years, as well as the violation of numerous national and international regulations related to pollution, occupational hazards, and labour rights. There is no monitoring body equipped to enforce basic environmental safety norms or to ensure protection for the workers directly involved in ship-breaking. Unfortunately, the workers (who are mostly migrants) are mainly temporary and are not covered by any labour benefits, as the labourers working in ship-breaking are not recognised by any labour laws. The labourers dismantle the ships with their bare hands, live in poor housing and sanitary conditions, and little attention is paid to their health and safety concerns. Hazardous wastes are released into the environment during the scrapping process, exposing labourers to toxic substances. Many workers are injured or even killed by physical hazards. Main causes of death are fire/explosion, being hit by falling materials, falls, suffocation, and inhalation of toxic fumes. Even their sleeping quarters are not free from toxic exposure. In Bangladesh, to take one example, worker mortality has been estimated at one death per day (the highest in the region), be it either the slow death resulting from exposure to a cocktail of deadly chemicals or death due to the common explosions caused by the torching of residual fuels from uncleaned vessels and other kinds of accidents. Almost one out of every three or four workers is estimated to suffer from cancer, making ship-breaking one of the deadliest industries in the world. Most fisher folk in the coastal region have changed their profession due to environmental degradation and have either migrated or found an alternative occupation in and around the yard. Decades of state apathy and refusal to address the worker health epidemic, combined with the state’s open support for the ship-breaking industry, indicate a lack of political will to protect the environment and labour rights. The mishaps led to pressure groups within ship-owning countries, urging their governments not to send their ships to scrapping yards with poor safety and environmental records. The ship-breakers, on their part, insist that the ship-owners should decontaminate the ships before selling them off to the scrap yards. Most ships being dismantled today were built in the 1970s, prior to the banning of many hazardous substances under the Basel Convention. A number of environmental groups including Greenpeace, Basel Action Network (BAN), and various labour groups have sharply criticised the ship-breaking industry (including ship-owners, ship-breakers, and concerned authorities) for their blatant disregard for the environment, human rights, and international law. While in the long term it is expected that minimum standards on environmental and labour conditions in the ship-breaking industry will be enforced through the United Nations maritime organisation, the International Maritime Organisation (IMO), a key question is who will pay for the cost of improved labour conditions and the environmental effort. In the meantime, it is the workers who are paying the cost for the lack of action.

Sources

Case Study 23. The lives behind the piles. - Amanda Fortier
Stepping over piles of rotting fruit, torn fabric, and smashed tins, Sahir Cisse lights a Marlboro and expertly manoeuvres his way through his workplace. Mbeubeuss landfill site, located just outside Senegal’s capital city, Dakar, has been around for thirty-five years. On a daily basis, more than 1,300 tons of waste is dumped onto the 600 hectares of soil, further polluting the air and water with poisonous dioxins, PCBs and explosive and chemical solvents. Mbeubeuss is considered one of Dakar’s most dire environmental hazards. Since 1960, Dakar’s population has increased five-fold to 2.5 million, and solid waste production averages around 460,000 tons. The Italian-owned company contracted to deal with Dakar’s solid waste management, AMA, has only been able to gather less than 50 per cent of this amount. Hundreds of union and non-union employees rummage through mounds of household, industrial, and septic waste. Truck drivers like Cisse may earn up to 30,000 to 40,000 CFA (US$53 to US$71) daily. This offers enough incentive to risk the ensuing health and safety implications. Aside from the obvious threats of toxic fume inhalation and chemical explosions, there are countless truck accidents and instances of onsite drug and alcohol abuse.
For an estimated 300 individuals, Mbeubeuss is more than a workplace. It is their home. With each unloading vehicle at the dump comes hope for survival: a pair of shoes, an iron wire, or an electrical piece to repair and sell at the market. Many of these garbage collectors live just below the landfill site in a small makeshift village. Their walls are made from worn bed-sheets and refurbished iron-rods, their rooms from collected garbage pails and styrofoam blocks. There are six restaurants, scattered general stores, and even a center for prayer. Officials pledged in 2003 to close the site, but construction of the new site 80 kilometres away is delayed due to lack of funding.

Source
Fortier, A. (2006). The lives 80 kilometres away are delayed due to lack of funding.

Case Study 24. Food vendors on the streets of Kinshasa. - Françoise Barten and Martha S. Cedeño Gargano
The preparation and selling of food on the streets of Kinshasa-capital of the Democratic republic of Congo-involves a large number of low-income workers. There is a high demand for street food within the city (that is, ‘ready-to-eat’ food), since it is more economical for some population groups to acquire, considering the price of food, coal and/or gas and the time that they would have to invest in preparing the food themselves.
Street food preparation and selling in Kinshasa is an economic activity that mainly involves women. A recent study found that of a total of 256 food sellers, 55% were women, and 25% of the women were heads of households. 93% of all food vendors interviewed confirmed that food sales were their primary source of income and survival. The daily income for 59% of the food vendors was between US$20 and US$31, while 8% of the food vendors had a lower income than US$20.
In general, food sellers are found on the main avenues in the city, in particular at the crossroads of main avenues or on the streets that link the city with other districts. At these places, the affluence of persons and possible clients is constant during the day. The majority of the food vendors that earn more than US$20 are to be found along an avenue in the centre of town, a heavily trafficked area during all hours of the day and where food is sold during 24 hours per day. In this area there is also a large number of children living on the streets and of homeless people.
Nearly all (97%) food vendors that were interviewed implement these activities without complying with the regulations that have been established by government. This implies that they do not pay any required licences nor do they have the corresponding sanitation permits.
The working conditions of the food vendors in the streets of Kinshasa are extremely precarious. First, selling occurs on public roads, on the main avenues and intersections (cross-sections) where a high number of cars circulate during the day. There is a high emission of toxic gases and high levels of noise pollution.
Secondly, the food vendors are constantly threatened with the loss of their only economic source of income. Street food selling is illegal. It does not occur within the framework established by the state, but is to some extent allowed by the local authorities. This insecurity provokes a constant source of psychological stress for the sellers. Corrupt policemen and officials who demand a percentage of earned income in exchange for permission to continue the commercial activities also harass the food sellers.

Source

Coverage: National - Type of source: Household or labour force survey. - Age: 15+

<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>INFORMAL ECONOMY EMPLOYMENT AS A PERCENTAGE OF EMPLOYMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MEN</td>
</tr>
<tr>
<td><strong>HIGH INCOME</strong></td>
<td></td>
</tr>
<tr>
<td><strong>TRANSITION ECONOMIES OF CENTRAL AND EASTERN EUROPE</strong></td>
<td></td>
</tr>
<tr>
<td>Slovakia</td>
<td>30.5</td>
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<tr>
<td><strong>UPPER MIDDLE INCOME</strong></td>
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<tr>
<td>South Africa</td>
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<td><strong>AFRICA</strong></td>
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<tr>
<td>Barbados</td>
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<tr>
<td>Mexico</td>
<td>27.8</td>
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<tr>
<td>Panama</td>
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<td>Venezuela</td>
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<td><strong>LATIN AMERICA AND THE CARIBBEAN</strong></td>
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<tr>
<td>Mali</td>
<td>30.8</td>
</tr>
<tr>
<td>Uganda</td>
<td>30.6</td>
</tr>
<tr>
<td><strong>ASIA AND THE PACIFIC</strong></td>
<td></td>
</tr>
<tr>
<td>India</td>
<td>55.4</td>
</tr>
<tr>
<td>Kyrgyzstan</td>
<td>25.7</td>
</tr>
<tr>
<td>Nepal</td>
<td>67.4</td>
</tr>
<tr>
<td>Pakistan</td>
<td>65.8</td>
</tr>
<tr>
<td><strong>TRANSITION ECONOMIES OF CENTRAL AND EASTERN EUROPE</strong></td>
<td></td>
</tr>
<tr>
<td>Rep. of Moldova</td>
<td>6.3</td>
</tr>
</tbody>
</table>

Coverage:
- Urban:
- Mixed household and enterprise survey.
- Official estimates.
- Integrated survey of households.
- Not available.

Type of source:
- Household or labour force survey.

Remarks:
- Coverage limitation: Excluding agriculture.
- Coverage limitation: Excluding electricity, gas and water sectors.
- Geographic limitation: Metropolitan Lima.
- Geographic limitation: Excluding Chechen area.
- Geographic limitation: Metropolitan Lima.
- Geographic limitation: Excluding the rural population of Rondônia, Acre, Amazonas, Roraima, Pará and Amapá. Notes: Totals include employees who did not indicate the kind of employment (formal or informal) and/or the number of persons employed in the enterprise, as well as employers who did not indicate the number of their employees.

**Table 5.** Employment in the informal economy. Small or micro-enterprise (national definition) in 1999-2001. Coverage: Urban. - Type of source: Household or labour force survey - Age: 10+

<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>INFORMAL ECONOMY EMPLOYMENT AS A PERCENTAGE OF EMPLOYMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MEN</td>
</tr>
<tr>
<td><strong>UPPER MIDDLE INCOME</strong></td>
<td></td>
</tr>
<tr>
<td><strong>LATIN AMERICA AND THE CARIBBEAN</strong></td>
<td></td>
</tr>
<tr>
<td>Argentina 10, 11</td>
<td>40.8</td>
</tr>
<tr>
<td>Chile 3, 8</td>
<td>35.3</td>
</tr>
<tr>
<td>Costa Rica 9, 13</td>
<td>21.8</td>
</tr>
<tr>
<td>Uruguay 7, 22</td>
<td>33.6</td>
</tr>
<tr>
<td>Venezuela 8, 13</td>
<td>46.3</td>
</tr>
<tr>
<td><strong>LOWER MIDDLE INCOME</strong></td>
<td></td>
</tr>
<tr>
<td><strong>AFRICA</strong></td>
<td></td>
</tr>
<tr>
<td>Tunisia 1, 3, 9, 17, 18, 23</td>
<td>24.5</td>
</tr>
<tr>
<td><strong>ASIA AND THE PACIFIC</strong></td>
<td></td>
</tr>
<tr>
<td>Thailand 4</td>
<td>46.9</td>
</tr>
<tr>
<td><strong>LATIN AMERICA AND THE CARIBBEAN</strong></td>
<td></td>
</tr>
<tr>
<td>Bolivia 12</td>
<td>59.2</td>
</tr>
<tr>
<td>Brazil 13</td>
<td>42.8</td>
</tr>
<tr>
<td>Colombia 3, 24</td>
<td>55.1</td>
</tr>
<tr>
<td>Ecuador 10</td>
<td>51.1</td>
</tr>
<tr>
<td>Jamaica 1, 2, 9, 13, 22</td>
<td>26.2</td>
</tr>
<tr>
<td>Paraguay 13, 15</td>
<td>38.3</td>
</tr>
<tr>
<td>Peru 7, 16</td>
<td>53.4</td>
</tr>
<tr>
<td><strong>LOW INCOME</strong></td>
<td></td>
</tr>
<tr>
<td><strong>AFRICA</strong></td>
<td></td>
</tr>
<tr>
<td>Kenya 1, 2, 9, 13</td>
<td>43.9</td>
</tr>
<tr>
<td>Uganda 4, 19, 21</td>
<td>67.6</td>
</tr>
<tr>
<td><strong>LATIN AMERICA AND THE CARIBBEAN</strong></td>
<td></td>
</tr>
<tr>
<td>Nicaragua 9, 14</td>
<td>51.5</td>
</tr>
</tbody>
</table>

Coverage:

1 National.
2 Mixed household and enterprise survey.
3 Establishment sample survey.
4 Age: 7+.
5 Age: 12+.
6 Age: 13+.
7 Age: 14+.
8 Age: 15+.
9 Not available.
10 Geographic limitation: Excluding agriculture and mining sectors.
11 Coverage limitation: Excluding agriculture and mining sectors.
12 Geographic limitation: Cities with more than 2,000 inhabitants.
13 Geographic limitation: Cities with more than 5,000 inhabitants.
14 Geographic limitation: Eight main cities.
15 Geographic limitation: Greater Asunción.
16 Geographic limitation: Lima.
17 Geographic limitation: Excluding villages with less than 200 inhabitants.
18 Coverage limitation: Manufacturing (excluding slaughtering and oil-works), trade (excluding peddlers) and services sectors.
19 Coverage limitation: Manufacturing (excluding slaughtering and oil-works), trade (excluding peddlers) and services sectors.
20 Geographic limitation: Cities with more than 5,000 inhabitants.
21 Geographic limitation: Cities with more than 2,000 inhabitants.
22 Geographic limitation: Greater Buenos Aires.
23 Geographic limitation: excluding electricity, gas and water and communication sectors.

Child labour

Child labour is not a new phenomenon. Children have worked throughout history and the use of children as labourers continues today, mainly in low- and middle-income countries (see Case study 25). In fact, it is estimated that 317 million children between the ages of 5 and 17 are economically active; 218 million of these are child labourers and approximately 126 million are engaged in hazardous work (see Table 6). In 1999, 174 countries unanimously adopted ILO Convention 182 calling for urgent action to address the worst forms of child labour. A decade later, a report prepared by the United States Department of Labor (Bureau of International Affairs, 2009a) that included detailed profiles of child labour in 122 countries and 19 territories/regions concluded the issue demanded increased engagement. An associated report detailed the wide array of goods (from bananas and fashion accessories to pornography) produced by child labour and forced labour (Bureau of International Affairs, 2009b). Secretary of the US Department of Labor Hilda Solis noted that the global economic crisis was exacerbating the situation by forcing even more children prematurely out of school and into the workforce “often in exploitive or hazardous conditions” (Bureau of International Affairs, 2009a: xiii). It is important to define what we mean by child labour before we proceed any further. International organisations such as UNICEF and the ILO share a common understanding that a child is any person under 18 years of age, but there are differences in their definitions of child labour. UNICEF considers a child labourer to be any child below 12 years of age working in any type of economic activity, or those from 12 to 14 years of age engaged in occupational duties not considered “light work” (UNICEF, 2006). This relatively broad definition is complimented by a very specific one from the ILO. The ILO Worst Forms of Child Labour Convention No. 182 from 1999 defines the types of work that are unacceptable for children. These forms involve slavery or compulsory labour, prostitution, pornography, human trafficking, war, drug dealing or trafficking, or any illicit activity, and any work which, by its nature or the circumstances in which it is carried out, is likely to harm the health, safety or morals of children. This convention has been ratified by nearly 87 per cent of ILO members, who represent 77 per cent of the children around the world (ILO, 2006). The ILO’s insistence on putting a spotlight on the effects of child labour has been crucial in the fight against its most harmful forms, which include work activities that are mentally, physically, socially or morally harmful, and those that affect schooling and the safety of children.

As with many working conditions, a review of the literature on the topic of child labour identifies basic problems with the data. Although in certain areas indigenous and tribal children form the majority of child labourers, child labour among indigenous people continues to remain poorly documented. Many countries do not record this sort of data, and most
studies that yield specific country data give approximate numbers, which can make the available data by country imprecise and difficult to compare. Due to these barriers, most international organisations working on child labour issues prefer to work with regional data (Bille Larsen, 2003).

Immediately apparent in the data is the high level of economically active children in poor nations. This is the result of a shift in the frequency of child labour at the end of the 19th Century, when it became much more frequent in low-income countries (Basu & Tzannatos, 2003). It is important to recognise this distinction, since child labour is a very different problem in the high-income regions than it is in middle- and low-income countries. In wealthy countries, child labour accounted for about 2.5 million children under the age of 15 in 2000 (see Figure 11 and Map 5). In low-income countries, however, child labour varied from 4 per cent in Timor-Leste, Asia, to 67 per cent in Niger, Africa, close to the estimates reported from Togo (63%) and Burkina Faso (57%), which have values similar to those of other African countries, namely Sierra Leone, Ghana and Chad. Males were more likely to be in the labour market than females in the majority of countries (UNICEF, 2006).

The condition of child labour is uniquely dangerous for children because it affects their mental and physical health and development. A growing number of studies have demonstrated that health problems are one of the main negative effects of child labour. These effects vary in nature, ranging from direct or indirect workplace-related diseases and injuries, increased vulnerability to biological or toxic agents due to their immature immune systems, and ergonomic risks resulting from inadequate dimensions of tools and equipment, to the impairment of physical, mental and social development due to limited time for resting, playing and studying, as well as other health and developmental problems. Therefore, child labour is associated with problems related to the physical, physiological, mental and social development of children. Child labour may also directly compromise height, which can be regarded as a biological indicator of social injustice, and has recently been viewed as a relevant component of so-called physiological capital (Eijkemans, Fassa, & Facchini, 2005; Gunnarsson, Orazem, & Sánchez, 2006; Dantas, 2005; Duyar & Ozener, 2005; Fassa, 2003; Yamanaka & Ashworth, 2002; Fogel, 2003; Hawamdeh & Spencer, 2002).

Table 6. Child labour according to world regions and activity in 2000 and 2004.

<table>
<thead>
<tr>
<th>REGION</th>
<th>CHILDREN POPULATION [MILLION]</th>
<th>ECONOMICALLY ACTIVE CHILDREN [MILLION]</th>
<th>ACTIVITY [PERCENTAGE]</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2000</td>
<td>2004</td>
<td></td>
</tr>
<tr>
<td>Asia and Pacific</td>
<td>655.1</td>
<td>650.0</td>
<td>127.3</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>122.3</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>19.4</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>18.8</td>
</tr>
<tr>
<td>Latin America and Caribbean</td>
<td>108.1</td>
<td>111.0</td>
<td>17.4</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>5.7</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>16.1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>5.1</td>
</tr>
<tr>
<td>Su-Saharan Africa</td>
<td>166.8</td>
<td>186.8</td>
<td>48.0</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>49.3</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>28.8</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>26.4</td>
</tr>
<tr>
<td>Other Regions</td>
<td>269.3</td>
<td>258.8</td>
<td>18.3</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>13.4</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>6.8</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>5.2</td>
</tr>
<tr>
<td>World</td>
<td>1199.3</td>
<td>1266.6</td>
<td>211.0</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>190.7</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>17.6</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>15.8</td>
</tr>
</tbody>
</table>

Case study 25. Are we going backward in the global economy? - Charles Kernaghan and Barbara Briggs

Forced to work 13 ½ hours a day, six days a week for an 81-hour workweek, 2,000 child cotton mill workers aged 10 to 18 went out on a six-week strike in Paterson, New Jersey, beginning in July 1835. The children demanded an 11-hour day, but had to settle for a compromise: 12 hours a day Monday through Friday and 9 hours on Saturday, for a 69-hour week. Their pay at the time was $2.00 a week, which in today's dollars would be $44.08 or 64 cents an hour. Child labor has not changed much in today's world. In 2006, between 200 and 300 child garment workers as young as 11 years old, and some perhaps even younger, were found working in the Harvest Rich factory in Bangladesh. They were being forced to work 12 to 14 hours a day, often seven days a week, sometimes with grueling, mandatory all-night, 19- to 20-hour shifts. During busy periods, these child workers could be at the factory 80 to 110 hours a week, while earning just 6 ½ cents to 17 cents an hour — only one-tenth to one-quarter of what the child workers were paid in Paterson, New Jersey, back in the early nineteenth century. Daily production goals are arbitrarily set by management and are excessive. For example, the child workers are allowed just 24 seconds to clean each pair of Hanes underwear, using scissors to cut off any loose threads. They are paid just one twenty-third of a cent for each operation. The workers must receive permission to use the bathroom and are limited to two, or at most three, visits per day. The bathrooms are filthy, lacking toilet paper, soap, and towels. Sometimes (on average two days a week) the bathrooms even lack running water. Anyone spending too much time in the bathroom will be slapped. Speaking during working hours is strictly forbidden and workers who get caught are punished. The workers say that the factory drinking water is not purified and sometimes makes them sick. The sewers are provided only hard stools without cushions or backs. If the workers bring their own cushions, management takes them away. The workers say the factory is very hot and they are constantly sweating while they work. According to the workers, Harvest Rich does not respect women workers’ legal right to three months maternity leave with full pay. Pregnant women have to quit and return as new workers. For being one minute late, a worker can be punished with loss of their attendance bonus for the full month. If the workers bring their own cushions, management takes them away. The workers say the factory is very hot and they are constantly sweating while they work. According to the workers, Harvest Rich does not respect women workers’ legal right to three months maternity leave with full pay. Pregnant women have to quit and return as new workers. For being one minute late, a worker can be punished with loss of their attendance bonus for the full month. The workers say they do not receive national public holidays, nor are they allowed the legal vacation time they are due. The workers at Harvest Rich have no voice and no rights. If the workers bring their own cushions, management takes them away. The workers say the factory is very hot and they are constantly sweating while they work. According to the workers, Harvest Rich does not respect women workers’ legal right to three months maternity leave with full pay. Pregnant women have to quit and return as new workers. For being one minute late, a worker can be punished with loss of their attendance bonus for the full month. The workers say they do not receive national public holidays, nor are they allowed the legal vacation time they are due. The workers at Harvest Rich have no voice and no rights. Anyone daring to ask for their proper pay, or demanding that their most basic legal rights be respected, will be attacked and fired. The rights of freedom of association and to organise are 100 per cent denied. The children report being routinely beaten, slapped, and cursed at for falling behind on their production goals, making mistakes, taking too long in the bathroom, or for being absent for a day due to sickness. One can only imagine what would happen to the child and teenage workers in the Harvest Rich factory in Bangladesh if they dared declare a strike. At best, they would face beatings and firing.

Source
Case Study 26. Bridgestone Corporation maintains slave-like conditions in Liberia. - The International Labor Rights Fund

In Liberia, the Firestone Natural Rubber Company, a subsidiary of the Bridgestone Corporation, operates one of the world’s largest rubber plantations. Since the plantation opened in 1926, company housing, mainly single room mud huts with no electricity, running water, or toilet facilities, has never been refurbished and updated to modern safety standards. Firestone’s plantation workers and their children toil under the same slave-like conditions they have endured for the past 80 years. Extracting latex, rubber’s key ingredient, from rubber trees is a dangerous and strenuous endeavour. To meet the exorbitant daily quotas, children are called upon to assist their parents; this practice is encouraged by the plantation’s overseers. The children’s labour usually includes cutting trees with sharp tools, applying pesticides by hand, and hauling two buckets on a pole, each filled with more than 30 kg of latex. Every day, these child labourers have to work long hours and are thus denied the right to basic education. Access to the company-run schools is further impeded as parents must present a costly birth certificate in order to register their children. On the huge (almost 500 km²) plantation, tappers and their families are isolated from the world, totally dependent on Firestone’s inadequate provisions for everything from food to housing to health care. Firestone Natural Rubber not only abuses human rights but also the environment. According to Friends of the Earth USA, local organisations have documented the continuous release of toxins into the environment and the factory has contaminated the adjacent Farmington River and other waterways. Furthermore, plantation workers are exposed to toxic chemicals and compounds on a daily basis while tapping. Firestone Natural Rubber, however, does not admit to its abusive practices on the Liberian plantation. Daniel Adomitis, the president of the company, stated in 2005 that each worker taps about 650 trees a day, spending a couple of minutes at each tree. Assuming a tapper spends two minutes at each tree, he or she has to work for more than 21 hours a day to meet the daily quota of 204 kg. According to the ILRF, plantation workers have to tap up to 1000 trees every day to meet the exorbitant quota. If workers don’t fill their quotas, their wages are reduced by half. They have no choice but to seek the aid of their children. These child labourers are deprived of their childhood and of a basic education. A lack of schooling and the perpetuation of slave-like conditions tighten the workers’ dependence on the company and the cycle of poverty. Waste dumping and pollution further deteriorate the workers’ well-being as well as their livelihood. Child labourers describe their lives as “trapped in poverty and coercion”. Moreover, the merciless exploitation of Liberia’s people and natural resources by Bridgestone is directly linked to the nation’s impoverishment, as the raw materials produced in Liberia are sent elsewhere for processing, thereby shutting out the possibility of added value. Firestone must provide workers with basic rights, including a living wage and the freedom of association; it must end all child and forced labour and set achievable quotas; it must adopt health and safety standards; it must stop exposing workers to toxic compounds and chemicals, improve housing, schools, and health care centres to provide safe and comfortable facilities; it must ensure public disclosure of revenue and all types of foreign investment contracts; it must stop releasing chemicals into the environment and redress all environmental damage; and it must publicly disclose the identity and quantity of all toxic compounds that it releases or transports.

Source
EMPLOYMENT, WORK, AND HEALTH INEQUALITIES - A GLOBAL PERSPECTIVE

Many children suffer in unacceptable working conditions that are similar to the worst forms of child labour, such as combat in war, prostitution, drug selling, or hazardous job tasks, unsafe workplaces, excessive work time, and sometimes slave-like conditions (see Case study 26). Although more prevalent in low- to middle-income countries, child labour is a severe problem, stunting a child’s physical and mental growth. With hundreds of millions of children affected across the entire planet, this is a startling trend.

Slavery and bonded labour

Older forms of slavery were based on legal ownership and ethnic and racial division. Relationships between slaves and slave owners were often long-term and sometimes multi-generational. The “new” forms of slavery, however, are based not on formal ownership but rather on entrapping legal instruments such as contracts and debts. It has been estimated that there are 27.9 million victims of slavery globally, of which 26.4 million are in Asia (Bales, 2000; 2007).

The ILO estimates that, of the 12.3 million people who are victims of forced labour, approximately 9.5 million reside in the Asian and Pacific regions (making up 77% of the total number of forced labourers) followed by Latin America and the Caribbean (11%). The remaining people are distributed throughout Sub-Saharan Africa (5%), industrialised economies (3%), the Middle East and North Africa, and transition economies (2% each) (Table 7) (Belser, Cock, & Mehranl, 2005).

The act of slavery has many meanings. It was defined in the League of Nations Slavery Convention of 1926 as the “status or condition of a person over whom any or all of the powers attaching to the right of ownership were exercised”. ILO convention no. 29 (1930), defined forced or compulsory labour as “all work or service, which is exacted from any person under the menace of any penalty and for which the said person has not offered himself voluntarily”. This definition encompasses situations such as slavery, practices similar to slavery and debt bondage. ILO convention no. 105 (1957) further specifies that forced labour can never be used for the purpose of economic development or as a means of political education, discrimination, labour discipline or punishment for having participated in strikes (ILO, 2005). This situation has also been defined as “a social and economic relationship marked by the loss of free will where a person is forced through violence or the threat of violence to give up the ability to sell freely his/her own labour power” (Bales, 2000; 2007).

We must distinguish between extreme forms of employment and working conditions and what constitutes slavery or forced labour. It is the type of arrangement that links the person to the "employer"
that determines whether a person is in a situation of forced labour, and not the type of activity he or she is actually performing, however hazardous the conditions of work might be. For example, practices that constitute the use of slavery or forced labour include the use of force to make someone work (through mental or physical threat), taking ownership of or controlling another human through mental, physical or threatened abuse (to the victim or members of his or her family), dehumanising another human being, treating an individual as a commodity or as property to be bought and sold, and using physical constraint or placing restrictions to limit the individual’s freedom of movement (Anti-Slavery International, 2006).

To be even more specific for the sake of investigation, the ILO has identified eight different categories of forced labour, including slavery and abductions, compulsory participation in public works, forced labour in agriculture and remote rural areas, with coercive recruitment practices, domestic workers, bonded labour, forced labour exacted by the military, forced labour as a result of trafficking, and prison-linked forced labour (ILO, 2005).

Until this 2005 ILO publication gave worldwide estimates (see Table 7), there had been no accurate estimation of the extent of forced labour on a global scale. The reason is that it is a notoriously difficult phenomenon to measure. The exaction of forced labour is usually illicit, occurring in an underground economy and escaping national statistics as well as traditional household or labour force surveys. Governments are sometimes reluctant to probe into and recognise its existence within their national borders (Pawar, 1998). Furthermore, it is hard to collect evidence from victims, not only due to psychological trauma and communication gaps (resulting from language barriers), but also because they may feel reluctant to come forward and provide testimony due to a fear of reprisals from their exploiters or of action against them by immigration and other law enforcement authorities (ILO, 2005).

Thus, researchers are left with data that are difficult to work with. Nonetheless, there are a number of clear trends in the emergence of forced labour and slavery. We explain here how demographic changes in low- to middle-income countries, the forces of globalisation, and a dangerous mix of tradition and political unrest all contribute to the prevalence of forced labour and slavery.

First, rapid population growth in countries from Asia and Africa, where slavery is still prevalent, has aggravated resource constraints, inequality and poverty. In these countries, most of the population belong to the adolescent age group and the rapid increase in unemployment has led to the deterioration of the value of human life. Their helplessness and desperation make them vulnerable to forced labour.
Therefore, an increased supply of potential workers in the countries where slavery already exists has further brought down the price and has only made the practice more prevalent (Bales, 2000; 2007).

Second, neo-liberal trends also explain in part the rise of new forms of employment coercion, where employers in the emerging private sector capitalise on world market opportunities by extracting as much labour as possible from a cheap and often unprotected workforce. With global pressures on suppliers to reduce costs by every available means, retailers and intermediaries can take advantage of the intense competition between suppliers in order to squeeze profits out of them. Many suppliers are paid a product price that barely allows them to break even. Thus, to make a profit, they have to reduce labour costs even further. In many countries, this pressure has been accompanied by two other trends which have contributed to forced labour: the increased supply of helpless migrant workers and the deregulation of labour markets, which can blur the boundaries between formal and informal economies (Lahiri-Dutt, 2006; ILO, 2005; Loewenson, 2001).

Globalisation has also challenged the farming and agricultural sectors, the major means of livelihood in developing regions. Large numbers of people are forced to migrate from rural to urban areas, into shanty-towns, and into situations of terrible vulnerability when subsistence agriculture is replaced by cash crop economies with a corporate influence, when corrupt governments militarise and force people from their land, and when ethnic groups and indigenous people are evicted from their territories (Acharya & Marjit, 2000; Bhattacherjee, 2000).

Third, the role of tradition serves to reinforce the practice of forced labour into a vicious cycle of slavery. In some societies, the poorest members of society can be compelled to work, or induced into debt, which they or even their descendants find impossible to repay despite very long hours of hard work. They thus become locked in a cycle of poverty from which they cannot escape.

In fact, the persistence of forced labour in some areas of the world is partly the result of very long-standing patterns of discrimination against certain ethnic and caste minorities. In Asia, the incidence of bonded labour has been and remains particularly severe among the Scheduled Castes and Scheduled Tribes in India, among indigenous minorities in western Nepal, and among non-Muslims in Pakistan (Srivastava, 2005). In Latin America today, as was the case centuries ago, the main victims of forced labour are indigenous peoples. Typically these indigenous groups lived in previously isolated regions, where comparatively recent settlement...
has encouraged a demand for cheap labour, and where there is virtually no state presence to provide protection against forced labour. At the same time, land and tenancy reforms, together with the extension of labour law provisions to rural areas, have not prevented the emergence of new patterns or manifestations of forced labour.

Aggravating the powerful reinforcing effect of the tradition of slavery is political unrest. This is a particularly salient issue in Africa, where contemporary forced labour and slavery-like practices are more apparent in countries with a recent history of slavery and with reports of continuing patterns of discrimination against persons of slave descent. In addition, there are regions throughout the whole continent that are disturbed by ongoing civil war, displacing thousands of people and compelling them to live as refugees. With no alternative, they often turn to forced labour to supply much needed income (Martens, Pieczkowski, & Vuuren-Smyth, 2003; Fitzgibbon, 2003).

Yet another type of slavery is bonded labour. Bonded labour is a type of debt bondage, mainly found in South Asia, that is defined in broad terms as a system under which a debtor enters into an agreement with the creditor to provide his own work, or that of somebody else, for a specified or unspecified period of time, either without wages or for less than the minimum wage. Bonded labourers give up the freedom of changing employment, the right to move freely from place to place and the right to sell their property or the product of their labour at market value (Srivastava, 2005; ILO, 2001).

Unfortunately, bonded labour ensnares those who are least able to work their way out of it, namely women, children and migrants. With some 5.7 million children in forced or bonded labour, 1.2 million as victims of trafficking, 300,000 children involved in fighting forces, 1.8 million in prostitution and pornography, and 600,000 in illicit activities such as drug trafficking, today's statistics are staggering (see Case study 27). On average, women and girls constitute 56 per cent of victims of forced economic exploitation.Regarding forced commercial sexual exploitation, they are an overwhelming majority (98%) (ILO, 2005; 2006) (see Case study 28).

Migrants also have little to no recourse against such labour. Poor women are triply disadvantaged by their gender, membership in low castes or other low-status groups, and by virtue of being in bonded or otherwise exploitative labour arrangements. This forced labour most directly affects those people working at the margins of the formal economy, with irregular employment or migration status. The precarious legal status of millions of undocumented migrant women and men makes them even more vulnerable to coercion in industrialised countries (ILO, 2005; WHO, 2005).

"No, we have never tasted chocolate." Millions of people in Britain eat chocolate every day, what would you say to them? "If I had to say something to them, it would not be nice words. They buy something that I suffer to make. They are eating my flesh."

Source: Lawrence, L. (2001, April 22). We bought boy slaves' freedom for pounds 20 each; Filmmakers expose brutal child slave trade on cocoa plantations. SundayMirror.
The major force behind the high numbers of forced labour distributed worldwide is the practice of human trafficking, which also affects women, children and migrants especially severely. Globally, there are at least 2.4 million people in forced labour as a result of trafficking in persons, representing about 19.8 per cent of total forced labour. This estimate includes both transnational trafficking and trafficking within countries. Table 8 shows that 60 per cent of all global trafficking takes place in Asia and the Pacific, followed by industrialised economies (10%) and then Latin America and the Caribbean (10%). However, transition economies, the Middle East and North Africa, and industrialised economies all have higher proportions of forced labour contributed by trafficking when compared to other regions (94.3%, 88.1%, and 74.8% respectively). Overall, Asia and Pacific had the lowest (14.3%) proportion (Belser et al., 2005).

The scale of the problem belies the individual impact on the health of slaves or forced labourers. This dimension needs greater public health attention not just because of the sheer scale of the problem, but also for its known association with gross violations of human rights and the creation of dramatic health inequalities. At the most basic level, the employee-employer relationship essentially determines the health of forced labourers on account of physical and mental trauma from coercive conditions including restriction of movement and violence (see

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**Table 7.** Total and regional distribution of forced labour (absolute number and rates per million) in 2005.

<table>
<thead>
<tr>
<th>REGION</th>
<th>CATEGORIES OF FORCED LABOUR</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>State-imposed</td>
<td>Commercial Sexual Exploitation</td>
</tr>
<tr>
<td>Industrialized economies</td>
<td>19,000 (20)</td>
<td>200,000 (211)</td>
</tr>
<tr>
<td>Transition economy</td>
<td>1,000 (2)</td>
<td>98,000 (242)</td>
</tr>
<tr>
<td>Asia and Pacific</td>
<td>2,186,000 (642)</td>
<td>902,000 (265)</td>
</tr>
<tr>
<td>Latin America and Caribbean</td>
<td>205,000 (374)</td>
<td>115,000 (210)</td>
</tr>
<tr>
<td>Sub-Saharan Africa</td>
<td>70,000 (102)</td>
<td>50,000 (73)</td>
</tr>
<tr>
<td>Middle East and North Africa</td>
<td>7,000 (23)</td>
<td>25,000 (81)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>2,488,000 (395)</td>
<td>1,390,000 (220)</td>
</tr>
</tbody>
</table>


**Table 8.** Forced Labour by trafficking in 2005.

<table>
<thead>
<tr>
<th>REGION</th>
<th>TRAFFICKING (absolute number)</th>
<th>TRAFFICKING OF TOTAL FORCED LABOUR [%]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Industrialized economies</td>
<td>270,000</td>
<td>74.8</td>
</tr>
<tr>
<td>Transition economy</td>
<td>200,000</td>
<td>94.3</td>
</tr>
<tr>
<td>Asia and Pacific</td>
<td>1,340,000</td>
<td>14.3</td>
</tr>
<tr>
<td>Latin America and Caribbean</td>
<td>250,000</td>
<td>19.0</td>
</tr>
<tr>
<td>Sub-Saharan Africa</td>
<td>130,000</td>
<td>19.6</td>
</tr>
<tr>
<td>Middle East and North Africa</td>
<td>230,000</td>
<td>88.1</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>2,440,000</td>
<td>19.8</td>
</tr>
</tbody>
</table>

Case study 29). Even if not restricted, fear of detection and deportation can leave undocumented victims of forced labour reluctant to access health and social services. This precarious employment condition creates a host of associated problems.

Workers’ health is in general exacerbated by these conditions. Their pre-existing health problems create a state of multiple morbidities and high mortality as well as to the spread of disease to unaffected populations. Current research shows the presence of various health problems or risk in every individual victim, owing to deplorable living conditions, physical and mental trauma, and the inaccessibility of health care and other social supports.

Outside of the workplace, economic disparity, malnutrition and food insecurity, poor working conditions, and a lack of social support all prevent access to affordable health care, compensation and rehabilitation. Empirical evidence of the adverse effects that this situation creates for workers’ and their dependents’ health is documented in the form of physical violence and mental trauma, perilous working conditions, the absence of welfare measures, and the reinforcing of cultural barriers, which all exacerbate this trend of slavery and forced labour (Fassa, 2003; WHO, 2002).

Case study 27. The bitter taste of sweet chocolate: Child labour exploitation in West Africa. - Joan Benach

People around the world share a love of chocolate, a delicious and pleasurable product. It’s a prosperous business, too; according to the International Cocoa Organization, global sales were US$ 74 billion in 2006. The United States is the world’s largest chocolate market, while Western Europe consumes the largest share of chocolate products (45%); particularly, Germany, Belgium and Switzerland are among the countries with the largest consumption per capita in the world. Many chocolate consumers, however, would have a bitter taste in their mouths if they knew that the cocoa in the candies or cookies they enjoy had been produced by exploited children in Africa.

About two million cocoa farmers working across West Africa produce more than half of the beans used to make chocolate or the cocoa butter used for cosmetics. In the Ivory Coast alone, about 7 million individuals are engaged in cocoa-related economic activities. A 2002 report by the International Institute of Tropical Agriculture estimated that the number of children working in dangerous conditions in cocoa production in West Africa was 284,000, more than 70 percent of whom were in the Ivory Coast. Many children work under the worst forms of child labour for long and punishing hours, using dangerous tools and facing frequent exposure to toxic pesticides as they travel great distances in the grueling heat. Thousands of children are trafficked from extremely poor countries like Mali and Burkina Faso to work as slaves, suffering frequent beatings and other cruel treatment. In 2001, the British TV documentary “Slavery: A Global Investigation,” by Kate Blewett and Brian Woods, claimed that 90 percent of Ivory Coast cocoa plantations use forced labour, including many children. Child trafficking has spread in West and Central Africa, driven by huge profits and partly controlled by organised networks that transport children both within and between countries. Mali’s Save the Children Fund director, Salia Kanie, stated that “people who are drinking cocoa or coffee are drinking their blood. It is the blood of young children carrying 6 kg of cocoa sacks so heavy that they have wounds all over their shoulders. It’s really pitiful to see.”

In an attempt to avoid government regulation, intense media scrutiny, and pressure from activists, major cocoa companies made a voluntary commitment to implement the Harkin-Engel Cocoa Protocol to stop these practices and debated a label that would certify chocolate products as being free of child labour. All of the major chocolate firms signed on and agreed to work with unions, civil society and government officials in a partnership designed to ensure that all cocoa bean products would be grown and processed without violating internationally accepted labour standards. Moreover, the signatories to the protocol agreed to develop and put in place by July 2005 a certification assuring consumers that the cocoa they were buying had not been produced or processed under these conditions. Unfortunately, the companies did not meet that deadline. While they trumpeted a few pilot programs, companies continued to purchase and reap profits from child cocoa labour.
Today children still toil, picking cacao in unsafe and unfair conditions. In 2006, an in-depth investigation in Ivory Coast by the BBC reporter Humphrey Hawksley found no evidence that industry efforts were changing cacao plantations and concluded that “no one is in charge of the efforts put in place under the Cocoa Protocol. There’s no place the buck stops. In the cocoa belt, it’s only a short drive to find children working with machetes amid some of the worst poverty anywhere in the world”. The Cocoa Protocol doesn’t address the lack of educational opportunities suffered by child labourers in West Africa either.

While some NGOs and activists want to abandon the protocol, and some governments want to adopt a social label and ban imports of cacao that can’t be shown to be fairly traded, these strategies have not addressed the economic factors that perpetuate forced child labour in West Africa. First, the oversupply of cacao makes its price low, and farmers have very little power to bargain effectively for higher prices. Second, in a region where nearly two-thirds of the population lives on less than $1 a day, the compensation for the temporary loss of a child keeps the rest of the family from going hungry.

This exploitation will only stop when policymakers in developed and poor countries meet their human rights obligations, enforce the law, and address the lack of opportunities, power, and education, as well as the cultural customs that allow individuals to be abused. Also, companies must take responsibility for their supply chains and develop strategies to ensure that their suppliers don’t rely on forced labour.

**Sources**

**Case study 28. The beer-girls of Cambodia.** - Françoise Barten and Martha S. Cedeño Gargano

According to recent estimates in Cambodia, between 4,000 and 5,000 young women are employed in selling beer for large multinational companies such as Heineken and Carlsberg Dommelsch to clients that visit the restaurants in big cities.

The work of the young girls consists first of ensuring that the clients that visit the restaurant select the type of beer that they represent, and second in ensuring that they will consume as much of that beer as possible.

The young beer sellers earn approximately US$60 per night, this being about half the amount needed to satisfy minimal needs. In order to complement this salary, one third or half of the girls prostitute themselves twice or three times monthly. It is estimated that the annual revenue of beer selling ranges between US$15,000 and US$42,000.

The young beer sellers are continuously exposed to several health risks. A large number of the girls consume alcoholic drinks, since one of the selling strategies is to drink jointly with the client. A recent study among 42 beer sellers found that 75 per cent of the sellers consume an average of one and a half litres of beer each night, 27 nights per month.

**Source**

**Case study 29. Slavery and intentional violent deaths in Brazil.** - Iberê Thenório

Brazil’s level of mortality due to intentional violent causes is one of the highest in the world. These deaths have traditionally occurred in great metropolitan urban areas where organised crime established their headquarters and expanded their actions to slums and vulnerable poor neighbourhoods. However, a recent analysis of the geographic distribution of violent deaths (made in 2007 by Waiselfisz for UNESCO) revealed that violent-death areas are quickly spreading towards the countryside, particularly in regions where slavery has been reported.

Specifically, it has grown in municipalities located in deforested areas in the Amazon, where there are areas of farming expansion, such as the north region of the Mato Grosso state, and in the south and southeast of the Para state. These are the places where most slave work has been reported and addressed. According to the Shepperd Commission for the Earth, Comissão Pastoral da Terra [a prominent Catholic organisation] from 1995 to 2006, around 4,553 bonded workers were freed in Mato Grosso and 8,177 from Para, which
represents approximately 56.8 per cent of all cases reported in Brazil during that period of time. In 2006, 444 slaves were freed in Mato Grosso, while in Para state, 1,180 enslaved workers were freed. The map shows that the homicide rate by municipalities and regions estimated for 2002 through 2004 ranged from 101.4 to 61.7 per 100,000 inhabitants, higher than the 57.2 per 100,000 in Rio de Janeiro or 48.2 per 100,000 in São Paulo, the two largest metropolitan areas in the country. It is possible that this finding is a result of improvements in documentation and record-keeping of distant and isolated places in the Amazon region, compared to the mortality information systems of the great metropolises. However, there are reports of intense land disputes which ended up with fatalities among workers and activists as well, which were not always recorded as occupation-related deaths. In 2005, Sister Dorothy Mae Stang was murdered at age 73, while defending the land reform and the interests of small farmers from the city of Anapu, in the Para state, in the Amazon region.

7.4. WORKING CONDITIONS

The global formal workforce, that is, employees who have a formal contractual relationship with employers, constitutes about half of the world’s population (more than 3,000 million workers). When informal work and work at home are taken into account, the large majority of the whole population is involved in work. Work is not only the means through which most people provide for their daily sustenance, but also an issue that is central to understanding the way society distributes wealth and power, and can lead to a more or less egalitarian distribution of goods and allocation of resources. Work does not just determine peoples’ standard of living; it is also a key social determinant of health. Poor working conditions, through an endless number of occupational hazards, threaten workers’ safety and health, reduce well-being and working capacity, and thus affect the quality of working life and the economic well-being of workers and their families. Furthermore, in extreme cases, impoverished workers even need to take life-threatening decisions such as selling their organs (see Case study 30).

In the two last decades, important economic and technological developments have helped to reduce some occupational health problems, mainly in wealthy countries. Yet in poor countries, where the majority of the world’s working population live, exposures to occupational hazards have even intensified (WHO, 1995; Hogstedt, Wegman, & Kjellstrom, 2007). Indeed, in addition to the growing industrialisation of some large middle- and low-income countries, transfers of chemical substances and materials, changes in work organisation, and high exploitation of the work force are leading to old and new epidemics in the field of occupational health. Work-related deaths, including injuries but also those caused by cancers, cardiovascular disease, and communicable diseases, are estimated at about 2 million
annually. Globally, every day about 5,000 workers die due to work-related diseases (Hämäläinen, Takala, & Leena, 2007). Work-related injuries and diseases have a profound effect on the health of the working population, involving an enormous and unnecessary burden and suffering for workers’ families and communities, and a high economic loss for firms and countries.

Depending on the political tradition of each country, its economic activity and level of industrialisation, the development of laws, regulations and social protection, the type of industrial relations, and the power and involvement of unions, workers are more or less likely to be exposed to hazardous occupational factors. Poor countries that still employ a major part of the workforce in agriculture and other types of primary production face occupational health problems that are different than those of rich countries. Faster industrialisation, urbanisation, a great increase in construction, and agricultural mechanisation in middle- and low-income countries have led to a rise in the number of workers exposed to traditional (e.g., heavy physical workload) and new (e.g., work-related stressors and precarious work) occupational hazards. Heavy physical work often combined with heat stress, occupational injuries, pesticide poisonings, organic dusts and biological hazards are the main causes of occupational morbidity. These hazards are aggravated by numerous non-occupational factors, including parasitic and infectious diseases, poor hygiene and sanitation, poor nutrition, general poverty, and illiteracy. A growing number of studies (mainly conducted in wealthy Anglo-Saxon countries) illustrate the positive effect of unions and worker participation, particularly through safety representatives, occupational health, reducing occupational injuries, increasing the training of workers, and stimulating the firms into implementing more effective preventive policies (Menéndez, Benach, & Vogel, 2009).

The globalisation process has increased unequal work-related transfers between countries. A particularly important problem is the transfer of hazardous substances, materials and persons between rich and poor countries. Transfers can have either positive or negative impacts on the health of workers and the environment. But nothing that is unacceptable in the exporting country should be transferred to the importer, no matter what the legislation of the recipient country states about such practices.

There are three main types of transfers that are typically involved. First, raw materials, products and minerals are produced and extracted from workers in poor countries, where
workplaces under the control of multinational corporations or their subsidiaries control commodity prices and appropriate most of the profits of these economic transfers. In the most unstable and insecure regimes, a process of war and social destruction is left behind. A second important transfer is that of products and hazardous materials and substances, which mainly end up in poor countries, where they constitute a threat both to the health of workers and the environment. A final important transfer is that of human beings. Workers from the south often migrate to wealthy countries to work under the most difficult, low-paid and hazardous jobs that workers in rich countries often reject for themselves. High-skilled professionals from poor countries also migrate to the wealthy regions, where they find places to develop their skills, such that poor countries lose an important source of human resources while rich countries profit from this workforce transfer. An example is the approximately 60 million health workers worldwide and the unequal distribution of health workers throughout the world. There are severe inequalities between rich and poor countries, as well as differences within countries, especially between urban and rural areas. About two-thirds of health workers provide health services, while the remaining third is management and support workers. Each year, substantial numbers of health workers leave the health workforce, helping to provoke shortages which compromise the delivery and quality of health services. Fifty-seven countries, most of them in Africa and Asia, face severe workforce shortages. The WHO estimates that at least 2,360,000 health service providers and 1,890,000 management support workers, or a total of 4,250,000 health workers, are needed to fill this gap. Without prompt action, the shortage will worsen. For example, in Africa, the region south of the Sahara, which contains 11 per cent of the world’s population and 24 per cent of the global disease burden, holds only 3 per cent of the world’s health workers (WHO, 2006). In order to prevent social dumping and the over-exploitation of workers who are not able to defend themselves, compliance with standards should be internationally controlled and should not be compromised for any reason whatsoever. Universal minimum standards are needed for the health, safety and social protection of workers in all countries.

Similarly to countries and firms, the unequal distribution of working conditions is a key contributor to social inequalities in health through multiple occupational hazards. Exposures and mechanisms vary significantly according to occupations and social groups through key social axes such as social class, race or
Ethnicity, gender, age, and migration status (see Case studies 31 and 32). Several social aspects of work may raise health concerns; for example, the gender distribution and segregation of jobs and equality in the workplace, social relationships between managers and employees, and social support from fellow workers are all aspects of work which may enrich or reduce social contacts. In many services and public sector jobs, social pressure from customers, clients or the public may create an additional psychological workload.

The kind of work women and men do plays a significant role in determining their socioeconomic position in society and explains their differential exposures to health-promoting and health-damaging factors. By and large, compared to men, women all over the world face more difficult hiring standards, fewer opportunities for training, lower pay for equal work, less access to productive resources, worse physical and mental working conditions, lower participation in economic decision-making, and fewer promotion prospects. These factors negatively affect the status of women’s health and social position relative to men, and consequently have an important impact on gender inequities in health (Östlin, 2002). A number of the occupational health problems faced by women are known in both poor and rich countries. In the former, heavy physical work, the double burden of job and family, less developed working technologies, and traditional social roles are important factors which increase the burden of female workers. In wealthy countries, where women also face a double burden, lower-paid manual jobs are often left to female workers (see Case study 33). Also, the design of machinery and work tools are often made according to male anthropometry, despite the fact that female workers use the same equipment. Women may also face problems of occupational exposures that are hazardous to reproductive health. Numerous studies have shown adverse reproductive health outcomes among women exposed to pesticides, solvents and organic pollutants, heavy workloads, postural factors and shift work. For example, in many low-income countries there is a high concentration of the female labour force in agriculture. Cash crop production of fruits, vegetables and flowers involves exposure to toxic chemicals. Women and men in Africa are differentially exposed to pesticides, and women’s exposures have a greater tendency to be invisible to health care personnel (Kisting, 2005). The adverse health effects of pesticide exposure include poisoning, cancer, skin diseases, abortions, premature births, and malformed babies, as has been shown...
among floricultural workers in Colombia (Case study 38). Pesticides and chemicals are also widely used in high-income countries, where agricultural workers are often excluded from occupational health and safety legislation. In many service occupations, female workers may be exposed to the threat of violence from clients or to sexual harassment from fellow workers. Over the last decade, an increasing number of studies have indicated adverse health consequences of sexual harassment at work (Kauppinen, 1998). A survey among nurses in a hospital in Turkey revealed that 75 per cent of the nurses reported having been sexually harassed during their nursing practice: 44 per cent by male physicians, 34 per cent by patients, 14 per cent by relatives of patients, and 9 per cent by others (Kisa & Dziegielewski, 1996). Sexual harassment may result in guilt and shame, anxiety, tension, irritability, depression, sleeplessness, fatigue and headaches, which in turn may lead to absenteeism and reduced efficiency at work.

One survey on gender inequality, work and health (Messing & Östlin, 2006), however, shows that in low-income countries we know little about the health effects of working conditions for women. One reason for this is that systematic research is difficult. Women’s work in many countries is still performed in the domestic sphere and in the informal economy, and is thus invisible in the public, economic, and institutional spheres. As a result, many work-related hazards, injuries and diseases are not recorded as occupational, are not compensated by work insurance systems and are not included in occupational health databases. Research also indicates a higher than average risk of unemployment among low-paid female workers, which may also have negative social and health consequences on families.

With this in mind, let us turn now to a review the global impact of occupational injuries, work-related hazards and outcomes, and workplace psychosocial stressors in their relation to health.
Case study 30. The working poor selling their organs to survive. - Joan Benach and Hani Serag

Over the past three decades, organ transplantation has developed from being an experimental procedure performed only in a few advanced medical centres to being a common treatment carried out in many hospitals throughout the world including many South American, Middle Eastern and African countries. Survival rates have increased markedly over the past decade, and in many countries there is now a high demand for organ transplants. For example, in 2005 in the European Union, only 57.5 percent of organ needs were covered, and in the United Kingdom and the United States, more than 6,000 and 70,000 patients, respectively, were on the waiting list for kidneys. Even though buying and selling organs is illegal in most countries, the circulation of body parts transcends national boundaries, and there is a flourishing black market of human organs worldwide. In general, the limited information available shows that the flow of living-donor organs (mostly kidneys) follows an unequal distribution that goes from south to north, poor to rich, black to white, and female to male.

The procedures to obtain organs vary. In Japan, for example, patients have for many years used intermediaries with connections to organised crime, the "body mafia", to locate paid kidney donors in other countries. In other cases, wealthy patients use internet sites on which people post organs for sale, or travel great distances to other countries to secure a transplant.

It seems that Egypt has turned into a regional hub for the human organ trade. While there are no official statistics, in a country where social inequality and poverty are very high, more and more impoverished working or unemployed Egyptians are selling their organs. Organ-selling in Egypt evolved into an organised business in 1987, eleven years after Egypt’s first kidney transplant. The doctors' union banned live-donor transplants from Egyptians to foreigners in 1987 and prohibited newspaper advertisements in which kidneys were sought. Nevertheless, as the scars on the sides of many Egyptians in impoverished Cairo neighbourhoods testify, dealers in kidneys and other organs have found a safe and lucrative customer stream. As the head of an Egyptian doctors’ union pointed out, “a Saudi patient can pay up to US $80,000, split between the doctor, the donor and the go-between [...] A Jordanian or a Saudi who needs a transplant comes to Egypt accompanied by a relative as an official cover and then looks for an Egyptian or a Sudanese who is ready to sell his organ” (Bassoul, 2006).

In an interview with the daily Al-Masri Al-Yom, three Egyptians explained that the price for seeking better-paid jobs in the Gulf was a kidney. Asked to undergo a medical examination beforehand, the doctor then “discovered” they were all suffering from a kidney infection requiring immediate surgery. They woke up later in a hospital with a missing kidney, and a few days later the health ministry caught a trafficker red-handed as he was selling a kidney to a Saudi citizen for US $3,500.

While in the U.S. and the European Union selling organs is a crime that can incur high fines and even jail, in Egypt the lack of proper legislation feeds a booming black market. In the Philippines, many people have sold kidneys and other organs to rich Westerners seeking transplants. Despite the lack of reliable data, it seems that the trafficking of human organs is one of the fastest growing illicit trades in the country. A study by the University of the Philippines revealed that about 3,000 people in one slum area near Manila sold a kidney for prices ranging from US $1,400 to US $2,500 (Cullen, 2007). Although human organ trafficking is illegal in the Philippines, the voluntary donation of an organ is not. The availability and willingness of many working poor to sell their organs is a marker of their vulnerability. They sell them because they have nothing else to sell to survive. In fact, many are so weak and malnourished that they can die within months of the removal, unless they get advanced medical care. While in the Philippines about 6,000 people are suitable kidney transplant candidates, only 5 per cent actually receive transplants because of an insufficient organ supply and the unaffordability of the operative procedure for most patients (Aguilar & Siruno, 2004).

References

Case study 31. The 21st century “Jungle”: Taylorist work organisation and health inequalities in a Spanish slaughterhouse. - Salvador Moncada i Lluis, Clara Llorens Serrano and Teresa Castellà Gardenyes

Hazardous working conditions are unequally distributed among populations and have been identified as a major cause of health inequalities. Research on the social class, gender, age, and ethnic segregation of workplaces, unemployment, downsizing and precarious employment, for example, have provided good evidence of such a negative impact. Hazardous working conditions, however, contribute not only to generating but also magnifying existing health inequalities among populations by pushing workers who are injured or sick from previous exposures away from employment, towards hazardous working conditions. In this way, working class people are more frequently ill than middle or upper-middle class workers. The contemporary Spanish slaughterhouse provides a glaring example of how such health inequalities are tied to the workplace.

The table below shows the percentages of workers by tertile of self-perceived general health (low, medium and high, measured using the Spanish version of SF-36), by age group, of the working men and women of a Spanish slaughterhouse, as well as the same information for a control group: a Spanish working population from a population-based representative
survey. The slaughterhouse employs 170 people (60% women; 90% manual workers; 6% administrative; and 4% managers and supervisors, all of whom are men) and constitutes a typical example of Taylorist work organisation, with strong job segregation according to planning/execution and gender. Most employees there work in low-content, repetitive tasks, under high psychological demands, low control, uncomfortable ergonomic and physical conditions (working posture, repetitive movements, high humidity and low temperature), and are exposed to safety hazards related to the use of cutting machines and tools. Cross-sectional data shows that the best self-perceived health rises among workers as age increases for both the men and the women of the slaughterhouse, showing a "survival effect". This is the opposite of what we might expect and is observed in the case of the control population. That is, only healthier people "survive" to old ages in this company because people who become ill are pushed away from their jobs at younger ages. Confirmation that this was the most likely explanation was obtained by interviewing worker representatives and managers in the context of a health-risk assessment procedure forced by the union workers.

More than a century ago, Upton Sinclair's novel *The Jungle* strikingly illustrated the brutal working conditions of physical danger, insecurity, fear, exploitation, and filth in the Chicago meatpacking industry, helping to force the long-stalled Pure Food and Drug Act and the Meat Inspection Act, which became laws in the US in June 1906. In the beginning of the 21st century, this Spanish slaughterhouse case study exemplifies the need to implement and enforce new laws to drastically transform the widespread, very unhealthy Taylorist model of work organisation.

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<th>Case study 32. Occupational health inequalities in the United States: The workforce changes, but patterns persist. - Dana Loomis</th>
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Throughout its history, the economy of the United States has depended on the labour of workers from ethnic and racial minority groups and new immigrants. In the early years, these workers helped build the nation; the system of plantation agriculture that was established in the south during the colonial period was sustained by the work of Africans brought to the New World as slaves. As the nation expanded and industrialised in the nineteenth century, new immigrants from Europe toiled in the factories of the north, and Chinese labourers built the railroads and worked the mines in the west. Today, a rapidly-growing population of migrants from Latin America fills the demand for labour in construction, cleaning, landscaping, food service, and other essential but low-paying occupations. The American economy's historical dependence on minority and immigrant labour is linked to pervasive patterns of discrimination that have resulted in inequalities in both exposure to occupational hazards and health outcomes. African-Americans have endured a particularly long history of discriminatory placement in dirty and dangerous jobs. A notable example of these practices in the modern era was documented in an epidemiological study of workers in the U.S. steel industry (Lloyd, 1971): excess lung cancer in this large cohort was almost entirely attributable to a tenfold increase in lung cancer mortality among workers on the top side of the coke ovens (a hot location with heavy exposure to fumes), of whom 80 per cent were African-American. Recent research suggests that discriminatory work assignment also occurs with respect to injury hazards, and that it continued to operate in the last decades of the twentieth century. Data from the state of North Carolina for 1977-1991 show divergent patterns of employment by race and higher rates of fatal occupational injury among African-Americans compared to white workers, which persisted even after adjustment for employment structure (Loomis & Richardson, 1998). These findings suggest differences in risk between African- and European-American workers supposedly performing the same job. The ethnic and gender profile of the U.S. workforce is continuing to evolve, as it has throughout the nation's history, but although the groups affected may change, occupational health disparities based on ethnicity and race persist. Our research with national data suggests that as hispanic workers began to move into the U.S. labour force in large numbers in the 1990s, they began to replace African-Americans as the...
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Group with the highest risk of fatal occupational injury: while all other ethnic groups enjoyed decreasing risks of fatal injury on the job during that decade, the rates for Hispanic workers actually increased [Richardson, Loomis, Bena, & Bailer, 2004].

References


Many studies have reported a poorer health status among employed women who face high family and domestic demands [Waldron, Weiss, & Hughes, 1998; Artazcoz, Borrell, & Benach, 2001; Artazcoz et al., 2004]. It has also been reported that hiring a person to do domestic tasks is associated with good self-perceived health status among married female workers after adjusting for age and social class. No such association was found among married male workers [Artazcoz et al., 1999]. But, what are the working conditions and health status of these domestic workers, who are mostly women? A priori, this is a group in a poor position from a gender and social class perspective.

In 1994, 11 per cent of female employees in Catalonian [a region in northern Spain with a population of about seven million] worked in the cleaning sector (which includes both buildings and private homes). Their mean age was higher than the rest of occupations (42.1 versus 36.3 years), with lower educational levels and a higher percentage of previously married women (14% versus 7%). Additionally, the family burden among those married or cohabiting was higher than that of women in other occupations; 63 per cent lived in household units of four persons or more, compared to 54 per cent of other women [Artazcoz, Cortés, Benach, & Benavides, 2003].

Employment conditions were also poorer than in other occupations. In Barcelona, the capital of Catalonia, in 2000, 18 per cent worked with no contract and 21 per cent with temporary contracts. Accordingly, their health status was poorer than that of women in other occupations, even when compared with other manual workers (see Figure).

The employment and working conditions in this sector are difficult to begin with, and in addition, the women who work in this sector often also face heavy family responsibilities and economic difficulties, which negatively affect their health. However, research and prevention actions addressed to this group are still scarce. Paradoxically, the work these women do may well protect the health status of more privileged women, but they themselves are exposed to poor working and living conditions and, consequently, have a high prevalence of health problems.

Figure. Prevalence of different health conditions among employed females by occupational social class. Catalonia Health Survey, 1994.

References
Occupational injuries

Occupational injuries are among the most visible negative effects of poor employment and working conditions. According to the best available worldwide estimates, the number of non-fatal occupational injuries that cause at least three days’ absence from work is 264 million per year, more than 700,000 injured workers per day (Hämäläinen, Takala, & Leena, 2006). It has been calculated that annually, the global number of fatal injuries is approximately 350,000, meaning that every day, 970 workers die due to their working conditions. Currently, fatal and non-fatal occupational injuries produce about 10.5 million disability-adjusted life years (DALYs): about 3.5 years of healthy life lost per 1,000 workers every year globally. This is responsible for 8.8 per cent of the global burden of mortality (Concha-Barrientos, Nelson, Fingerhut, Driscoll, & Leigh, 2005). This enormous burden of disease is unequally distributed by social class, gender, ethnicity, age, and migrant status (see Case studies 34 and 35).

Structural changes from agricultural and industrial to service economies, with outsourcing of dangerous industries to poor countries, together with stricter regulation of preventive measures in companies, result in a decrease in occupational injuries in rich regions. Nevertheless, in the EU-15 it has been estimated that over 121,000 people die each year due to an occupational injury or by a disease caused by working conditions (ILO, 2005). Conversely, while they are decreasing in wealthy countries, work-related injuries are growing in middle- and low-income countries. This picture is particularly worrisome (see Case study 36). Based on occupational injury rates estimated by the World Bank region (Figure 12), the risk of fatal and non-fatal occupational injury in China and India is about two and a half times higher than in the Established Market Economies’ region (basically Europe and North America). This difference is five times higher in the case of Africa south of the Sahara economic region. Rich countries have the lowest rates. Fatal rates in Sweden and the United Kingdom are 1.9 and 0.8 per 100,000 workers, respectively, while in Mozambique or Kenya the fatality rates are 21.6 per 100,000 workers, similar to that in Bolivia, where the fatality rate is 21.9. These inequalities in occupational health are even more evident when we compare occupational injuries between two pairs of neighbouring countries located in sensitive areas, where economic and social differences are huge, Mexico and the USA, and Spain and Morocco. Occupational injury rates in Mexico (fatal 15.9 and non-fatal 121.3) are roughly three times higher than in the USA (fatal 5.2 and non-fatal 39.6). Even more dramatic differences can be seen between Spain (8.9 and 68.03) and Morocco (47.8 and 364.9), where they are approximately five times higher. These differences may in fact be higher, because underestimation bias is probably more significant in poor countries.
The related economic costs due to compensation, lost working time, interruption of production, training, and medical expenses are routinely estimated to amount to 4 per cent of annual global GDP, thus representing the enormous figure of some US$1,250 billion in 2001. It has been calculated that an average of 5 per cent of the workforce is absent from work on any given day, though this may vary from 2-10 per cent depending on the sector, type of work and management culture.
(ILo, 2005). Although governments may pay for some medical services or for sickness benefits, the cost to public health budgets and insurance is ultimately borne by society as a whole, and high rates of injuries and cases of poor health might have an impact on national productivity as well. A study by the European Commission estimated that in the year 2000, the costs of occupational injuries in the EU-15 was €55 billion a year (European Commission, 2004). At the firm level, only a small fraction of the world’s workforce is covered by compensation systems, so most workers receive no income during absences from work. Workers suffering long-term disability may also lose important skills and thus find it harder to find future work or at least to continue in the work for which they have been trained. The rate of participation in the labour force for disabled workers is about two-thirds that of non-disabled, with only half of the likelihood of being in a full-time job. In developing countries, the earnings of disabled workers can reach one-third of the wage of comparable non-disabled persons (Dorman, 2000).

Case study 34. Non-fatal injuries among young workers. - Curtis Breslin

Studies in wealthy countries show that the risk of job-related injury is 1.2 to 2 times higher among young workers (defined as age 15-24) than it is among older employees (Breslin & Smith, 2005; Centers for Disease Control and Prevention, 1998; Dupre, 2001). When young people are injured at work, the potential social and economic consequences are high: if an injury results in permanent impairment, a young person will experience more years of disability than an adult worker who is similarly injured. A number of questions about these workers can be raised. What are the employment patterns for young workers? In North America, many youth work even during the school year. For example, according to a 2003 Canadian Labour Force Survey, 69 per cent of 15-19 year olds, and 89 per cent of 20-24 year olds said they had worked at some time during the previous year. In North America, young workers, especially teenagers, are concentrated in jobs in the service and retail sectors (Breslin & Smith, 2005). What kinds of non-fatal injuries are most common among young workers? Young workers are more likely than older workers to sustain cuts, contusions, and burns (Breslin, Koehoorn, Smith, & Manno, 2003). But they are most commonly affected by sprains, strains and musculoskeletal problems like back pain, just like their older colleagues. Why are young workers at a higher risk for job-related injuries? Two factors, unsafe working conditions and perceived workload, were consistently associated with youth work injuries in a recent systematic review (Breslin et al., 2007). How can injuries in young workers be prevented? Education alone is not enough to prevent workplace injuries among younger workers or those who are new on the job. Although more research is needed to determine what is most effective for young workers, the following approaches are currently recommended: removing hazards, installing guards on machinery, and making other changes to the physical work environment that eliminate unsafe work conditions; developing workplace programs, policies and work practices aimed at maintaining a safe work environment; educating and training workers to anticipate, recognise, and control hazards in the workplace; and better enforcement of occupational health and safety regulations.

References
Case study 35. Immigrant day labour in the United States: Occupational safety and health implications. - Rosemary K. Sokas and Susan Buchanan

Immigrant workers in the United States account for virtually all growth in jobs over the past two decades. The impact of globalisation (in Mexico and Latin America especially, but also in Africa, parts of Asia, and Eastern Europe) has resulted in an influx of undocumented workers who face an extraordinary array of occupational hazards as they work in a growing shadow economy. One survey confirmed high rates of work among undocumented immigrants (91%), often at low-wage temporary jobs, with an additional 22 per cent and 36 per cent wage penalty for undocumented Latin American men and women respectively. It also confirmed high rates of self-reported unsafe working conditions, and a low rate of service utilisation, although 70 per cent paid taxes (Mehta, Theodore, Mora, & Wade, 2002).

Day labour is one form of nonstandard working arrangements. Other forms include part-time work, temporary help, self-employment, contracting out, employment in the business services sector, or home-based work (Quinlan, Mayhew, & Bohle, 2001). Day labour may be contracted formally through temp agencies, which may place workers in manufacturing facilities as well as service and construction work. Day labour of this type employs high numbers of women and African-Americans and creates significant challenges to traditional work protection enforcement. Informal or street-corner day labour is among the most precarious of all employment types. It is chiefly an open-air, urban phenomenon found not only in the US, but also in Japan, Mexico and South America. In the US, the workers are mostly immigrants, overwhelmingly male, often displaced, and are usually hired by home owners or small contractors to perform unskilled work in construction or landscaping (Valenzuela, 2003). In this setting, formal workplace protections are almost entirely absent.

In response to concerns about rising rates of fatal traumatic injuries among workers with Hispanic surnames in the US, S. Richardson reviewed 4,167 fatal injuries that took place between 1994 and 2000, determining that excess mortality was found exclusively among foreign-born Hispanic workers who had a fatality rate of 6.1/100,000 compared to 4.5/100,000 for US-born Hispanic workers and 4.6/100,000 for all U.S. workers (Loh & Richardson, 2004). Benajides et al. (2006) explored the relationship between temporary employment and increased rates of fatal and nonfatal traumatic injuries among temporary workers in Spain, and suggest that occupation and duration of employment play a major role. Day labor presents the extremes of intrinsic work/task hazards and short job duration, and combines these with a virtual lack of resources and a small absence of government protection. These factors presumably contribute to the excess mortality rate among immigrant Hispanic workers in the US, but significant challenges exist both for demonstrating the extent of the problem as well as for developing interventions. Occupational injuries are common amongst street-corner day labourers, but calculating injury rates is challenging due to the constantly shifting denominator: workers enter and leave the workforce frequently and perform different jobs every day. Three investigations which interviewed street-corner day labourers about workplace safety and occupational injury found worrisome reports of unsafe work practices, little use of PPE, and little to no safety training (Valenzuela, Theodore, Melendez, & Gonzalez, 2007; Buchanan, Nickels, & Morillo, 2005). Injury rates were estimated at five to six times the rate for US construction workers. Self-reported hazardous activities included working at heights (roofs, scaffolds, ladders), demolition, heavy lifting, eye hazards, and heat/cold exposure.

One response to the challenges faced by immigrant workers has been the development of worker centres, which now number in excess of 100 nation-wide (Cho, Oliva, Sweitzer, Nevarez, & Zanoni, 2007; Fine, 2006). Workers are non-profit, non-governmental organisations that take a variety of approaches to offer support, ranging from developing indoor locations and day-labour hiring hall services to problem-solving for wage and hour discrimination, as well as other concerns requiring legal service access. Many centres are worker-led, and have begun to join immigrant rights actions. Occupational safety and injury prevention are growing areas of concern amongst workers affiliated with these centres, which frame workplace safety as a right and provide the organisational structure that may be the most effective means to implement interventions aimed at preventing occupational injury among day labourers.

References
Case study 36. Employment and working conditions in the Chilean salmon industry: The case of divers. - Orielle Solar

The salmon industry has become one of the most dynamic and rapidly growing industries in Chile. About 85 per cent of salmon companies have their own processing plants, and 65 per cent also have their plants for producing food for the fish, which is the main input and a key factor in this area of activity. In 2006, Chile exported 383,700 tons of salmon, which brought the country about $2 billion in income.

Norway and Chile together represent 77 per cent of the global production of salmon farmed on floating platforms (Norway, 39%, and Chile, 38%). Of the companies currently operating in Chile, 40 per cent are multinationals, and 60 per cent of capital comes from Norway. Currently, about 48,000 people are employed in salmon farming, or 7 per cent of Chile’s total employed workforce.

Of the salmon-processing-plant workforce, 76 per cent is unskilled or low-skilled. Short-term or temporary workers are estimated to make up 30 per cent of the workforce in the industrial processing sector, and 20 per cent of the marine-farming sector. Outsourcing of services by large companies occurs in almost all sectors of the Chilean economy. It is estimated that more than half of the workforce in the salmon industry is provided by subcontractors.

Salmon farms are generally located in areas far from population centres, adding the problem of isolation to the basic safety risks workers confront. Work on marine salmon farms takes place in the open air, in all weather, on platforms that float on the ocean. These platforms consist of narrow catwalks around a cage that holds the salmon and moves with the waves. Sacks of food for the fish are transported on these walkways, and nets must be attached and manipulated. The unique way work is organised causes additional threats, as there are often incentives for dangerous, high-risk activities contravening the few safety regulations accepted at these salmon farms. Some of these high-risk activities are examined below.

Divers constitute one of the key groups of workers in salmon farming. There are more than 3,500 divers working in the salmon industry. Together, they perform more than 4 million dives each year. Their main tasks are removing dead fish and inspecting, cleaning and installing nets. These tasks are where serious and fatal work accidents happen most frequently. In the last 15 years, Chilean divers have suffered 845 work accidents. The majority of these can be described as acute illness provoked by inadequate decompression: 21 per cent of these accident victims died (180 workers) and 227 cases were identified as serious accidents.

Divers generally work six-day weeks, about half of the time on a shift system. Most commonly, salaries are composed of a fixed rate, plus a percentage dependent on productivity, often with additional bonuses for high productivity. The large majority of divers are hired through contracting or subcontracting firms. The risks inherent in diving are accentuated by the absence of clear diving schedules and emergency rescue plans, as well as by safety deficiencies in the air compressors used. Moreover, in most salmon centres, the basic norm of complete rest after diving is routinely violated, because workers have to alternate between diving and other work aboard the salmon raft. Between February 2005 and June 2006, 18 deaths were recorded in the salmon industry, 8 of them divers. One death per month is a very high figure, especially hard to justify in an industry where 40 per cent of the production is generated by multinational companies that also produce industrial salmon in their countries of origin, where high labour standards are maintained.

The causes of the divers’ deaths were linked to equipment deficiencies, but also to the way the work is organised, given the frequency and depth of dives. An industry monitor from the area explains that: “the industry hires these divers because they are cheaper. They are fishermen who come from the traditional, small-scale, independent fishing sector and suddenly find themselves working in an industrial context. They have to go down to the depths of the sea and then come back up several times a day, without an adequate decompression program or other necessary equipment. From the physiological standpoint, this is fatal, because it increases the risk of pressure sickness.” Divers acknowledge that they sometimes go as deep as 65 meters, when officially their training and equipment should not allow them to work at depths greater than 20 meters. A study found that, among a sample of 157 divers active in the salmon industry, 87 per cent had been affected by diving-related illnesses in the course of their careers.

It is important to emphasise that these workers come from the local independent fishing industry. They generally have low levels of education and income, little or no experience as members of a salaried workforce or with labour unions, and are unaware of current labour laws. In addition, these workers have usually been hastily inserted into a large-scale industrial operation, are recruited individually, rather than collectively, and are drawn into an export sector of prime importance for the local and national economy. The result is that workers are vulnerable and not likely to negotiate improvements in their employment and working conditions. To do so, they would need support through real action on the part of the state, which would have to shift the axis of employment conditions from productivity to equity in workers’ health.

In 2007, legislation was passed in Chile to regulate subcontracting firms and their relationships with the companies that hire them. It remains to be seen how this will impact the aquaculture sector.

Sources


Work-related hazards and outcomes

Millions of workers in both rich and poor countries are regularly exposed to thousands of chemicals, hundreds of biological factors and dozens of physical conditions with significant consequences for their health. Individual or combined exposures to these hazards contribute to the appearance of millions of occupational diseases, stress reactions, job dissatisfaction and an absence of well-being (WHO, 1995; Hogstedt, Wegman, & Kjellstrom, 2007). It is estimated that occupational hazards account for 37 per cent of back pain, 16 per cent of hearing loss, 13 per cent of chronic obstructive pulmonary disease, 11 per cent of asthma, 8 per cent of injuries, 9 per cent of lung cancer and 2 per cent of leukaemia. These work-related hazards caused 775,000 deaths worldwide in 2000. There were five times as many deaths in males as in females (647,000 vs 128,000). The leading occupational cause of death among the six risk factors was unintentional injuries (41%) followed by COPD (40%) and cancer of the trachea, bronchus or lung (13%). In 2000, workers who developed outcomes related to occupational hazards lost about 22 million years of healthy life worldwide. By far the main cause of years of healthy life lost [measured in DALYs], within occupational diseases, was unintentional injuries with 48 per cent of the burden. This was followed by hearing loss due to occupational noise (19%) and COPD due to occupational agents (17%). Males experienced almost five times greater loss of healthy years [DALYs] than females. Lower back pain and hearing loss have in common the fact that they do not directly produce premature mortality, but they cause substantial disability and have multiple consequences for the individual and society, particularly for workers suffering the outcomes at an early age (Concha-Barrientos et al., 2004).

Even in wealthy regions such as the European Union, there is a strong need to prevent traditional occupational diseases caused by physical, chemical and biological factors, with data showing that many of these hazards [e.g., breathing smoke, fumes, dust or powder, and exposure to vibrations and noise] have remained rather stable or have even increased in the last 15 years (Parent-Thirion, Fernández Macías, Hurley, & Vermeylen, 2007). Moreover, high-quality information is lacking and the standard data available often underestimates the real situation, (Concha-Barrientos et al., 2004). In Spain, for example, the overall percentage of workers probably exposed to carcinogens has been estimated to be 25.4 per cent (Kogevinas, Van der Haar, Fernández, Kauppinen, & Ferrer, 2006), a figure that rises to 52 per cent in the most dangerous sectors of activity (Kogevinas et al., 2000). In 2004, the Spanish registry on
occupational diseases identified nearly 30,000 diseases (most of them not serious and without sick leave), and only two deaths. Much more detailed analyses, however, have estimated that annually there are 80,000 cases of occupational diseases and 16,000 deaths (García, Gadea, & López, 2007).

It is estimated that around one-fourth of the workforce in rich countries and more than three-fourths in poor countries are exposed to such physical factors, and in some high-risk sectors such as mining, manufacturing and construction, all workers may be affected (WHO, 1995). Physical and mechanical factors produced by unshielded machinery and unsafe structures like noise, vibration, ionising and non-ionising radiations and microclimatic conditions are known to affect health (Hogstedt et al., 2007). For example, noise-induced hearing loss has been found to be one of the most prevalent occupational diseases. Another example is exposure to mineral dusts that cause fibrotic responses in the respiratory system and are associated with an elevated risk of cancer. Pneumoconioses have been found to occur in as many as half of workers most heavily exposed to silica, coal dust or to asbestos filaments (WHO, 1995).

Chemicals are increasingly used in virtually all types of work, including non-industrial activities such as hospital and office work, cleaning, cosmetic and beauty services and numerous other services. Thousands of chemical products in use in today’s workplaces constitute an important threat to worker’s health, although the extent of exposure varies widely according to country, occupation, and industry. Exposures are most prevalent in industries processing chemicals and metals, in the manufacture of several consumer goods (e.g., metal products and plastic boats), in the production of textiles and artificial fibres, and in the construction industry. Metal poisoning, solvent damage to the central nervous system and liver, pesticide poisoning, dermal and respiratory allergies, cancers and reproductive disorders are among the health effects of such exposures. In some countries, more than half of the workers in certain high-risk industries may show clinical signs of occupational disease, which also has an adverse effect on working capacity (WHO, 1995). Nevertheless, only a few hundred hazards, such as chemical (e.g. benzene, chromium, nitrosamines), physical (e.g. ultraviolet radiation, ionizing radiation) and biological (e.g. aflatoxins, tumor viruses) ones, have been identified as occupational carcinogens. The most common cancers resulting from occupational carcinogenic exposures are cancers of the lung, bladder, skin, liver, haematopoietic tissue, bone and soft connective tissue. A particular
product of concern is asbestos, which has been severely restricted in rich countries but is largely used in poor countries, with some evidence showing that mortality caused by mesothelioma has been rising in recent decades (Hogstedt et al., 2007). Currently, about 125 million people in the world are exposed to asbestos in the workplace. According to global estimates, at least 90,000 people die each year from asbestos-related lung cancer, mesothelioma and asbestosis resulting from occupational exposures. In addition, several thousands of deaths can be attributed to other asbestos-related diseases as well as to non-occupational exposures to asbestos. The burden of asbestos-related diseases is still rising, even in countries that have banned the use of asbestos in the early 90s (WHO, 2006). Two concrete illustrations of work-related hazards are shown in Case studies 37 and 38 in a rich and a poor country, respectively.

Case study 37. Occupational cancer in the Paris suburb of Seine-Saint-Denis: First results of a Pro-active Study. - Annie Thébaid-Mony

To examine the increase in cancer cases and the inequalities in cancer incidence in the most industrialised district of the Paris region, a network of medical staff, researchers and public health institutions decided to create a permanent multidisciplinary network, GISCOP 93, for registering occupational cancer cases in Seine-Saint-Denis. The objectives of GISCOP 93 are to study the occupational histories of patients suffering from cancer in order to identify those who have been exposed to occupational carcinogens, to assess whether the French compensation system is adequately providing rights to compensation for such patients, and to study the occupations exposed to carcinogens in order to identify priorities for prevention of occupational cancer.

New patients in three hospitals within the Seine-Saint-Denis district who are diagnosed with lung, pleura, larynx, sinus and ethmoid, and urinary tract cancer, mesothelioma or leukaemia are registered by clinicians. The patient’s job history is reconstructed in a face-to-face interview between the patient and sociologists from the research team. Experts in toxicology, industrial hygiene and occupational health review every period of the patient’s job history to calculate their exposure to the occupational carcinogens present in the IARC list, in the EU directive, and in the French regulation for prevention. The experts are not trying to establish the causal link between such exposure and the disease but to determine whether the patient can legitimately notify the compensation board of their cancer as an occupational disease according to the rules of the French compensation system. Compensation procedures are registered by the SCOP research team.

From March 2002 to March 2007, a reconstruction of job history has been made for 655 patients, basically characterised by precariousness and a low level of qualification. Out of the 655 job histories, 84.5 per cent demonstrate occupational exposure to carcinogens, especially in the sectors of construction, maintenance, car repair and metal work. Only one in six of the exposed patients has been compensated.

This study emphasises the importance of occupational exposure to carcinogens in contingent work. It also reveals that, with the exception of asbestos exposure, whereas there has been some success in profiling and compensating victims, a gap exists between the rules of compensation for occupational cancer and the state of scientific knowledge, as well as the reality of patients’ jobs and working conditions.

Sources
Employment relations and health inequalities: a conceptual and empirical overview

Case study 38. The health of female floricultural workers in Colombia and the International Flower Campaign. - Jairo Ernesto Luna García

The development of floriculture in Colombia is often presented as a successful case of a new entrant into the international market, since in only a few decades, roses and chrysanthemums produced mainly by women have gained ground as a way to express feelings in many northern countries, making Colombia the second most important exporter, with an international market share of 11 per cent (Farné, 1998).

Floriculture was promoted by the World Bank not only in Colombia, but also in various countries in Latin America, Africa and Asia which enjoy ideal natural conditions of water and suitable soil. There, the argument went, with intensive manual labour they could produce goods that would earn foreign exchange, which would subsequently flow back northwards in the form of payments of onerous foreign debt (FIAN, 2008).

In the case of Colombia, production of fresh-cut flowers for the international market began near Bogota during the 1960s, and later expanded to other regions of the country, particularly Antioquia, near the city of Medellin. By 2006 Colombian flower exports had risen to a value of $967 million. In 2007 a total area of 7,290 hectares was dedicated to floriculture, employing over 98,000 people, with 60 per cent being women.

Employment conditions in this sector have suffered deterioration, with the implementation of policies of job "flexibilisation", and at the same time an intensification of workload (in the 1980s one woman would be responsible for looking after 24 furrows of flowers, and by the 1990s, and now, this figure has risen to 42 furrows). Various complaints have been filed addressing limited freedom to unionise and the persecution of women seeking to organise themselves in order to defend their rights (see also Case study 11).

Job conditions are affected by the technology employed, including monoculture underneath plastic, intensive use of agricultural chemicals under extreme temperatures, and the division of labour into areas of propagation, cultivation, and post-harvest processing, with intense manual work predominating in all areas (Corporación Cactus, 2007).

The health conditions of women working in Colombia’s flower-growing sector are the subject of several studies which have revealed problems in their reproductive health (Idrovo & Sanín, 2007), the presence of cumulative trauma, as well as significant psychosocial impacts. These findings have led to an international campaign demanding growers and marketers to be more socially responsible regarding women working in floriculture. The campaign has revealed the multiple facets of globalisation, in which flowers that bring happiness to some women have only thorns for others.

References

Workplace psychosocial stressors.

The globalisation of economic activity has created new demands for competitiveness, productivity and adaptability between countries and firms, and in particular more pressure on workers in an increasingly deregulated labour market (Benach, Benavides, Platt, Diez-Roux, & Muntaner, 2000). This new work environment has increased managerial pressures and the amount of precarious jobs and work insecurity, shift work and overwork with irregular, longer, and more intense working hours (see Case studies 39 and 40). Under those circumstances, workers experience adverse health effects through both material and social deprivation and suffer from a variety of physiological and psychosocial problems. Additionally, new problems such as the threat of violence, which is associated with a number of psychological symptoms, are now more visible than before (Hogstedt,
Worldwide, few studies determining the effects of psychosocial stressors on working life and related health effects have been reported, and information is based on indirect evidence, aggregated data, or case reports. However, in some wealthy countries, developed theoretical models and extensively empirical findings are available (Marmot, Siegrist, & Theorell, 2006).

The main conceptual models of psychosocial working conditions used in health research have separated the measurement of potentially stressful working conditions from the health effects of work stress. A widely used work stress model, developed by Karasek & Theorell (1990), conceptualises work stress in terms of the psychological demands of work and the degree of control over working conditions. In Karasek’s initial formulation of the model, it was hypothesised that high job demands, together with low control over working conditions, would be particularly bad for health. This was labeled job strain. The Karasek model was developed further by the addition of a third dimension related to degree of social support at work. A supportive working environment is considered to be one in which employees receive good support from both colleagues and supervisors and where employees receive clear and consistent information from their supervisors. A different model of working conditions, the effort-reward imbalance model, developed by Siegrist (1996), is based on the notion of social reciprocity. This model proposes that a combination of putting high effort into work without adequate reward is detrimental to health. Effort includes both extrinsic and intrinsic components (for example, work over-commitment) and reward includes esteem or respect, career opportunities including job security and promotion prospects, and financial remuneration.

The concept of organisational justice is a more recent model for psychosocial working conditions which may have health consequences (Kivimäki, Elovainio, Vahtera, & Ferrie, 2003). This model concerns fairness of treatment at work and has procedural and relational dimensions. Relational justice refers to the extent to which supervisors consider employees’ viewpoints, are able to suppress personal biases, and take steps to deal with their employees in a fair and truthful manner. The procedural component relates to the fairness and consistency of formal decision-making procedures in an organisation.

Although there have been some attempts to obtain objective measures of psychosocial working conditions, it is more common for psychosocial working conditions to be based on self-reported questionnaire measures collected through surveys of employees. Self-report measures have the advantage that they take account of the employees’ perception of their work environment, which may
itself be an important determinant of health. Work characteristics can vary within the same occupation, depending, for example, on the style of the line manager. Self-report measures also capture this variation. On the other hand, it has been argued that health status can influence perceptions of work characteristics (reverse causality) and that self-report can lead to “sole source” bias (Muntaner & O’Campo, 1993; Macleod et al., 2002; Macleod & Smith, 2003). Thus, the inclusion of people with negative affectivity characteristics (the tendency to complain in general) may induce spurious associations between self-report measures of both work and health.

There is a considerable body of evidence from prospective studies showing that all three of these models of work stress are associated with health. In the UK, these associations have been studied in depth in the Whitehall II longitudinal cohort study of 10,308 London-based civil servants. Predictors of incident coronary heart disease included low control at work and high job demands, effort-reward imbalance (see Figure 13) and relational justice. Working conditions including low job control, high job demands, low levels of social supports at work, effort-reward imbalance and relational injustice were associated prospectively with psychiatric morbidity. Low decision latitude and low levels of social supports were associated with increased rates of sickness absence, and indicators of both effort-reward imbalance and relational justice were associated with medically-certified spells of sickness absence. Table 9 summarises the evidence from the Whitehall II study for associations between the different dimensions of psychosocial working conditions and health.

**Figure 13.** Effort reward imbalance at work and coronary heart disease in 1997-2000.

Adjusted by age, sex and grade

Other studies, mostly carried out in wealthy countries, have also demonstrated associations between psychosocial working conditions and both mental and physical health. A systematic review and meta-analysis of prospective studies reported that job strain, effort-reward imbalance and organisational injustice were all associated with the incidence of coronary heart disease, although the magnitude of effects varied between studies (Kivimäki et al., 2006). A meta-analysis

Table 9. Working conditions and health: summary of Whitehall II study findings to date.*

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<th>WORK CHARACTERISTIC:</th>
<th>ASSOCIATED WITH:</th>
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<td>Low decision latitude</td>
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<td>- Alcohol dependence</td>
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<td>- Poor mental health</td>
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<td>- Poor health functioning</td>
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<td>- Back pain</td>
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<td>- Sickness absence</td>
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<td>- Coronary heart disease</td>
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<td>High job demands</td>
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<td>- Coronary heart disease</td>
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<td>Low social support at work</td>
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<td>- Poor health functioning</td>
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<td>- Sickness absence</td>
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<td>Combination of high effort and low rewards</td>
<td>- Alcohol dependence</td>
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<td>- Diabetes</td>
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<td>- Coronary heart disease</td>
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<td>Low relational justice</td>
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<td>- Coronary heart disease</td>
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<td>High job strain (low control and high demands)</td>
<td>- Weight gain and weight loss</td>
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<td>Isostrain (low control, high demands, lack of support)</td>
<td>- Metabolic syndrome</td>
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<td>Organisational change</td>
<td>- Poor mental health</td>
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<td>- Poor self-rated health</td>
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<td>- Increased general symptoms</td>
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<td>- Increased incidence of longstanding illness</td>
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<td>- Increase in blood pressure</td>
</tr>
<tr>
<td>Job insecurity</td>
<td>- Poor mental health</td>
</tr>
<tr>
<td></td>
<td>- Poor self-rated health</td>
</tr>
<tr>
<td></td>
<td>- Increased general symptoms and minor health problems</td>
</tr>
<tr>
<td></td>
<td>- Increased use of health services</td>
</tr>
<tr>
<td></td>
<td>- Sickness absence</td>
</tr>
<tr>
<td></td>
<td>- Sickness presenteeism</td>
</tr>
<tr>
<td></td>
<td>- Increase in blood pressure</td>
</tr>
</tbody>
</table>

* A comprehensive list of publications is available at http://www.ucl.ac.uk/whitehallII/
of studies of psychosocial work stressors and mental health found consistent evidence that low decision latitude, high job demands, low social supports at work, job strain and effort-reward imbalance were risk factors for subsequent mental health problems (Stansfeld & Candy, 2006). Finally, evidence suggests that job stressors such as high job demands, low job control, low social support, few rest break opportunities (Bongers, Kremer, & Ter Laak, 2002), and job strain (Rugulies & Krause, 2005) contribute to the development of musculoskeletal disorders of the upper extremity (such as carpal tunnel syndrome and tendinitis) and of the lower back, after taking into account physical job demands. Acute injuries have also been associated with psychosocial stressors (Hanecke, Tiedemann, Nachreiner, & Grzech-Sukalo, 1998; Clarke, Sloane, & Aiken, 2002).

Another psychosocial characteristic of work linked to ill-health is threat-avoidant vigilant work, which involves continuously maintaining a high level of vigilance in order to avoid disaster, such as death. This is a feature of a number of occupations at high risk for CVD, e.g., truck drivers, air traffic controllers, and sea pilots (Belkic et al., 2000). The strongest evidence for threat-avoidant vigilance comes from studies of single occupations, where professional drivers, particularly urban transport operators, emerge as the occupation with the most consistent evidence of elevated risk of CVD (Belkic, Emdad, & Theorell, 1998; Tuchsen, 2000).

Although there appears to be some conceptual overlap between the three work stress models, empirical evidence suggests that they each independently influence health. From this perspective, an important scientific question has been posed. Are these observed associations causal or are they a product of methodological problems associated with epidemiological studies of psychosocial factors and health such as reverse causality, reporting bias and residual confounding?

In spite of these concerns, there are plausible biological pathways which may mediate the association between work stress and health. In the Whitehall II study, there was a dose-response association between iso-strain (a combination of high demands, low control and low support) and the metabolic syndrome, a cluster of physiological risk factors which increase the risk of heart disease and diabetes (Chandola, Brunner, & Marmot, 2006). Body mass index is another potential intermediate factor that has been associated with job strain. Next, opportunistic studies of the effects of change in working conditions can provide stronger evidence for a causal link. For example, studies that have taken place in the context of downsizing have shown an association between change in working conditions and subsequent health. In the Whitehall II study, adverse changes in
working conditions following civil service restructuring predicted increased rates of sickness absence (Head et al., 2006). Intervention studies can provide the best evidence for a causal link between working conditions and health. In addition, intervention studies may offer indications of how best to implement improvements to working conditions. So far, intervention studies that evaluate the effect of changing working conditions on health have tended to be conducted in small samples, and findings have not been conclusive. More recently, findings from workplace intervention studies have demonstrated that interventions aimed at improving psychosocial working conditions lead to short-term reductions in sickness absence and reduced mental health problems. Further research is needed in this area, including evaluation of the development and implementation of workplace interventions, as well as their effectiveness.

Workplace trends in developed countries resulting in part from economic globalisation, such as the growth of job insecurity, contingent (temporary and part-time) work, and new systems of work organisation, appear to be increasing work stress (Kompier, 2006). European surveys show continuing increases in work intensity and job demands between 1990 and 2005, but no changes or slight declines in job control or autonomy (Eurofound, 2006), suggesting an increase in the prevalence of job strain. Overall the body of evidence on psychosocial working conditions and health has led to recognition by policy-makers of work stress as a workplace hazard and calls to begin discussions on setting reference values (Benavides, Benach, & Muntaner, 2002) similar to standards already existing in many countries for physical workplace hazards.

Case study 39. Managerial pressure and mental illness: an avoidable achievement. - Carles Muntaner and Haejoo Chung

The workers of Hitech RCD Korea have the typical "bad luck" with traditional holidays that they share with their fellow citizens. Some of them received letters indicating their dismissal right before the New Year’s holiday in 2003 (Lee, 2005). This is a common practice among employers, where getting fired during holidays is a common company strategy designed to minimise negative reactions in the community.

Two years later, Hitech management did it again. On the day before the 2005 Chu Suk holiday, the biggest holiday in South Korea, workers received word of the decision that they would be denied compensation for a work-related debilitating illness (Park, 2005). Once again, on a holiday during which workers had looked forward to spending time with their families, it was instead an occasion for anger and sadness. The debilitating illness that was the subject of the compensation decision was "adjustment disorder," a disease recognised by the American Psychiatric Association (APA) and the WHO as "AD, with co-morbid depression". The question was, can it be caused by the work environment? According to the APA's Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), AD is a maladaptive reaction to identifiable stressful life events, such as divorce, job loss, physical illness, or natural disaster. This diagnosis assumes that the condition will remit when the stress ceases or when the patient adapts to the situation. It is our observation that AD can be produced by working conditions, particularly in a country with such strong anti-labour legislation as South Korea’s.

Actually, in occupational health, it is widely known that mental disorders such as depression or adjustment disorders are a common consequence of work stress (see, for example, the ILO Encyclopedia of Occupational Safety and Health). Two disciplines, psychiatric epidemiology and sociology of mental health, study the effects of work organisation on mental disorders. By "work organisation" we mean the social organisation of work involving aspects such as autonomy, workload, management style, or worker–management relations. For example, manual workers often show high rates of psychiatric disorders. The use of this job
Classification (i.e., “manual worker”) as an indicator of economic inequality has a long tradition in mental health research. Because job type is an indicator of control over the labour process, it is also a marker of workplace effects on mental health. In addition to being manual workers, Korean Hitech workers were exposed to a particularly hazardous form of work organisation for years, being subjected to constant vigilance with cameras and often facing degrading and humiliating treatment (such as denial of the right to go to the bathroom). It is not surprising that workers exposed to this kind of workplace abuse could suffer from poor mental health.

It is also known that the impact of Korean employment conditions on workers’ mental health is worse for immigrants, minorities and, in particular, union members. This happens because of their labour market vulnerability and the hostility of management to union organisers and members: this is often the case in authoritarian regimes. There are also studies showing a high prevalence of depression in nursing professions due to overwork and supervisor abuse (Muntaner et al., 2006a). Abusive workplaces have been associated with anxiety and depression, counting among them many blue collar (manual) workplaces (Muntaner & Eaton, 2004). In the Hitech case, abuse took many forms. For example, on one occasion workers were kept from opening the door for ventilation.

Hazardous workplaces can increase the risk of depression. It has been shown that work characterised by absence of worker control or planning is associated with major depression (Mausner-Dorsch & Eaton, 2000). Also, the negative effects of conflict with management have been associated with depression. Recent evidence points to management abuse, labour law violations, and threats of being fired as potential risk factors for depression (Muntaner et al., 2004; Muntaner et al., 2006b). In several studies carried out in the United States, physical demands also predicted psychiatric episodes (Muntaner, Tien, Eaton, & Garrison, 1991). Physical demands have been associated with psychiatric illness in other populations as well (Muntaner et al., 2004). The Korean Hitech workers were actually exposed to all of these risk factors simultaneously over the last five years.

The bright side of the studies mentioned above is that they suggest the possibility of prevention, since they impinge on factors that might be modified by union pressure or legal victories ensuring a healthy workplace without abuse. Some researchers feel that the reorganisation of work can improve the productivity and health of the workers, while others affirm that the relentless search for profits is by definition in conflict with workers’ mental health (Muntaner & Eaton, 2004). We do see that several countries, including Sweden, Spain, and the UK, have legislation on the unacceptable levels of work stress, and provisions are made to use these laws in arbitration. One example is the Norwegian Worker Protection and Working Environment Act of 1977, amended in 2004 (particularly Sections 1, 7, 12 and 14). This act allows companies to be fined by the state for promoting environments conducive to low autonomy, management harassment, lack of freedom on the job, overwork, threats of firing, psychological harassment, mobbing, and illegal threats to union members. To protect workers around the globe from the mental health effects of managerial pressure such as those suffered by Korean Hitech workers, fair employment measures should be promoted by the ILO. Next, governments should enact them widely to support the worker’s basic right to mental health.

References

Lee, H. E. (2005, May 10]. All trade union members were diagnosed as clinically depressed. Hankyerae.

Case study 40. Health consequences of over work; the case of Japan. - Joan Benach, Tsutomu Hoshuyama, Yutaka Yaseu and Paul Landsbergis

Although average working hours vary widely across countries, approximately 22 per cent of workers worldwide are working more than 48 hours per week. The worst situation takes place in developing/poor countries, where hundreds of millions of workers must work over 50 hours per week. In Peru and Indonesia, for example, at least half of the workers work such excessive hours. The expansion of informal employment and service sectors are major sources of longer working hours, particularly in industries with shift work and "unsocial" hours such as wholesale and retail trade, hotels and

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Restaurants, and transport, storage and communications. In Jamaica, for example, working hours for security industry workers have been estimated at 72 hours per week (Lee, McCann, & Messenger, 2007).

In some wealthy countries such as Japan, however, employees also work for very long hours, an issue related to the structure of employment relations, work organisation and production methods, and a culture of labour that promotes long work hours. Working for long hours has been associated with health-related effects such as fatigue, mental health problems, and cardiovascular and musculoskeletal disorders (Landsbergis, 2004, Johnson & Lipscomb, 2006). In Japan, serious social concern over health effects due to excessive working hours has been reported since the 1970s, when a number of deaths due to overwork (karōshi) with claims for compensation were identified. In the 1980s, media and public concern increased, and the Japanese government began to publish karōshi statistics regularly. Between 2002 and 2006, about 300 cases of deaths were recognised for compensation by the Ministry of Health, Labour and Welfare, as deaths due to cardiovascular attacks (e.g., strokes and myocardial infarction) triggered by excessive workload (Iwasaki, Takahashi, & Nakata, 2006). Karōshi deaths have been linked to long working hours, shift work, and irregular work schedules. Most victims had been working long hours exceeding 3,000 per year. Although precise data on the incidence of these deaths are not available, it has been estimated that one-third of cerebrovascular or cardiovascular disease cases in the 20 to 59 years old age group (more than 10,000 deaths annually) in Japan might be work-related (Kawahito, 1992). However, a significantly more conservative estimate has also been given (Nishiyama & Johnson, 1997). Data on compensated cases of karōshi indicate that most are male, and that about 40 per cent occurred in the 50-59 year age group (in 2006). However, about half of all compensated cases occurred in workers younger than 50 years old. Contrary to the public image of the karōshi victim as a higher status white-collar (non-manual) worker, compensated cases included many blue-collar (manual), service, and clerical workers, in addition to white-collar workers (Ministry of Health, Labour, and Welfare, 2007). It is possible, of course, that compensated cases are not representative of the much larger number of estimated karōshi cases. The extent of cardiovascular-disease risk associated with excessive work has not been clarified completely.

Deaths from cardiovascular diseases due to overwork may represent the tip of the iceberg, simply revealing the most visible indicator of the health effects of overwork. Thus, karōshi may also include other acute deaths related to delayed medical treatment due to a lack of free time to see a doctor, or suicides attributable to overwork. The number of suicide cases in Japan has been increasing since 1990, accounting for more than 30,000 deaths annually since 1998. In addition to deaths from overwork, karōjisatsu (overwork-related suicide) is a spreading occupational threat and a social problem in Japan. Some evidence has linked deaths by suicide to working long hours and experiencing heavy workloads (Amagasa, Nakayama, & Takahashi, 2005). The age distribution of the 205 compensated cases of karōjisatsu in 2006 was younger than the distribution of compensated karōshi cases. Only 16 per cent of the cases occurred in the 50-59 year age group (in 2006), while 18 per cent occurred in the 40-49 year age group, 40 per cent in the 30-39 year age group and 18 per cent in the 20-29 year age group. Similar to karōshi cases, compensated karōjisatsu cases included many blue-collar (manual), service, and clerical workers in addition to white-collar workers (Ministry of Health, Labour and Welfare, 2007). However, once again it is also possible that compensated cases are not representative of the larger number of estimated karōjisatsu cases.

The Japanese government has tried to address the problem of overworking by encouraging workers to take leave when they start families or need to care for elderly parents, and promoting a five-day work week. In 2002, the government provided its first countermeasures for the prevention of karōshi, launching a program for the prevention of health impairment-associated overwork, stating that they should not work more than 45 hours overtime per month. In 2006, a governmental intervention in the form of administrative guidance to employers and their employees was enforced for cases where overtime work exceeds 100 hours per month. Attempts to reduce hours and resist pressure to overwork have been largely unsuccessful thus far due to the long-standing and widespread practice of overtime by employers to increase productivity, recent increases in part-time positions, lack of job security, and workers’ need to work long hours to make ends meet. Recently, the first legal cases of karōshi have appeared in countries like South Korea (gwarosa) and China, a phenomenon which might be due to increasing industrialisation and changes in work organisation, as well as the work culture shared among the East Asian countries.

References
“We know what makes us ill. When we are ill we are told that it’s you who will heal us. When we come to you our rags are torn off us and you listen all over our naked body. As to the cause of our illness, one glance at our rags would tell you more. It is the same cause that wears out our bodies and our clothes.”

Bertolt Brecht
This chapter explores the pathways linking social determinants with individual health. Pathways are a shortcut for hypothetical causal chains whose mechanisms have, for the most part, yet to be uncovered. Gaps in knowledge are identified for these pathways, which are divided into three levels: the macrosocial level (for example, the employment rate), the middle-range or institutional level (labour contracts and other forms of employment relations), and the microsocial level (working conditions such as the psychosocial work environment). This section ends with case studies that illustrate the complexity of uncovering pathways and mechanisms in this area.

8.1. MACRO-SOCIOLOGICAL EMPLOYMENT RELATIONS AND THE HEALTH OF NATIONS

Our model (Figure 14) begins with power relations as macrosocial determinants of employment conditions (i.e., the type of employment arrangement or “axes” in our terminology), employment inequalities according to gender, ethnicity, race, migrant status (“dimensions” in our terminology), as well as other social determinants such as social and health policies. In turn, employment relations determine proximal working conditions, which are shaped by the employers’ need to maximise labour effort and profits. The explicit link between employment and working conditions (the reduction of labour costs and the maximisation of labour effort) are what sets our model apart from conventional social epidemiology (Marmot, 2004) and occupational health (Karasek & Theorell, 1990). Our model also includes social networks as a moderating force on the effects of employment and working conditions on individual health. However, we do not touch on these non-employment related factors in the following analyses.

Power relations (mostly in governments and labour markets) can be characterised by indicators such as gender inequality in the labour market or the proportion of precarious or informal workers. Thus, country-level macro-sociological indicators of inequalities in employment relations offer an initial macrosocial level of analysis of population health. Causal pathways originating at the national level cannot be uncovered with intra-country, individual-level data since macrosocial factors are held constant within countries (see Rose, 1992). Labour market indicators at the national level have been incorporated in just a small number of recent population health studies (Muntaner et
Employment relations and health inequalities: pathways and mechanisms

Figure 14. Macro-structural theoretical framework linking power relations, labour market and welfare state policies with employment conditions (studied pathways are highlighted).

Meaning of the arrows represented in the model:
- Influence
- Mutual influence
- Interaction or buffering
- Influence at various levels

Source: Preapred by the authors

al., 2002; Navarro et al. 2003; Navarro et al., 2006; Chung & Muntaner, 2006), despite the fact that employment relations are defining features of welfare states (Esping-Andersen, 1990; Huber & Stephens, 2001). In Europe, union strength indicators (such as union density and collective bargaining coverage) overlap with welfare state regime types, predict health at the national level (Navarro et al., 2006) and are associated with welfare state redistribution policies (e.g., universal health care). At a proximal level of analysis, a country’s employment relations determine exposures that affect workers’ health via two social causal pathways: compensation and working conditions.

In low- and middle-income countries, labour markets are characterised by the large size of the informal sector, more hazardous and inequitable employment relations including child labour, slave labour, poverty wages, and women’s unemployment and underemployment rates. Below, we present an illustration of the
macro-level relation between labour market inequality and population health. Country level data is analysed based on the country’s position in the world system, that is, in tiers of the world’s income distribution. We used indicators measuring the prominence of the informal sector in the country’s labour market and the inequality in its labour market. Labour market inequality was measured as a factor score composed of four variables: child labour (%), working poor (%), employment-to-population ratio (EPR), and the labour force participation (LFP) gap (detailed methods, data and analyses are included in Section 2 in the Appendices).

Semi-peripheral (middle-income) and peripheral (low-income) positions in the World System (Babones, 2005) were obtained by dividing countries into GNP tertiles. Our classification uses population-weighted Gross National Product per capita (GNPpc) generated through the World Bank’s Atlas Method (adjusted for exchange rates). We constructed a labour market inequality factor score based on the five indicators of labour market inequality listed above.

Associations between labour market inequality and population health are shown in Tables 10 and 11, with peripheral countries represented in the former and semi-peripheral countries in the latter. Factor scores have significant associations with health, excepting only a few indicators. Among peripheral countries, lower labour market inequality is positively associated with longer life expectancy and healthy life expectancy (HALE) for both men and women. Higher labour market inequality is associated with a higher probability of dying for men and women, higher under-5, infant, neonatal and maternal mortality rates and more deaths from cancer and injury. Years of life lost by communicable diseases are also significantly and positively associated with labour market inequality for both sexes. Also, the age-standardised mortality rate by non-communicable diseases is associated with labour market inequality (p=0.08). Similar relationships between labour market inequality and health were observed among semi-peripheral countries with few exceptions. The injury rate and the age-standardised mortality rate due to non-communicable disease did not show significant associations with labour market inequality (p=0.398 and 0.121, respectively).

The association between labour market inequality and male and female HALEs is graphically presented in Figures 15 and 16. R-square values are close to 0.5 for peripheral and semi-peripheral
countries, showing negative relationships between labour market inequality and male and female HALEs. These $R^2$ values of around 0.5 provide some macro-social evidence for using labour market inequalities to understand the population health impact of employment relations at the national level.

In conclusion, while labour institution indicators (i.e., union density) are scarcely recorded in peripheral countries, labour market inequalities correlate significantly with health outcomes. In semi-peripheral countries, labour market inequalities are significantly associated with a range of health outcomes. However, a large informal sector in these countries does not necessarily mean worse population health (data not shown). This could be due to a large presence of small entrepreneurs in addition to workers in the informal sector. Some studies have also found evidence that labour institutions in wealthy countries are associated with population health indicators [Navarro & Shi, 2001; Muntaner et al., 2002; Navarro et al., 2003; Chung & Muntaner, 2006; 2007]. Taken together, these associations constitute a body of evidence that suggests the effects of employment relations on population health (e.g., Rose, 1992; Susser, 1994; Schwartz, 1994).

An alternative approach to the above is to ascertain the extent to which employment conditions vary across countries and whether some welfare regimes bring about more salutary employment and working conditions. Grouping countries into clusters of homogeneous labour market characteristics can be an efficient way to summarise global variation in employment conditions. Thus, we divided countries into three groups according to their position in the world system, using an analytical tool based on national incomes [Babones, 2005]. Next, using data from the ILO’s KILM Dataset and the World Health Organization (years 2000 and 2004), we conducted cluster analyses of middle- and low-income countries.

For core (wealthy) countries, we used OECD data to generate labour market clusters. Core countries yielded 3 clusters based on unionisation rates, on a logarithmic scale, and an employment protection legislation index. The resulting clusters largely correspond with Esping-Andersen’s welfare state regime types. Countries in the Social Democratic cluster [see Figure A5, in Section 2 in the Appendices] showed distinctively higher unionisation rates compared to the Corporatist and Liberal clusters. What separates Corporatist countries from Liberal countries is the level of employment protection: the former exhibit stronger labour protection for both full-time and temporary workers compared to the latter.
Table 10. Bivariate associations of the labour market inequality score with various health outcomes among peripheral countries.

<table>
<thead>
<tr>
<th>HEALTH OUTCOMES</th>
<th>PEARSON CORR</th>
<th>SIG. (2-TAILED)</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy at birth (years) males 2004</td>
<td>-0.671</td>
<td>&lt;0.001</td>
<td>81</td>
</tr>
<tr>
<td>Life expectancy at birth (years) females 2004</td>
<td>-0.681</td>
<td>&lt;0.001</td>
<td>81</td>
</tr>
<tr>
<td>Healthy life expectancy (HALE) at birth (years) males 2002</td>
<td>-0.678</td>
<td>&lt;0.001</td>
<td>81</td>
</tr>
<tr>
<td>Healthy life expectancy (HALE) at birth (years) females 2002</td>
<td>-0.697</td>
<td>&lt;0.001</td>
<td>81</td>
</tr>
<tr>
<td>Probability of dying per 1,000 population between 15 and 60 years (adult mortality rate) males 2002</td>
<td>0.592</td>
<td>&lt;0.001</td>
<td>81</td>
</tr>
<tr>
<td>Probability of dying per 1,000 population between 15 and 60 years (adult mortality rate) females 2002</td>
<td>0.617</td>
<td>&lt;0.001</td>
<td>81</td>
</tr>
<tr>
<td>Probability of dying per 1,000 live births under 5 years (under-5 mortality rate) both sexes 2004</td>
<td>0.678</td>
<td>&lt;0.001</td>
<td>81</td>
</tr>
<tr>
<td>Infant mortality rate (per 1,000 live births) 2004</td>
<td>0.647</td>
<td>&lt;0.001</td>
<td>81</td>
</tr>
<tr>
<td>Neonatal mortality rate (per 1,000 live births) 2000</td>
<td>0.491</td>
<td>&lt;0.001</td>
<td>81</td>
</tr>
<tr>
<td>Maternal mortality rate (per 100,000 live births) females 2000</td>
<td>0.719</td>
<td>&lt;0.001</td>
<td>81</td>
</tr>
<tr>
<td>Cancer, age-standardised mortality rate (per 100,000 population) 2002</td>
<td>0.363</td>
<td>&lt;0.001</td>
<td>81</td>
</tr>
<tr>
<td>Injuries, age-standardised mortality rate (per 100,000 population) 2002</td>
<td>0.467</td>
<td>&lt;0.001</td>
<td>81</td>
</tr>
<tr>
<td>Communicable diseases both sexes, years of life lost by broader causes (%) 2002</td>
<td>0.673</td>
<td>&lt;0.001</td>
<td>81</td>
</tr>
<tr>
<td>Non-communicable diseases both sexes, Age-standardised mortality rate (per 100,000 population) 2002</td>
<td>0.196</td>
<td>0.080</td>
<td>81</td>
</tr>
</tbody>
</table>

Source: Prepared by the authors

Figure 15. Association between labour market inequality factor score and healthy life expectancy among peripheral countries in 2002.
Table 11. Bivariate associations of the labour market inequality score with various health outcomes among semi-peripheral countries.

<table>
<thead>
<tr>
<th>HEALTH OUTCOMES</th>
<th>PEARSON CORR.</th>
<th>SIG. (2-TAILED)</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life expectancy at birth (years) males 2004</td>
<td>-0.604</td>
<td>&lt;0.001</td>
<td>39</td>
</tr>
<tr>
<td>Life expectancy at birth (years) females 2004</td>
<td>-0.647</td>
<td>&lt;0.001</td>
<td>39</td>
</tr>
<tr>
<td>Healthy life expectancy [hale] at birth (years) males 2002</td>
<td>-0.681</td>
<td>&lt;0.001</td>
<td>39</td>
</tr>
<tr>
<td>Healthy life expectancy [hale] at birth (years) females 2002</td>
<td>-0.701</td>
<td>&lt;0.001</td>
<td>39</td>
</tr>
<tr>
<td>Probability of dying per 1,000 population between 15 and 60 years [adult mortality rate] males 2002</td>
<td>0.538</td>
<td>&lt;0.001</td>
<td>39</td>
</tr>
<tr>
<td>Probability of dying per 1,000 population between 15 and 60 years [adult mortality rate] females 2002</td>
<td>0.624</td>
<td>&lt;0.001</td>
<td>39</td>
</tr>
<tr>
<td>Probability of dying per 1,000 live births under 5 years [under-5 mortality rate both sexes 2004</td>
<td>0.749</td>
<td>&lt;0.001</td>
<td>39</td>
</tr>
<tr>
<td>Infant mortality rate (per 1,000 live births) 2004</td>
<td>0.748</td>
<td>&lt;0.001</td>
<td>39</td>
</tr>
<tr>
<td>Neonatal mortality rate (per 1,000 live births) 2000</td>
<td>0.762</td>
<td>&lt;0.001</td>
<td>39</td>
</tr>
<tr>
<td>Maternal mortality rate (per 100,000 live births) females 2000</td>
<td>0.611</td>
<td>&lt;0.001</td>
<td>38</td>
</tr>
<tr>
<td>Injuries, age-standardised mortality rate (per 100,000 population) 2002</td>
<td>0.139</td>
<td>0.398</td>
<td>39</td>
</tr>
<tr>
<td>Non-communicable diseases Both sexes, Age-standardised mortality rate (per 100,000 population) 2002</td>
<td>0.252</td>
<td>0.121</td>
<td>39</td>
</tr>
<tr>
<td>Communicable diseases both sexes, years of life lost by broader causes (%) 2002</td>
<td>0.701</td>
<td>&lt;0.001</td>
<td>39</td>
</tr>
</tbody>
</table>

Source: Prepared by the authors

Figure 16. Association between labour market inequality factor score and healthy life expectancy among semi-peripheral countries in 2002.

Source: Prepared by the authors
The first of the semi-peripheral clusters (labelled “Residual”) include the wealthier recently industrialised countries of East Asia as well as former communist countries that provided some kind of centralised welfare services to their populations. Countries in the second cluster (“Emerging”) are largely Latin American countries that have histories of developing small welfare states. The last cluster of middle-income countries (“Informal”) consists of oil-rich and other countries that lack formal labour institutions as well as welfare services. The labour markets of semi-peripheral countries are characterised by growing levels of employment informality but maintain some degree of stability and rule of law, approximating them to the labour markets of wealthier OECD countries. Some, such as Chile, have developed their own forms of emerging welfare state institutions.

However, countries on the global periphery (that is, low-income countries) represent a different level of labour-market instability altogether. The first of the peripheral clusters (“post-communist”) is largely comprised of former communist countries that had established labour and welfare services institutions. Plagued by a heavy reliance on informal work (the second “informal” cluster), some of these countries face severe insecurity in their labour markets. In other countries (the “insecure” cluster), war, political instability, authoritarian regimes, and foreign interventions threaten the rule of law and the protection of workers (Stubbs & Underhill, 2006).

These clusters in high-, middle- and low-income countries highlight the difference between labour institutions and informal labour markets. Labour institutions are closely related to the strength of the welfare state. In other words, labour institutions are the means by which the state regulates the labour market (e.g., provisions for collective bargaining). Labour institutions, measured through union density and collective bargaining coverage, correlate closely with welfare state regime type in wealthy countries. On the other hand, informal labour markets emerge in the absence of state regulation (Majid, 2001). Semi-peripheral countries show a mixture of formal labour institutions and informal labour markets. For example, some have emerging (e.g., East Asian and some Latin American) or residual welfare states (e.g., Eastern bloc). Therefore labour markets’ impact on population health...
should be analysed based on both labour institutions and informal labour market characteristics.

We examined the relationship between country clusters and a number of mortality indicators. Figure 17 shows the relation between labour market inequality clusters and maternal and child indicators for men and women in core, semi-peripheral and peripheral countries. Among core countries, the Liberal cluster (US, UK, Ireland) have the worst indicators. In semi-peripheral countries, those with larger informal labour markets show worse indicators. Finally, among peripheral countries, those with insecure labour markets (e.g., African countries with internal and external violent conflicts) have the cluster’s worst indicators.

The relationship between labour market inequality clusters and healthy life expectancy for men and women in core, semi-peripheral and peripheral countries is presented in Figure 18. Among core countries, the Liberal cluster (US, UK, Ireland) have a lower healthy life expectancy, while in semi-peripheral countries, those with larger informal labour markets have a worse healthy life expectancy. Finally, among peripheral countries, those with insecure labour markets (e.g., African countries with internal and external violent conflicts) have the worst healthy life expectancy in the cluster.

Figures 19 and 20 (pages 214 and 215) show, respectively, the years of life and years of healthy life (in millions) hypothetically lost by the population of Sweden (which fits the “Northern European Social Democratic” political type), in comparison to countries of other political types. In order to obtain Sweden’s years of life lost in comparison to some other specific political type, we proceeded as follows. First, we calculated the difference between Sweden’s life expectancy and the median life expectancy across 21 age groups (<1, 1-4, 5-9, 10-14, 95-99, ≥100) for the other types. Next, the years of life lost by the population of Sweden were obtained for each age group by multiplying the difference obtained above by the population of Sweden in each age group. The years of life which the Swedish population has hypothetically lost, compared to the other typology, is obtained by adding the years of life lost in each of the 21 age groups. The years of healthy life lost were calculated by an analogous procedure, but using the expected years of healthy life instead. The results show that if Sweden were to have belonged to the typology “Most insecure”, the male population would hypothetically have lost 92 million years of life and 98 million years of healthy life. On the other hand, Swedish women would hypothetically have lost 96 million and 102 million years of life and healthy life, respectively.
Figures 21 and 22 (pages 216 and 217) respectively show the years of life and healthy life (in millions) hypothetically gained by the population of Niger, when its type (most insecure) is compared to all other types. In order to calculate the years of life gained by Niger with respect to some other specific typology, we followed the same steps as in the case of Sweden, but instead calculated the life expectancy differences as the difference between the median life expectancy for the particular type and the life expectancy in Niger for the 21 age groups ($<1$, $1-4$, $5-9$, $10-14$, ..., $95-99$, $\geq100$). The results show that, if Niger were to have belonged to the “Social Democratic” type, the male population would have hypothetically gained 177 million years of life and 157 million years of healthy life. Women in Niger, on the other hand, would have gained 198 and 172 million years of life and healthy life, respectively.
8.2. EMPLOYMENT CONDITIONS

A full account of how employment conditions negatively affect the health of workers needs to include a detailed exposition of generic as well as specific social, psychological and biological pathways. Although most pathways and mechanisms seem fairly general (e.g., unemployment can be a risk factor for depression, alcoholism and cardiovascular disease), there is also room for specific disorders tied to the negative effects of particular employment relations in specific populations (e.g., developmental disorders linked to child labour, post-traumatic stress disorders linked to soldiering, slavery or bonded labour). In the following section we have summarised what we understand as the general and specific pathways underlying our six dimensions of employment relations.

In order to present pathways and mechanisms linking employment dimensions to health inequalities as well as current...
knowledge gaps, we adopt a “realist” perspective on current knowledge regarding social mechanisms linking employment relations to health inequalities. Therefore, we seek to compile evidence from various sources that are compatible with our model (see Chapter 4). This also means that we may not have enough information to confirm every pathway included in our model. Despite this, we should be able to find evidence that is broadly compatible with the pathways hypothesised by the model. We concentrate here on the relationship between employment conditions and health. These dimensions may share some common pathways (e.g. lack of autonomy at work leading to mental illness) but may also be characterised by specific pathways (e.g., child labour leading to low growth). At the proximal level, the pathways between social stress and disease (in large part a direct or indirect consequence of...
Employment relations and health inequalities: pathways and mechanisms

Figure 20. Hypothetical years of healthy life lost by the male and female populations of Sweden compared to the average life expectancy of each labour market cluster of countries in 2002.

Source: Prepared by the authors

Employment relations are well understood and common to a host of social determinants. Social epidemiology and its associated disciplines have provided only a partial picture of the pathways and mechanisms linking employment dimensions to health inequalities. Moreover, a large majority of studies have been conducted in wealthy countries, thus precluding the examination of pathways and mechanisms that might be more important to low- and middle-income countries (e.g., informal labour, employment relations in extreme poverty and war, bonded labour and slavery). The remaining research questions to be examined are many. For example, what are the underlying pathways and mechanisms explaining the different effects of precarious employment by gender, migrant status, or race/ethnicity? What are the pathways...
and mechanisms underlying the higher morbidity of precarious workers? What are the health-damaging pathways and mechanisms among immigrants from different social classes? What are the mechanisms underlying the often-observed statistical interaction between age, gender, or race/ethnicity and employment conditions in producing health inequalities? In light of these considerations, we have included sections on "selected scientific findings", "selected case studies" and "gaps in knowledge" for each employment dimension. Our main goal in this chapter is to show the main links between employment conditions and health inequalities, both directly and through working conditions (see Figure 23).
**Figure 22.** Hypothetical years of healthy life gained by the male and female populations of Niger compared to the average life expectancy of each labour market cluster of countries in 2002.

Source: Prepared by the authors

**Full-time permanent employment**

The “standard” full-time permanent employment arrangement that characterised the post-WWII labour-capital agreement in many industrialised countries determines a host of wages, benefits and psychosocial working conditions. Nevertheless, the growth of non-standard work arrangements in wealthy countries and the predominance of informality in low- and medium-income countries made us consider “full-time permanent employment” as the reference against which these more hazardous employment relations should be compared. Full-time permanent employment relations vary in their levels of psychosocial exposures such as autonomy (Marmot, 2004), physical and psychological demands (Karasek & Theorell, 1990), effort-reward imbalance (Siegrist, 1996), organisational justice (Elovainio,
Leino-Arjas, Vahtera, & Kivimaki, 2006), job insecurity (Ferrie, Shipley, Marmot, Stansfeld, & Smith, 1998) and managerial pressure (Muntaner et al., 2004). They can also vary in terms of experiencing physical, biological and chemical hazards. Ultimately, the level of physical and psychosocial exposures at the workplace determined by power will depend on the workers’ stratification (social class, gender, race/ethnicity, age), type of occupation and work organisation (see also section 8.3. on “working conditions”). Phenomena such as gendered and ethnic occupational segregation, discrimination in the workplace or wage inequalities also shape health inequalities among full-time permanent workers. Since our central issue is employment relations, in the following sections we will focus on “non-standard” employment relations.
Selected scientific findings

**Whitehall II article describing employment grade inequalities in health and their determinants**

The Whitehall study of British civil servants, begun in 1967, showed a steep inverse association between social class (as assessed by grade of employment) and mortality from a wide range of diseases. Between 1985 and 1988, we investigated the degree and causes of the social gradient in morbidity in a new cohort of 10,314 civil servants (6,900 men, 3,414 women) aged 35-55 (the Whitehall II study). Participants were asked to complete a self-administered questionnaire and attend a screening examination. In the 20 years separating the two studies there has been no decrease in social class-based differences in morbidity: we found an inverse association between employment grade and prevalence of angina, electrocardiogram evidence of ischemia, and symptoms of chronic bronchitis. Self-perceived health status and symptoms were worse in subjects in lower status jobs. There were clear employment-grade differences in health-risk behaviours including smoking, diet and exercise, as well as in economic circumstances, possible effects of early-life environment as reflected by height, social circumstances at work (e.g., monotonous work characterised by low control and low satisfaction) and in social supports. More attention should be paid to the social environments, job design and consequences of income inequality.

**Source**


**Class and gender inequalities in wages and working conditions for full-time employees**

Work shapes health inequalities via several pathways, including hazards in the workplace as well as economic resources derived from work.

Income has been repeatedly associated with measures of health and disease. A recent analysis of the 1980-83 and 1991 editions of the national Living Conditions Survey in the Netherlands shows a clear and steep gradient in mean annual net income by occupational social class among full-time workers. Within occupational groups, a gender pay gap also exists, with women being paid less on average than men. For instance, in 1991, among men, higher employees had a mean annual income of 22,034 Euros; intermediate employees, 17,080; lower employees, 14,637; and lowest rank employees, 12,781. Among women, mean incomes for those categories were 16,914 euros, 13,670 euros, 11,567 euros, and 10,490 Euros, respectively. A European review on the gender pay gap finds inequality in all the countries studied, with women’s earnings ranging between 64 per cent and 86 per cent of men’s, with a generally slow trend towards narrowing the gap.

Physical and psychosocial risks at work are also unequally distributed according to socioeconomic status. In the 2000 edition of the cited Dutch survey, labourers clearly had the worst physical working conditions, measured with a scale integrating several hazards. For these workers, scores were 4.21 for men and 2.56 for women, compared to 1.32 and 1.29 among lower employees or 0.86 and 0.50 for higher employees. The gradient in physical exposures within employees is present but narrow. On the other hand, it is steeper for a psychosocial risk such as skill discretion. Figures for Europe are available for different occupational groupings: legislators and managers, professionals, technicians, clerks, service and sales workers, agricultural workers, craft-related trade workers, plant and machine operators, elementary occupations and armed forces. Professionals have the lowest prevalence of monotonous tasks and one of the lowest of physical and ergonomic hazards, as well as the highest frequency of “learning new things”. On the other extreme lie those working in elementary occupations (in terms of psychosocial risks), craft workers (in terms of physical risk such as noise and dust), and agricultural workers (in terms of painful positions and heavy loads, repetitive movements and continuous high speed).

**Sources**


Employment, work, and health inequalities - a global perspective

Working in racially segregated occupations is associated with poor health, regardless of worker’s race.

**Background:** Racial segregation provides a potential mechanism linking occupations with adverse health outcomes.

**Methods:** An African-American segregation index ([I(AA)]) was calculated for US worker groups from the nationally representative pooled 1986-1994 National Health Interview Survey (N = 451,897). Ranking and logistic regression analyses were utilised to document associations between [I(AA)] and poor worker health.

**Results:** There were consistent positive associations between employment in segregated occupations and poor worker health, regardless of covariate adjustment or stratification (e.g., age, gender, income, education, or geographic region). This association between segregation and poor health was stronger for White workers as compared to African-American workers.

**Conclusions:** This recent example in the US shows that occupational segregation negatively affects all workers. Potential mechanisms need to be identified through which occupational segregation may adversely impact worker health.

**Source**

Selected case studies

**Case study 41. Health and the social relations of work in small enterprises. - Joan M. Eakin**

In many countries (and more so in developing nations), about one-third of the workforce is employed in enterprises with fewer than fifty workers, with most of these having fewer than ten. Rates of injury are higher in small workplaces, and formal prevention activities are typically minimal and difficult to promote (Hasle & Limborg, 2006). Small workplaces have distinctive organisational features, including a relatively low social distance between employers and workers, minimal managerial infrastructure, informal and personalised relations of authority and an internal moral economy of mutual expectations and obligations. Although many are actually family businesses, they are widely characterised as “like a family,” meaning that workers are treated and “cared about” as persons more than as units of labour. Occupational health systems, however, are largely designed for large, unionised workplaces, and have limited or perverse effects on small organisations (Eakin & MacEachen, 1998; Eakin, MacEachen, & Clarke, 2003). For example, efforts to engage employers in preventive responsibilities can be thwarted by the employers’ understanding of their relationship with workers. “I don’t babysit them [workers]” declares the proprietor of an auto repair shop. “...Besides, you can’t tell a welder what to do! I leave it [safety] up to them.”

When illness or injuries occur in small workplaces, they can spawn serious interpersonal strain and loss of trust, which can precipitate an increasing sensitivity to the conflicting interests of labour and capital among workers (“He [employer] was like a father to me. But when you get hurt and cannot work, you are like garbage. I see now, he only cares about the business”) and a sense of betrayal and desperation in employers (the loss of a key worker can put the entire enterprise in jeopardy). Such social dislocation can lead to resistance and retaliation, compounding the potential for conflict: an assembly worker with unheeded illness claims “pays back” her employer by not reporting production errors as she formerly did, while an employer offers an injured worker a hated, meaningless “modified” job hoping that she will quit and relieve him of his legal obligation to re-employ an injured worker. Clearly, one size does not fit all: any attempt to change health-damaging working conditions has to take into account the distinctive social relations of work in small workplaces.

**References**
Case study 42. Work-family interference as a determinant of sick leave in Dutch university employees. - Nathalie Donders

Emancipation waves in the second half of the twentieth century have led to considerable increases in the participation of women in the Dutch labour force (Bekker, Gjerdingen, McGovern, & Lundberg, 1999). As women's share of paid employment rose, their share of unpaid work fell. This is, nevertheless, primarily because women devote less time to (unpaid) domestic work and not because men are making greater efforts at home. Women are often presumed to be suffering from a “double burden”: having job responsibilities away from home while remaining responsible for domestic activities, including child care.

Much research has been conducted on the relationships between work and care and various health outcomes, but very little attention has been paid to sick leave as an outcome measure. Sick leave imposes considerable direct and indirect costs on employers and society, and in order to take preventive measures, it is necessary to investigate and understand the determinants of sick leave in both men and women.

We conducted a study on the role of work-family interference in explaining sick leave for university employees (Donders, 2005). Work-family interference (WFI) is defined as “a form of interrole conflict in which the role pressures from the work and family domains are mutually incompatible in some respect” (Greenhaus & Beutell, 1985). Two directions can be distinguished: work can interfere with family life (W>Fi) and family life can interfere with work (F>Wi) (Frone, Russell, & Couper, 1992).

Our questionnaire data (N=1843; response rate: 49.1%) showed the “traditional” inequities in the distribution of working hours, child-care tasks, and household chores: men were working longer hours outside the home while women were spending more time than their spouses taking care of the children and the home. Men’s and women’s complaints at work differed. Men reported higher work pressure and more role conflict than the women. Women, on the other hand, reported unpleasant treatment and less favorable conditions for work variety, use of professional skills, communication, employment terms, career opportunities, possibilities for learning, decision latitude and autonomy. Women also reported more fatigue, emotional exhaustion, perceived health complaints and took more sick leaves.

We also investigated differences in the strength of the associations. Men showed significantly stronger associations between work pressure and satisfaction with employment terms and W>Fi, whereas the association between the age of the youngest child and F>Wi was significantly stronger for women than it was for men.

Sick leave was most often taken due to perceived health complaints, presence of chronic disease and a life event in the private domain. For both sexes, W-FI had a strong effect on fatigue, emotional exhaustion and perceived health complaints, and an indirect effect (through perceived health complaints) on sick leave. Unexpectedly, F-WI played a far less important role than W-FI. Having childcare arrangements was associated with more sick leaves, especially for women (women are probably responsible for making childcare arrangements, and this may require a lot of energy). A work-related life event contributed to the explanation of sick leave in the men, whereas perceived support from the children seemed to protect the women from sick leave.

We concluded that there were considerable sex differences in the associations of work- or family-related antecedents (W-FI, F-WI with ill health. Our population consisted of employees at a university and was therefore a rather specific group, so it is possible that university employees differ from the general population in ways that affect associations between the variables investigated in this study. However, more and more jobs with high physical demands are being replaced by jobs that chiefly involve mental demands and higher levels of autonomy. Thus, there will be increasingly more workers who are comparable with our respondents.

References
Case study 43. Sexual orientation, work and health. - Jordi Lozano

Practices of a homosexual nature constitute a very widespread social phenomenon. According to the first Kinsey report, published in the middle of the 20th century, the prevalence of the practice of exclusively homosexual relations was 3-4 per cent, that of preferentially homosexual relations was 10 per cent, while some 30 per cent of the population had engaged in satisfying voluntary homosexual relations at least once in their lives (Kinsey, Pomeroy, & Martin, 1948). Although the findings of later studies have shown considerable variation depending on the historical, cultural and geographical context, it is agreed that homosexual orientation is common and widespread among the population (Michaels & Lhomme, 2006). Despite their frequency, homosexual practices have historically suffered considerable rejection and persecution in many countries. Major religions have often regarded these practices as sinful, and much of society still considers them a crime punishable by imprisonment or even death.

The dominant culture continues to show considerable rejection of homosexuals due to prejudices associated with abnormality, vice, sin or disease. It should not be forgotten that in the USA, homosexuality was considered a disease until 1973, and that the World Health Organization did not exclude homosexuality from the International Classification of Diseases until 1990. Today the situation of homosexuality is penalised in 86 countries, six of which still have capital punishment (Ottosson, 2008; International Lesbian and Gay Association, 2008). The situation of legality does not, however, impede assaults and even the murder of homosexuals or the diffusion of homophobia in society. This term, first coined in the mid-1950s, has been compared to xenophobia or racism and means an irrational fear of, aversion to, or discrimination against homosexuality or homosexuals, gays, bisexuals and transsexuals (Borriol, 2001). “Internalised homophobia” on the other hand, is a term used to describe a prejudice against one’s own homosexuality, which affects self-esteem and self-acceptance (Vihuales, 2002).

In general, social homophobia is related with the existence of a higher risk of suffering health-related problems. For example, lesbians, gays and bisexuals have higher risks of attempting suicide (2.5 times), suffering depression (1.5 times) and of abusing alcohol and other drugs (1.5 times) than heterosexuals (King et al., 2008). Male adolescent homosexuals in particular constitute an especially vulnerable population whose risk of suicide is higher than that of people with a heterosexual orientation (Koupany, 1987; Remafedi, French, Story, Resnick, & Blum, 1998; Russell & Joyner, 2001). Studies conducted in various Northern European countries suggest that, on average, life expectancy among the homosexual population is between 22 and 25 years shorter (Cameron & Cameron, 2007).

In regard to the occupational and family settings, many homosexuals hide their sexual orientation and have lower self-esteem, factors which are related with health inequalities. One occupational example which generates stress, depression and even despair is the social rejection associated with HIV/AIDS. On one hand, homosexuals tend to avoid going to the doctor for fear of repression, discrimination or stigmatisation, thus leading to a false picture of the situation with respect to infection in the population; and on the other, seropositive homosexuals carry a double-stigma which not only reduces their self-esteem but also reduces engagement in preventive practices. In those countries where homosexuality is penalised, homosexual labour rights are restricted and it is not easy to perform studies on their health. Protection against discrimination based on sexual orientation is only legislated in the European Union (as per the Fundamental Rights expressed in the Amsterdam Treaty) and a few other countries. However, even when discrimination is illegal, it may still be exercised in occupational settings, arising from a need to hide sexual orientation, fear of being found out or through indirect forms of mobbing, all of which may have important effects on physical and mental health.

In the European Union, Canada, Australia and certain states in the USA, where the level of social homophobia is lower, laws have been passed which protect homosexuals from social, employment and work-related discrimination. One example is the recognition by the Council of Europe in October 1981 of a person’s right to self-determine their sexual orientation, which demands the elimination of all forms of discrimination against homosexual persons and of aversive therapies without consent. Furthermore, the European Parliament has approved anti-discriminatory recommendations related with sexual orientation, treating same-sex couples equally in terms of marriage as well as the adoption and education of minors. It is also worth noting that certain multinational firms, such as Google and IBM, have developed policies facilitating the inclusion of the homosexual population in occupational settings.

The case of José Carreño

José Carreño, a 34-year old Chilean, immigrated to Spain in 2001. In Chile he worked in a large firm where his homosexuality was never a problem, since he hid the fact from his colleagues, effectively living a double life. He even pretended, in day to day conversations at work, to have a girlfriend. A close female friend would accompany him to social events and appear to be his partner. Maintaining this fiction caused him a certain amount of anxiety and stress.

Carreño recalls having depression as an adolescent. He did not accept his homosexuality and isolated himself from his surroundings. The topic of his sexual orientation, which was assumed to be heterosexual, was never mentioned in the family. “One says nothing, and nobody asks”, he explains. However the recriminations began when he reached the age for having a girlfriend. He did not pair up with any girl or marry. He continued lying to his friends whenever anyone made homophobic insinuations, prompted by his not having a girlfriend. Thanks to his work, he was able to leave home and avoid being the neighbourhood “queer”. His work and business studies allowed him to lead his own medium-to-low social class lifestyle. He
would go to local gay bars in Santiago de Chile. However, staff rearrangements in his company made him redundant, leaving him without resources. Thus, he was faced with choosing between emigration and going back to his family home and its “unbreathable” atmosphere, as he has called it, which involved being pressured to marry. He decided to go to Spain and chose Barcelona because of its reputation as an open and cosmopolitan city. In Chile, he was leading a double life, “closeted”, hiding. In Spain, he presented and manifested himself everywhere from the start as gay, including at work where he reports “feeling comfortable and performing better”, since he no longer had anything to hide.

Four years ago, the Catalan Regional Government set up an Equality Programme for homosexual, transsexual and bisexual persons, an exemplary and pioneering institution which promotes their normalisation and equality in the community. This is an ongoing experiment, with institutional institutional backing and backing, in an area which is largely only tackled in legal terms and by voluntary organisations (to date, never by the administration, with the single exception of Sweden’s Homosexuals’ Ombudsman). José Carreño is currently president of ACATHI (Asociación Catalana de Homosexuales Inmigrantes), whose aim is the integration of immigrant homosexuals, who find themselves doubly discriminated, even facing triple discrimination if they are carriers of HIV/AIDS.

Conclusions and proposals

Despite recognition of the rights of persons of homosexual orientation in the European Union and other regions of the world, a large number of people still suffer situations of homophobia, discrimination and stigmatisation in their family and occupational settings, which generate vulnerability and problems. There are currently no systematic studies which permit obtaining a complete, global view of the impact of these problems on health and inequality. The present division in the United Nations (with about 50% of countries in favour of homosexuality) paralyses the realisation of studies, policies and international encounters similar to those organised in the case of women and gender problems. The most immediate political proposals are as follows: [1] that local and national public administrations should facilitate the resources necessary to allow studies to be conducted, as well as the diffusion of current problems and set-up of policies that would lead to improvements in the social and occupational situations of homosexuals; [2] that a Global Observatory on homophobia should be created which, in collaboration with NGOs such as the International Lesbian and Gay Association (ILGA) and Amnesty International (AI), as well as professionals and universities, should perform a global diagnosis of the state of homophobia and its effects on health in the world (examples of which include problems such as occupational mobbing, the “invisibility” of lesbian women or the socio-occupational problems of homo-parental families); [3] creation an International Policy Institute which would help to eradicate homophobia and elaborate programmes of international advisory to countries intended to aid the legal and social normalisation of homosexuality, including the problems of bisexual and transsexual persons.

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References

Case study 44. Gender-based Exposures to Violence at Work. - María Menéndez

Workers, managers and supervisors are confronted on a daily basis with many work and personal problems. When relations deteriorate, the workplace is transformed into a hazardous and dangerous setting and violence emerges. Violence at work has been defined as “any action, incident or behaviour that departs from reasonable conduct in which a person is assaulted, threatened, harmed, injured in the course of, or as a direct result of, his or her work” (International Labour Organization, 2004). Although both women and men are victims of violence at work, gender-based patterns of exposure to workplace violence are significantly influenced by the sexual division of labour. For example, because of their prevalence in the occupation, women health-care workers are more often exposed to aggression from clients and patients, while men may be disproportionately represented among evening shift workers in small retail outlets, therefore being more frequently subjected to hold-ups and related forms of violence. As a result of this gendered division of labour, there are real differences between the incidence rates for male and female workers (Mayhew, 2002). These variations are minimal where male and female workers do the same job tasks under similar conditions, although men appear to experience slightly higher levels of physical violence and women are marginally more frequently victimised through verbal abuse and sexual assaults. These gender-based variations in levels of exposure to risk are also apparent across countries (Chappell & Di Martino, 2006).

Among women, the global impact of violence (both inside and outside the workplace) is dramatic. Women are concentrated in many of the higher-risk occupations, particularly as teachers, social workers, nurses and health-care workers, as well as bank and shop workers. It has also been shown that women are more vulnerable to violence from co-workers due to their inferior position in the labour market and its concomitant reduced bargaining power. The continued segregation of women into low-paid and low-status jobs (with men in well-paid, higher-status jobs and supervisory positions) contributes to gender-based differences in exposure to particular forms of workplace violence, such as homicide or bullying (mental violence). For example, in the United States, homicide accounts for 31 per cent of all traumatic occupational fatalities for women, compared with 9 per cent for men. In Finland, exposure to bullying is significantly higher for women than for men.

References

Unemployment

Increased exposure to unemployment is one of the pathways by which socioeconomic inequality and racial discrimination affect health [Ahmed, Mohammed, & Williams, 2007]. In a recent analysis of the mechanisms explaining the socioeconomic gradient in health from a life course perspective, cumulative unemployment from ages 16 to 30 was a major social mechanism underlying the gradient in health among both men and women [Steijn, Need, & Gesthuisen, 2006]. The health consequences of unemployment are well-known for both men and women, and early unemployment has been shown to have lasting negative effects for later employment [Steijn et al., 2006]. The question of whether the relationship between unemployment and ill health could be due to either exposure or health-related selection (i.e. prior poor health status increases the risk of unemployment) has been much-debated in the literature [Winefield, 1995; Novo, 2000], though few studies can control for health-related selection. Available research
supports the hypothesis that both selection and exposure are important in explaining the association between unemployment and ill-health. As has been demonstrated in prospective studies, the exposure effect may be strongest after control for health-related selection (Claussen, 1999; Hammarström & Janlert, 2002; Novo, 2000; Burgard, Brand, & House, 2007). Some major longitudinal studies in psychiatric epidemiology, such as the Baltimore Epidemiologic Catchment Area (ECA) follow-up study (Eaton, Muntaner, Bovasso, & Smith, 2001), show stronger effects of “social causation” over “social selection” for common mental disorders such as major depression.

There is still a lack of both theoretical models for and empirical research on the possible mechanisms mediating between unemployment and ill-health. Theoretically, the following causal pathways related to exposure have been proposed. Economic deprivation models assume that unemployment leads to a deteriorated economic position for the unemployed, which in turn worsens the prerequisites for good health (Janlert, 1991). Consistently with this model, excess risk of mental distress has been shown to be concentrated among people who are unemployed with no benefits (Artazcoz, Benach, Borrell, & Cortès, 2004) or those who are financially worse-off (Thomas, Benzeval, & Stansfeld, 2007). According to the stress theory of unemployment (Kagan & Levi, 1975), unemployment and uncertainty about one’s future work situation may act as a stressor, which in turn can lead to physiological changes including risky health behaviours as well as deteriorated health. A recent study demonstrated impairment in immune function related to chronic stress among unemployed people, with a substantial recovery for those who obtained new employment (Cohen et al., 2007). The social support model is closely connected to the stress model and implies that unemployment leads to increased social isolation, which in turn can either have direct health effects or decrease the buffering effect of social support (Roberts, Pearson, Madeley, Hanford, & Magowan, 1997). In the control model, the lack of decision latitude and control over life that unemployment brings with it can lead to deteriorated health (Karasek & Theorell, 1990). The latent function model developed by Marie Jahoda (1982) is based on what needs (beyond economic ones) a job should fulfill in order to be a good job. These needs are such that employment provides a time structure to the day as well as regularly shared experiences and contact with others. Moreover, employment contributes to status and identity and provides opportunities for striving for collective goals and purposes.
Thus, mechanisms can be prioritised as follows. Social causation has been shown to be of more importance than health selection. Among the mechanisms of social causation, the economic deprivation model has received the most support, followed by the stress model. The next priority is given to Marie Jahoda’s model of latent functions, while the lowest priority is given to the social support and control models.

**Selected scientific findings**

**Unemployment and mortality in the OPCS Longitudinal Study in the UK**

The mortality of men aged 15–64 who were seeking work the week before the 1971 census was investigated by means of the OPCS Longitudinal Study, which follows a 1 per cent sample of the population of England and Wales. In contrast to the current position, only 4 per cent of men of working age in 1971 fell into this category. The mortality of these unemployed men in the period 1971-81 was higher (standardised mortality ratio: 136) than would be expected from death rates for all men in the Longitudinal Study. The socioeconomic distribution of the unemployed accounts for some of the raised mortality but, after allowing for this, a 20–30 per cent excess remains. This excess was apparent for both the 1971-75 and the 1976-81 periods. The data offer only limited support for the suggestion that some of this excess resulted from men becoming unemployed because of their ill-health; the trend in overall mortality over time and the pattern by cause of death were not those usually associated with ill-health selection. Previous studies have suggested that stress accompanying unemployment could be associated with increased suicide rates, as were again found here. Moreover, the mortality of women whose husbands were unemployed was higher than that of all married women (standardised mortality ratio: 120), and this excess also persisted after allowing for their socioeconomic distribution. The results support findings by others that unemployment is associated with adverse effects on health.

**Source**


**Excess mortality of unemployed men and women during a period of rapidly increasing unemployment in Finland**

**Background:** Previous studies have found evidence of higher mortality rates among unemployed people than among those in employment, but the effect of changes in national unemployment rates on this association is unclear. We studied mortality in both men and women during a period of rapidly increasing unemployment in Finland.

**Methods:** In this prospective study of mortality in the Finnish population aged 25–59 years (2.5 million people), baseline sociodemographic data were obtained from the 1990 census and information on employment status in 1987–92 from Statistics Finland’s labour force data files. Mortality follow-up was established by record linkage to death certificates from 1991 to 1993.

**Findings:** Individuals who experienced unemployment between 1987 and 1992 had greater mortality than those in employment after controlling for age, education, occupational class, and marital status. The mortality ratios for men and women who were unemployed for the first time in 1990, at a time of low national unemployment, were 2.11 (95% CI 1.76–2.53) and 1.61 (1.09–2.36), respectively. These values were lower for those who were unemployed for the first time in 1992 when the national unemployment rate was very high (men 1.35 [1.16–1.56], women 1.30 [0.97–1.75]). The jobless who were re-employed had higher mortality than those who were continuously employed, but not as high as those who remained unemployed.

**Interpretation:** We have found that the association between unemployment and mortality weakens as the general unemployment rate increases. Studies that took place when the unemployment rate was low may thus overestimate the effect of unemployment on mortality because of unaccounted confounding.

**Source**

**Health inequalities in the workforce: the core-periphery structure of labour markets**

A study conducted in Finland among 15,468 persons who were at work or seeking a job distinguished between unemployed people using income-based compensation, subsidised income, and fixed basic daily allowance, a measure which is sensitive to income differentials. Results of this study show that the health effects of unemployment were strongest for those with the greatest material disadvantage (unemployed with basic allowance). These findings are in line with the hypothesis of financial strain as a major source of poor health among the unemployed. The fact that subsidised and compensation income unemployed people are found in relatively good health gives grounds to underline the importance of employment and social policy measures. The impacts of these measures are most clearly apparent with respect to depression and particularly the non-elevated depression rates among women in subsidised work. This may also indicate a gender difference in the mental health-promoting effect of these re-employment programmes. A study in the U.S. showed a corresponding association with government entitlement benefits. It seems that "interruption" of unemployment less effectively alleviates the socioeconomic and psychological impact of unemployment among men. All in all, the highly significant gender difference in the association between unemployment and depression may indicate that men's values are mainly work-oriented, while women may attach more importance to family and other spheres of life. Our results showed the poorest mental health for the long-term, low-income unemployed. These findings, based on a dichotomised variable derived from Beck's Depression Inventory (BDI), were confirmed by using a sum score measure. For instance, in permanently employed men, the estimated marginal mean was 4.93 (95% CI: 4.64, 5.21), while the respective figure in low-income unemployed men was 9.47 (95% CI: 8.64, 10.30). Most participants in the subsidised re-employment programmes come from the low-income unemployed group, which also comprises individuals who are unable to work, even as subsidised employees. Health-related selection mechanisms may also operate in entrance to re-employment programmes, as the odds for physician-diagnosed disease among subsidised men were relatively low. On the other hand, their “paradoxically” high odds for poor self-rated health may reflect a situation where working in the subsidy programme after unemployment may reveal defects in participants’ functional capacity, further affecting their health perceptions. The basic allowance provides for no more than a minimal subsistence income, and there are more recipients of this type of allowance than those who receive compensation-income benefits among the Finnish unemployed. Thus, the high prevalence of mental health problems seen in the former group is an alarming finding (e.g. 48% of the age group 40–44 years were trapped in Beck's depression screen). The question of whether the high odds for disease are due to previous labour market disadvantages and occupational hazards rather than actual unemployment needs to be approached with longitudinal data in future studies.

**Source**


**Selected case studies**

**Case study 45. Parental joblessness and the health of their children.** - Maria Bačkova-Sleškova

Since the family is one of the most important determinants of child and adolescent development, many events within the family can affect a child, either directly or indirectly. Parental unemployment is one of the most serious family events. Already Jahoda, Lazarsfeld and Hans (1933), who conducted one of the first studies on the undesirable effects of unemployment in the 1930s, noticed that joblessness affects not only unemployed persons themselves but also their spouses and, particularly, their children. A few years after this study, Mirra Komarovsky (1940) published a valuable work on a sample of unemployed men and their families. Since that time, several studies have produced interesting results on this topic.

Generally, it has been found that when one or both parents are unemployed, both the physical and mental health of children and adolescents are impacted. For example, parental unemployment increases psychosomatic symptoms, chronic illness, depressive symptoms, psychiatric disorders, behavioural and emotional problems, neglect and abuse, bed-wetting and infections. It affects self-rated health and long-term well-being and drains the self-esteem of children and adolescents. These effects have been found in many countries.

These links between parental unemployment and adverse physical and psychological symptoms in their children depend on many factors, some of which have already been investigated. First, the gender of parents: there
is evidence that men and women perceive and live their unemployment differently, which may differently affect their children. Studies show that a father’s unemployment more negatively influences child health (Piko & Fitzpatrick, 2001; Sleskova et al., 2006a). Second, the effect of parental unemployment on their children seems to differ by country. There is a possibility that, in countries where the unemployment rate is higher and where the unemployment benefits are lower, children suffer more from parental unemployment (Sleskova et al., 2006b). Third, there is a question of the role of financial stress in the relationship of parental unemployment to children’s health. Since financial stress is tightly connected with unemployment as well as with the health of children, it might be supposed that financial stress alone explains this relationship. However, recent studies show that the negative effect of parental unemployment on the health of their children remain, even after taking into account the lack of financial resources (Reinhardt, Madsen, & Kohler, 2005; Sleskova et al., 2006a).

On the other hand, many other factors need to be studied. For example, still open is the question of changes of parental support and behaviour toward the child and adolescent during the period of unemployment. Unclear also is whether the gender of the child plays a role.

Although we still do not know the pathways by which parental unemployment affects the health of their children, it is important to recognise the suffering of children when their parents are jobless.

References

Case study 46. Interaction between gender, social class, and work in health inequalities. - Lucía Artazcoz, Joan Benach and Carme Borrell

Research on health inequalities has often considered work as an essential element of conceptual frameworks that differ by sex. Whereas among men the analysis has been focused on social class (often measured through occupation), among women it has been dominated by the role framework, emphasising women’s roles as housewives and mothers, with paid employment seen as an additional role (Sorensen & Verbrugge, 1987). The dominance of the role framework in studying ill health among women contrasts with the paucity of attention to family roles (and their associated burdens) and their influence on men’s health.

On the other hand, studies about the social determinants of women’s health have often neglected the importance of social class. These different approaches are consistent with the traditional sexual division of society, which assigns men a primary role in the public and labour spheres, while women occupy a primary role in family life. Nowadays, in a context of transition from the traditional gender roles to more equal positions for men and women in society, a framework which integrates both approaches is needed in order to fully understand work-related health inequalities. For example, one study reported a higher impact of unemployment on men’s mental health among married manual workers, whereas for women, being married, and particularly living with children, acted as a buffer. It also found that the mediating effect of social class on the impact of unemployment on mental health differed by gender and family roles (see figure) (Artazcoz, Benach, Borrell, & Cortès 2004). It has also been reported that the negative impact of the domestic workload on female workers’ health is restricted to those of low job status (Artazcoz, Borrell, & Benach, 2001). Moreover, it has been found that the impact of flexible employment on mental health depends on the type of contractual arrangement, gender and social class, and it is restricted to less-privileged workers, women and manual male workers (Artazcoz, Benach, Borrell, & Cortès, 2005). These results illustrate the importance of analysing work-related inequalities in health in a framework which integrates the social class and gender inequalities approaches.
Precarious employment

There are many potential mechanisms through which different types of these employment forms may differentially damage the health of workers. Precarious employees can suffer adverse health effects through material or social deprivation and risks, as well as hazardous work environments (Benach & Muntaner, 2007). Thus, experiencing various kinds of precarious jobs and the insecurity and vulnerability associated with them is likely to be associated with more hazardous working conditions and higher income inequality. For example, compared to regular workers, temporary workers are more often exposed to hazardous working conditions and intense noise, work more often in painful and tiring positions, perform repetitive movements more
often, have less freedom to choose when they take personal leave (Letourneux, 1998) and are far less likely to be represented on health and safety committees (Quinlan & Mayhew, 2000). A systematic review of studies on temporary employment and health suggests that temporary workers suffer from a higher risk of occupational injuries as compared with permanent employees (Virtanen et al., 2005), a finding which has been repeated in a more recent study with both administrative and field data (Fabiano, Curro, Reverberi, & Pastorino, 2008). Another study has shown that several forms of temporary employment are associated with higher rates of musculoskeletal disorders and psychosomatic symptoms than are found for permanent employment (Aronsson, Gustaffson, & Dallner, 2002). In addition, non-permanent workers know less about their work environment, feel more constrained by their status to complain about work hazards, and have more difficulties for changing their working conditions (Aronsson, 1999).

Workers under situations of precarious employment may face greater demands or have lower control over the work process, two factors which have been associated with higher levels of stress, higher levels of dissatisfaction, and more adverse health outcomes. For example, workers with temporary contracts are twice as likely as permanent workers to report job dissatisfaction, even after adjusting for various individual- and country-level variables (Benach, Gimeno, Benavides, Martínez, & Torné, 2004). Non-permanent workers enjoy less job autonomy and control over time on the job than workers with permanent contracts, are likely to be employed in less-skilled jobs (Eurofound, 2001) and have worse health outcomes when compared with permanent workers (Benavides, Benach, Diez-Roux, & Romana, 2000; Kivimäki et al., 2003; Benavides et al., 2006). Temporary jobs tend to have lower wages than permanent jobs and often have lower benefits such as paid vacations, sick leave, unemployment insurance and other fringe benefits, as well as less access to training. All these adverse factors may increase the risk of developing behaviours which put one’s health at risk, as well as of producing detrimental psychological and physio-pathological changes, which lead to poorer health outcomes. For example, there is evidence that temporary employment is associated with increased deaths from alcohol-related causes and smoking-related cancer (Kivimäki et al., 2003).

Evidence from psychosocial studies has also provided important results. The experience of job insecurity has been associated with poorer physical and mental health outcomes (Ferrie, Shipley, Marmot, Stansfeld, & Smith, 1998). In one study, perceived job insecurity was the single most
important predictor of a number of psychological symptoms such as mild depression (Dooley, Rook, & Catalano, 1987). Workers exposed to chronic job insecurity are more likely to report minor psychiatric symptoms than those with secure jobs. Moreover, relative to workers who remained in secure employment, self-reported morbidity was elevated among workers who lost job security. Workers exposed to chronic job insecurity had the highest self-reported morbidity, indicating that job insecurity acts as a chronic stressor. Among those who regained job security, adverse effects, particularly in the psychological sphere, were not completely reversed by removal of this threat (Ferrie, Shipley, Smith, Stansfeld, & Marmot, 2002). The impact of job insecurity on mental wellbeing has also been described in the context of currently industrialising countries (Edimansyah et al., 2008). Downsizing, which can lead to increased job insecurity, has also been shown to be a risk to workers’ health. Thus, a significant linear relation has been observed between the level of downsizing and long periods of sick leave attributable to musculoskeletal disorders and trauma (Vahtera, Kivimäki, & Pentti, 1997). Self-reported health status deteriorates among workers anticipating a job change or loss in a group of middle-aged, white-collar civil servants (Ferrie, Shipley, Marmot, Stansfeld, & Smith, 1995). Overall, research on self-reported job insecurity and workplace closure presents consistent evidence of their significant adverse effects on self-reported physical and mental health (Marmot, Ferrie, Newman, & Stansfeld, 2001); these effects may be higher among people with poor labour market chances (Rugulies, Aust, Burr, & Bültmann, 2008). Finally, there is also some evidence of the association between self-reported job insecurity and subclinical atherosclerosis (Muntaner et al., 1998).

Job insecurity, like several physical and psychosocial working conditions, is unevenly distributed and more concentrated among manual and lower-grade occupations and is an important factor contributing to social class inequalities in health, particularly psychological health and among younger adults (Matthews, Manor, & Power, 1999; Borg & Kristensen, 2000; Ferrie, Shipley, Stansfeld, Smith, & Marmot, 2003). In the United States, non-standard forms of employment (“contingent workers”) are concentrated among women, black and hispanic people and low-income families (Cummings & Kreiss, 2008).

Although job insecurity and temporary employment have been shown to be good predictors of the health of precarious employees, they only provide a partial picture of new employment relations. They are insufficient for explaining the mechanisms by which new work arrangements are affecting the health of a growing flexible workforce. For example, self-perceived job insecurity may not be able to capture the impact of structural determinants of employment...
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“You only have the right to work, not to anything else.”
Source: Luisa Fernández, a tomato picker from Immokalee, Florida, with no work contract, no overtime pay, no maternity leave, and no paid vacation or sick leave. In Oxfam America Interview, Immokalee, Florida, July 22, 2003.

such as domination or a lack of unionisation or benefits on workers’ health (Benach, Amable, Muntaner, & Benavides, 2002). On the other hand, the study of temporary employment may also be inadequate for explaining many of the complex situations produced by precarious employment. In fact, the common use of “control” under precarious employment relationships can go beyond the notion of “decision authority” and create new types of uncertainty in expectations regarding issues such as future work, income, benefits, or schedules. For example, precarious workers are likely to work under different power relationships than those in standard jobs, resulting in limited rights in the workplace. These and other limitations highlight the need to develop conceptual and measurement alternatives based on the social structure of new forms of work organisation, such as precarious employment.

Selected scientific findings

Temporary employment and risk of overall and cause-specific mortality

The population provided by the 10-Town Study includes 85,271 municipal employees (22,853 men and 62,418 women) and 7,080 long-term unemployed people (3,739 men, 3,341 women) aged 18–63 years. The employed constitute the total full-time staff who had worked more than 6 months between 1990 and 2000 in the service of 10 Finnish towns. Four categories were used: permanent employees, employees who moved from a temporary to a permanent job, temporarily employed workers, and long-term unemployed persons. Mortality data collected from the national mortality register (1990-2001) analysed all-cause mortality and deaths from cardiovascular disease, cancer, external causes and smoking- and alcohol-related causes. Temporary employment was associated with higher mortality than permanent employment (Men, HR=1.61, CI:1.25-2.09; Women HR=1.24, CI:1.01-1.54) but with lower mortality than unemployment. Mortality ratios were mainly increased for deaths from external causes. Socioeconomic confounding is unlikely to explain these findings. Temporary employment was associated with increased deaths from alcohol-related causes (Men, HR=2.0, CI: 1.4-2.9; Women HR=1.7, CI:1.1-2.5) and smoking-related cancer (Men, HR=2.8, CI:1.3-6.0). Moving from temporary to permanent employment was associated with a lower risk of death than remaining continuously in permanent employment (Men and women combined, HR=0.7, CI:0.5-0.9).

Source

Types of employment and health in the European Union: changes from 1995 to 2000

This study examines two cross-sectional surveys of a representative sample of the European Union’s total active population (n=15,146 workers in ES1995 and n=21,703 workers in ES2000). Based on their comparability in both surveys, four health indicators were considered: job dissatisfaction, stress, fatigue and backache. The study compares the associations between various types of employment and four health indicators for the EU in ES1995 and ES2000, by gender. Non-permanent employees reported high percentages of job dissatisfaction but low levels of stress. Small employers were more likely to report fatigue and stress but less likely to report job dissatisfaction. Sole traders were more likely to report fatigue and backache. Workers in full-time employment almost always reported worse levels of health indicators than part-time workers. Results by gender were similar in both surveys. Overall, a slight increase in all health indicators was observed in the ES2000 compared to ES1995 and results were very consistent between both surveys, suggesting that causal interpretation may be enhanced.

Source
Social inequalities in the impact of flexible employment on different domains of psychosocial health

This study takes place in Catalonia (a region in northeast Spain), using a cross-sectional health survey. It examines four types of contractual arrangements: permanent contract, fixed-term temporary contract, non-fixed-term temporary contract, and no contract. Multiple logistic regression models separated for sex and social class (manual and non-manual workers) were fitted, controlling for age. Some forms of temporary contracts are related to adverse health and psychosocial outcomes, with different patterns depending on the outcome analysed as well as on sex and social class. Fixed-term temporary contracts were not associated with poor mental health status. The impact of other forms of flexible employment on mental health depended on the type of contractual arrangement, sex and social class, and it was restricted to less privileged workers, women, and manual male workers. Among both manual and non-manual male workers, those with fixed-term temporary contracts were less likely to have children when married or cohabiting. Non-manual male workers were also more likely to remain single (aOR=2.35; CI=1.13,4.90).

Source

Associations between temporary employment and occupational injury: what are the mechanisms?

Data systematically recorded for 2000 and 2001 by the Spanish Ministry of Labour and Social Affairs on fatal and non-fatal traumatic occupational injuries were examined by type of employment and type of accident, while adjusting for gender, age, occupation, and length of employment in the company. In the study period, there were 1500 fatal and 1,806,32 non-fatal traumatic occupational injuries which occurred at the workplace. Incidence rates and rate ratios (RR) were estimated using Poisson regression models. Temporary workers showed a rate ratio of 2.94 for non-fatal occupational injuries (CI:2.40,3.61) and 2.54 for fatal occupational injuries (CI:1.88,3.42). When these associations were adjusted by gender, age, occupation and, especially, length of employment, they lose statistical significance: 1.05 (CI:0.97,1.12) for non-fatal occupational injuries and 1.07 (CI:0.91,1.26) for fatal occupational injuries. Lower job experience and knowledge of workplace hazards, measured by length of employment, is a possible mechanism explaining the consistent association between temporary workers and occupational injury.

Source

Selected case studies

**Case study 47. Precarious employment and health.**

Common trends in modern working life include global competition for labour markets, organisational changes (such as downsizing and mergers) and increasing use of various kinds of temporary work arrangements (Gowing, Kraft, & Campbell Quick, 1998). Even economic booms do not seem to be bringing an end to these changes, which may subject a substantial part of the workforce to increased stress and job insecurity. Approximately 9 per cent of employees are estimated to be insecurely employed, which constitutes a total of several million people in Europe alone (De Witte, 2005).

Since the recessions that hit most industrialised countries during the 1990s, evidence has accumulated of health risks to the survivors of corporate downsizing. The Finnish Raisio study showed that the risk of health problems, as indicated by medically-certified sickness absence and other indicators of health, increased after major downsizing. An especially high increase in sickness absence was found in workplaces with a high proportion of older employees. Half of this excess risk was attributable to an elevated level of work stress, as indicated by increased workload, increased job insecurity and reduced job control (Kivimäki, Vathera, Pentti, & Ferrie, 2000). The adverse health effects of downsizing have been shown in several other studies (Quinlan, Mayhew, & Bohle, 2001) as well as in a large Finnish cohort, the 10-Town study, showing increased cardiovascular mortality (Vathera et al., 2004), use of psychotropic drugs (Kivimäki et al., 2007) and rates of disability pensions (Vathera & Kivimäki, 2005).

The association between temporary employment and health is less clear. Although temporary employment has been associated with mortality (Kivimäki et al., 2003) and psychological morbidity (Virtanen et al., 2005), several null findings have also been reported. In some datasets, temporary employees had higher injury rates but lower sickness absence rates than
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permanent employees (Virtanen et al., 2005). Financial strain, job insecurity, deficient benefits and on-the-job-training, lack of prospects for promotion and exposure to hazardous working conditions have been suggested as potential pathways through which temporary employment can damage worker health (Benach, Benavides, Platt, Diez-Roux, & Muntaner, 2000; Kalleberg, Reskin, & Hudson, 2000). Since the majority of studies on temporary employment and health have been cross-sectional, more research is needed to examine the long-term effects of temporary employment on health.

As expectations of continued high economic growth have evaporated in industrialised countries with the advent of the global economy, downsizing and other forms of precarious employment have become an increasingly common labour market trend. Research evidence suggests that precarious employment is a crucial public health issue.

References


Case study 48. Precarious employment, health, and the life cycle. - Wayne Lewchuk, Marlea Clarke and Alice de Wolff

As precarious employment relationships become more common, two questions need to be explored. Is precarious employment concentrated amongst younger and older workers? Do the health effects of precarious employment vary across the life cycle? We use survey data and interviews to explore these questions. We found that precarious forms of employment [including working through a temporary employment agency, working on a contract of less than one year or being self-employed] are most common amongst individuals under age 25 and least likely for those between 25 and 50. Compared with this middle-age group, young workers and those over 50 are two to three times more likely to be in precarious employment relationships. Among non-full-time students, the differences are less dramatic but still significant. Those under 25 and those over 50 are 50 per cent more likely to be in precarious employment than those in the middle-age category. However, almost one-quarter of the individuals in our sample who were between the ages of 25 and 50 were still in precarious forms of employment. The second question is whether precarious employment has differential effects on health throughout the life cycle. We were particularly interested in whether middle-aged workers were experiencing more stress than younger and older workers in precarious employment. In general, the data do not support this hypothesis. Focusing on individuals in precarious employment relationships, self-reported overall health status declines with age, but the prevalence of stress at work and employment-related pain was not associated with age. Our research suggests that factors other than age are more significant in explaining the relationship between health and precarious employment. Regardless of age, individuals who feel they are on a path to something better cope reasonably well with precarious employment, and those who value [and can afford to value] the flexibility and lack of commitment associated with precarious employment also cope well. The most significant health effects were reported by a third group who felt trapped in their position with little hope of gaining better employment. The relationship between the life cycle and
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these three categories of precariousness was relatively weak. This was especially the case for the third group, who felt
trapped and were drawn from all age groups.

Source
Clarke, M., Lewchuk, W., de Wolff, A., & King, A. (2007). ‘This just isn’t sustainable’: precarious employment, stress and

Case study 49. Increases in dispatching nonstandard workers: a case of facilities maintenance work in Korea. - Il Ho Kim,
Haejo Chung and Carles Muntaner

“The university used to provide extra money for snacks when I was employed as a cleaner. When my contract was changed to a
dispatched worker’s, all the benefits I had from the school stopped. In the department where I work, there is a mixed pool of regular
employees as well as dispatched workers in the same workforce. We dispatched workers are not allowed to have the same benefits as
regular workers. Since the school considers us to be contracted by dispatching agencies, they are not willing to give benefits other than our
salary. We received so much unfair treatment. If we are injured or ill, we need sick leave, right? But with sick leave, we are not allowed to come
back to work. So, we have to quit the job against our will in cases like this. When injured, we should find our own ways of getting “Industrial
Accident Compensation Insurance.” The company was not willing to compensate for the injury that occurred during work. Regarding salary,
the cleaners in regular positions received approximately 1,400–1,500 dollars a month, whereas dispatched cleaners got 420 dollars a month.”

The above story is from a man working at a Korean university through a dispatching agency. There are about 100 cleaners and
220 porters in the school who used to work there as standard employees. In 1996, this type of employment was beginning to be
outsourced to dispatching companies. Since then, this workforce has been increasingly filled by the dispatched nonstandard
workers: from 40 per cent in 1996 to 90 per cent in 2000. These workers face discrimination in their jobs.

At present, there are about 700 worker-dispatching companies in Korea, which employ 90 per cent of Korea’s facility-
maintenance workers. With poor working conditions and a lack of concern from both society and their employers, these workers
are suffering from double exploitation; they are exploited first by the dispatchers and then by their employers. In comparison with
standard workers in the same jobs, dispatched workers receive far lower wages and cannot invoke labour rights. Despite the fact
that they have an employment contract with the dispatching company, they are under the managerial direction and control of the
contracting company. Their employment security is thus doubly threatened. In the process of making an employment contract,
workers have to sign the contract presented to them by the dispatching company. In fact, it is not a contract but a memorandum
which states that the worker is aware that the job he or she assumes is both temporary and supervised.

The average working week of a facility-maintenance worker is of 72-80 hours, well in excess of the standard Korean 44-
hour work week. However, in spite of such overtime, the average weekly wage for these workers typically falls between $400
and $600. Such low wages cause workers to change their jobs frequently. Within three years, almost the entire maintenance
staff of the above university turned over. Many workers left after less than one year.

In addition, most of these working environments are harmful and dangerous, and workers often suffer damage to their
eyesight and hearing. They are also more likely to contract respiratory diseases and pneumonia. Finger amputation and
death from falls are frequent accidents, but nothing has been done to protect them or promote good health on the job. Their
health problems have not been specifically reported in official data. The table below profiles the adverse effect of precarious
work on health using data from a national health survey in South Korea.

<table>
<thead>
<tr>
<th>Employment status</th>
<th>“Poor” self-rated health</th>
<th>Chronic disease</th>
<th>Musculo-skeletal</th>
<th>Mental</th>
<th>Mortality rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEN</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standard</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Nonstandard</td>
<td>2.15 (1.44-3.23)</td>
<td>1.33 (1.00-1.78)</td>
<td>2.60 (1.73-3.91)</td>
<td>16 (0.01-3.08)</td>
<td></td>
</tr>
<tr>
<td>WOMEN</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standard</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Nonstandard</td>
<td>1.97 (1.35-2.86)</td>
<td>1.64 (1.22-2.21)</td>
<td>1.49(1.01-2.18)</td>
<td>2.77 (1.32-5.83)</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3.01 (1.50-6.03)</td>
</tr>
</tbody>
</table>

Source
Labour market flexibility has brought about a situation of chronic insecurity for salaried workers in high income countries that is characterised by a high proportion of temporary contracts, lowered wages, lessened social protection and benefits, as well as an increase in worker vulnerability (i.e., powerlessness, defenselessness) (Benach & Muntaner, 2007). It is to be expected that these new features of employment conditions will have an impact on workers’ health, but epidemiological evidence is lacking. There is some evidence of chronic job insecurity (Ferrie, 2001) and temporary contracts (Benavides et al., 2006; Virtanen et al., 2005) that shows how flexible jobs can be harmful to health. Our preliminary results from a Spanish survey (see Case study 21) show that precarious employment is unequally distributed in the population, constituting a greater burden for women, younger, less-qualified and immigrant workers, which makes its study most significant in the context of social inequalities in health. The purpose of the present study is to describe the association between employment precariousness and self-perceived general and mental health in salaried workers in Spain.

Data come from the Psychosocial Factors Survey carried out between 2004 and 2005 by the Barcelona Union Institute of Work, Environment and Health (ISTAS). They used a multistage stratified random-route sampling procedure to recruit a sample of 7,650 wage earners who were interviewed at home. For this study, we only included salaried workers, both temporary and permanent (n=6,968).

We used the Employment Precariousness Scale (EPRES), which uses six dimensions (temporality, empowerment, vulnerability, wages, rights and exercise of rights) to measure employment precariousness (Amable, Benach, & González, 2001). The scale, whose values range from 0 to 4, was treated as a categorical variable with three levels: none or low precariousness (0<1), moderate precariousness (1<2), high and very high precariousness (≥2). Perceived general and mental health was measured with the Spanish version of the generic health questionnaire SF-36.

As expected, self-perceived health, especially mental health, worsens as employment precariousness increases, as is shown in the figure below. General health averages drop from 81 in subjects with none/low precariousness to 72 in subjects with high/very high precariousness among workers at or under the age of 30, and from 76 to 69 among workers over 30 years old. Mental health means drop from 80 to 67 and 76 to 64, respectively. Mental health averages among subjects with high/very high precariousness fell under the reference values for the general Spanish population (Alonso et al., 1998).

**Figure.** Mean (95%CI) General and Mental health (SF-36) ratings by level of Employment Precariousness in workers up to or over 30 years of age.
Trends are similar for both women and men, with a steeper drop in both mental and general health among women from both age groups (results not shown). These results show significant differences in the levels of mental and general health according to employment precariousness, showing that this is a significant public health issue, concerning social inequalities, which deserves further and broader research to inform policy-making with respect to health inequalities.

References


Informal employment

Relations between informal employment conditions and occupation-related health outcomes which may result in health inequalities are seldom studied. Generally, occupational data are not always available for the informal economy, or there is lack of quality data in large demographic and health-related databases. Also, the lack of official statistics on workers in the informal economy, the scattered spatial distribution of its shops and workers and the uniqueness of workplaces, such as those which characterise domestic employment, are all drawbacks for this research. Besides its association with poverty (which makes it difficult to separate any specific health effects), other methodological problems are the lack of accepted standard definitions of informal employment, its large heterogeneity of occupations, trades, employment arrangements, and health and safety hazards. Research efforts have been qualitative descriptive case studies (Hussain-Huq, 1995; Holland, 1995; Nilvanrangkur et al., 2006), quantitative (Hernández, Zetina, Tapia, Ortiz, & Soto, 1996; Loewenson, 1998), and community-based surveys comparing informal workers with formally-hired workers (Bisgrove & Popkins, 1996; Santana, Loomis, Newman, & Harlow, 1997; Santana & Loomis, 2004; Ludermir & Melo Filho, 2002). Available evidence consistently shows that workers submitted to informal employment relations have less favourable health indicators than those holding formal jobs (Hernández et al., 1996). These studies, however, do not consider the heterogeneity of the informal sector, which includes small entrepreneurs, self-employed workers and salaried workers. Most
studies have addressed occupation-related health issues and only a few describe the relations between informality and health inequities using overall health effects. In the UK, results from the British Household Panel Survey 1999-2001 show that small employers and own-account workers are at an increased risk of having a limiting illness, for both men [Adjusted Hazard Ratio, AHR=1.47 95%CI:1.09-1.98] and women [AHR=2.42; 95%CI:1.49-3.94], yet no statistically significant results were reported for illness recovery [Bartley, Sacker, & Clarke, 2004]. For both men and women, there is a strong positive association between a country’s increasing proportion of informal jobs and death and DALY for all diseases.

Being in informal employment relations may cause mental distress because of job insecurity (i.e., the threat of losing their jobs). Under this framework, workers expect fair relations between efforts spent on the job and what they get in return, particularly salaries and promotions, recognition and job security. An imbalanced effort-reward relation may lead to perceptions of injustice, emotional distress and poor self-esteem, which is a plausible scenario among informal workers. There is empirical evidence that asymmetric effort-reward job perceptions are associated with cardiovascular disease, poor self-perceived health, and several mental disorders [Siegrist & Marmot, 2004]. These effects may be exacerbated in situations of social vulnerability, as in the context of workers in informal employment relations, who lack any enforceable contract. Results from several community-based cross-sectional studies have shown that women in informal jobs were more likely to have minor mental disorders than those with formal job contracts, using adjusted relative measures for the number of symptoms of mental disorders [Santana et al., 1997] or standardised psychiatric diagnoses [Ludermir & Lewis, 2005]. This association was not observed among men [Ludermir & Lewis, 2005]. For example, informal rag pickers were more likely to have minor mental disorders than other workers in their neighbourhoods [Da Silva, Fassa, & Kriebel, 2006]. In developed countries such as the US and Canada, positive associations have been observed between self-employment and stress [Jamal & Badawi, 1995] and self-perceived health [Dolinski & Caputo, 2003], but other studies did not find similar evidence. For instance, Prottas and Thompson (2006) examined self-employment and stress, family conflict and job satisfaction. Crude positive associations disappeared when adjusted by socio-demographic and work-related factors such as hours worked, job

Young shoe-shiner in La Paz (Bolivia).
Source: Joan Benach [2010]
Employment relations and health inequalities: pathways and mechanisms

pressure and job autonomy. Furthermore, in a study conducted in London, no differences in physical and mental health, assessed through depression, anxiety and visits to a general practitioner over a one year period, were found for self-employed workers (Parslow, Jorm, Christensen, Jacomb, & Rogers, 2004). Other reported psychosocial stressors in informal workplaces are violence, sexual abuse (Oliveira, 2006) and discrimination (Iriart et al., 2006), which have been reported for female domestic workers (Oliveira, 2006; Sales & Santana, 2003) and construction workers (Iriart et al., 2006). Most women engaged in weaving with informal jobs in Thailand reported stress as a result of pressures to maintain the quality of products, the tight time schedule and monetary debts related to their jobs (Nilvarangkul et al., 2006). In South Africa, approximately 25 per cent of women street vendors reported an experience of abuse, either physical or verbal, and 29 per cent reported having been robbed at work (Pick, Ross, & Dada, 2002).

One explanation for these inconsistencies is that the category of “self-employed” is very heterogeneous in wealthy countries such as the US, where it captures both professionals and low-skilled workers (Muntaner, Hadden, & Kravets, 2004). However, it must be reiterated that, even in wealthy countries, self-employment status implies self-responsibility for safety precautions, which in the context of manual jobs can result in lower compliance and higher risk of occupational injuries and diseases (Mirabelli et al., 2007). Currently, in the US the injury rate among self-employed workers is double the national average (Cummings & Kreiss, 2008).

Informal jobs have also been examined in terms of nutrition-related outcomes. Though poverty is correlated with poor nutrition, the relationship becomes more complex when employment status is taken into account. For instance, data from the Cebu Longitudinal Study from the Philippines showed that low-income women in informal jobs consumed more calories, protein and iron through commercial sources than those in the informal economy’s upper income group. Also, lactating women were more often engaged in breastfeeding when in the informal economy (Bisgrove & Popkin, 1996). However, Hernández et al. (1996) analysed street vendor mothers from Mexico City to identify health outcomes related to child care practices. Because access to child care was limited, women left their children at home, usually under the supervision of other older children, or they brought them to their workplaces. Without adequate supervision, children who stayed in their mothers’ workplaces had an increased proportion of gastrointestinal diseases and injuries than the corresponding prevalence estimated for the overall population.
Selected scientific findings

The health impact of occupational risks in the Zimbabwe’s informal sector

Information about occupational health in the informal sector is lacking, despite its growing contribution to employment. The author describes a survey of occupational health in urban and rural informal sector workers in Zimbabwe. Common hazards included poor work organisation, poor hygiene, ergonomic hazards, hazardous hand tools and chemical exposures, particularly to pesticides and solvents. An annual occupational mortality rate of 12.49/100,000 was half the formal sector rate. Reported rates of 131 injuries/1,000 workers and 116 illnesses/1,000 workers exceeded formal sector rates tenfold and a hundredfold, respectively (although the distribution of injuries by economic sector correlated significantly with formal sector rates). The survey found high levels of musculoskeletal and respiratory illness, which had been thought to be under-detected in formal systems. A fifth of the injuries had resulted in permanent disability with little consequent job loss, but with no compensation granted. The author recommends improvements to occupational health in the informal sector, and suggests a broader survey of occupational morbidity in all sectors of employment.

Source

Does women’s work improve their nutrition? Evidence from the urban Philippines

Women’s market work in developing countries is thought to improve their well-being directly through increased income for health-related purchases and indirectly through elevating women’s status within the household. While a number of studies have looked at the effects of women’s work and the cost of women’s time on child nutrition and welfare, the direct effects of women’s work on their own welfare have been largely untested. Using data on 1963 urban Filipino women from the Cebu Longitudinal Health and Nutrition Survey, we examined the relationship between women’s work and their dietary intakes of energy, protein, fat, calcium and iron from home- and commercially-prepared foods. Determinants equations for home and commercial intakes were estimated simultaneously to adjust for non-independence. Appropriate methods were used to deal with selectivity, endogeneity and unobserved heterogeneity. Nearly half [48%] of the women worked for pay, and commercially-prepared foods made up an important part of working women’s diets. Not only did women’s work improve the quality of their diets, but there were strong distributional implications; lower-income women gained more than higher-income women. The employment sector also influenced women’s dietary patterns. Informal non-wage work was associated with increased intakes, whereas formal sector work was associated with decreased intakes. The positive effects of work in the informal sector were greater for women from low-income households.

Source

Fatal occupational injuries among self-employed workers in North Carolina

Background: Research suggests that rates of occupational injury and death may be higher among self-employed workers than among the wage and salaried population. This analysis was conducted in order to describe the demographic and occupational characteristics, as well as injuries, activities, and occupations of self-employed workers who were fatally injured on the job.

Methods: Characteristics of workers by type of employment were compared using data from the North Carolina Office of the Chief Medical Examiner, 1978-1994. Age-, activity-, and industry-specific fatality rates in self-employed workers (N=395) were contrasted with those for privately employed people (N=1,654).

Results: The highest fatal injury rates among the self-employed occurred in agriculture, retail and transportation industries. Homicide deaths occurred more frequently among self-employed workers; and deaths resulting from unintentional injuries occurred more frequently among non-self-employed workers.

Conclusions: Elevated occupational mortality death rates among self-employed workers, especially in retail and transportation industries, provide justification for addressing the work-related conditions of self-employed workers in North Carolina.

Source
Informal jobs and non-fatal occupational injuries

**Objectives:** In Brazil, workers without a formal job contract represent approximately half of the labour force, yet there are no official statistics on occupational injuries for them. This study estimates the annual incidence of non-fatal work-related injuries for workers with and without job contracts and examines gender differences.

**Methods:** This is a community-based study carried out with a random cluster area sample of the residents of Salvador, the capital of the state of Bahia, in northeast Brazil, with a population of 2.7 million inhabitants. Individuals from 18 to 65 years of age who reported having a paid job comprise the study population (n=2907). Data were obtained in individual household interviews with questionnaires applied by trained field workers.

**Results:** The overall estimated annual incidence rate (IR) was 5.6/100 full-time equivalent workers (FTE). The incidence of injuries differed between workers with informal (IR=6.2/100 FTE) and formal jobs (IR=5.1/100 FTE), and according to gender (IR=5.8/100 FTE for female and 5.5/100 FTE for male), but these differences were not statistically significant. Statistically significant positive associations between informal jobs and non-fatal work injuries were observed among women with medium education [incident rate ratio (IRR) 2.02, 95% CI 1.00-4.00] and women with black skin (IRR 1.71, 95% CI 0.99-2.97) who perceived a job as dangerous (IRR 2.00; 95% CI 1.09-3.64) or who had no occupational training (IRR 2.08; 95% CI 1.05-4.20).

**Conclusions:** This study shows that non-fatal work injuries are a common health problem among adults in urban Brazil, regardless of the type of job contract or gender, which points to a need to improve workers’ health and safety programs for formal and informal hired workers.

**Source**

Informal recycling and occupational health in Santo André, Brazil

The collection of recyclables is a widespread activity among the urban poor, particularly in countries with large socio-economic disparities. The health of recyclers is at risk because of unsafe working conditions, socio-economic exclusion and stigmatisation. Our study focuses on the health problems and occupational risks of informal recyclers (known in Brazil as catadores). In 2005, we conducted an in-depth socio-economic survey of 48 informal waste collectors in Santo André, Brazil. Almost all workers reported body pain or soreness in the back, legs, shoulders and arms. Injuries, particularly involving the hands, are frequent. Flu and bronchitis are common, and one recycler had contracted Hepatitis-B. Policy-makers at all levels of government need to address the pressing health issues affecting large numbers of informal recyclers in Brazil and abroad. Recyclers need to be involved in the design of waste management policies and the public must be educated about the important environmental service these people provide.

**Source**

Selected case studies

**Case study 51. Migrant Filipina domestic workers.** - Victoria Porthé and Emily Q. Ahonen

Filipinos are on the move. In 2006, there were more than a million Filipinos working abroad. While they may end up in any part of the world, many Filipinos migrate to the Middle and Far East [Ehrenreich & Russell Hochschild, 2002]. About two-thirds of those workers are women (Salazar Parreñas, 2002). Once in the destination country, many work in household services. In fact, according to the Philippine Overseas Employment Administration (Sena, 2007), 98 per cent of the Filipino household workers abroad are women. In 2005, Kuwait, Hong Kong, and Lebanon were the top destinations for Filipina domestic workers.

These women leave the Philippines because of a complex mix of political and economic causes. After IWorld War II, when it gained independence from the United States, the Philippines were the second richest country in Asia. When elected president Ferdinand Marcos was unable to seek a third term, he continued to rule by decree beginning in the early 1970s. In 1986, Benigno Aquino, who was the opposition leader, returned from exile and was assassinated. Under pressure, Marcos allowed an election, which was believed fraudulent and was followed by street protests. Eventually, Aquino’s widow, Corazon Aquino, was recognised as the winner. After the nonviolent People Power revolution, she called for the creation of a new constitution. Brief growth was followed by the Asian financial crisis of 1997, which continues to undermine the Philippines’ economy. Today, there is widespread poverty in the country.
But internal conditions in the Philippines are not the only factor responsible for its high rate of migration. Worldwide, differences between wealthy and poor countries have grown and wage differentials between countries are still huge. A Filipina domestic worker in Hong Kong can earn over 15 times the amount she could earn at home as a teacher (Ehrenreich & Russell Hochschild, 2002). Also, the dependence of poor countries on loans from the IMF and the World Bank means those countries must adopt structural adjustment programs, which often lead to a reduction in social, “non-competitive” services, with negative consequences for the poor (Ehrenreich & Russell Hochschild, 2002). At the receiving end of migration, the increased presence of women in the labour force in rich countries means that many of them are unable to manage their homes and care for dependents on their own. The help they need has not typically come from their male partners, nor have most governments in wealthy countries adjusted social policies to accommodate the new realities of women in the labour market. As such, “women’s work” in these wealthy countries is frequently transferred to women from poorer countries. This is one of the biggest reasons why Filipina domestic workers are currently employed in more than 100 countries (Salazar Parreñas, 2002). It is also important to note that women migrants from the Philippines, or from other low-income countries, are seldom the least-affluent or least-educated in their home countries (Ehrenreich & Russell Hochschild, 2002).

Because domestic workers work in private environments, generally out of the public eye, they can be particularly vulnerable to abuses by employers or employment agencies. Long working hours, few days off, excessive control of their physical appearance, low or withheld pay and even physical, psychological or sexual abuse have been reported (Constable, 2002).

One of the biggest barriers to better regulation of the household worker sector is that many governments classify such work as “informal.” Frequently, domestic workers are completely excluded from labour laws, or existing laws are weak and poorly implemented. This means that employers have almost free reign to demand hard work in often very poor employment and working conditions (Human Rights Watch, 2006). This, combined with the invisibility described earlier, makes for an extremely vulnerable group of workers.

The situation of these workers becomes more complex when their place in the Philippine economy is considered. Remittances, mostly from migrant domestic workers, constitute the economy’s largest source of foreign currency (Salazar Parreñas, 2002). It is estimated that anywhere from 34-54 per cent of Filipina families live on money sent from workers abroad (Ehrenreich & Russell Hochschild, 2002). Globally, remittances are sometimes seen as a solution to the problems of poor countries (DeParle, 2007).

Given that tighter regulation would impact family, local and national economies, there is at least strong inertia on the part of supply-side governments to maintain the status quo of domestic workers abroad. Wealthy receiving countries also benefit from this labour, which allows women to contribute to the economies in their adopted countries through paid work. But within this network of economic and development gains, it is clear that we need to draw more attention to the needs of migrant domestic workers.

References


Case study 52. Sweatshop crucifixes made in China. - Charles Kernaghan, Barbara Briggs, Jonathan Giammarco and Alexandra Hallock

First it was toys, then clothing and sneakers, sporting goods, furniture, and now crucifixes. Crucifixes are being made at the Juxingye Factory in Dongguan, China, by mostly young women—some just 15 and 16 years old.

They are forced to work 14- to 15 and-a-half-hour shifts, from 8 A.M. to 10 or 11:30 P.M., seven days a week. There are also frequent 17- to 18-hour shifts ending at 1 or 2 A.M. and even monthly, all-night 22-and-a-half to 25-hour shifts when shipments are scheduled to leave for the US. Overtime is mandatory and anyone missing even a single overtime shift will be docked a full day’s wages. Workers are routinely at the factory over 100 hours a week, sometime forced to work 51 hours
After a 19-hour shift, one worker cried out, “Jesus, take pity on me! I’m going to die of exhaustion.” Workers are paid just 26.5 cents an hour, which is half of China’s legal minimum wage of 55 cents an hour [itself below subsistence level]. After fees are deducted for room and board, a worker’s take-home wage can drop to just 9 cents an hour. They are housed in primitive and filthy company dorms, sleeping on narrow double-level metal bunk-beds that line the walls, where they drape old sheets or plastic over their cubicles for privacy. There is no other furniture, not a table, chair or bureau, and the rooms reek of perspiration. The walls are filthy, smudged with black, with spider webs clinging to the ceiling. The bathrooms are so damp and dirty that moss grows on the floor.

Workers describe the company food as “awful.” The soup is a large pot of water with a few vegetable leaves and drops of oil floating on top. In the so-called “meat dish,” the bits of meat are so small that the workers cannot lift them with their chopsticks.

Workers fear that they may be handling toxic chemicals, but they are not told the names of the chemicals and paints, let alone their potential health hazards. They are not provided an employment contract, which is legally mandated in China. Lack of a contract further strips them of the legal rights afforded full-time workers under Chinese law. The crucifix workers have no paid sick days, maternity leave, paid holidays or health insurance—all of which are mandated under Chinese law. The punishment for missing a day, even for illness, is 2-and-a-half days’ wages. Every single labour law in China, as well as the United Nations/International Labour Organization’s worker rights standards, is being grossly violated at the Junxingye factory, leaving the young workers trapped in an abusive sweatshop, stripped of their rights, voiceless, and with no place to turn for help.

It appears that the $4.6 billion US Association for Christian Retail has decided, en masse, to follow Wal-Mart to China, where they can exploit defenceless workers and pay them pennies an hour to produce their religious goods. Saint Patrick’s Cathedral, Trinity Church and the Association for Christian Retail lack even rudimentary corporate codes of conduct and these religious organisations do not have any factory monitoring program either. Its 2,055 member stores and suppliers cannot promise, and in fact do not even attempt to promise, to the American people that their religious products are made under humane conditions by workers whose legal rights are protected and who are fairly paid.

Source

Case study 53. Undocumented immigrants in one European country: The case of Spain. - Emily Q. Ahonen and Victoria Porthé

In Spain, foreign residents number 3,880,000, or 8.7 per cent of the total population (Instituto Nacional de Estadística, 2006). It is difficult to estimate the number of undocumented people in the country, we can get an idea from the number of requests for “regularisation of status” in the most recent 2005 process. That year, 688,419 people applied for regularisation of their status, and 575,941* were approved (Izquierdo Aguilera, 2006). This leaves 112,478 people potentially in a legally irregular situation, if nothing else changed for them. In contrast, by comparing the number of people holding residence permission with those counted in civil registers, we arrive at a discrepancy of 66,192, about half the number of people denied regularisation (Ministerio de Trabajo y Asuntos Sociales, 2007) Clearly, there is great variation in estimates of the magnitude of this discrepancy between population counts and documented residents, but by any calculation there is a large undocumented population in Spain. The employment scenarios of this population can be alarming, not only because of poor employment and working conditions (undocumented workers are frequently employed in the underground economy), but also because of how those conditions affect their chances to integrate into their adopted society and obtain a dignified quality of life.

The following information is based on a project currently being carried out in Spain about immigration, work and health. Undocumented Moroccan workers living in Barcelona were interviewed about their working conditions, health and quality of life. The group was characterised by average educational attainment. The majority worked in manual jobs in Spain, principally in the service, construction and food-service sectors. The workers were between 23 and 44 years old and the majority were men. It was especially difficult to reach undocumented women in this group, and so this study supplies little information about that demographic.

The workers discussed the impact of their legal situation on their everyday lives. Not having “papers” affected them not only in their employment possibilities, but also in their non-working lives. Without documentation, not only could they not access quality work, but they were also without social benefits, access to housing, social and cultural services and could not improve their economic situation. Most important, they were subject to the abuses and arbitrariness of their employers and faced huge obstacles in claiming their rights. One participant commented: “Well, a foreigner normally puts up with everything out of necessity; while you can keep going, well, there are people who might take advantage of that…” [Moroccan man]
Without a labour contract, one’s situation is unstable and highly uncertain. The workers commented that their working days were ten and even fourteen hours long, without compensation for overtime, holidays or night-time work. At the same time, they perceived their incomes to be inferior to those of documented workers: “From six in the morning to six at night... There is a night shift we work sometimes, from one-thirty in the morning until closing... Working more hours, cheaper...” (Moroccan man)

Some commented that they had been required to expose themselves to high-risk situations, which they could not avoid because of their economic dependency on their jobs: “You don’t even think about it because you have to do it, there’s no other...” (Moroccan man); “No, I don’t say anything, because I don’t have a job and I can’t say anything” (Moroccan man). While they tended to minimise the risks, they were conscious that a serious injury would bring grave consequences because they had no social protection. Undocumented workers believed that their biggest risk was the vulnerability that came with that status.

The situations of these workers most clearly had repercussions in their mental health. They described the centrality of work and their legal situation in the illness that many suffered. They described insomnia, suffering, nervousness, and obsessive thoughts, among other things: “undocumented people suffer, they suffer a little bit more than documented people, yes, I think so, I think so” (Moroccan man); “It’s hard for me to fall asleep, and the thoughts... when there are so many thoughts, your head doesn’t even know what it wants”; “then there are nightmares, so many things, so many problems” (Moroccan man).

This group’s legal situation is one of vulnerability and powerlessness. Labour unions could acquire a fundamental role in the protection and empowerment of these workers, but the majority of them did not participate in union activity. For their part, unions have not adopted fully effective strategies for integrating this group.

The irregular situation, occupational and social, that characterises these workers not only complicates their integration and stability, but also exposes them to a high level of uncertainty and marginalisation within the adopted society. Integration through a poor-quality job not only predicts problems in occupational health and risk prevention, but also in the overall health of undocumented workers.

* This number is approximate. It is calculate by subtracting the 3.021.808 foreigners with authorisation or residence visa/card number from the number of foreigners registered in the Municipal Register of Inhabitants (3,88 million). In Ministerio de Trabajo y Asuntos Sociales. Secretaría de Estado para Inmigración y Emigración. Observatorio permanente de la inmigración. Extranjeros con permiso de residencia el 31 de diciembre de 2006.

**References**


### Child Labour

A growing number of studies have shown that health problems are one of the main negative effects of child labour. These effects vary in nature ranging from occupation-related diseases and injuries, directly related to hazards in the workplace or when commuting, to increased vulnerability to biological or toxic agents due to an immature immune system, ergonomic risks resulting from inadequate dimensions of tools and equipments, and impairment of physical, mental and social development due to limited time for resting, playing and studying, among other health and developmental problems. Therefore, child labour has been repeatedly associated with problems related to the physical, physiological, mental and social development of children.
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(Gunnarson, Orazem, & Sánchez, 2006; Fassa, 2003). There is also a strong consensus among researchers that many working children are involved in warfare, prostitution, drug selling, hazardous job tasks, unsafe workplaces and excessive work time, among others (ILO, 2006). Extreme workloads may lead to various disorders because of children’s lesser bone elasticity, strength and capacity to support heavy workloads. These factors can lead to musculoskeletal symptoms among child labourers (Huk-Wieliczuk, 2005; Ayala & Rondón, 2004). Some of the reported health effects of child labour appear late in adulthood, such as those related to reduced height (Dantas, 2005) and alcohol and drug abuse (Forster, Tannhauser, & Barros, 1996).

According to data from the ILO (2006), 69 per cent of all child labourers work in agriculture, ranked as one of the three most hazardous sectors as demonstrated by its higher mortality and morbidity, even for adults (Fassa, 2003). Some of the threats faced by children when working in agriculture are exposures to chemical agents such as pesticides, heat and harsh weather, repetitive work, hazardous equipments (hoes, tractor, etc), excessive work hours, demanding physical work, noise and biological agents such as dust. All these risk factors can lead to both immediate and adult health problems, such as musculoskeletal disorders, cancer, hearing loss, impaired lung function, infectious diseases, chronic cough, asthma, and pesticide poisoning (Ayala & Rondón, 2004; Fassa, 2003; Edmonds & Pavnick, 2005; Khan, Hameed, & Afridi, 2007; Green, McAlpine, Semple, Cowie, & Seaton, 2008). According to a study conducted by Briceño and Pinzón (2005), pesticide poisoning is also a risk for children working in marketplaces when their activity involves carrying or handling fruits and vegetables with pesticides.

In urban areas, child labour prevails in the informal economy, like home-based production, street selling, recycling, child caring, rag picking, pottering, stone crushing, construction and paid housework, which is also known for imposing poor work conditions on them that lead to the occurrence of health problems in the short run or during adulthood (ILO, 2006; Santana, Cooper, Roberts, & Araujo-Filho, 2005; Fassa, Fachini, Dall’ Agnol, & Christiani, 2000; Doocy, Crawford, Boudreaux, & Wall, 2007; Green et al., 2008). Employing children as domestic servants is a very
common practice among the Indian middle class, even among physicians (Mishra & Arora, 2007). Child prostitution is found worldwide, is regarded as a gross violation of human rights and dignity and has been estimated as affecting 10 million individuals, particularly in Asia (Willis & Levy, 2002). Children involved with prostitution are exposed to mental and physical abuse and are at risk of drug addiction, AIDS and many sexually transmitted diseases, as well as of premature and undesired pregnancy (Fassa et al., 2000; UNICEF, 1997 cited in Fassa, 2003). This problem affects the health potential that every person has when she is born and whose deterioration needs to be avoided throughout the lifespan. However, since growth is known to be related with nutrition at an early age, and child labour is closely associated with poverty, teasing out these two factors from correlations is still a challenge for epidemiologists. Hawamdeh and Spencer (2002) argue that child labour may have an unfavourable effect on ones’ physiological capital, as measured by its impact on growth. To minimise the confounding impact of the social-economic variable in their study, the authors selected two groups of boys according to their socio-economic class. They selected 135 Jordanian working boys and 405 non-working schoolboys living in the same geographic region and between the ages of 10-16 years. Their study found that regardless of socio-economic circumstances, child labour among Jordanian boys increases the risk of stunting and wasting. For instance, they encountered a significant clinical difference between the 2 groups: 5.3 cm in height and 250 g in weight for those aged 14 years. The risks of growth impairment faced by working boys also intensify their risk of adverse health outcomes in adulthood (Hawamdeh & Spencer, 2002; 2003).

A couple of studies in Brazil addressed the association between child labour and self-perceived health at adulthood, and they consistently observed that individuals who started work under 10 years (Kassouf, Mckee, & Mossialos, 2001) or 14 years of age (Dantas, 2005) were more likely to report poor self-perceived health than those who did not have antecedents of child labour. However, Huk-Wieliczuk (2005), studying rural children in Poland, did not find a correlation between heavy workload and poor self-reported health. This inconsistency might be explained by differences in the age range across the population surveyed. Kassouf et al. (2001) canvassed former child labourers aged 18-65 while Huk-Wieliczuk (2005) interviewed children who were
working at the time of the study and who were likely sent to work because of their good health standing.

Besides direct individual effects, child labour can also indirectly determine health inequities at the population level. As already mentioned, child labour is a major cause of illiteracy, low education and poorly trained low-skilled workers. Low education or illiteracy are widely known as one of the most consistent predictors of mental diseases (Patel & Kleinman, 2003), poor nutrition, stunting (Ram, 2006), lower life expectancy and a range of unhealthy behaviours (Low, Low, Baumler, & Huynh, 2005; Fassa, 2003) among several other health outcomes at childhood or adult age. Poorly-educated workers will also be trapped in low-income, unsafe and substandard jobs, a major cause of poverty, in addition to suffering limited chances of social mobility and attainment of better health status and life quality for their families (Case & Paxson, 2006). So child labourers, whose educational achievement is lessened due to work, are further penalised in the health realm. Since education is considered a major component of human capital, a set of abilities and attributes required for the fulfilment of social and human needs, it is also a determinant of productivity and wealth. Moreover, studies from Brazil have shown the crucial role of parents’ educational level, especially the mother’s, on children’s health and nutritional status. (Kassouf et al., 2001). Elsewhere, a mother’s high level of education has been closely linked to lower child mortality rates (Fassa, 2003). More highly-educated parents provide better nutrition and health care for their offspring. Therefore, if we take this a step further, an indirect consequence of child labour might be that former child labourers make poorer health-related decisions for their children.

Most studies on child labour and health are descriptive in nature, were developed with small samples, lack well-defined design, study populations and measurements and are poorly analysed. These drawbacks limit conclusions and external validity. Studies focusing on the long-term health impacts of child labour are essential since children have many years of life ahead of them and more time to contract illnesses (Ayala & Rondón, 2004). Moreover, the impact of child labour on health is underestimated because its long-term physiological repercussions generally do not appear in statistics related to health consequences for child labourers. Health care professionals usually do not recognise this causal pathway since most of them do not see children as workers (Eijkemans, Fassa, & Facchini, 2005; Silveira & Robazzi, 2003).
Selected scientific findings

Health of children working in small urban industrial shops

**Aims:** To explore associations between work status and multidimensional health indices in a sample of urban Lebanese children.

**Methods:** A cross-sectional survey was used to compare 78 male children (aged 10-14 years) working full time in small industrial shops, and a comparison group of 60 non-working male schoolchildren. All children lived and worked or studied in the poor neighbourhoods of three main Lebanese cities.

**Results:** Working children reported frequent abuses. They smoked and dated more than the comparison group. They also reported a higher number of injuries (last 12 months) and recent skin, eye, and ear complaints (last two weeks). Physical examination revealed more changes in their skin and nails, but no differences in height or weight compared to the non-working group. A higher blood-lead concentration was detected among working children, but no differences in haemoglobin and ferritin. No differences were noted between the two groups of children regarding anxiety, hopelessness and self-esteem. The drawings of the working children, however, revealed a higher tendency to place themselves outside home and a wider deficit in developmental age when compared to non-working children.

**Conclusion:** Significant differences were found between working and non-working children with respect to physical and social health parameters, but differences were less with regard to mental health. Future research should focus on (1) more sensitive and early predictors of health effects, and (2) long-term health effects. The generalisability of findings to other work settings in the developing world should also be tested.

**Source**

The prevalence of mental health problems in Ethiopian child labourers

**Background:** Child labour refers to a state in which a child is involved in exploitative economic activities that are mentally, physically, and socially hazardous. There are no prevalence studies on the magnitude of psychiatric disorders among child labourers.

**Methods:** A cross-sectional population survey was conducted in Addis Ababa using the Diagnostic Interview for Children and Adolescents (DICA). Subjects were a random sample of 528 child labourers aged between 5 and 15 years and comprising child domestics, street-workers and private enterprise workers. These were compared with 472 non-economically active controls.

**Results:** The aggregate prevalence of any DSM-III-R childhood emotional and behavioural disorders was found to be 16.5 per cent, with 20.1 per cent and 12.5 per cent among child labourers and controls respectively, OR < 1.89 (95% CI, 1.34–2.67, p < .01). Internalising disorders such as mood disorders were significantly higher among the labourers than the non-labourers, OR < 6.65 (95% CI), 2.20–22.52, p < .001. Anxiety disorder was seen over twofold among child labourers, while psychosocial stressors were one and half times more likely among the study subjects than controls. When all factors were taken into account, child labour status was the only significant factor in determining DSM-III-R diagnosis.

**Conclusion:** In this study, childhood emotional and behavioural disorders are found to be more common among child labourers than among non-labourers. We recommend a larger study to look into childhood disorders and risk factors in child labour. As part of the concerted effort, government, NGOs and the public should at least view child labour as a menace in a child’s development, with risk of psychosocial difficulties.

**Source**

The health impact of child labour in developing countries

**Objectives:** Research on child labour and its effect on health has been limited. We sought to determine the impact of child labour on children’s health by correlating existing health indicators with the prevalence of child labour in selected developing countries.

**Methods:** We analysed the relationship between child labour (defined as the percentage of children aged 10 to 14 years who were workers) and selected health indicators in 83 countries using multiple regression to determine the nature and
Adolescent students who work: Gender differences in school performances and self-perceived health

In a prospective cohort study, the hypotheses that adolescent students who work have poorer school performances, more sick days and poor self-perceived health were examined. From a one-stage random cluster area sampling of 2512 households in Bahia, Brazil, 888 students 10-21 years of age were asked to answer questionnaires. School dropouts were more common among working students, independently of gender. Both full-time (\textit{p}\textsubscript{adjusted} = 2.43; 95\% CI: 1.49-3.96) and part-time (\textit{p}\textsubscript{adjusted} = 2.07; 95\% CI: 1.28-3.35) working males were more likely to report frequent class skipping. Among females, paid jobs were also associated with poor self-perceived health, but not after adjustment for age and socio-economic status. Brazilian labour legislation for adolescent workers needs to be revised to take into account that jobs can compromise educational achievement.

Source

Early entrance to the job market and its effect on adult health: evidence from Brazil

Objective: To determine the effect of employment during childhood on self-reported health in adulthood.
Method: A cross-sectional household survey, with households selected through two-stage sampling, in urban and rural areas in the northeast and southeast of Brazil. A total of 4940 individuals, aged between 18 and 65 years, were included. The main outcome measure was self-reported health.
Results: There has been a marked reduction in the proportion of people starting work during childhood although, even in the youngest age group, nearly 20 per cent of males began work when under 10. Early entrance into the labour market is strongly associated with low levels of both education and income, with income differentials remaining at later ages. Age when starting work is also linked to current household income, with approximately 35 per cent of those starting work when 15 or over in the top quartile of household income, compared to 12 per cent of those starting work when under 10. Males, children living in rural areas and non-whites are most likely to start work early. In univariate analyses, the younger a person started working, the greater the probability of reporting less than good health status as an adult. This persists through all ages, although the difference attenuates with increasing age. In multivariate analyses, adjustment for education or household income substantially reduces the effect but fails to eliminate it in several age bands up to the age of 48, indicating that age when starting work has an independent effect on self-reported health in adulthood.
Conclusions: The debate about the appropriate policy response to child labour is complex, requiring a balance between protecting the health of the child and safeguarding the income of the family. These findings indicate the need for more research on the long-term consequences of beginning work at an early age.

Source
Selected case studies

Case study 54. Lifetime health consequences of child labour in Brazil. - Rosa Amélia Dantas and Vitma Santana

The relevance of early experiences to health in adulthood has been the focus of recent epidemiological studies. The life course approach has been helpful in revealing important facts of social, cultural, psychological and biological pathways to disease and developmental dysfunction. Child labour is common in many developed and, in particular, developing countries, and its association with health problems such as work injuries and occupational diseases has been demonstrated in studies conducted throughout the world (Roggero, Mangiaterra, Bustro, & Rosati, 2007). Less studied are the life-time consequences of child labour on health, although the plausibility of this hypothesis has been suggested by several authors.

A study carried out in the city of Aracaju, the capital of Sergipe State, Brazil, the smallest state in the country, evaluated the hypotheses that a history of child labour and a low age at first job compromise self-perceived health and height in adulthood. The study population was a random single-stage cluster sample of 1,727 families living in the city, corresponding to 3,262 adult workers from 18 to 65 years of age. Data collection was based on individual household interviews with questionnaires filled out by trained interviewers. Results show that average height among adult women who reported work as children was 1.62m, lower than the 1.63 estimated among the reference group (p<0.05). Among males, the difference was even higher: 1.68m compared to the reference group’s 1.72m (p<0.05). Also, there was an inverse association between height and age at first job (p<0.01). These differences were adjusted by skin colour, education and socioeconomic position. Another finding was the higher prevalence of poor self-perceived health among women with a history of child labour as compared to those who did not work in childhood, independently of socio-economic position, smoking, age, alcohol consumption and obesity. No association was found among males. These findings are close to other research reports (Cortez et al., 2007; Hawamdeh & Spencer, 2003) and clearly show that, beyond the immediate effects on children’s health, child labour also compromises physiological capital and the adult’s self-perceived health, which are both indicators of quality of life and well-being, thus reproducing health inequalities across generations.

References

Case study 55. The use of child soldiers in Uganda. - Joan Benach and Carles Muntaner

In over twenty countries including Angola, Burma, Burundi, Colombia, the Democratic Republic of Congo, Lebanon, Liberia, Nepal, Sierra Leone, Sri Lanka, Sudan and Uganda, children are direct participants in war. Denied a childhood and often subjected to horrific violence, an estimated 200,000 to 300,000 children are serving as soldiers for both rebel groups and government forces in armed conflicts. These young combatants, some as young as eight years old, participate in all aspects of contemporary warfare, serving as porters, cooks, guards and human mine detectors. They also participate in suicide missions, carry supplies and act as spies, messengers or lookouts. Physically vulnerable and easily intimidated, children typically make obedient soldiers. Many are abducted or recruited by force and often compelled to follow orders under threat of death. Others join armed groups out of desperation. As society breaks down during conflict, leaving children without access to schools, driving them from their homes or separating them from family members, many children perceive armed groups as their best chance for survival. Others seek escape from poverty or join military forces to avenge family members who have been killed.

Children are uniquely vulnerable to military recruitment because of their emotional and physical immaturity. They are easily manipulated and can be drawn into violence that they are too young to resist or understand. Children are most likely to become child soldiers if they are poor, separated from their families, displaced from their homes, living in a combat zone or have limited access to education. Many children join armed groups because of economic or social pressure, or because they believe that joining a military group will offer food or security. Others are forcibly recruited, “press-ganged” or abducted by armed groups. Both girls and boys are used as child soldiers. In some countries, like Nepal, Sri Lanka and Uganda, a third or more of the child soldiers have been reported to be girls. In some conflicts, girls may be raped or given to military commanders as “wives.”

Children are sometimes forced to commit atrocities against their own family or neighbors. Such practices help ensure that the child is “stigmatised” and unable to return to his or her home community. In some countries, former child soldiers...
have access to rehabilitation programs to help them locate their families, get back into school, receive vocational training and re-enter civilian life. However, many children have no access to such programs. They may have no way to support themselves and are at risk of re-recruitment. The ILO Convention on the Worst Forms of Child Labour prohibits the forced or compulsory recruitment of children under the age of 18 for use in armed conflict. It has been ratified by over 150 countries.

Children have been abducted in record numbers by the Lord’s Resistance Army (LRA) in Uganda and subjected to brutal treatment as soldiers, labourers and sex slaves. Since June of 2002, an estimated 5,000 children have been abducted from their homes and communities— a larger number than any previous year of the sixteen-year-old conflict and a dramatic increase from the less than 100 children abducted in 2001. Children have been targets of LRA abductions throughout the conflict between the LRA and the Ugandan government in the northern part of Uganda. Conservative estimates place the total number of children abducted at more than 20,000. Children are abducted from their homes, schools and off the streets. They are frequently beaten and forced to carry out raids, burn houses, beat and kill civilians and abduct other children. They must carry heavy loads over long distances and work long hours fetching water, firewood, gathering food and performing domestic duties. Many are given weapons training and some are forced to fight. The LRA, moreover, uses brutal tactics to demand obedience from abducted children. Children are forced to beat or trample to death other abducted children who attempt to escape, and are repeatedly told that they will be killed if they try to run away. Children who fall behind during long marches or resist orders are also killed. Many others have been killed in battle or have died from mistreatment, disease and hunger. Girls are used as domestic servants for commanders and their households. At age fourteen or fifteen, many are forced into sexual slavery as ‘wives’ of LRA commanders and subjected to rape, unwanted pregnancies and the risk of sexually transmitted diseases, including HIV/AIDS. Angela P. was only ten when she was abducted by the LRA. At age fifteen, she was forced to become a ‘wife’ to an LRA commander. She gave birth to two children in the bush. The first, a boy, she named Komakech, which means ‘I am unfortunate’. The second, a girl, she named Can-Oroma, meaning ‘I have suffered a lot’.

Children are also recruited as soldiers by the Ugandan government. Boys as young as twelve are lured into joining the Local Defense Units with promises of money. After training, they may be used to fight with the UPDF against the LRA, in some cases inside Sudan. Boys who have escaped or been rescued from the LRA are also recruited by the UPDF while in UPDF custody for debriefing. For the children who escape or are released, the future also looks grim. Most are fearful of reabduction. They want to return to school, but many don’t feel it’s safe at home. Many have other family members still in captivity. Most bear physical or psychological scars. Gunshot wounds, skin problems from walking long distances and sexually transmitted diseases are the major physical problems affecting returnees.

**Sources**

**Case study 56. Child labour in Peru. A market porter and his son working in a Lima wholesale market.** - Walter Varillas
The story of Gregorio and his son summarises that of many who have migrated from the countryside to the city of Lima, whether because of political violence, limited possibilities for education or a lack of labour market chances. Forced to work in extremely dangerous conditions, he has taken his son to help in the job, knowing no other type of work besides carrying sacks or as a construction labourer.

Gregorio is 42 years old and has worked pushing a barrow for 30 years, which he combines with spells in construction work*. He moved to the city from the mountains south of Ayacucho to escape political violence, and with only a background of agricultural work, took to pushing a barrow, as it needed no previous experience. He belongs to one of Lima’s wholesale market workers’ unions: their system is that when a worker is off sick, which is fairly frequent due to the excessive loads they carry, he receives a minimal economic subsidy for two weeks. They lift sacks, for example potatoes, which weigh between 140 and 160 kg, and transport up to 8 of them using wooden barrows, yielding a total weight of between 1.2 and 1.5 tonnes. His working day is from 2 A.M. to midday, meaning he cannot spend time with his family. He knows no other job. Suffering intense back pain, he estimates that he will hold out for two more years, not knowing what will happen after that; by then he will virtually be crippled. Although he can read and write, many of his fellow workers can’t (over 50% of them) (Varillas, 2006). Gregorio must pay $3.50 a day to rent his barrow, so his earnings at the end of the day range from $4 to $6.
Gregorio’s son also works pushing a barrow at the same market as his father. He is 10 years old and has already been working for one and a half years. His working day is from 4 A.M. to midday and he distributes small goods from wholesalers to retailers, loading his barrow with 250 to 300 kg or carrying items weighing up to 50 kg. The main health risks he faces are excessive weight burden (lumbago, etc.), traffic injuries and violence (robery, aggressions). We asked him, “Why do you do this job, which may be bad for your health?” He replied that he needs the money for his family, and because his father does the same job. His school performance is not very good, he often can’t go due to muscular and back pain, is discriminated against by his companions because of the work he does (he arrives dirty and sweating to class and falls asleep) and he doesn’t enjoy studying. From speaking with his father, we came to the conclusion that it is not essential for Gregorio to work. But the idea that work will make him responsible, and a man, predominates. A study conducted in 2004 with support from the ILO found that, while justification for sending children to work was often economic, there is also a cultural factor in this sector (parents/tutors know no other way to earn a living).

* It must be taken into account that 60 per cent of workers in Peru are informal, only 4.5 per cent have occupational risk insurance coverage, and the unionisation rate is only 4.5 per cent (Varillas, 1997). This explains why Peru has the highest fatal accident rate among the group of countries studied by the ILO in 2006: 18.9 fatal accidents per 100 thousand workers.


**References**


**Slavery and bonded labour**

As compared to the health effects of other types of employment conditions (including unemployment), the links between forced labour and health are very complex and challenging due to their clandestine nature and pervasive denial of its existence by authorities. The working environment, in terms of the employer-worker relation, essentially determines the health of forced labourers on account of the physical and mental trauma produced by coercive action including restriction of movement, physical force and violence. Even if not restricted, fear of detection and deportation can leave undocumented victims of forced labour reluctant to access health and social services. But, along with this, for employee-employer relations, the associated economic exploitation, malnutrition and lack of food security, hazardous working conditions and social isolation also determine access, affordability and availability of health care, compensation and rehabilitation. Although by definition, forced labour is differentiated from poor working conditions or hazardous working environments, very often they are engaged in these employment conditions and the overly exploitative nature of the employer-worker relation pushes them into worse conditions (Fassa, 2003; WHO, 2002). Empirical evidence on adverse health outcomes and health inequalities
resulting from physical violence and mental trauma, risky behaviours, absence or inaccessible welfare measures, and cultural barriers has been shown. Moreover, even after the legal abolition of slavery, it still persists to some extent and also negatively affects health.

**Selected scientific findings**

**A socioeconomic survey of kidney vendors in Pakistan**

In recent years, Pakistan has emerged as one of the largest centres for commerce and tourism in renal transplantation. Kidney vendors belong to Punjab in eastern Pakistan, the agricultural heartland, where 34 per cent of people live below the poverty line. We report results of a socioeconomic and health survey of 239 kidney vendors. The mean age was 33.6 +/- 7.2 years (M:F 3.5:1). The mean nephrectomy period was 4.8 +/- 2.3 years. Ninety per cent of the vendors were illiterate. Sixty-nine per cent were bonded labourers who were virtual slaves to landlords, 12 per cent were labourers, 8.5 per cent were housewives and 11 per cent were unemployed. Monthly income was $US15.4 +/- 8.9 with 2-11 dependents per family. The majority (93%) worked for debt repayment with a mean debt of $1311.4 +/- 819. The mean agreed selling price was $1737 +/- 262. However, they received $1377 +/- 196 after deductions for hospital and travel expenses. Postvending, 88 per cent had no economic improvement in their lives and 98 per cent reported deterioration in general health status. Future vending was encouraged by 35 per cent to pay off debts and freedom from bondage. This study gives a snapshot of kidney vendors from Pakistan. These impoverished people, many in bondage, are examples of modern day slavery. They will remain exploited until a law against bondage is implemented and new laws are introduced to ban commerce and transplant tourism in Pakistan.

**Source**


**Population-based survey methods for quantifying associations between human rights violations and health outcomes among internally displaced persons in eastern Burma**

**Background:** Case reports of human rights violations have focused on individuals’ experiences. Population-based quantification of associations between rights indicators and health outcomes is rare and has not been documented in eastern Burma.

**Objective:** We describe the association between mortality and morbidity and the household-level experience of human rights violations among internally displaced persons in eastern Burma.

**Methods:** Mobile health workers in conflict zones of eastern Burma conducted 1834 retrospective household surveys in 2004. Workers recorded data on vital events, mid-upper arm circumference of young children, malaria parasitaemia status of respondents and household experience of various human rights violations during the previous 12 months.

**Results:** Under-5 mortality was 218 (95% confidence interval 135 to 301) per 1000 live births. Almost one-third of households reported forced labour (32.6%). Forced displacement (8.9% of households) was associated with increased child mortality (odds ratio = 2.80), child malnutrition (odds ratio = 3.22) and landmine injury (odds ratio = 3.89). Theft or destruction of the food supply (reported by 25.2% of households) was associated with increased crude mortality (odds ratio = 1.58), malaria parasitaemia (odds ratio = 1.82), child malnutrition (odds ratio = 1.94) and landmine injury (odds ratio = 4.55). Multiple rights violations (experienced by 14.4% of households) increased the risk of child (incidence rate ratio = 2.18) and crude (incidence rate ratio = 1.75) mortality and the odds of landmine injury (odds ratio = 19.8). Child mortality risk increased more than fivefold (incidence rate ratio = 5.23) among families reporting three or more rights violations.

**Conclusions:** Widespread human rights violations in conflict zones in eastern Burma are associated with significantly increased morbidity and mortality. Population-level associations can be quantified using standard epidemiological methods. This approach requires further validation and refinement elsewhere.

**Source**

Child slavery in Hong Kong: Case report and historical review

An 11-year-old girl was admitted with multiple injuries sustained during a one-year servitude doing domestic labour. She was acquired from her parents in Mainland China by a relative in Hong Kong. The child’s parents received a sum of money that the child had to repay with work. Her hardship was characterised by long hours of incessant labour and physical torture when she failed to meet the demands of her mistress or her mistress’ children. This case resembles Mui Tsai, a form of child slavery and exploitative domestic labour that was rife in Hong Kong a century ago, and illustrates the new challenges to child rights and protection consequent to the increasing social and economic integration between the Hong Kong Special Administrative Region and Mainland China.

Source

Child prostitution in Thailand

Child prostitution is an old, global and complex phenomenon, which deprives children of their childhood, human rights and dignity. Child prostitution can be seen as the commercial sexual exploitation of children involving an element of forced labour, and thus can be considered as a contemporary form of slavery. Globally, child prostitution is reported to be a common problem in Central and South America and Asia. Of all the south-east Asian nations, the problem is most prolific in Thailand. In Thailand, there appears to be a long history of child prostitution, and this article explores the factors that underpin the Thai child sex industry and the lessons and implications that can be drawn for health care and nursing around the world.

Prostitution is detrimental to the child both physically and emotionally (Muntarbhorn, 1996: 10). It is in breach of the child’s rights and a gross violation of dignity, according to the 1989 UN Convention on the Rights of the Child, consequently undermining the child’s development and esteem (Barnardo’s, 1998).

As a result of poor living conditions, prostituted children are often at increased risk of other infectious diseases (such as tuberculosis), malnutrition and related disorders (Flowers, 2001). Child prostitutes are also at high risk of mental illness, substance abuse and violence, including injuries, rape and death (Ward, Day, & Webber, 1999). The serious risk of contracting sexually-transmitted diseases may pose a greater danger to public health than in adult prostitutes (Willis & Levy, 2002). In Thailand, for example, those young prostitutes found to have contracted disease are sent back to their places of origin without medical treatment, where they may continue the chain of transmission (Lintner & Lintner, 1996, cited in Lim, 1998).

For sexually-active children, there is also a high risk of complicated pregnancy and further dangers from subsequent backstreet abortions. When the pregnancy is not terminated, there is a risk of the “chain effect”, where mothers tend to be at great risk of perpetuating the behavioural cycle of physical, emotional or sexual abuse with their offspring (Lim, 1998).

Source

Referenced in the article:

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Selected case studies

Case study 57. Human trafficking and involuntary servitude under the U.S.-Jordan free trade agreement. - Charles Kernaghan and Barbara Briggs

The U.S.-Jordan Free Trade agreement went into effect in December 2001. Over the next five years, apparel exports from Jordan to the United States soared by 2,300 per cent, growing from $521.1 million in 2000 to $1.2 billion in 2006. This was touted as a model agreement since, for the first time, workers’ rights standards and environmental protections were included in the core of the agreement. Yet something went deeply wrong, and this agreement quickly descended into human trafficking and involuntary servitude. As of 2007, at least 36,149 guest workers are employed in Jordan’s 114 garment factories, at least 70 per cent of which are foreign-owned, mostly by Asian investors. The guest workers come from Bangladesh, China, Sri Lanka and India. Bangladeshi guest workers had to pay $1,000 to $3,000 each to unscrupulous manpower agencies in Bangladesh to purchase two- to three-year contracts to work in Jordan. This is an enormous amount of money in Bangladesh, and as poor workers, they had to borrow the money on the informal market at exorbitant interest rates of 5 to 10 per cent per month. From the minute they took the loans, these workers were in a trap, a race against time to pay off their growing debts. The workers were promised that they would be able to earn $134.28 a month for regular hours and up to $250 a month with overtime. They were also promised that all housing, food and medical care would be free and that they would live well, “like they do in the West”. They would get at least one day off a week, sick days, vacation time and national holidays. But there was a catch: the contract tied the guest workers to just one factory, prohibiting them from working elsewhere.

One hundred fifteen workers from Bangladesh purchased contracts to work at the Al Shahaed Garment factory in Irbid, Jordan. Upon their arrival at the airport, management immediately confiscated their passports. The workers were not provided with residency permits, thus they could not go out on the street without fear of being detained by the police for lack of the proper papers. Once in the Al Shahaed factory, the workers found themselves forced to work shifts of 15, 38, 48 and even 72 hours straight, often going two or three days without sleep. They worked 7 days a week. Workers who fell asleep at their sewing machines would be slapped and punched. Instead of being paid the $250 a month that the ad promised, the workers earned 2 cents an hour, or $2.31 for a 98-hour workweek. Workers who criticised the food the company provided were beaten with sticks and belts. Twenty-eight workers had to share one small 3.65-by-3.65-metre dorm room, which had access to running water only every third day. These workers sewed clothing for Wal-Mart. When, in desperation, the workers demanded their legal wages, they were forcibly deported and returned to Bangladesh without their back wages. Many of these workers are now hiding in Dhaka city and peddling bicycle nickshaws to survive. They cannot return to their home villages because they have no possible way to pay off the mounting debt they incurred to go to Jordan in the first place. These and many other cases were denounced in the report the national labor committee released in May 2006. By July 2006, Shariff al Zuibi, Jordan’s Trade Minister, declared, “Our inspection regime may have failed us and may have failed us miserably.” Jordan’s labour department had just 88 labour inspectors to oversee 98,000 business operations, and the primary role of the labour department inspectors was to issue work permits to foreign guest workers. By law, Jordan’s unions were not permitted to organise foreign workers. Today (2007), the Jordanian government has closed at least ten of the worst garment factories, over 1,000 workers have been relocated to better factories, and conditions and treatment have improved in many factories across Jordan. Although the government has seriously responded to reports of continued violations, much remains to be done. The guest workers are still denied the freedom of association and the right to organise. Moreover, we do not know of any case where the foreign guest workers were paid the outstanding back wages legally due to them. Nor do we know of a single prosecution of factory owners for human trafficking and holding tens of thousands of workers under conditions of involuntary servitude.

Sources

Case study 58. Economic structures enabling slavery in the United States. - The National Economic and Social Rights Initiative

The increasing concentration of wealth in the United States continues to have deleterious effects on human well-being. In the agricultural sector this translates into increased purchasing power in the hands of fewer and larger food purchasers. Currently, the agricultural industry is firmly in the control of large, consolidated buyers and retailers. Buyers use their vast market power to obtain volume discounts, exerting a strong downward pressure on their suppliers’ prices. This market power has vastly increased in recent years. In a March 2004 report on the conditions of migrant farmworkers in the United States, Oxfam America identified a significant shift in an important economic indicator known as the
Many employment- and work-related health inequalities are socially “invisible” or neglected. Comparisons across countries are difficult given the diversity of forms of employment, working conditions and the ensuing barriers to reaching worldwide standardised definitions. Empirical evidence concerning the impact of employment relations on health inequalities is particularly scarce for low-income countries, small-size firms and rural settings.

International and national health information systems lack data on employment relations and health inequalities. This problem is particularly acute among low and middle-income countries. Two examples of this are the lack of comparable data on informal employment and the health-related consequences of forced labour. Governments and health agencies should therefore establish adequate surveillance information systems and research programs to gather public health data associated with employment conditions, and all forms of precarious employment and work, giving attention to the singularities of each context (Muntaner et al., 2010).
There is a lack of theoretical and empirical research on the mechanisms and explanations linking employment conditions to poor health outcomes. More longitudinal empirical research and reviews are needed in relation to issues such as the mediating mechanisms between employment dimensions, their interrelation and several health outcomes. Studies of employment dimensions should stratify by social class, gender, age, ethnicity, race and migration status. There is also a need to investigate externalities and spill-over effects on the health of other workers, families/children and the community. The use of mixed-methods, integrating quantitative, qualitative and historical research could contribute to a better understanding of the pathways, mechanisms and explanations linking employment dimensions and health inequalities.

Another important area in need of further research is the evaluation of employment policies and other employment interventions to reduce health inequalities. There is a need to develop better explanatory models, both for guiding public health interventions and for the evaluation of these interventions.

Some of the main research gaps on the employment dimensions studied in this book are summarised as follows.

**Full-time permanent employment**

- More analytical longitudinal research as well as realist reviews and meta-analyses are needed on issues such as the benefits and hazards for physical and mental health related to full-time permanent employment and its mediating mechanisms.
- There is a need to capture multiple dimensions of full-time permanent employment in different social contexts and for different types of workers. Employees should be better characterised according to a spectrum of employment relations that takes into account workers’ rights, inequality in terms of wages and benefits, workers’ participation, etc. Causal linkages between social, political and economic contexts, traditional physical and psychosocial workplace conditions and their impact on health inequalities should be thoroughly investigated.
- Likewise, it is necessary to evaluate policies and employment interventions at various levels (labour market, organisational) to reduce health inequalities.

**Unemployment**

- Most studies on unemployment are descriptive. More analytical longitudinal research as well as realist reviews and meta-analyses would provide a better understanding of the pathways, mechanisms and explanations linking unemployment and health inequalities.

“We have lots of problems like inadequate toilet facilities. Many of us have had to leave our small children at home, sometimes unattended. We want crèche facilities. Childcare facilities will relieve us of a lot of anxiety and in turn employers’ shipments will not suffer.”

Source: People’s Health Movement. (2002). Voices of the Unheard: Testimonies from the People’s Health Assembly.
are needed on unemployment in relation to issues such as the mechanisms mediating between unemployment and physical health, health behaviours and mental health. To analyse the reasons for job loss (e.g., distinguishing between being fired, dropping for personal reasons, family requirements or health problems) may enhance the characterisation of mechanisms.

- More studies are needed with an ecological perspective on the impact of levels of and changes in unemployment on the health of the entire workforce and the whole population, although it may be difficult to rule out methodological pitfalls. Rises of unemployment could induce or be connected to parallel rises in precarious and informal employment as well as loss of workers’ rights and power.

- Research is needed on the impact of unemployment on health inequalities in middle- and low-income countries. The definitions and health outcomes studied should be adapted to each context. Research on unemployment should consider a wider range of health outcomes (e.g., infant mortality, HIV, etc.), and take a variety of mechanisms into account, including both macro and micro policies and interventions.

- There is a need to analyse gender differences and social contexts in analyses of the impact of unemployment on health and health inequalities.

- Differences in the effects of unemployment related to receipt of benefits should be taken into account in future research. Moreover, differences in such effects according to gender, family roles and social class should be considered in the formulation of policies regarding unemployment compensation.

- Health impact assessments of actual or potential unemployment policies should be carried out and delivered to policymakers.

**Precarious employment**

- There is an urgent need to identify general dimensions able to capture multiple situations of precariousness in different social contexts and for different types of jobs and workers, moving beyond the use of partial indicators such as temporality and perceived insecurity.

- Data of higher quality with more refined health information systems, especially in mid- and low-income countries, are also needed. New designs, instruments, measures and comparable definitions capable of analysing the specific mechanisms through which precarious employment may damage worker’s health are needed. Studies on the prevalence and health consequences of new
forms of precarious employment and on hard-to-reach precarious employees are needed to shed public light on potentially hazardous situations.

- More potent theories of precariousness are needed. There is a lack of theoretical frameworks showing the links and pathways between the political and economic contexts, the generation of precarious employment and poor health outcomes. Main psychosocial models may be not able to capture distal structural social factors related to inequalities in power, class relations and work organisation.

- There is a pressing need for more powerful epidemiological designs that integrate several levels of individual and contextual variables at the national and regional levels, as well as studies that integrate quantitative and qualitative data.

- The differential impact of unemployment according to class, gender, age, ethnicity, race and migration status and its mechanisms (linked, for instance, to the economic safety net) should be studied.

- There is a need for evaluation of policy interventions at various levels. Research should focus mainly on preventing precarious employment.

Informal employment

- There is a lack of clear definitions, reliable estimations of prevalence and empirical evidence concerning the impact of informal employment on health and health inequalities, particularly for rural settings and poor countries.

- Heterogeneity in informal employment should be taken into account, as it relates with a diversity of social and health hazards. For example, self-employed workers may be vulnerable to economic cycles and insecurity, whereas exploitation may be an issue relevant to domestic workers; informal workers in the street may suffer from air pollution and police harassment; immigrants in the black economy may suffer one or more of these hazards. Public research institutions should enhance specific studies on these groups who are not represented by unions and play a role as their advocates in order to change policies and/or employers’ commitment.

- The close links with other social and occupational factors need to be more carefully considered in analyses, particularly their role as confounders or intermediary variables, since they may represent part of the construct of informality on labour market placement rather than an extraneous artefact in the causal pathways.
• Qualitative studies or participatory research may help clarify some remaining issues, such as the dynamic between informal and formal employment, decisions concerning leaving formal jobs and access to health care and preventive resources.

• Policies on informal employment should be evaluated, taking into account a broader spectrum of employment relations and health consequences (e.g., specific policies may harm workers by shifting hazards towards them or to even more hidden jobs or unemployment). The development and evaluation of strategies for injury prevention, health promotion and social protection in informal settings is a pressing issue.

• Cooperative models of organisation and production management based on solidarity need to be developed and their impact evaluated in comparison to individual bank loans.

Child labour

• Despite the concentration of child labour in developing and poor countries, there is a need to study the phenomenon in developed countries such as the U.S., where child labour is growing due to substantial immigration and relaxation on law enforcement. Further research should focus on at-risk population groups such as migrants.

• Child labour increases children’s exposures to multiple health hazards and developmental disorders. However, there is limited literature addressing the issue of child labour and its health effects. Most of the available literature on this topic focuses more on the working conditions of children and on the concurrent effects of child labour on health. As such, there is a gap in knowledge about the lasting effects of child labour on health inequities, which may range from long-lasting disabilities to reduced socioeconomic achievement due to lack of education.

• There is a pressing need to develop specific criteria for assessing the degree to which children’s health is damaged by work, since most measures are based on adults’ standards.

• In poor countries, there is a massive gap in data regarding work-related injuries among children. Health care professionals could be of great assistance in understanding the child labour dimension of employment relations and its impact in health and health inequalities. Health care professionals must be trained to help improve statistics on the links between child labour and health and to reduce the underestimation of injuries, deaths and other health problems due to child labour. Due to the lack of accurate national data about child labour, this strategy would be of
great assistance in improving global statistics. Hence, these types of figures would help to monitor the situation of child labourers better, and to elaborate policies and programs for the eradication of child labour.

**Slavery and bonded labour**

- Knowledge on forced labour and its health dimensions is still very limited due to its secrecy, inadequate understanding and lack of proactive roles of concerned authorities.
- Studies on slavery and bonded labour have mainly given a qualitative picture of disease patterns and the role of social determinants. There is little understanding, however, of the demand pattern for forced labour in different sectors. Hence, it is necessary to construct detailed spatial and temporal analyses of existing and emerging regions of economic growth centres and the movement of the child labour force.
- As long as the victims can deliver physical work and service, they have a chance at survival. But once they become old and are physically disabled, their plight is destitute. Therefore, there is a need for further study exploring its geriatric health dimension.
- Studies show that law enforcement, social service providers and lawyers have a better understanding of trafficking and forced labour, but there is a need for more institutionalised research and outreach activities concerning case detection and management which should involve medical professionals, social workers and cooperating employer organisations as well. There is a need to pay more attention to the economic and political dimensions that promote and sustain bonded and slave labour, as well as its health consequences. New legal and enforcement action is urgently needed.
- Future research should identify the precise health and medical consequences of forced labour including the nature of the maladies and their durations, the best practices for identifying and administering services to survivors, and the level of recovery to be expected following treatment. This information should be used to develop screening protocols to help health care professionals identify pre-existing or potential health problems. Research should be conducted to determine what kinds of follow-up health care would be needed for survivors who choose to return to their countries of origin as well as how to solicit survivor’s active participation so that future programs will meet the needs of survivors from diverse cultural backgrounds.
- There is need for research on new forms of displaced persons, also known as “environmental refugees” (along with political refugees and...
migrant trauma survivors), due to growing environmental degradation and declining land fertility, particularly in developing countries. This phenomenon might result in millions of people who are vulnerable to various diseases and all forms of exploitations including forced labour.

8.3. WORKING CONDITIONS

In this section, we discuss evidence on the way working conditions are contributing to the production of health inequalities. Health-related working conditions are very broad. A difference exists between “material” and “psychosocial” working conditions. The first refers to physical impacts, the toxicity of agents or the effects of maladjusted work stations or devices (ergonomic working conditions). These material working conditions relate more or less directly to health through a number of physical, chemical and biological processes resulting from exposure (Figure 24). Psychosocial working conditions include harmful characteristics of work organisation or the activity content of jobs.

Psychosocial working conditions are related to health via the “stress process”. The stress process leads to health problems as a result of modifications in the extent to which people can cope with stress and through physio-pathological and behavioural changes. As indicated in Figure 24, there is also a clear link between employment conditions and working conditions. This link creates situations of cumulative adversity in precarious, informal, forced and other types of employment differing from the standard of full-time employment. Employment conditions (for example, job insecurity) can also have stressful consequences. Adverse working conditions are in fact far more prevalent in non-standard employment conditions (see Figure 24).

WORKING CONDITIONS AND HEALTH, PATHWAYS AND MECHANISMS

While, for the sake of this overview, a distinction between types of working conditions is maintained, in reality they are sometimes less easy to separate. For example, high work pressure is clearly an aspect of psychosocial work organisation, while at the same time it can be very demanding in a physical sense, too. So, material hazards can have psychosocial implications, and psychosocial hazards can have material consequences (Macleod & Smith, 2003).
Material working conditions

Research on material working conditions has largely followed two approaches. Clinically-oriented studies have often investigated very specific types of working conditions in specific occupations. In those studies, social inequalities often remain unaddressed. Social epidemiological studies mostly rely on broad, self-reported material working conditions. In the overview below, essentially the latter approach is followed. Material working conditions are discussed in different groups: load-related hazards, vibrations, noise, extreme temperatures, dangerous situations, ergonomic risk factors and toxic exposures.

Load-related risks are the result of mechanical shocks, forceful gripping of tools and machines, external loads related to the use of force and the impact of hard or sharp edges (Muggleton, Allen, & Chappell, 1999). Important risk groups include various kinds of industrial workers (Hansson & Jensen, 2004), maintenance personnel (Kumar & Kumar, 2008), construction workers (Hildebrandt, Bongers, Dul, Van Dijk, & Kemper, 2000) and health

Figure 24. Theoretical framework linking working conditions and health inequalities [studied pathways are highlighted].

Meaning of the arrows represented in the model:

- Influence
- Mutual influence
- Interaction or buffering
- Influence at various levels

Source: Prepared by the authors
care personnel (Dawson et al., 2007). Research on the consequences of load-related working conditions is concentrated on complaints concerning the upper limbs, neck/shoulders (Andersson, Fine, & Silverstein, 2000; van der Windt et al., 2000) or lower back (Andersson et al., 2000; Keyserling, 2000). More serious disorders, such as hernias, spinal degeneration, carpal tunnel syndrome, tendinitis or inflammations, are also associated with load-related working conditions (Andersson et al., 2000; Hoozemans, Van der Beek, Frings-Dresen, Van Dijk, & Van der Woude, 1998; Muggleton et al., 1999). Furthermore, effects on exhaustion and occupational stress are also common (Akerstedt et al., 2004; Laaksonen, Rahkonen, Martikainen, & Lahelma, 2006).

The impact of vibrations is defined by their magnitude, frequency, duration and direction. Vertical vibrations seem to involve the highest discomfort (Griffin, 1998). There is also a difference between whole-body vibrations and hand-transmitted vibrations. The first are common in drivers and operators of construction equipment (Kittusamy & Buchholz, 2004). Hand-transmitted vibrations are most common in workers using hand-operated tools and machines. Long-term and daily exposure to vibrations is associated with health problems ranging from cardiovascular, respiratory, and physiological changes to musculoskeletal problems, effects on the central nervous system, gastro-intestinal complaints, reproductive problems and various stress reactions (Griffin, 1998; Keyserling, 2000).

Noise can be considered as one of the most common workplace hazards in the world (Dunn, 2000). It is most prevalent in manufacturing, transportation, construction and the primary economic sector (Dunn, 2000). Hearing loss and tinnitus are the most prominent health consequences (Suter, 1992). In most cases, the hearing loss is only temporary, though chronic consequences often go unnoticed until the hearing loss has attained disabling proportions (Suter, 1998). At that point, psychosocial consequences related to communication problems start to emerge (Riediker & Koren, 2004). Indirect health effects also include general irritation, sleeping problems and fatigue, hormonal changes, increased blood pressure, cardiovascular problems, health and safety impairment and concentration problems (Passchier-Vermeer & Passchier, 2000).

In order to preserve the body temperature between its ideal limits, the human organism has developed a set of reactions and
behavioural strategies (Vogt, 1998). However, a work environment that is too hot or too cold, in combination with insufficient protection, constitutes a health hazard. Overheating can be a problem in industrial jobs requiring heavy work during warm weather or in closed, heated places (Leffler & Hu, 2000). Health problems are caused by insufficient blood circulation, imbalances in the supply of water and other essential elements and hyperthermia (Ogawa, 1998). Acute consequences of overheating are heat syncope, heat oedema, heat cramps, heat exhaustion and heat stroke (Ogawa, 1998). Cold stress is an environmental hazard which affects people working outdoors, in cold places or handling cold substances (Leffler & Hu, 2000). Important effects are restrained functioning, respiratory problems, hypothermia and cold injuries (Holmér, 1998). Also, both cold stress and overheating can exacerbate the stress reactions to other demanding working conditions (Holmér, 1998).

Exposure to dangerous situations leads to an increased risk of injuries. These may be provoked by physical agents (such as mechanical energy, electricity, chemicals, ionising radiation, etc.) or by the sudden absence of essential elements, such as oxygen (Castillo, Pizatella, & Stout, 2000). Important causes of worker injury include traffic accidents, falls, the physical impact of objects and bad movements or slips. The most affected sectors are manufacturing, transportation and construction (FAO, 2008). While the direct cause of an accident is often clear, there is often a complex interaction of underlying indirect causes (Castillo et al., 2000). Frequent consequences of accidents include fractures, lacerations, abrasions, burns, amputations and poisoning (Castillo et al., 2000).

Ergonomic risk factors are related to straining movements and postures, which are often related to “learned automatisms”. That is, people are inclined to perform a specific activity always in exactly the same way, resulting in situations of overload (Kumar & Kumar, 2008). Particularly demanding types of movements are wrist flexions and extensions, wrist radial and ulnar deviations and upper limb movements and postures (Muggleton et al., 1999). Ergonomic hazards are most common in industrial sectors and agriculture, but also in (routine) white collar work and care-provision (Parent-Thirion, Fernandez, Hurley, & Vermeylen, 2007; Wahlstrom, 2005).

Toxins are substances like dusts, fumes, mists, vapors and gases, with a harmful effect on the human body. The physiological
reactions to these toxins can be separated into chronological steps: absorption, distribution, transformation and excretion. In some instances there is also a period of storage in the human organism. The main routes of absorption are via the respiratory system, the skin and the gastrointestinal system. Once absorbed, some toxins have direct effects (for example, on the skin). Most of them however, are picked up and transported by blood circulation to specific parts of the body where they are stored or start to react. The chemical or biological reaction process often leads to a transformation to a less toxic form, however there are known exceptions, such as carcinogens. The main routes of excretion are the kidneys and the liver (Frumkin & Thun, 2000).

Scientific findings

**Causal explanations for class inequality in health—an empirical analysis**

One of the most important issues for research on social class inequalities in health are the causes behind such differences. So far, the debate on class inequalities in health has mainly been centred around hypotheses on artifactual and selection processes. Although most contributors to this branch of research have argued in favor of causal explanations, these have received very little systematic scrutiny. In this article, several possible causal factors are singled out for empirical testing. The effect of these factors on class differences in physical and mental illness is studied by means of logit regressions.

On the basis of these analyses, it is shown that physical working conditions are the prime source of class inequality in physical illness, although economic hardship during upbringing and health-related behaviours also contribute. For class inequality in mental illness, these three factors plus weak social network are important. In sum, a large part of the class differences in physical as well as mental illness can be understood as a result of systematic differences between classes in living conditions, primarily differences in working conditions.

**Source**

**Social inequalities and workplace hazards in Europe**

Health hazards at work are a major determinant of poor health and injuries, even though remarkable progress towards healthier workplaces can be observed in many European countries. In the 1990s, for example, work-related ill health was the fourth major contributor to the total disease burden in the 15 countries that belonged to the EU before 1 May 2004 (Diderichsen, Dahlgren, & Vägerö, 1997). The proportion of the total burden of disease caused by work-related risk factors is, however, different in different countries. For the 15 countries that belonged to the EU before 1 May 2004 as a whole, for example, 3.6 per cent of the total burden of disease was directly related to the work environment, while in Sweden it was only 2.2 per cent (Diderichsen et al., 1997).

This indicates that significant possibilities still exist for reducing work-related poor health and premature death. Major hazards include exposure to chemicals, biological agents, physical factors, adverse ergonomic conditions, allergens, different safety risks and varied psychosocial factors. Studies in Eastern Europe have also shown that the balance at work between effort and reward has a significant inverse association with self-reported health and depression, as well as with alcohol use (Pikhart et al., 2001; Walters & Suhrcke, 2005). Conversely, the social aspect of a working environment can constitute a very positive determinant of health. For many people, the feeling of doing something useful together with colleagues is one of the most important dimensions of life and positive health.
Psychosocial working conditions

The definition of psychosocial working conditions is not always clear. Unlike material working conditions, they are not directly measurable. Instead, measures of psychosocial working conditions are in most cases indirectly derived from sets of items, representing theoretical concepts (Siegrist, Benach, McKnight, Goldblatt & Muntaner, 2009). First of all, psychosocial occupational risk includes a number of “demands” related to the organisation of work tasks (work pace, complexity of work, emotional load, etc.). Features related to the content of the work task, such as low autonomy or skill discretion, also fit the description. Occupational stress models emphasise the harmful nature of combinations between demands and work autonomy. One famous example is the situation of “job strain” in the Demand-Control model (DC) (Karasek et al., 1998).

Elements of interpersonal relations at work constitute psychosocial hazards. Good examples are low social support from colleagues or superiors (Johnson & Hall, 1994), organisational team climate (Rentsch, 1990), and so on. Employment conditions may also have psychosocial consequences, such as job insecurity attitudes following exposure to precarious employment conditions. The Effort-Reward-Imbalance model (ERI) shows the health effects of a disequilibrium between the efforts made by workers and insufficient rewards in terms of wage, other material compensations or career prospects (Siegrist, 2002). Moreover, with the increase of precarious and other non-standard forms of employment, the psychosocial consequences of uncertainty, lack of future prospects or feelings of powerlessness have come to the fore (Benach & Muntaner, 2007).

Overall, psychosocial models have been criticised for leaving social structure (e.g., social class) out of explanations and for reducing the effects of work on health to psychological variables (Muntaner & O’Campo, 1993).

Links with physical health outcomes have also been demonstrated. Bio-psychosocial models attribute the experience of physical pain and discomfort to interacting combinations of material, psychosocial and individual characteristics (Blyth,
Macfarlane, & Nicholas, 2007). Good examples of physical consequences of psychosocial working conditions are provided by musculoskeletal complaints and cardiovascular outcomes. The psychosocial work environment is assumed to influence musculoskeletal complaints through a number of pathways. People working in adverse psychosocial circumstances are reported to have a higher secretion of catecholamine, faster heart rhythm, higher blood pressure and greater muscular tension (Frankenhaeuser & Gardell, 1976). Stress-related muscular tension increases the static load of the muscles, which may result in more fatigued muscles and the discomfort associated with it (Westgaard & Bjorklund, 1987). In addition, stressed individuals may change their behaviour and as a result, increase muscular tension (Lim, Sauter, & Swanson, 1998). For example, stress may result in the application of more force than necessary in performing tasks. Furthermore, psychosocial factors can also increase the ergonomic demands of a task, for example, by having to work harder or faster (Lim et al., 1998). Finally, perceptual mechanisms may also interact with the effects of physical movements or postures (Sauter & Swanson, 1996). For example, symptoms related to a specific working position may emerge more quickly in dull or routine jobs.

Another interesting case is provided by cardiovascular disease (CVD) and its related risk factors (Belkic, Landsbergis, Schnall, & Baker, 2004). High blood pressure appears to constitute one of the main pathways between adverse psychosocial working conditions and CVD (Belkic et al., 2004; Brisson, Larocque, Moisan, Vezina, & Dagenais, 2000; Greiner, Krause, Ragland, & Fisher, 2004; Schnall, Schwartz, Landsbergis, Warren, & Pickering, 1998; Vrijkotte, Van Doornen, & De Geus, 2000). ERI has also been associated with other risk factors, such as LDL/HDL cholesterol (Peter et al., 1998; Siegrist, 1990), body mass index (BMI) (Kivimäki et al., 2002) and new cases of Type 2 diabetes (Kouvonen et al., 2006). Links between ERI and behavioural risk factors, such as being overweight, smoking, heavy alcohol use, and physical inactivity have also been demonstrated (Kouvonen et al., 2006; Siegrist & Rodel, 2006). The BMI is related to the metabolic syndrome, a cluster of physiological factors increasing the risk of heart disease and diabetes, which is linked via a dose-response relationship with situations of job stress (Chandola, Brunner, & Marmot, 2006).

On the other hand, it has also been shown that material working conditions are related to psychological outcomes (De Croon, Blonk, De Zwart, Frings-Dresen, & Broersen, 2002;
Laaksonen, Rahkonen, Martikainen, & Lahelma, 2006). The associations may be of a physical or chemical nature (for example, solvents affecting the central nervous system) or may result from the appreciation of situations as harmful (Levi, 1998). The latter possibility integrates material risk factors with the stress process.

The study of psychosocial working conditions has yielded enough evidence to evoke policy attention for such issues as job redesign and worker participation (Karasek et al., 1998). Nevertheless, the dominant approach is also open to criticism. Perhaps most important is the largely uncritical use of concepts resulting from stress models, without referring to or, even worse, being aware of their sociological and psychological conceptual foundations. Moreover, to assume that the psychosocial work environment can be reduced to a trade-off between psychological demands and control is overly simplistic (De Jonge & Kompier, 1997; Muntaner & O’Campo, 1993). Additions to the basic Demand-Control model, like the social-support concept (Johnson & Hall, 1988), the ERI-model (Siegrist, 2002) or the various expansions of the concept of demands (De Jonge, Mulder, & Nijhuis, 1999; Soderfeldt et al., 1996), have partially dealt with these criticisms. Nevertheless, the simplicity critique stretches further. An interesting point is the status of the concept of “control”, which is more than just individual mastery of a specific situation. Control is also a characteristic of the social structure, related to the notion of power, class relations and the extent of exploitation in the labour process (Muntaner & O’Campo, 1993). As a result, and despite being highly relevant for research in social health inequalities, there is a lack of knowledge about the relations between control over specific (work) situations and an individual’s structural socio-economic position in society (Vanroelen, 2009).

In addition, the triangular relationship between perception, the personality characteristics steering individual perception and one’s place in the social structure is often approached too simplistically by introducing controls for personality traits (Spector, Zapf, Chen, & Frese, 2000). This brings us to the question of whether the exclusive use of self-reports in approaches assessing the psychosocial work environment is appropriate. Individual self-reports should at least be supplemented with more objective measurements, based on expert assessment or on collective appreciations resulting from qualitative participatory approaches involving the workers (Muntaner & O’Campo, 1993).
Case study 59. Psychosocial hazards and work process design in Spain* - Clara Llorens Serrano, Salvador Moncada i Lluís, Ramon de Alós Moner, Ernest Cano Cano, Ariadna Font Corominas, Xavier Gimeno Torrent, Pere Jódar, Vicente López Martínez and Amat Sánchez Velasco

Although the adverse effects on health of psychosocial hazards are well-documented, studies analysing the work organisation factors that create them are scarce, hindering researchers' ability to propound effective and lasting preventive actions (MacDonald, Härenstam, Warren, & Punnett, 2008). Using data coming from the Spanish Psychosocial Hazards Survey 2004-05 (Moncada, Llorens, Font, Galtés, & Navarro, 2008), a representative sample of the Spanish wage-earning population (N=7,612), we analysed relations between harmful exposures to psychosocial hazards, and labour management practices. Information was obtained by the administration of a standardised questionnaire in workers' households and included the 21 psychosocial scales of the validated COPSOQ's Spanish questionnaire [ISTAS21] as well as questions on labour management practices and working conditions. Associations were assessed by fitting multivariate logistic regression models.

Analyses show that lack of skills development and low esteem are related to labour management practices regarding work process design (Llorens et al., 2007). When organisational practices do not delegate or include consultative direct participation methods (i.e., when management consults and delegates decisions to workers on how to perform tasks) the risk of having low skill development [age-adjusted Odds Ratio: aOR:8.5; CI95%=6.8-10.7] and low esteem [aOR: 9.5; CI95%=6.3-14.4] is much higher than when labour management practices include participative methods. Frequency of low skills development varies depending on functional mobility practices too. Thus, it is higher [aOR:3.4; CI95%=1.9-6] among those workers who repeatedly perform the same tasks as compared to those who carry out varied and complex jobs involving the tasks of a superior professional group – upward functional mobility. What's more, performing other tasks of the same or of an inferior professional group [horizontal and downward functional mobility] entail the risk of low skill development [horizontal aOR:2.7; CI95%=1.4-5.12; and downward aOR:3. CI95%=1.2-4.2]. Multivariate analysis shows that these associations between labour management practices regarding work process design and psychosocial hazards are independent of the worker's occupation, gender, age, country of birth, economic sector and the presence of worker's representatives. In other words, unhealthy labour management practices seem to be independent of socio-demographic and structural workplace features. Studies of labour market segmentation, however, show that the application of these management practices is segregated and associated with occupational health inequalities (Rubery, 2007; Lundberg, Hemmingson, & Hogstedt, 2007).

In Spain, the work organisation of many firms is based on management practices following old Tayloristic principles (i.e., division of work between execution and design tasks and maximum breakdown, standardisation and repetition of execution tasks) for an important number of workforce segments. Under Tayloristic management, workers' abilities and knowledge are ignored in everyday work, and so are the basic human needs for learning and autonomy. Workers are treated as mere work instruments, implying lack of recognition as professionals and as human beings. The adverse effects of Taylorism on psychosocial risks and health have been documented (Belkic, Landsbergis, Schnall, & Baker, 2004). Collective direct participation formulas and upward functional mobility can produce a health-promoting impact and reduce psychosocial exposure (since they increase job complexity), so long as they are recognised in terms of wages and worker willingness is considered under bargaining criteria, without control and standardised procedures, individualisation, or uncertainty, which all involve chaotic differentiation (Hvid, Lund, & Pejtersen, 2008).

As opposed to individual-focused strategies in a context of commercial boom of the "stress industry" (Kompier & Kristensen, 2004), results of this study suggest the need to make profound changes in work organisation and labour management practices in order to achieve an improvement in worker health, and reducing psychosocial hazards.

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References


PATHWAYS BETWEEN WORKING CONDITIONS AND SOCIO-ECONOMIC HEALTH INEQUALITIES

The most important pathway linking working conditions to health inequalities runs through the differential distribution of adverse working conditions among workers (Siegrist & Theorell, 2006). Some typical “exposure clusters” may be located in the general working population (Vanroelen, Moors, Levecque, & Louckx, 2010). Often traditional material hazards are found to cohere, together with organisational features, such as low control over work tasks and atypical schedules or employment conditions (Passchier-Vermeer & Passchier, 2000). Other distinctive patterns are seen for female-dominated human service occupations (in which high physical demands are linked with high emotional demands and work schedule flexibility, and highly specialised and skilled jobs), which are characterised by high psychological demands (Söderfelt et al., 1996; 1997; Burchell, Day, & Hudson, 1999; Vanroelen et al., 2010). These different clusters have strong links with social positions. In addition, patterns in the distribution of working conditions according to the position of countries in the World-System can be seen.

Another pathway is constituted by social differences in susceptibility to the adverse effects of working conditions. Finally, there is an additive pathway running through employment conditions. Workers employed in non-standard conditions are at a higher risk of encountering more adverse working conditions.

Differential exposure to adverse working conditions

There are clear international differences in the division of harmful working conditions. The relative political strengths of forces in the market (corporations, institutions and unions), government (parties) and society (community and its forms of organisation) in a country are key determinants of the development of laws, regulations and social protection, which influence working conditions. In the context of globalisation, a lack of barriers to move production from one country to another exacerbates these inequalities.
to another increases the power of companies and corporations, who can easily search for less-regulated markets. The consequence is a global "domino effect" of labour market down-regulation. In order to open their markets, and in an attempt to shape working conditions that widen profit margins for corporations, governments collaborate in hindering the development of trade unions and limiting their involvement in work organisation and occupational health and safety matters (Lundberg, Hemmingsson, & Hogstedt, 2007). As a result, stricter regulation in rich regions parallels an outsourcing of dangerous industries to poor countries with less regulation. The position of a country in terms of the core-periphery system is therefore a major determinant for the distribution of health-affecting working conditions (Sarkar, Muntaner, Chung, & Benach, 2009).

Within high income countries, adverse working conditions are unequally distributed, varying according to the socio-economic position (SEP) of the workers. There is considerable evidence for a higher prevalence of adverse traditional material working conditions in manual, non-managerial and lower-skilled workers (Borg & Kristensen, 2000; Lundberg et al., 2007; Nizeborala, Marquie, Baracat, Esquirol, & Soulat, 2003; Vahtera, Virtanen, Kivimäki, & Pentti, 1999; Schrijvers, Van de Mheen, Stronks, & Mackenbach, 1998). Furthermore, shift work and other types of atypical work schedules are more common in lower SEPs (Costa et al., 2004).

The picture regarding psychosocial working conditions is more complex. High psychological demands and increased effort are often found to be more of a problem in higher SEP groups (Melchior et al., 2005; Siegrist, 2004; Vanroelen, Levecque, Moors, Gadeyne, & Louckx, 2009). In contrast, other psychosocial characteristics, such as low control, low intrinsic quality of work tasks and low rewards (Borrell, Muntaner, Benach, & Artazcoz, 2004; Bosma et al., 1997) are more prevalent in lower SEP jobs. The same holds for the particularly stressing combination-effect of job strain (Bosma, Peter, Siegrist, & Marmot, 1998; Tsutsumi, Kayaba, Theorell, & Siegrist, 2001) and ERI, when considered over a complete working career (Chandola, Siegrist, & Marmot, 2005). Only for social support are socio-economic differences found, and these are very little (Borg & Kristensen, 2000; Melchior et al., 2005). As a result of the different distribution of psychological demands, there is some debate about the impact of psychosocial working conditions on social health.
inequalities [Bosma et al., 1997; Chandola, Brunner, & Marmot, 2006]. However, overall, the lower one’s assets in the labour market, the higher the risk of having a job with unhealthy working conditions. Consequently, unequally distributed adverse working conditions are contributing to the socio-economic gradient in health [Borg & Kristensen, 2000; Lundberg et al., 2007; Monden, 2005].

Apart from SEP, other “social axes” also lead to unequally distributed working conditions. In core industrialised countries, hazardous and schedule flexibility-related working conditions are more prevalent in male workers [Hunt & Annandale, 1993; Parent-Thirion, Fernández, Hurley, & Vermeylen, 2007]. A notorious exception to this general rule are the female-dominated occupations in personal service provision and health care [Tervo-Heikkinen, Partanen, Aalto, & Vehvilainen-Julkunen, 2008]. Psychosocial risk factors, such as emotional demands [Pedersen, Mahler, & Hansen 2005], low job control and other indicators of low-quality task contents [Aittomaki, Lahelma, & Roos, 2003; De Smet et al., 2005; Pedersen et al., 2005] are consistently reported to be more prevalent in women than in men. The same holds for job strain [D’Souza et al., 2005; Tsutsumi et al., 2001]. High levels of effort and of quantitative demands, on the other hand, are often found to be more common in men [Hunt & Annandale, 1993; Li, Borgfeldt, Samsioe, Lidfeldt, & Nerbrand, 2005], even though contradictory findings have been reported [De Smet et al., 2005; Niedhammer & Chea, 2003]. When household work, informal work, informal care provision, etc. are included, a completely different picture emerges, certainly with regard to the distribution of levels of effort and demand [Artazcoz, Benach, Borrell, & Cortès, 2004; Artazcoz, Borrell, & Benach, 2001; Borrell et al., 2004]. Also age, as a social construct, can be an axis of social inequality. In general, younger workers face more physical risks [Aittomaki, Lahelma, Roos, Leino-Arjas, & Martikainen, 2005; Niezborala et al., 2003], higher efforts/demands [Niezborala et al., 2003; Tsutsumi et al., 2001] and fewer rewards [Niedhammer & Chea, 2003; Siegrist, 2004]. The oldest age groups have lower control over their work [Niezborala et al., 2003; Tsutsumi et al., 2001]. In addition, age effects of physical and psychosocial working conditions tend to be stronger in men than in women.

An important underlying causal pathway explaining these social differences involves the degree of worker control and participation. These are key protective factors, not only with regard to promoting a fairer and more egalitarian decision-making process within firms but also for the analysis and effective implementation of preventive policies. Employment relations are thus intimately related with
working conditions. Certainly, psychosocial working conditions are strongly determined by the distribution of power and authority, the related degree of alienation of workers, and their degree of exploitation (Muntaner et al., 2006).

Labour unions are the most effective instrument of workers in their struggle to bend the balance of power in their direction and-as a result-help them ensure good health and safety at work (Johansson, 2002). Evidence shows that, when trade unions are stronger, information and workplace hazard standards increase, health and safety systems function better and the effectiveness of actions by workers is higher (Menéndez, Benach, & Vogel, 2009). Consequently, when explaining the relation between working conditions and health inequalities, the impact on these broader concepts of “worker-empowerment” need to be investigated.

Selected scientific findings

**Social class and self-rated health: Can the gradient be explained by differences in life-style or work environment?**

The purpose of the present paper is to describe differences in work environment and life-style factors between social classes in Denmark and to investigate to what extent these factors can explain social class differences with regard to changes in self-rated health (SRH) over a five-year period. We used data from a prospective study of a random sample of 5001 Danish employees, 18-59 years of age, interviewed at baseline in 1990 and again in 1995. At baseline, we found higher prevalence in the lower classes of repetitive work, low skill discretion, low influence at work, high job insecurity, and ergonomic, physical, chemical, and climatic exposures. High psychological demands and conflicts at work were more prevalent in the higher classes. With regard to life-style factors, we found more obese people and more smokers among the lower classes. The proportion with poor SRH increased with decreasing social class at baseline. The follow-up analyses showed a clear association between social class and worsening of SRH: the lower the social class, the higher the proportion with deterioration of SRH. There was no social gradient with regard to improved SRH over time. Approximately two-thirds of the social gradient with regard to worsening of SRH could be explained by the work environment and life-style factors. The largest contribution came from the work environment factors.

**Source**

Borg, V., & Kristensen, T. S. (2000). Social class and self-rated health: can the gradient be explained by differences in life style or work environment? *Social Science and Medicine, 51*, 1019-1030.

Selected case studies

**Case Study 60. Psychosocial working conditions and social inequalities in health. - Jenny Head and Tarani Chandola**

Large and persistent social class differences in health have been observed in the United Kingdom, despite the existence of the National Health Service, which has for more than fifty years providing universal access to health care. Earlier explanations for this health gap suggested that these inequalities originated in material circumstances such as poverty and deprivation, as well as behavioural lifestyles such as smoking. However, the first Whitehall study, conducted among British civil servants, made clear that inequalities in health were not limited to the health consequences of poverty or conventional risk factors for ill health. Psychosocial factors such as work stress were hypothesised to fill in the unexplained part of the social gradient in mortality, mental well-being and sickness absence. The nature of working conditions has changed considerably in most industrial countries. A substantial part of the economically active population are now more likely than ever to work on temporary contracts, for a fixed term, and in insecure employment. These adverse working conditions tend to be more prevalent in lower socioeconomic occupations and disadvantaged
occupational classes—the lower the socioeconomic position, the higher the risk of exposure to adverse and stressful working conditions (Siegrist, 2002).

However, not all dimensions of stressful working conditions are more prevalent in lower SES occupations. Higher job demands, as characterised by the job strain model, tend to be more prevalent in higher SES occupations (Bosma et al., 1997). In addition, workers in higher SES jobs may be exposed to greater work effort, a characteristic of the effort-reward imbalance model (Siegrist et al., 2004). On the other hand, lower job control (Bosma et al., 1997) and fewer rewards (Siegrist et al., 2004) tend to characterise lower SES occupations. Furthermore, when the social gradient in the overall measure of stressful working conditions (job strain and effort-reward imbalance) is analysed, rather than specific components, work stress tends to be reported primarily by those in lower SES occupations (Tsutsumi, Kayaba, Tsutsumi, & Igarashi, 2001). Even when greater effort-reward imbalance is reported by higher SES workers earlier in their career, lower SES workers tend to report a greater deterioration in their working conditions over their career lifetime (Chandola, Siegrist, & Marmot, 2005).

There is some debate about whether stressful working conditions account for some of the social gradient in health. Low control, (Bosma et al., 1997), job strain (Chandola, Brunner, & Marmot, 2006), and effort-reward imbalance (Chandola et al., 2005) have been found to account for some of the social gradient in different measures of health. On the other hand, not all dimensions of adverse psychosocial working conditions contribute to explaining social inequalities in coronary heart disease (Suadicani, Hein, & Gyntelberg, 1993). If stressful working conditions mediate the effect of SES on health, we would expect to find strong evidence of the association between low SES and stress-related biomarkers. There is some conflicting evidence from the scientific literature. Some report that lower SES is not associated with biological markers for stress (Dowd & Goldman, 2006), while others find that lower SES is associated with higher biological stress responses in terms of a greater cortisol awakening response (Wright & Steptoe, 2005).

In summary, adverse working conditions tend to cluster in lower SES occupations. Most of the studies show that some dimensions of stressful working conditions mediate or moderate the effect of social inequalities in health, although a minority of studies questions this link.

References

Effect modifiers of the health effects of adverse working conditions

Another pathway assumes that social health inequalities emerge because of social differences in susceptibility to adverse working conditions – even with similar types and levels of exposure (Diderichsen, Evans, & Whitehead, 2001; Emslie, Hunt, & Macintyre, 1999a). This mechanism is functioning at the same time as, sometimes even cross-cutting, the mechanism of differential exposure. Differences in susceptibility (i.e., effect modification)
have been illustrated with regard to gender and SEP-related health. The underlying mechanism is, however, difficult to uncover, since the working conditions of different social groups are hardly ever completely comparable (Emslie et al., 1999a; Emslie, Hunt, & Macintyre, 1999b), in particular between men and women (Messing & Silverstein, 2009). Given the already limited attention paid to social variables in occupational health research, certainly these cases of effect modification are less frequently studied (Wege et al., 2008). The effects are mostly not as strong, compared to differential exposure. Nevertheless, differences in susceptibility are adding important nuances to the pathway between work and social health inequalities.

Socio-economic differences in susceptibility are predominantly studied with regard to psychosocial working conditions. Research shows that, among men, the impact of job strain on CVD is stronger in blue-collar workers than in higher-SEP jobs (Johnson & Hall, 1988; Theorell et al., 1998; Hallqvist, Diderichsen, Theorell, Reuterwall, & Ahlbom, 1998). Similar findings are made in male and female workers for associations between ERI and CVD (Kuper, Singh-Manoux, Siegrist, & Marmot, 2002) and between job strain and high blood pressure (Landsbergis, Schnall, Pickering, Warren, & Schwartz, 2003). In a study by Wege et al. (2008), no effect modification is reported for associations of job strain with poor self-rated health, angina pectoris or depression, nor for associations of ERI with poor self-rated health or angina pectoris. In contrast, differences in susceptibility are found for the association between ERI and depression. In each of the above-cited studies, the effects of job stress are stronger in lower SEPs. The same holds for the SEP-interaction effects of the associations of immaterial demands and social support with emotional well-being and persistent fatigue, respectively (Vanroelen, Levecque, Moors, & Louckx, 2010). In contrast, however, the associations between persistent fatigue and job control and between employment uncertainty and emotional well-being are reported to be stronger in higher or intermediate SEPs (Vanroelen et al., 2010).

With regard to gender-related differences, Karlqvist, Tornqvist, Hagberg, Hagman, and Toomingas (2002) report that female VDU-operators experience more serious consequences of a number of VDU-related physical exposures and job strain on musculoskeletal complaints. Other findings supporting the stronger impact of psychosocial working conditions on mental distress and physical health complaints in women are reported by, among others, Roxburgh (1996) and Tytherleigh, Jacobs, Webb, Ricketts and Cooper (2007),
while opposite findings are made by Denton, Prus and Walters (2004). However, the effect of gender interaction is questioned by others [Emslie et al., 1999b; McDonough & Walters, 2001; Pugliesi, 1995]. Apparently, the choice of study population (general population or specific occupational categories) affects whether differential vulnerability is found or not. Another issue concerns the exacerbating effect on health of the combination of work and household demands, which seems to be important in women but not in men [Artazcoz, Benach, Borrell, & Cortès, 2004; Hunt & Annandale, 1993].

Selected scientific findings

Musculoskeletal disorders are lower in gender-integrated occupations

**Background:** Musculoskeletal disorders represent a considerable public health problem and the most common diagnoses behind sickness absence and disability pensions. However, little is known about how sickness absence with these diagnoses varies with the strong gender segregation of the labour market.

**Aims:** A study was undertaken to investigate the association between musculoskeletal-related sickness absence and occupational gender segregation.

**Methods:** The study was population-based, and included all new sick leave spells exceeding seven days due to musculoskeletal diagnoses, comprising neck/shoulder pain, lower back pain, and osteoarthritis in Östergötland county, Sweden, which has 393,000 inhabitants (5% of the national population). The participants were all sick leave insured employed persons in Östergötland (N = 182,683) in 1985.

**Results:** Cumulative incidence of musculoskeletal-related sickness absence (≥7 days) was higher for women (7.5%, 95% confidence interval [C.I.] 7.3-7.7) than for men, (5.8%, C.I. 5.6-5.9), and the same was true for the mean number of sick leave days (women 81, C.I. 78-83; men 65, C.I. 63-68). Grouping occupations according to degree of numerical gender segregation revealed the highest incidence and duration of sickness absence for women in male-dominated occupations. For both genders, the lowest cumulative incidence and duration occurred in gender-integrated occupations.

**Conclusions:** Our results indicate a strong association between occupational gender segregation and musculoskeletal-related sickness absence. Further studies are needed to elucidate gender segregation of the labour market in relation to health and rehabilitation measures.

**Source**

Pesticide exposures of women in developing countries: Discriminations and scientific biases

Pesticide exposures of women in developing countries are aggravated by economic policy changes associated with structural adjustment programs and globalisation. Women in these countries, particularly in the agricultural sector, are increasingly exposed. Since they are concentrated in the most marginal positions in the formal and informal workforces, and production is organised in a gender-specific way, opportunities for women to control their exposures are limited. Data from developing countries show that: 1) women’s exposures to pesticides are significantly higher than is recognised; 2) poisonings and other pesticide-related injuries are greatly underestimated for women; 3) for a given adverse outcome from exposure, the experience of that outcome is gender-discriminatory; 4) erroneous risk perception increases women’s exposures. The hiatus in knowledge of gender-specific exposures and effects is related to gender biases in the nature of epidemiologic inquiry and in the literature, and the gendered nature of health workers’ practices and surveillance.

Recommendations are made for strong, independent organisations that provide opportunities for women to control their environments, and the factors affecting their health, as well as gender-sensitive research to address the particularities of women’s pesticide exposures.

**Source**
Employment conditions and working conditions

In core, industrialised countries, important improvements in occupational health have been accomplished during recent decades (Saari, 2001). However, in the EU, 5,500 people die each year and more than 75,000 people are permanently disabled as a consequence of occupational accidents, which indicates that it is still an important problem (Op De Beeck & Van Heuverswyn, 2002). The resilience of occupational hazards can in part be attributed to changes in employment conditions and associated higher work paces, greater flexibility and lower protection (Op De Beeck & Van Heuverswyn, 2002). In particular the rise of precarious employment is a point of concern. However, on average, all types of non-standard employment share the characteristic of incorporating worse working conditions, compared to full-time permanent employment.

Precarious employment creates higher uncertainty and may affect health and safety behaviour and regulations (Benach, Amable, Muntaner, & Benavides, 2002). The relationship between precarious employment and working conditions is often studied using the definition of temporary employment. A number of studies document a higher prevalence of accidents in different types of precarious workers, compared to workers in standard employment arrangements (Francois & Liévin, 2000; Goudswaard, 2002; Virtanen et al., 2005; Eloainio et al., 2005). Furthermore, temporary workers are more exposed to painful and tiring positions, intense noise, repetitive movements (Letourneux, 1998), low job autonomy and control over working time (Paoli & Merlié, 2001) and have less freedom to take personal leave (Letourneux, 1998). The underlying characteristics of precariousness at work, such as powerlessness, low worker involvement or the incapacity to exercise legal rights (Amable et al., 2006), are likely causes of these more adverse working conditions, since they imply having less possibilities to avoid hazardous working conditions or to negotiate improvements in working conditions.

Moreover, precarious employment means more than just temporary contracts, since uncertainty, powerlessness and under-protection of permanent employees also form part of the concept. A number of studies have investigated the health consequences of organisational justice, downsizing or exposure to work hours exceeding the legal standards. Low relational justice has been related to various health outcomes, including coronary heart disease (Kivimäki et al., 2004; Eloainio et al., 2005). Downsizing is related to elevated sickness absence, CVD and higher mortality (Kivimäki et al., 2000; Vahtera et al., 2004). These effects are often mediated by
the worsening in working conditions which accompanies the downsizing process, which includes increased levels of physical work demands or job insecurity and lower job control, skill discretion or worker participation (Kivimäki et al., 2000; Vahtera, et al., 2004). Long work hours are associated with a wide variety of health effects, including work accidents and injuries, musculoskeletal disorders, fatigue, psychological ill-health, unhealthy behaviours and outcomes related to CVD (Van der Hulst, 2003; Caruso & Waters, 2008). Self-employment may also be seen as a form of precarious employment, although there are many internal differences, for instance, between independent contractors and (small) business owners (Prottas & Thompson, 2006). Supposed advantages of greater autonomy are often counteracted by higher work pressure and longer hours. A study on self-employed workers in North Carolina found elevated occupational fatality rates, especially in retail and transportation industries. Furthermore, poor work organisation, poor hygiene, ergonomic hazards, dangerous hand tools and exposure to chemicals were reported (Mirabelli, Loomis, & Richardson, 2003).

Workers employed in the informal economy or informally employed workers in formal sectors often lack control over their working conditions. They can be deployed in the most dangerous activities, imposing a high risk of occupational injuries and diseases, while at the same time they are legally under-protected and vulnerable to firing and high exploitation (ILO, 2006). Awkward postures and exposure to toxic chemicals, excessive noise, poor sanitation, high workload, pesticides, violence and sexual assault (Iriart et al., 2006) are commonly observed in informal economy settings, along with little training and supervision and limited access to protective equipment.

Forced labourers and slaves are exposed to the worst hazards. They are forced into these adverse working conditions by the over-exploitative nature of the employer-worker relation (Fassa, 2003; WHO, 2002). However, the invisibility of forced labour makes it a difficult area to investigate. A greater effort should be made to document working conditions in these settings. Unacceptable working conditions are one of the worst features of child labour. Exposure to hazards in the workplace is especially harmful for children due to their increased vulnerability to biological and toxic agents as a consequence of their immature immune system, lower bone elasticity, strength, and capacity to support heavy workloads. Furthermore, tools and other equipment are often not designed to be used by children. Children working in agriculture are particularly
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at risk of exposure to chemical and biological agents, such as pesticides or dust, heat and harsh weather, repetitive work, hazardous equipment, excessive work hours, demanding physical work and noise (ILO, 2006).

Selected case studies

Case study 61. The link between employment relations and working conditions: Work schedule and work hours in relation to nurse injury. - Alison Trinkoff

Nursing jobs increasingly involve extended work schedules and heavy job demands, with recent studies showing the detrimental effects on the health of nurses (Caruso, Hitchcock, Dick, Russo, & Schmit, 2004; Trinkoff, Geiger-Brown, Brady, Lipscomb, & Muntaner, 2006; Trinkoff, Le, Geiger-Brown, Lipscomb, & Lang, 2006). Increased hours in a work environment with high physical and psychosocial demands can adversely affect nurses' health. In fact, chronic stress over time is known to affect the nerve, immune, and cardiovascular systems (McEwen, 1998). Research has found that physical and psychological job demands and extended work schedules increase risk of work-related injuries such as musculoskeletal disorders (Van der Hulst, 2003).

Currently, the U.S. Institute of Medicine recommends that nurses work no more than 12 hours in a 24-hour period and no more than 60 hours in a seven-day period, in order to reduce error-producing fatigue [Institute of Medicine (IOM) 2004]. Their report entitled “Keeping patients safe: Transforming the work environment of nurses” also incorporated baseline findings from our longitudinal study of nurse scheduling. In our study, over one-third of staff nurses reported that they typically worked 12+ hours a day. Among those working 12+ hours, 37 per cent rotated shifts (Trinkoff et al., 2006). On-call requirements were also very common (41%). Despite the long hours, few nurses took breaks; two-thirds typically took one or no breaks during their shifts. Although current evidence indicates that extended schedules can adversely affect nurses and patients, research on nurse scheduling has been limited, usually to certain work settings (such as hospitals), or certain schedule components (such as shift work or mandatory overtime only). More research is needed.

Because nurses are at high risk of MSD, especially neck and back injuries, and have the highest number of needlestick injuries, we therefore examined the relation of work schedules to MSD and needlestick incidence in nurses (Trinkoff et al., 2006; Trinkoff, Le, Geiger-Brown, & Lipscomb, 2007). We contacted 5,000 randomly selected actively licensed nurses from two U.S. states. Of these nurses, 4,229 were sent questionnaires (138 had invalid addresses, and 633 declined to enroll). Returned surveys were received from 2,624 nurses, for a 62 per cent enrollment rate, with follow-up rates for waves 2 and 3 of 85 per cent and 86 per cent, respectively. We found that onset of both injury types was independently related to work schedule, with long work hours significantly increasing the risk of injury. This was partly explained by workplace exposure to physical demands. In addition, time spent away from work was also related to injury, suggesting that inadequate rest and recovery was also an important risk factor for injury.

Although our study asked whether nurses were required to work extra hours, many of the nurses also worked long hours voluntarily. Studies of health effects of extended hours found that the health impact is comparable regardless of this distinction (IOM, 2004). Encouraging or requiring already tired nurses to work extra hours exacerbates a cycle of fatigue, and often leads to exit from the profession. This compounds staffing problems by creating nurse shortages, further increasing the pressure to work extended hours. Conversely, improving working conditions has been shown to decrease nurse vacancies and shortages (Luther et al., 2002).

Because workplace injuries to nurses incur extensive economic, psychological, and physical costs, it is extremely important to prevent them. Despite advances in protecting nurses, extended work schedules and related job demands are contributing to nurse injuries. These conditions, if modified, could lead to further injury reductions.

References


Gaps in knowledge

For most contemporary workplaces in core industrialised countries, the health effects of working conditions are relatively well-known. There is a long tradition of research reporting on the effects of very specific material working conditions in relation with somatic health outcomes. In the last decades of the 20th century, with the consolidation of occupational stress research, abundant evidence has accumulated linking factors related to the organisation, content and magnitude of work tasks to diverse psychological and physical outcomes. Moreover, the health effects of stressors related to the organisation of employment, such as flexible working times, job insecurity, downsizing and other uncertainty-provoking threats, are documented relatively well, at least among more or less standard wage-earners.

One area where knowledge about standard wage-earning populations is still lacking concerns the impact of interactions between different types of co-existing working conditions, as well as with various forms of social stratification (like gender, or ethnicity) and macro-social indicators (like welfare state types or countries’ levels of social inequality). Related to the latter point is the definition of “work”: especially for many women, but also for men, work is something more than just regularly paid daytime employment; it extends to household duties, informal care, voluntary work or additional paid work in the informal sphere. These kinds of interactions may exacerbate or modify the health effects of specific working conditions. In addition, research results have been biased in favor of larger organisational settings and common occupations, leaving some groups of workers, for example those employed in small firms, largely unaddressed.

With regard to the psychosocial work environment, there is also a need to consider more objective assessments of working conditions, instead of relying almost solely on self-reports. In this sense, alternative methods for the assessment of working conditions need to be considered, based more on a participatory approach, and focused on collective evaluation and preventive action. Moreover, data using diagnosed (and diversified) health outcomes, longitudinal information and data sources integrating information from different life spheres are also very scarce.
Bigger gaps start to emerge when situations other than regular wage-earning employment in core industrialised countries are considered. First of all, far less information is available on the health associations with working conditions in situations departing from that of standard full-time employment, even in the core countries. For example, it is less easy to ascertain the health and safety risks, harmful toxic exposures, work pace, etc. of self-employed workers or contingent workers who are frequently changing their place of work and/or employer. Even less is known about the working conditions characterising informal employment or forced employment. In addition to the precarious nature of the employment itself, workers engaged in these forms of employment tend to be more vulnerable and have a more precarious legal status than those active in the regular labour market (undocumented immigrants and refugees, children, working poor, people deprived of their civil rights, etc.). Finally, occupational health research is severely biased in terms of the needs of core western industrialised countries (Western Europe, North America, Australia, and Japan). As a result, probably the biggest challenge for occupational health inequalities research is to apply an equally close-knit conceptual framework of health-related working conditions to situations prevailing in peripheral and semi-peripheral countries (Chung & Muntaner, 2008).

Concluding remarks: complexity in employment relations, work, and health

The multicausality involved in social and psychosocial pathways makes complete models difficult to test. Several examples are presented to illustrate this point. A first example refers to South Africa, showing how epidemics of silicosis, pulmonary tuberculosis and HIV/AIDS in gold miners are intertwined (see Case study 62). A second example of multi-determination and reciprocal influences between employment and health is provided by our diagrammatic representation of the documentary Darwin’s Nightmare (see Case study 63). This film centers on the political economy of fishing in Lake Victoria, Tanzania. The conclusion that can be reached is one of great complexity, where ecology, economics, politics, culture and health are all interrelated, producing a devastating effect on the local population. No single discipline or method seems able to capture this complexity. Finally, we also present a case study involving migrant workers in Spain (Case study 64). Until new transdisciplinary approaches are
generated to deal with social complexity in public health we must be content with specific pathways and mechanisms that explain parts of models, and with pieces of evidence that are compatible with the main features of the model.

Case study 62. The intertwined epidemic of silicosis, tuberculosis and HIV in Southern African gold miners - Joan Benach, Montse Vergara Duarte and Yogan Pillay

Since the 1880s, South Africa has been the source of a large proportion of the world’s gold supply. In 1970, South Africa produced about 68 per cent of the world’s production, but since then the country’s gold production has dropped steadily. Although South Africa still is one of the world’s largest gold producers, since 2007, the most important gold producing country has been China.

In South Africa the mining industry has employed hundreds of thousands of miners, the majority being black workers from both South Africa and its neighbouring states, with a white minority occupying supervisory and management positions. A vast number of migrant workers from inside the country or neighbouring states entered the gold mining industry (about 400,000 in the 70s and 80s, and close to 130,000 in 2008).

Gold mining is labour-intensive and workers suffer from hazardous and stressful working conditions that have been responsible for high levels of disease and mortality. For example, between 1902 and 1930, a conservative analysis estimates that around 108,000 black miners died of disease and injury in South African mines (Marks, 2006). Mine workers have long been associated with an exceptionally high prevalence of various lung diseases such as silicosis resulting from prolonged exposure to silica dust in mine shafts. Studies have found a high prevalence in different areas of the country (between 22% and 37%) among former miners (Rees, 2005). During the 19th century, the arrival of large numbers of Europeans suffering from tuberculosis combined with the social changes associated with the discovery of minerals, especially the need to recruit migrant labour on a large scale, provided ideal conditions for the spread and increase of tuberculosis. The crowded and unsanitary living conditions combined with the stressful working conditions led not only to very high rates of silicosis and tuberculosis but also to pneumonia and other diseases. The migration labour system, which originated in the mining industry and was reinforced by apartheid-era laws, meant that workers from rural areas would spend many months away from their families and required them to return to their homes between contracts, when they became ill or when they were no longer able to find work. This process not only increased the vulnerability of miners but also resulted in the distribution of diseases in the rural areas being related to the extent to which the population had been involved in migrant labour.

This situation was worsened dramatically in the 1990s by the HIV-AIDS epidemic, as South Africa came to have one of the most severe epidemics in the world (approximately 5.7 million people living with HIV in 2007, almost 1,000 AIDS deaths every day, and about one out of five adults living with HIV/AIDS) (Join United Nations Programme on HIV/AIDS, 2008). Migration is associated with a breakdown of family structure and separated families, and contributes to the spread of HIV through an increase in the prevalence of high-risk sexual behaviours, including multiple concurrent partners (Coffee, Lurie, & Garnett, 2007). It is estimated that the prevalence of HIV/AIDS in mineworkers is between 20 and 30 per cent (Stevens, Apostolellis, Napier, Scott, & Gresak, 2006).

The combined effect of silicosis, tuberculosis and HIV infection in gold miners constitutes a striking example of the synergistic effect of risks and health problems exacerbating each other, which has created multiple and complex public health epidemics. Silicosis is a potent risk factor for tuberculosis, and even exposure to silica (without silicosis) predisposes individuals to tuberculosis (Rees & Murray, 2007). High rates of HIV transmission and confined, humid, poorly ventilated living conditions increase the risk of tuberculosis. Migration labour practices also damage the health of workers, increasing their risk of being HIV positive and contributing to the intertwined epidemic of silicosis, tuberculosis, and HIV/AIDS.

In the past few decades in particular, the many union strikes protesting against unsafe working conditions in mines across the country including mines devoted to the production of gold, platinum, and coal indicate that there is an urgent need for action to improve the situation of mine workers. Interventions should include increasing awareness and education on health conditions such as silicosis, tuberculosis and HIV/AIDS, particularly among prospective, current and former miners. This should include information on the rights of miners, compensation policies and what to do if legal rights are not met. There is also a need to increase access for mine workers to social and health services. Given that most mine workers are migrants, such rights should be extended to all migrant workers regardless of whether they are in the formal or informal sector and regardless of their documentation status. The latter aspect is particularly relevant, as the number of economic refugees from neighbouring Zimbabwe increases. A third type of action includes the effort to address prevention and treatment of tuberculosis and HIV in migrant miners, efforts that must not overlook the various socio-economic issues that contribute to the cross-border spreading of these epidemics (AIDS and Rights Alliance for Southern Africa, 2008).
Case study 63. Illustrating the complexity of the linkages between employment and health: The case of Lake Victoria.

Eirik G. Jansen, Joan Benach and Carles Muntaner

For hundreds of years, the population living around Lake Victoria in East Africa has been able to draw its sustenance from the lake’s rich fishing grounds. Until the last few decades, fish caught in the lake went primarily to the population of the surrounding areas. About 100,000 tons of fish were caught in the lake every year and the production, processing and trade of fish took place in the local communities with several hundred thousand men and women being employed in fishing-related activities.

In the 1960s, the English former colonialists stocked the lake with Nile perch, and during the 1980s the growth and catch of this predatory fish exploded, as enormous quantities of several hundred types of small fish were completely eaten up and eradicated by the Nile perch (Kaufman, 1992). In 1979 the catch of the Nile perch was 1,000 tons, and ten years later this amount had increased to 325,000 tons. Tens of thousands of unemployed and underemployed women and men made their way down to the beaches along Lake Victoria and found work as fishermen or in fish processing and trading. An international market for the fish developed quickly. Later, many millions of people in East Africa also started to demand the fish. In the early 1980s, the first processing factories, financed with foreign capital, were established along the shores of Lake Victoria. This is where the Nile perch was filleted. The fish fillets were mainly exported to Europe and Japan, where the Nile perch became quite popular, as large grocery store chains in the industrialised countries began to seek out the fish from Lake Victoria. In the early 1990s, more than 35 processing factories were established around the lake and an increasingly larger share of the catch was exported. Factories now have the capacity to process much more fish than they are able to gain access to. As a result, there is fierce competition among the processing factories for the fish, and today almost all the Nile perch that is able to be exported is filleted and sent abroad. The Nile perch remaining for the local population is the fish that is spoiled, rotten or too small to be filleted. The local processing factories buy the fish skeletons left over after the fillets have been cut away, and the small pieces of meat left on the bone are eaten. An entire industry employing several thousand people has developed in order to process the waste products from the Nile perch. Hundreds of thousands of poor people now eat the remains of the Nile perch after it has been filleted. How this could be? Why is it that hundreds of thousands of tons of high quality fish protein are consumed overseas, or by the urban and foreign elite in East Africa, while only the bones and head are left over for the majority of local people? (Jansen & Boye, 2008).

Darwin’s Nightmare (Sauper, 2004) provides a compelling, instructive picture that shows the great complexity of this process, wherein causal chains in ecology, economy, politics, culture and health systems are interrelated (see Figure), from changes in the lake’s ecology to the fishermen’s lack of employment, from the export of fish to wealthy countries to the import of weapons for the local African wars, from unemployment, illiteracy and poverty to prostitution and HIV/AIDS, from homelessness and the use of drugs to violence and disease, from poor working conditions to sickness and death. Despite the criticisms of the Tanzanian Government, the Lake Victoria Fisheries Organisation and other institutions, the facts portrayed in this film have been fully supported by scientists and experts (Kaufman, 2006; Flynn, 2006). In spite of the several hundred million dollars a year generated by the Nile perch fishery, very little remains to alleviate unemployment, poverty, malnutrition, lack of education, and suffering around the lakeshore. For instance, 50 per cent of the children around Lake Victoria are malnourished, and after many years of drought and poor harvests, millions of people in Tanzania face starvation (Flynn, 2006). Darwin’s Nightmare illustrates the complexity of the situation that workers face along the shores of Victoria’s lake in Tanzania, exposing the political economy of fishing as well as those who impose unhealthy living conditions on the locals. As said in the documentary, “Now there is a scramble for the natural resources of the world. Who is to get and who is to miss? And that is the law of the jungle. Those strong...
and tough animals, they have the chance of surviving more than the weak ones...When we say ‘the stronger’, in the world we are living, maybe we started viewing the Europeans as stronger than the rest, because they are the people who own the International Monetary Fund, the World Bank, and the World Trade Organisation” [Mkono, ex-school teacher] [Sauper, 2004].

**Figure.** Main interrelated ecological, economic, employment, work, social and health factors as depicted in the film “Darwin’s nightmare”.

**ECONOMY**
- Ban on private fishing (Fish reach high prices)
- Companies associated to market fish
- Quality controls of the fish (cold chain)
- Fish EXPORT to EU and Japan
- 2 flights a day
- 2 million white people eat Victoria-fish daily (Biggest export to EU)
- Food and affluence for European Union countries

**ECOLOGY**
- Nile Perch introduced in Lake Victoria in 60’s
- Eutrification (lack of oxygen) and killing off most fish species (cichlids)

**COMMERCIAL FISHING INDUSTRY FOR EXPORT**
- Foreign capital and private factories

**DEPENDENCY ON FISH NILE PERCH**
- Structural UNEMPLOYMENT, ILLITERACY and POVERTY
- Destruction of old fisheries, farms and local business
- Workers move from farms to the lake to become fishermen
- Lack of hospitals

**DISCARDED FISH FRAMES FOR INTERNAL CONSUMPTION**
- Cheap food

**INFORMAL ECONOMY / INFORMAL JOBS**
- Abandoned Women
- Poor Working Conditions
- Child Labour

**EMPLOYMENT CONDITIONS**
- Extra business “Empty” flights
- Plane Accidents
- Russian & Ukraine big and old planes
- Food and affluence for European Union countries
- Wars in Africa (millions of deaths)

**SOCIETY**
- Pilots
- Lack of security
- Religion
- No use of condoms
- Women prostitution
- Ammoniac gas
- Blindness
- Violence
- Women prostitution
- Alcoholism
- Street children
- No use of condoms
- Spread of AIDS
- Orphans
- Smoking
- Children Sniff glue
- Refuges
- Famine

**POLITICS**
- Control natural resources
- Control IMF, WB, WTO
- Ban on private fishing (Fish reach high prices)
- Donations
- UN World Food Program
- Extra business “Empty” flights
- Russian & Ukraine big and old planes
- Food and affluence for European Union countries
- Wars in Africa (millions of deaths)

**DISEASES AND DEATH**

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**References**


Case Study 64. Migrant agricultural workers in northern Spain. - Carlos E. Delclós Gómez-Morán

Context
Over the last two decades, Spain has undergone a significant and rapid transition from its past as a labour-exporting country to its current status as one of the world’s largest importers of labour. While as recently as 1991, foreign-born people made up less than one per cent of Spain’s total population, this number has increased every year since then to the extent that, according to the Spanish National Statistics Institute’s provisional data from municipal registers, updated to 1 January 2008, a total of about 6 million people (13.0% of the total population) currently living in Spain were born in another country, 2.45 million (5.3% of the total population) of whom are EU citizens (Instituto Nacional de Estadística, 2008). This rapid rate of change, coupled with dramatic variations in the ranking of countries of origin most strongly represented, is frequently cited by politicians and scholars alike as the major impediment to the reliability of data (especially over time) and, consequently, empirical research and informed political action on issues related to discrimination in the labour market resulting in poor employment relations, employment conditions, and working conditions. If statistically significant trends cannot be identified, the argument goes, it is far too difficult to identify the mechanisms which must be addressed.

While there is certainly some truth to this argument, it also contains a tacit dismissal of information that is difficult to quantify. In the following reflection concerning an experience that lasted one day, I hope to demonstrate that evidence of discrimination and its effects does not need to be quantified in order to be visible. Since the information used was obtained through personal experience and not scientific observation, I adopt a narrative approach in which I hope to contrast the nature of my own participation in a wine harvest with that of a diverse group of migrant workers. Despite not knowing the documentation status and contract type of the individuals mentioned, I can say without hesitation that the conditions to which they were subjected can effectively be described as hazardous and precarious.

Reflection
Associating wine with blood is hardly an original rhetorical trick. In fact, earnest scholars and magicians often warn their audiences of the dangers inherent in the ease with which one can basically associate anything with everything else (and thus undermine the logic underlying how they associate things with other things, or create a chaos in which blessings and curses become indistinguishable incantations). But these abstract considerations only occur to me now, as I write this reflection. While I, a graduate student and a city mouse in almost every sense of the term, was recreationally participating in a Catalan wine harvest, the association was quite literally visceral: I had cut my hand deeply without noticing, and couldn’t quite quantify the extent of the bleeding due to the mixing of blood and grape juice that had been taking place on my hand over a length of time I wasn’t entirely aware of. All I knew was that I was feeling a bit light-headed.

I had not noticed the occurrence of what turned out to be several gashes because the sharp and quick pain of those sharp and quick lesions was strongly outweighed by the sustained, increasingly heavy discomfort in my lower back, the result of awkwardly hunching over to push apart vines and leaves in order to get to the bunches of grapes that I was to cut. There must be a better way to do this that I’m not aware of, I thought, so I decided to approach one of the paid workers and ask him how he went about avoiding these cuts and awkward positions. The man closest to me, presumably from sub-Saharan Africa (in this part of the world), looked about my age and had also happened to stop cutting grapes for a moment, so I approached him.

One of my friends, the land-owner’s wife, had already told the workers that I was from the United States and spoke English, Spanish, and French. This coupled with the ridiculous-looking borrowed old clothing I was wearing so as not to soil my own essentially meant that there was little need to introduce myself or ask the often awkward question of what language we should communicate in. It also meant that I was not surprised when, after greeting the man in Spanish, he answered in perfect English.

“Hey man. Hard work, isn’t it?”

“It really is,” I replied, “I don’t know how y’all do this all the time. I just cut my hand a few times and didn’t even notice because my back hurts so much.”

“Yeah, that’s OK,” he said, wiping the sweat from his forehead with his stylish baseball cap. He wasn’t wearing gloves either. I asked him if he knew any way to reduce this pain in the lower back. He told me you just get used to it and went right back to picking grapes. I followed suit.
“So where are you from, in the States?” he asked. I told him I’m from Houston. “Ah, Texas,” he replied, which surprised me. Most folks I’ve encountered abroad (native, tourist, or immigrant) usually ask what state that’s in, after making sure they’ve said, “Houston, we have a problem,” in whatever language. I asked him where he was from, which is Dakar, and his name, which is Kulu. I found out that he had only been in Spain a couple of months and had been working the wine harvest in various towns over the previous three weeks. He also told me that he would never have dreamed he’d be stuck in agricultural work, that he’s a carpenter by trade but that there’s simply much more money in this work here than back home.

After discovering that I was eager to practice my rusty French, Kulu spoke to me in a potpourri of three languages that were not his native tongue. His proficiency in each was stunning, but especially so in Spanish, given the extremely short amount of time in which he had picked it up. Over the course of about four hours, I learned that we were exactly the same age at the time (24), felt equally out of place in a rural setting (although his cosmopolitan clothes, the same brands as the ones I didn’t want to dirty, were caked in mud and grape juice), and were equally passionate fans of many of the same hip-hop artists. This last similarity was what we talked about the most, since he was surprised at the fact that I knew of several mainstream Senegalese rappers and because Akon, a superstar in the United States based in Atlanta, is Senegalese.

Kulu then introduced me to Samba, another Senegalese man who was working a vine near the two of us. Samba did not speak English, so we communicated in a mix of (my) broken French and (his) Spanish peppered with Catalan words. It’s this last language that led me to believe he lived in Catalonia, so I was surprised to find that he actually lives in Cantabria. When I asked him where in Senegal he was from, he just laughed and said, “Don’t worry, you don’t know. Even Senegalese people don’t know!” Kulu clarified that Samba is from a small town. “Do you like Akon?” Samba asked me.

The owner’s wife approached us carrying two large buckets overflowing with grapes and a large bottle of water. She told us to drink up, which I did, but most of the African and all the Pakistani workers refused. Thanks, but it’s Ramadan, they explained. Samba smiled and took the buckets from her hands and emptied them into the flatbed of the truck. “Muchas gracias,” she said, to which he replied, “Sí, sí. De nada.”

“Yes, yes, always you’re welcome,” taunted another worker in a mix of French and Spanish. He was standing, smoking a cigarette, just as he had been every twenty minutes or so throughout the day. Samba ignored his comments with a knowing grin and a slight shake of his head. Through my short conversations with the man, I learned that he is from Cameroon and despises agricultural work. Despite having introduced myself by name, he would only refer to me as “cher”, an affectionate French term, like “my love”, which also happens to mean “expensive”. However, I could not tell from his tone whether this term was being used ironically or casually, and I never learned his name.

**Conclusion**

While it is clear that there is useful, quantifiable information missing from the reflection above, the fact that the workers’ documentation status and employment contract type cannot be inferred speaks volumes about the unequal power relations, precariousness, lack of representation, and discrimination faced by migrant workers in Spain. One needs only contrast Kulu’s case with my own to see that we live in vastly different realities, despite sharing several interests and key demographic characteristics (age, immigrant status, urban origin, fluency or a working knowledge of multiple languages). Thus, because it constitutes a process driven by globalisation (and all of the complexities this phenomenon implies), it is important that rigorous analyses of the experiences of migrant workers work to overcome the limits of scientific reduction by combining quantitative and qualitative approaches.

**Reference**

Young Bolivian miners working in the Cerro Rico in Potosí (Bolivia). Thousands of miners still suffer fatal injuries due to accidents, diseases such as tuberculosis and silicosis from exposure to dust and mineral particles, deafness by the noise of explosions and machines, and muscle aches because of spending long hours in uncomfortable positions. Their life expectancy at birth is estimated at about 45 years.

Source: Joan Benach (2010)
Policies and Interventions

“The knowledge that we already possess is sufficient, if put into practice, to achieve great health gains for all and to reduce our scandalous international and national inequalities in health.”

Geoffrey Rose
9.1. THE NEED FOR A POLITICAL PERSPECTIVE

There are a number of problems with the way in which many scientific studies view and understand the political issues that shape health policy. Broadly speaking, one of the main problems is a lack of attention to politics. The result is that the political roots of public health policy are very often reduced to financial or technical value-free processes. This approach ignores the influence of political ideology, beliefs, and values, in addition to the power of governments, unions, employers, corporations and scientific experts, among other actors (Levenstein & Wooding, 1997; Labonte, Schrecker, & Gupta, 2005). These social forces need to be considered in order to understand how political decision-making creates a balance between minimising the risk to workers and facilitating the profitability of firms. It turns out that, very often, meeting the definition of “acceptable risk” does not necessarily ensure a safe work environment. There are two distinct reasons for this outcome and both stem from a fundamental imbalance of power between employers and workers.

First, the distribution of political and economic power between capital and labour is structurally skewed in favour of the former. While it is commonly assumed that workers and employers share an interest and responsibility in maintaining a healthy working environment, the reality is quite different. In fact, there is a conflict of interest, because only the employer controls the means of production (i.e., technology) and at the same time she or he has a permanent goal of maximizing profit (Muntaner & Lynch, 1999; Muntaner, Eaton, Diala, Kessler, & Sorlie, 1998; Milgate, Innes, & O’Loughlin, 2002). This means that, while employers may have a long-term interest in reducing the economic costs of occupational diseases and injuries, the immediate investment required can be high and returns could take years to come in (Walters, 1985). This is how the distribution of political and economic power has a profound influence on workplace health and safety in capitalist economies.

This plays out in the administration of firms in two ways. First, at the whim of the prevailing economic conditions and the need to stay competitive, important decisions about occupational health, such as what constitutes a “satisfactory level of worker’s health and safety”, are often left to the employers, superceding health professional assessments. For multinational corporations, this also entails decisions about where to operate and what kind of standards will apply in different locations (Fustukian, Sethi, & Zwi, 2001). Moreover, employers faced with the choice between an unsafe working environment and a low level of profit often use economic incentives to lure workers into dangerous occupations, instead of spending money...
to reduce risks associated with that work. In these situations of exploitation and domination of labour, workers weigh the cost (e.g., an injury) versus the benefit (money) of working in these jobs.

Second, when scientists and experts do become involved, it is easy to discredit or manipulate findings to support the firm’s position. In the end, those in control of capital are in a better position to provide counter-opinions due to the structural imbalance of power, that is, of wealth and influence. This firm-level analysis can also be extended to the whole economy to explain the current economic crisis, which has been fuelled by decades of deregulation. Workers’ health is commonly defined by the scientific community as a technical problem, and conflicts over workplace hazards are typically referred to “experts” who determine whether particular work processes or substances are hazardous to health. For example, mainstream scientific knowledge commonly denies the validity of alternative evidence found in shop floors by unions or safety representatives. At the same time, definitions of occupational health by many physicians often adapt to a firm’s needs, serving to reinforce the domination of labour by capital. In fact, several studies have documented how experts employed by companies have withheld information, lied, distorted findings, or used poor methodologies to serve the interests of their employers (Berman, 1978; Berlinguer, Falzi, & Figa-Talamanca, 1996; Messing, 1999).

In both these ways, the conflict of interests between the responsibility for profit-maximisation and the domination of the workers often favours the employer’s benefits over the safety of the employee. Governments often wish to adopt a neutral role, mediating conflicts between workers and companies and, along with experts and employers, determining the nature of a safe workplace environment. But even this safety does not imply the absence of risk. It merely defines what is “acceptable” (Walters, 1985). Acknowledging this underlying political and ideological conflict over workers’ health is a necessary step to the process of understanding occupational health policy (Muntaner et al., 1998; Benach, Muntaner, Benavides, Amable, & Jódar, 2002).

9.2. MACRO POLICIES AND HEALTH: AN HISTORICAL PERSPECTIVE

This book has charted in previous chapters the health impacts of six specific employment dimensions: full-time permanent employment, unemployment, precarious employment, informal work, child labour and slavery (see section 7.3). To further understand their effects on workplace health, each must be viewed in a historical context.
Key influences affecting changes to employment dimensions over the past thirty years include the growing influence of corporations and the abandonment of Keynesian economic policies over the last four decades. In its place, a dominant neo-liberal model has emerged whose fundamental mission has been to facilitate conditions for profitable accumulation, with the consequence of transferring assets, wealth and income towards the upper classes and from poor to rich countries. These policies, often built on the dismantling of post WWII regulations, have not only increased social inequalities across countries and social groups, but have also favoured the ideology of microeconomic rationality as the validating criterion for all aspects of social life and thereby have universalised market dependence in society (Rupert, 1990; Navarro, 2007).

Neo-liberal policies and practices stem from the belief that competitive private markets deliver the best social outcomes including the following: (1) the reduction of state interventions in economic activities; this theory has not been followed in practice since many states have actually become more interventionist (e.g. in the US, with large subsidies to the agricultural, military, aerospace, and biomedical sectors); (2) corporatisation, commodification and privatisation of hitherto public assets; (3) reduction of public social expenditures; (4) deregulation of financial transactions and interest rates, and the removal of credit controls; (5) liberalisation of trade with removal of barriers to commerce; (6) the commodification and privatisation of land and the expulsion of peasant populations; (7) colonial, neo-colonial, and imperial processes of appropriation of assets, including natural resources ultimately backed by political violence; (8) conversion of various forms of collective property rights into exclusive private property rights; (9) more control over organised labour and limiting the right to organise; and (10) deregulation of labour with more “flexibility” in the labour markets, downsizing and outsourcing/off-shoring (Harvey, 2003; 2006; Navarro, 2007) [see Case studies 65, 66, 67 and 68].
Case study 65. Assessing employment policies in two clusters of core labour countries: Is there a contradiction between the performance of economic, social and health indicators? - Dennis Raphael

There are two main streams that constitute the employment policy literature. The first is that of traditional economic analysis that sees the assessment of employment policies being based primarily on employment or participation rates and associated unemployment rates and, second, on indicators of economic growth. These kind of economic analyses are seen as the major criteria of success in employment policies by the Organization for Economic Cooperation and Development (OECD) who provide these on an ongoing basis. The second stream is one that places employment policies within frameworks that consider the extent to which health and the determinants of health are influenced by these policies. This more diverse literature draws upon contributions from the political economy and the social development literatures.

The English-speaking nations (e.g., USA, UK, Canada, Australia, New Zealand) have been identified as implementing very different liberal approaches to economic and social labor market and social policies as compared to the well known Nordic nations (e.g., Sweden, Denmark, Norway, Finland) that follow a labor market and social approach informed by social democratic principles. Table 1 illustrates some of the data provided by the OECD indicators. In regards to the key indicators of economic growth and unemployment rates there are negligible differences between those two clusters of countries.

Table 1. Comparison between two clusters of core labour market countries on OECD economic indicators (liberal labour institutions and social democratic labour institutions).

<table>
<thead>
<tr>
<th></th>
<th>GROWTH IN PER CAPITA GDP</th>
<th>GROWTH IN LABOUR FORCE</th>
<th>UNEMPLOYMENT RATES</th>
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<tbody>
<tr>
<td><strong>Liberal</strong></td>
<td></td>
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<tr>
<td>Australia</td>
<td>3.9</td>
<td>3.2</td>
<td>2.6</td>
</tr>
<tr>
<td>Canada</td>
<td>3.5</td>
<td>2.9</td>
<td>2.9</td>
</tr>
<tr>
<td>New Zealand</td>
<td>3.7</td>
<td>4.3</td>
<td>1.7</td>
</tr>
<tr>
<td>UK</td>
<td>3.0</td>
<td>3.1</td>
<td>1.8</td>
</tr>
<tr>
<td>US</td>
<td>3.2</td>
<td>4.2</td>
<td>3.5</td>
</tr>
<tr>
<td><strong>Average</strong></td>
<td>3.5</td>
<td>3.5</td>
<td>2.5</td>
</tr>
<tr>
<td><strong>Social Democratic</strong></td>
<td></td>
<td></td>
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<tr>
<td>Denmark</td>
<td>2.5</td>
<td>1.9</td>
<td>3.1</td>
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<tr>
<td>Norway</td>
<td>3.3</td>
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<tr>
<td>Sweden</td>
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<td>Finland</td>
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<td><strong>Average</strong></td>
<td>3.1</td>
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Table 2 presents data that considers the two clusters of core labour market countries along three social determinants of health: poverty rates, income inequality, and union density, and three population health indicators: life expectancy, infant mortality, and low birthweight (OECD, 2005, 2006). There are profound differences between the two clusters on poverty rates, income inequality and Union density. Interestingly, health differences are not apparent for life expectancy but do emerge for the infant mortality and low birthweight data favouring the Social Democratic group of countries.

Table 2. Comparison between two groups of high labour market functioning nations on selected indicators of the social determinants of population health (SDPH) and population health itself.

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<tbody>
<tr>
<td></td>
<td>Poverty</td>
<td>GINI Income</td>
</tr>
<tr>
<td><strong>Liberal</strong></td>
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<tr>
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<td><strong>Average</strong></td>
<td>5.6</td>
<td>24.8</td>
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The Conference Board of Canada carries out extensive analyses of national performance on several sets of indicators: health, health determinants, education and skills environment, society, economy, and innovation (Conference Board of Canada, 2003; 2006). In their analyses they identify the top 12 performers in each area for display (Table 3) (Raphael, 2007). What is of particular interest is the excellent performance of the social democratic welfare states on the economy indicators in addition to the health and social indicators (Conference Board of Canada, 2006). All the social democratic Nordic nations do well on the set of economy indicators. These economy indicators include GDP per capita, GDP growth, productivity growth, unit labour cost, growth, inflation, deficit to GDP ratio, employment growth, unemployment rate, and long-term unemployment rate. Innovation indicators include spending on research and development, technological cooperation, patents in a range of areas, among others.

While it would be expected that the Nordic nations would do well on education and skills (e.g., high school and post secondary completion, reading, science, and math scores, and literacy, etc.), social (social expenditures, relative poverty, risk of poverty, incidence of low pay, etc.), and health indicators (e.g., life expectancy, premature mortality, infant mortality, suicide, health care spending and services, etc.), their also excellent performance on the economy and innovation indicators indicate there is no necessary contradiction between caring for a nation’s citizens and creating a dynamic and innovative economy. And the very poor performance of the liberal nations reinforces the views that the policy decisions being made in these nations have an excellent model to emulate. These findings offer strong support for implementing public policies associated with the social democratic nations rather than the liberal ones.

Table 3. National rankings on a range of indicators for selected countries (12 first positions).

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<th>Health</th>
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<th>Environment</th>
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Data adapted from:

References
Case study 66. The new global land grabbing as a new form of neo-colonialism. - GRAIN

Land grabbing has been going on for centuries. Well known examples include Columbus “discovering” America and the brutal expulsion of indigenous communities and white colonialists taking over territories occupied by the Maori in New Zealand and by the Zulu in South Africa. This process is alive today and the food and financial crises are triggering a new global land grab. The United Nations Food and Agriculture Organisation warned in 2008 that the race by agricultural commodity-importing countries to secure farmland overseas is creating a neo-colonial system. “Food insecure” governments that rely on imports to feed their people are snatching up vast areas of farmland abroad for their own offshore food production while food corporations and private investors, hungry for profits in the midst of the deepening financial crisis, see investment in foreign farmland as an important new source of revenue. As a result, fertile agricultural land is becoming increasingly privatised and concentrated.

There are two converging agendas driving two kinds of land grabbers. The first track is food security. Countries like Saudi Arabia, Japan, China, India, Korea, Libya and Egypt, which rely on food imports and are worried about tightening markets, have cash to throw around but are seeking to outsource their domestic food production by gaining control of farms in countries such as Uganda, Brazil, Cambodia, Sudan and Pakistan. While it might seem crazy that foreign governments are buying up farmland to produce and export food for their own citizens, this is the case in Darfur (Sudan), where the U.N.’s World Food Programme (WFP) is trying to feed 5.6 million refugees, and in Cambodia, where half a million people currently lack food. The second track is financial returns. Given the current financial meltdown, all sorts of players in the finance and food industries are turning to land, for both food and fuel production, as a new source of profit. The food and financial crises combined have turned agricultural land into a new strategic asset. In many places around the world, food prices are high and land prices are low. So there is money to be made by getting control of the best soils near available water supplies. Where these tracks come together is that, in both cases, it is the private sector that will be in control. In the drive for food security, governments are the ones taking the lead through a public policy agenda. In the drive for financial returns, it is strictly investors out doing business as usual. In both tracks foreign private corporations are getting new forms of control over farmland to produce food not for the local communities.

The list of food security land grabbers includes China, India, Japan, Malaysia and South Korea in Asia, Egypt and Libya in Africa, and Bahrain, Jordan, Kuwait, Qatar, Saudi Arabia and the United Arab Emirates in the Middle East. China is remarkably self-sufficient in food but it has a huge population, its agricultural lands have been disappearing to industrial development, its water supplies are under serious stress and the Communist Party has a long-term future to think of. With 40% of the world’s farmers but only 9% of the world’s farmlands, food security is high on the Chinese government’s agenda. With more than US$1.8 trillion in foreign exchange reserves, China has deep pockets from which to invest in its own food security abroad, with more than 30 recent agricultural cooperation deals in Asia and Africa giving Chinese firms access to “friendly country” farmland in exchange for Chinese technologies, training and infrastructure development funds. Most of China’s offshore farming is dedicated to the cultivation of rice, soybeans and maize, along with bio fuel crops like sugar cane, cassava or sorghum. Local farm workers hired to work the Chinese farms, in Africa for instance, often don’t know if the rice is to feed their own people or the Chinese. Given the hush-hush nature of a lot of these land deals, most people assume that the rice is to feed the Chinese, and a lot of resentment has been building up. In essence, China’s land grab strategy is a conservative one: the government is hedging its bets and maximising its options for the country’s long-term food supply. Gulf States such as Bahrain, Kuwait, Oman, Qatar, Saudi Arabia and the United Arab Emirates have scarce soil and water with which to grow crops or raise livestock, but they do possess enormous amounts of oil and money, which gives them powerful leverage to rely on foreign countries for their food. While China and the Gulf states are the biggest players, other countries are also moving aggressively to find farmland abroad. Japan and South Korea, which get more than 60% of their food from abroad, are two rich countries whose governments have opted to rely on imports rather than self-sufficiency to feed their people. African and Asian governments being approached for their lands are readily accepting the proposals. For them it means fresh inflows of foreign capital to build rural infrastructure, upgrade storage and shipping facilities, consolidate farms and industrialise operations. In Madagascar, about 70% of the country’s 20 million people live below the poverty line. South Korea is the fourth-largest importer of maize and among the 10 largest buyers of soybeans. Daewoo Logistics of South Korea has made efforts to secure a huge tract of farmland in Madagascar to grow food crops to send back to Seoul. The attempt of the company is to lease 1.3m hectares of farmland - about half the size of Belgium - from Madagascar for 99 years. Also, it planned to ship corn and palm oil harvests back to South Korea. Daewoo’s farm in Madagascar represents about half the African country’s arable land, according to estimates by the US government. Behind the rhetoric of win–win deals, the real aim of these contracts...
is not agricultural development, much less rural development, but simply agribusiness development. In mid 2009, after months of demonstrations marked by dozens of deaths, the new president of Madagascar announced the cancellation of the contract with Daewoo.

The private sector agenda

While governments may have food security agendas, the private sector has its own agenda: making money. The food crisis coupled with the broader financial crisis has turned control over land into an important new magnet for private investors. These are not typical transnational agribusiness operations, but a new interest in acquiring control over farmland itself. The two main players here are the food industry and, especially, the finance industry. Within food industry circles, Japanese and Arab trading and processing corporations are those most involved in overseas farm acquisitions. For the Japanese firms, this strategy is being woven into their organic growth. As for the Middle Eastern firms, they are riding on the wave of their governments going out and opening doors in the name of the global food crisis and the big threats to our planet’s future food supplies. This translates into forecasts of tight markets, high prices and pressure to get more from the land. All these factors make agricultural land a smart new toy to make profits with. Food has to be produced, prices will remain high, cheap land is available, it will pay off – that’s the formula. Throughout 2008, an army of investment houses, private equity funds, hedge funds and the like have been snapping up farmlands throughout the world – with great help from agencies like the World Bank, its International Finance Corporation and the European Bank for Reconstruction and Development, who are all greasing the way for this investment flow and “persuading” governments to change land ownership laws so that they can succeed. Morgan Stanley, which nearly joined the queue for a US Treasury Department bail-out, recently bought 40,000 ha of farmland in the Ukraine. This pales in comparison to the 300,000 ha of Ukrainian farmland that Renaissance Capital, a Russian investment house, has acquired rights to. Black Earth Farming, a Swedish investment group, has acquired control of 331,000 ha of farmland in the black earth region of Russia. Alpco-agro, another Swedish investment firm, has bought rights to 128,000 ha there. Landkom, the British investment group, has bought up 100,000 ha of agricultural land in Ukraine and vows to expand this to 350,000 ha by 2011. All of these land acquisitions are to produce grains, oils, meat and dairy for those in the hungry world market … that is, for those who can pay. The speed and timing of this new investment trend is amazing. So is the list of targeted countries: Malawi, Senegal, Nigeria, Ukraine, Russia, Georgia, Kazakhstan, Uzbekistan, Brazil, Paraguay, even Australia. They have all been identified as offering fertile land, relative water availability and some level of potential farm productivity growth. The time horizon investors are talking about is, on average, 10 years with projected annual rates of return of 10–40% in Europe or up to 400% in Africa. Again, what is new and special here is that these financial groups are acquiring actual rights to the land, and many of these moves were made in the last few months of 2008, when financial markets started collapsing.

Concluding remarks

According to estimates made by the Washington-based International Food Policy Research Institute (IFPRI), the amount of land under negotiation in deals to help cash-rich countries in the Gulf and Asia secure food supplies for their growing populations has reached 15 to 20 million hectares since 2006, roughly equivalent to cropland in Germany or France. The monetary value is a huge - $20 to $30 billion. The real problem with the land grab is not simply the matter of giving foreigners control of domestic farmlands but that these lands will be transformed from smallholdings or forests into large industrial estates connected to large far-off markets. Farmers will never be real farmers again. There is a need to invest in agriculture and South–South solidarity, and cooperative economy-building, outside the reach of Western imperialism, can be a good way to do it. But who will control these investments and who will benefit from them? The risk of seeing not just the food but the profits generated from these offshore farming operations being siphoned off to other countries, to other consumers who can pay or simply to foreign elites is real. What about land reform? It’s hard to imagine how conceding farmland to other countries, or to private investors, so that they can produce food to be shipped off to other people, can do anything but take us in the opposite direction and strike a blow at so many movements’ struggles for genuine agrarian reform and indigenous peoples’ rights. In Pakistan, farmers’ movements have raised the alarm about 25,000 villages that are bound to be displaced if the Qataris’ proposal to outsource part of their food production to Punjab province is accepted. In Egypt, small farmers in the Quean district have been fighting to get back 1,600 ha that were recently granted to Kobe Bussan, a Japanese agribusiness conglomerate, to produce food for export to Japan. In Indonesia, activists expect that the planned Saudi rice estate in Merauke, where 1.6m ha will be handed over to a consortium of 15 firms to produce rice
for export to Riyadh, will bypass local Papuans’ right to veto the project. Another big issue is that these deals will further entrench export-oriented agriculture. The heavy push over recent decades towards producing food for external markets rather than internal ones is what has made the impact of the 2007–08 food crisis so hard on so many people, particularly in Asia and Africa.

* For more information on GRAIN and food security, go to: http://farmlandgrab.blogspot.com

**Source**

**Case study 67. Is outsourcing the maintenance of U.S. airlines increasing safety risks?** - Joan Benach, Michael Quinlan and Carles Muntaner

At the same time that concerns about terrorism have increased security controls in airports, especially in the United States, the passenger rights issue has been given a low priority after 9/11 of 2001. As a consequence, airline service has deteriorated with respect to arrival times, mishandled baggage, bumped passengers, and consumer complaints. Some reports have also highlighted a less commonly known issue: airlines are increasing their reliance on overseas maintenance facilities, which are subject to less oversight and fewer inspections. Contracting this work has become an increasingly common practice, while major carriers have shed over 100,000 airline jobs in the past five years. As airlines have struggled with massive financial losses and sharp competition, many have shifted their maintenance work to outside vendors. In 2006, more than half of the major U.S. airlines’ maintenance work was done by third-party vendors, compared with just a third ten years ago.

What are, and what can be, the safety and health risks of the airline industry’s increasing reliance on outsourcing airline maintenance? While the airline industry and the Federal Aviation Administration claim that using third-party workers is not a problem, a number of reports have claimed that poor maintenance by outside contractors is increasing safety and health risk. Similar problems have been identified in Australia, where an audit of overseas maintenance for Qantas identified fourteen safety breaches (Sidney Morning Herald, 2007).

The extent of outsourcing airline maintenance to catastrophically compromise safety has already been demonstrated. In 1996, a Valujet DC-9 airliner crashed into the Florida everglades, killing all 110 on board. The incident was clearly linked to the use of independent contractors on maintenance activities (Rousseau & Libuser, 1997). In the two years prior to its crash, that same plane had made seven forced landings due to a variety of malfunctions. Investigators believed the crash was due to a fire sparked by oxygen generators in the jet’s forward cargo hold. It was alleged the hazard could have been prevented had workers for the maintenance firm, SabreTech, fitted a three-cent safety cap to the generators, something the Acting U.S. Attorney Guy Lewis described as a clear case of “putting corporate profits ahead of public safety.” In December 1999, the by then defunct (itself a regulatory issue) SabreTech was convicted by a federal jury on nine counts in connection with improper handling of oxygen generators blamed for the fire in the cargo hold of the doomed plane (Johnstone, Quinlan, & Mayhew, 2001).

Regulating outsourcing is already problematic (Johnstone et al., 2001), but these problems are exacerbated when foreign contractors are involved because they are outside the normal jurisdiction of U.S. (or other national) OHS legislation. Air transport, like long haul trucking (Saltzman & Belzer, 2007), provides an example of how outsourcing can potentially damage not only workers’ health but also public safety.

**References**
Case study 68. Workers' rights are human rights. - Orielle Solar, Joan Benach and Carles Muntaner

Until recently, the international human rights movement and non-governmental organizations, human rights scholars, and even labour organizations and advocates have given little attention to worker rights as human rights (Gross, 2003). Workers, however, have fundamental rights protected under international law. Article 23 of the Universal Declaration of Human Rights states that: “Everyone has the right to work, to free choice of employment, to just and favourable conditions of work and to protection against unemployment; everyone, without any discrimination, has the right to equal pay for equal work; everyone who works has the right to just and favourable remuneration for ensuring for themselves and their family an existence worthy of human dignity, and supplemented, if necessary, by other means of social protection; everyone has the right to form and to join trade unions for the protection of their interests”. These inalienable rights should not be restricted to officially certified or recognised unions but to all workers including minorities, even if they are a small portion of the total workforce.

These rights are not granted or given to workers by states and business. Employers and governments have the power to violate workers' rights such as the right to form and join unions of their choice, and to engage in activity in defence of their economic and political interests. For example, an extensive report conducted in the USA found that where employers can credibly threaten to shut down and/or move their operations in response to union activity, they do so in large numbers. More than half of all employers made threats to close all or part of the plant during the organizing drive. These threats were an extremely pervasive and effective part of employer campaigns: the election “win rate” associated with campaigns where the employer made plant closing threats was significantly lower (38%) than the win rate found (51%) in units where no threats occurred. Moreover, threats of plant closing seemed to be primarily motivated by the employer’s anti-union disposition, since they were found to be unrelated to the financial condition of the company, with threats no less likely to occur in companies in a stable financial condition than in those on the edge of bankruptcy. Threats included aggressive legal and illegal employer behaviour such as discharges for union activity, electronic surveillance, illegal unilateral changes in wages or benefits, bribes, etc. Unions were increasingly reluctant to file unfair labour practice charges in response to plant closing threats because of the difficulty in documenting and proving that verbal threats occurred, and because the remedies available for threats under U.S. private sector labour law were so limited (Bronfenbrenner, 2000).

Since the middle of the XXth century, “rights” as universal values and unconditional necessities have moved into the centre of political discourse, but there has been very little questioning of the conditions for the formation of such rights, their forms, or their objectives. For something to be proclaimed as a “right” it must be seen as natural and unconditional. Yet rights have a history, since they are proclaimed at particular historical moments for specific reasons. The post-World War II revival of “rights talk” paid little attention to worker rights as human rights, and most labour organizations were unwilling to assert their agenda in such language. However, how are rights constituted? Why do certain claims for labour rights become accepted at certain times and with what effects? While a discourse of the “rights of man” is mostly consistent with such a vision, the right of the citizen to be involved in organizing the economic life of the community is not. Capitalism creates the fantasy of a society in which individuals are free from any essential dependence on others (McIntyre, 2006). Workers’ rights and workplace democracy cannot be fully attained unless the rights of property are limited and economic and social rights are effectively implemented. International trade and investment policies, combined with ineffective labour laws, have created a climate that has emboldened employers to threaten to close, or actually close their plants, and to avoid unionization. Nevertheless, unions and social movements around the world are challenging this view.

References
Under neo-liberalism, the ideology of individualised self-interest and choice are seen as pre-eminent, while the significance of economic power imbalances amongst individuals and the counter-balancing role of collective interests are minimised. In this way, neo-liberalism has promoted individuals’ assumption of risk (e.g., individual pension plans rather than state pensions) and is much less sympathetic to redistributive mechanisms and social protection laws circumscribing business and commercial law and policies (on competition and the like) and more sympathetic to business practices such as downsizing, off-shoring, franchising, labour leasing, as well as greater flexibility in work arrangements, including “freer” international flows of labour (such as business and specialist migration or short-term entrants). The increased use of supply chains/subcontracting networks (at the national and international level), often driven by powerful corporations, has also accelerated changes to labour market conditions in both wealthy and poor countries.

In wealthy countries, the outcomes of these changes include a reduced social safety net for the unemployed and poor, job losses in the public sector, growth in job insecurity and precarious employment, a weakening (in practice) of regulatory protections, and the historical re-emergence of an informal economy, including home-based work and child labour [see Table 12]. This impact is further complicated by increased female workforce participation and an ageing population in these countries (see age axis in Chapter 2).

In poor countries, the reliance on neo-liberal economic policy has resulted in a model of economic development oriented towards productivity and supplying products to global markets in three ways. First, irrespective of their effects on local communities, the strategies employed include “race to the bottom” working conditions to attract overseas capital and the use of corporate-friendly, low-regulatory special export zones. Some of the harmful by-products of these practices include decreased domestic food production, rural dislocation, and social instability (Labonte, Schrecker, & Gupta, 2005). In addition, cuts to the public sector have had significant implications for education and health expenditures. It has been argued that weakening the capacity of the state to redistribute income has undermined the low income/high health outcomes a number of middle-low income countries had managed to achieve in previous decades (Labonte, 2001). The formal sector has experienced downsizing, job insecurity and outsourcing analogous to those in wealthy countries, while the already substantial informal sector, exempt from most forms of social protection, has grown...
in many instances. These are the three major setbacks to poor countries pursuing a neo-liberal economic framework.

These impediments are further exacerbated by a series of exogenous factors, multiplying the scale of the problem. Elaborate supply chains obfuscate the ultimate producer of goods and services in ways that help perpetuate work arrangements that often parallel the exploitation of vulnerable workers (women, children, and foreign-born workers) in wealthy countries over 100 years ago (Quinlan, Bohle, & Mayhew, 2001). Furthermore, corporate interests, predominantly neo-liberal policy instruments such as the World Bank, World Trade Organisation (WTO), and the International Monetary Fund (IMF), and the governments of some wealthy countries providing aid have in general not been sympathetic to the expansion or upgrading of social protection frameworks within poor countries. It cannot be presumed that most poor countries will follow the path of wealthy countries over the past century in terms of labour market intervention and social protection. While a scaled-back welfare state persists in wealthy countries (Taylor-Gooby, 2008), these policy interventions are diminishing with the fading of labour union influence.

The organised labour movement that played a critical role in encouraging this social protection in the first place (in conjunction with the political crises and depressions of the 1890s and 1930s) has been in decline and/or suppressed completely in some poor countries (Betcherman, Luinstra, & Ogawa, 2001), further facilitating the changes of the neo-liberal regime. The international wave of resistance to neo-liberalism has led, however, to significant mass strikes and protests in many countries. An analysis of workers' movements and struggle on a world scale, over the course of a century and within the totality of global capitalism, shows that workers in different places are linked by the global division of labour and the international state system. When capital organises a profitable strategy, it produces resistance, generating new strategies of accumulation, and hence new forms of resistance (Silver, 2003) [see Case study 69].

**Case study 69. Trade unionism, working conditions and social inequalities in health.** - Laurent Vogel

From its very start, trade unionism has faced the need to work out a policy addressing workers’ health, as this was affected by job-site physical activities. At the dawn of the industrial revolution, since workers were building the consciousness of being a class with specific interests within capitalist society, the physical aspect of that separate existence was beyond any doubt. The earliest systematic descriptions of the working world emphasise the many changes wrought upon the body by employment conditions. Observers from hygienists like Villermé to radical campaigners like Engels, with

"Dignified work for everyone, everywhere". May 1st Demonstration in Barcelona (Spain).
Source: Antonio Rosa (2008)
his account of the condition of the English working class, all describe these realities in painstaking detail. Being a manual worker has always meant having a body worn out before its time, under constant attack from toxic and health-endangering substances. Maintaining health or just staying alive required a strategy for collective defence.

This was the setting for the emergence of trade unionism, a particular kind of organisation within a wider whole that included mutual help associations, hardship and strike funds, co-operatives, labour exchanges and political parties. At the turn of twentieth century, the labour movement in all industrialised countries built up a complex set of organisations that defined a new and different sociality, forms of political action and visions of the future that were different from those of the other social classes.

Actions to mitigate social inequalities in health came to loom large in this process. These actions were simultaneously directed at the working conditions that damage health, and at the other factors in society that widen the social inequalities in health, such as inequalities in income, housing conditions, and access to care.

Activist, engaged social medicine appeared very early within the labour movement. In Berlin, for example, Dr. Salomon Neumann formed a health care association within the German Workers’ Brotherhood, which set up close communication between workers and doctors, allowing epidemiological research done by workers themselves and initiating demands for preventive medicine. The association had 9,000 members when it was proscribed in 1853.

The battle for health was first waged without divorcing working conditions from other living conditions. So, attempts to fight tuberculosis were coupled with demands for better housing, better pay, rest breaks, shorter working time, and clean air in work places.

From the nineteenth century onward, the struggle for health brought direct participation of workers to the fore, both in identifying the problems and in establishing a bargaining position by which solutions could be achieved. Among the labour movement’s various initiatives were hygiene congresses held in France by professional organisations and workers who, based on their own experience, offered a precise picture of working conditions in the main sectors of activity, and informed about the most evident deficiencies concerning hygiene and safety, expressing the desire for a better life. Workers want practical reforms, justified by the medico-scientific knowledge offered to them by leftist doctors and engineers. They want also to participate and supervise the change they are asking for. The call for the organisation of one of those congresses on workers’ health, held in France in 1904 as an initiative of the labour movement, is a case in point. In it, the worker demands listed were “to hold a workers’ conference, in which they recounted their own personal, real-life experiences in practice, under the deplorable health conditions in which they were generally forced to work, to make known the physical and mental distress, diseases and infirmities that result from the lack of hygiene . . . , and to come up with practical solutions” (Bouillé, 1992).

Struggles waged in the nineteenth century include the strikes to outlaw white phosphorus in the match industry, the strikes to get white lead paint banned, and, of course, the ongoing campaign to limit the working day and ban child labour. In many cases, those struggles were carried out by successive generations of workers with different results between the countries. White phosphorus in the fabrication of matches was banned in Finland in 1872, but it was not until 1912 that a federal tax eliminated white phosphorus matches from the market in the United States.

The introduction of compensation schemes for work-related risks had conflicting effects in many countries. It helped the victims of work accidents survive by providing them with replacement income, but it often deflected the focus away from actions to improve health and safety conditions at work. The political dimension of health and safety at work was obscured by narrowly technical approaches. Two approaches in particular are notable: health damage was monetised and work-related health problems were outsourced to specialists in prevention.

In the 1960s and 1970s, a new momentum had a major impact on trade union action on health and safety at work. Working conditions were again being questioned, leading labour movements in many countries to resume the fight against social inequalities in health in many different ways by coupling demands on work hazards with a more holistic solution. The Italian health reform of the 1970s was a particularly advanced scheme, which introduced across-the-board action on all the social determinants of health, with action by workers and the public as the prime mover. A resurgent trade union policy for health and safety at work that transcends national differences has resulted, and is further informed by two new inputs: environmental protection (especially the fight to replace the most dangerous chemicals) and feminist awareness of a specific gender dimension to work-related health problems. This resurgence has prompted many trade union organisations to develop their own tools for research and action to support the crucially important work done by workers’ safety representatives.

Sources

Table 12 provides a generalised comparative historical summary illustrating some of the shifts in labour market conditions, union presence, social protection apparatuses, and other areas of state activity relevant to health. The dates were selected to broadly capture the period of laissez-faire capitalism prior to significant social protection and collective regulation (1880), the highpoint of Keynesian post-war economics and the welfare state (1970), and the present day neo-liberal ascendancy marked by a return to market-driven policies and a weakening of social protection and the welfare state (2009). One critical outcome affecting most, if not all, countries was the splintering or trifurcation of work-related standards (minimum wages/industrial relations, occupational health and safety, and workers’ compensation) into three separate regulatory regimes (Carson & Hennenberg, 1988). As Table 12 indicates, comparison between wealthy countries in 1880 and poor countries in 2008 reveals some striking parallels in terms of labour market conditions, the power of labour, health infrastructure, and social protection (Steinmo, Thelen, & Longstreth, 1992; Quinlan et al., 2001).

### Table 12. Work and the protection of workers’ health in wealthy and poor countries in 1880-2010.

<table>
<thead>
<tr>
<th></th>
<th>WEALTHY COUNTRIES</th>
<th>POOR COUNTRIES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1880</td>
<td>1970</td>
</tr>
<tr>
<td>Employment security and contingent work</td>
<td>No regulated job security</td>
<td>Secure jobs norm (except women) in small contingent workforce</td>
</tr>
<tr>
<td>Minimum labour standard laws (wages and hours)</td>
<td>No minimum wage or hours laws (except children)</td>
<td>Universal minimum wage and hours laws</td>
</tr>
<tr>
<td>Extent of union membership and collective bargaining</td>
<td>Union density low (&lt;10%) and limited collective bargaining</td>
<td>Union density 25–50% and extensive collective bargaining</td>
</tr>
<tr>
<td>Extent of vulnerable groups of workers</td>
<td>Extensive exploited vulnerable groups (women, immigrants, home-workers, young and homeless, old)</td>
<td>Still vulnerable groups (women, immigrants and home-workers) but more circumscribed</td>
</tr>
<tr>
<td>Extent of occupational health and safety law</td>
<td>Limited OHS law (factories, mines and poorly enforced</td>
<td>Expansionary revision of OHS laws initiated</td>
</tr>
<tr>
<td>Extent of workers’ compensation system</td>
<td>No workers’ compensation system</td>
<td>Mandated workers’ comp/injury insurance system</td>
</tr>
<tr>
<td>Extent of public health infrastructure (water, hospitals, sewer etc)</td>
<td>Little public health infrastructure sewer, hospitals, water</td>
<td>Extended public health infrastructure/ health insurance</td>
</tr>
<tr>
<td>Social security safety net (sickness, age and unemployment benefits)</td>
<td>No age pension, social security, unemployment benefits</td>
<td>Age pension/social security, unemployment benefits</td>
</tr>
<tr>
<td>State activity in utilities, education and transport</td>
<td>Limited state involvement in education and transport</td>
<td>Wide government involvement in education, transport, utilities</td>
</tr>
</tbody>
</table>

Source: Prepared by the authors
9.3. EMPLOYMENT-RELATED INTERNATIONAL POLICIES AND ACTORS

The fact that many of the changes in employment practices (including global subcontracting networks) described in this book transcend national boundaries, the traditional venue of labour standards and social protection law, has raised fundamental questions about how health issues are to be addressed. Options to address this include enhancing the extra-territorial application of labour law (as is already occurring with environmental law) or incorporating labour standards into commercial contracts where legal enforcement mechanisms already exist (Mundlak, 2009; Nossar, 2007). While valuable, these options lack immediate global coverage.

A logical response would be to look towards international labour standards that could ensure that global trade and business practices do not result in a “race to the bottom”, as countries strive to retain their competitiveness. However, labour standards are not a component of WTO agreements or rulings, with some governments labelling them as culturally insensitive or “hidden” protectionism (DiCaprio, 2004; Servais, 2004). Although labour standard provisions are to be found in some “free” trade agreements, they are often ambiguous or lack enforcement provisions (Martin, 2005). For example, a study of child labour provisions in US free trade agreements found that they were ineffective, being largely generic without supporting empirical standards or targeted enforcement practices (Chilcoat, 2008).

This indicates a broader impotence of international organisations to affect change in this area. For instance, the International Labour Organization (ILO) has sought a chair at the table and has secured some dialogue with the WTO, but the failure to make labour or environmental standards part of the global framework of trade, commerce/lending and capital or labour movements has arguably marginalised its influence on these developments (World Trade Organization [WTO], 1996; ILO, 1997; 2000, Fustukian, Sethi, & Zwi, 2001). At the same time, the ILO has produced reports on “fair globalisation”, reported on child labour, and proposed new standards on work at home, as well as abuses of labour standards. A major limitation for the ILO is that, unlike the WTO, it is a tripartite body (including employer/corporate representatives as well as governments antithetical to worker interests), meaning that the development of new standards is often a lengthy process.

Even after consensus is reached, affecting change remains difficult. Unlike the rulings of the WTO, ILO standards and recommendations do not include punitive measures for countries that fail to meet these standards.

Hundreds of child workers have been withdrawn from domestic service thanks to CHODAWU (Conservation, Hotels, Domestic and Allied Workers Union) and the ILO’s International Program on the Elimination of Child Labour (IPEC) (United Republic of Tanzania).

Furthermore, steps to implement standards once ratified vary enormously. Similarly, the United Nations Global Compact on corporate citizenship is essentially a voluntary exercise and, while formally targeting both forced and child labour, has not addressed gender inequality in poor countries, even though women make up a disproportionate share of precarious and informal employment (Kilgour, 2007).

More success has arguably been achieved at the social and political level. Here, community groups including religious bodies and ethnic associations, unions, and Non-Governmental Organisations (NGO’s), have sought to garner public support (including consumer boycotts) to pressure industry and government into taking action on the worst abuses of employment practices in both wealthy and poor countries. To this end, new forms of community organisations and alliances have appeared (Osterman, 2006). Examples include informal worker alliances in poor countries and the “fair-wear” garment workers and anti-child labour campaigns in Europe, the USA, Latin America, and Australia. In Norway, a broad alliance of unions and community groups formed For Velferdsstaten (For the Welfare State) to campaign against market liberalism and privatisation in favour of social welfare and public services. Sometimes out of their own volition, but also in response to community pressure, a number of private corporations (such as large retailers) and NGOs have adopted ethical or corporate social responsibility (CSR) codes in relation to the labour and occupational health and safety standards of both their domestic and, more importantly for poor countries, international suppliers.

Yet even these successful ventures have their limits. Compliance with these voluntary codes has often been problematic due to less-than-rigorous monitoring and enforcement on the part of the corporation or evasion on the part of suppliers (frequently a subcontractor multiple steps removed from the original contract), sometimes with the active connivance of local government or its officials (Jenkins, 2001; Locke, Qin, & Brause, 2006; Fig, 2007; Utting, 2007; Lum, 2003). Evidence indicates that voluntary codes, despite being of some value, especially in terms of initiating international protocols, are not an alternative to mandated standards due to serious limitations in coverage and compliance (Bremer & Udovich, 2001; Sobczak, 2003; Pattberg, 2006).

Alternative methods of extending the reach of laws governing labour standards have been suggested to supplement ILO standards and voluntary codes of conduct (Locke, Kochan, Romis, & Qin, 2007). This includes domestic disclosure regulations on corporations based in a particular country, which would obligate them to reveal
who actually produced a good or service (even if that activity was undertaken externally) and under what labour conditions (Doorey, 2005). Some existing models of supply chain regulation at the national level, which incorporate disclosure requirements as well as union/community involvement in enforcement and directly mandate labour standards, could arguably be extended internationally. It is worth noting that the latter were secured following political mobilisations of workers and community groups.

In 2009, UN Special Rapporteur on human rights and counter-terrorism Martin Scheinin claimed that since “multinational corporations, international organisations [and] armed groups and terrorists now have the powers to negate or destruct human rights” there is a need for making actors other than states accountable. Corporations suspected of abusing human rights should thus face the full force of international law through trial by a new global court. In Scheinin’s view, this “World Court of Human Rights” would involve the establishment of a global tribunal that would, for the first time, have a mandate to try private companies accused of human rights abuses, as well as the power to enforce legally-binding judgments on transnational companies and organisations in addition to governments and, crucially, would be able to demand compensation for victims (The Commonwealth, 2009).

In Table 13, we present a matrix with different options for international policies and actors according to the defined employment conditions presented.

**Table 13.** Selected examples of international policies (international organisations, unions, employers, civil society).

<table>
<thead>
<tr>
<th>Proposed Policy</th>
<th>Actors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Global compact - corporate citizenship initiative (including child &amp; forced labour)</td>
<td>United Nations</td>
</tr>
<tr>
<td>Promote decent work agenda</td>
<td>ILO</td>
</tr>
<tr>
<td>Ratification ILO framework convention</td>
<td>ILO</td>
</tr>
<tr>
<td>Further ratification of C 182 and C 138 on child labour</td>
<td>ILO</td>
</tr>
<tr>
<td>WTO agreements; include employment and working conditions</td>
<td>WTO</td>
</tr>
<tr>
<td>Promote basic occupational health services, linked with PHC</td>
<td>WHO</td>
</tr>
<tr>
<td>Include employment and working conditions in regional policies and agreements</td>
<td>WTO, regional trade mechanisms</td>
</tr>
<tr>
<td>Global ban of hazardous products (eg asbestos)</td>
<td>International organizations</td>
</tr>
<tr>
<td>Control the application of double standards between and within countries (including top of corporate chain responsibility for employment practices at any subsequent level/ country damaging workers’ health)</td>
<td>OECD, regional trade mechanisms, multinationals, WTO, ILO, financial institutions [IMF, WB]</td>
</tr>
<tr>
<td>Promote compliance OH in multinational corporations</td>
<td>Corporations</td>
</tr>
<tr>
<td>Strengthen employment and working conditions considerations in collective bargaining tools and processes (unions) including multi-lateral/multinational agreements and inter-union movement agreements and strategies (eg US and China re wage levels)</td>
<td>Unions</td>
</tr>
<tr>
<td>Strengthen intersectoral action on WFCL (create alliance between ILO, WHO, WTO, UNICEF, with involvement of unions and employer organizations)</td>
<td>UN and others</td>
</tr>
<tr>
<td>Global movement (civil society) against trade involving WFCL</td>
<td>Civil society</td>
</tr>
<tr>
<td>Global movement (civil society) against trade involving slavery and bonded labour</td>
<td>Civil society</td>
</tr>
</tbody>
</table>

Source: Prepared by the authors
9.4. EMPLOYMENT-RELATED POLICY OPTIONS FOR REDUCING HEALTH INEQUALITIES

This section presents a framework for identifying and classifying employment-related policy initiatives. The framework evaluates policies that have already been implemented, as well as those policies that are being implemented now in order to suggest possible designs for future policies that aim to reduce health inequalities related to employment conditions. Such a framework is necessary thanks to the complex reality of working conditions, which must be systematically organised to produce useful policy recommendations. As we have established, employment-related health inequalities arise from a variety of factors and manifest themselves through various pathways from the “macro” to the “micro” social conditions and contexts of work and employment. Thanks to the preceding theoretical treatment linking employment conditions and health inequalities, we are ready to identify points of entry for successful policy interventions. Figures 25 and 26 illustrate these entry points in relation to the conceptual frameworks used in this book.

Figure 25. Policy entry points in the macro-theoretical framework.

MODEL OF DEVELOPMENT Historical, Political and Ecological context
[poverty, income inequality, economic structure, environment, productivity, technology, education, culture]

Source: Prepared by the authors
Policy entry point A refers to any change in the power relations between the main political and economic actors in society. Political power is understood here, in a broad sense, as not limited to traditional political actors (such as political parties) but also including any actor essential to the understanding of a country's social context. For example, in contemporary societies, political actors include political parties, trade unions, corporations, transnational companies, banks, employer associations, and civil society organisations.

Policy entry point B refers specifically to modifications of employment conditions which reduce exposure and vulnerability to health-damaging factors. These policy initiatives could include, for example, regulating temporary work to promote safety and health in the workplace and during working hours.

Policy entry point C relates to actions modifying working conditions, such as health-related material hazards in the workplace, behaviour changes and psychosocial factors present in the workplace or living situation.

Policy entry point D relates to different types of interventions which may reduce the unequal social consequences produced by poor health and psychopathological change.

Demonstration by informal sector workers through the streets of Managua (Nicaragua).
Source: Antonio Rosa [2004]
These points of entry illustrate the variety of ways of implementing policies targeting health inequalities related to employment conditions. The prevailing policy emphasis, however, does not address the broader social issues that create pervasive patterns of health inequality. Instead of targeting welfare state provisions, most health policy, in accordance with neo-liberal recommendations, pertains to the workplace, which does not influence the wider problem of a lack of worker protection (Lynn Skillen, 1996).

These usually ineffective policy frameworks follow three perspectives. First, from the biomedical perspective, the “lifestyle approach” converts the social problems of work into private, individual problems. Second, the environmental perspective emphasises acceptable exposure limits for biological, chemical, ergonomic and physical hazards. This ignores psychosocial hazards and the organisational context (Addley, 1999). A third perspective, the classic epidemiological approach, emphasises the surveillance of hazard outcomes (diseases and injuries) but not surveillance of the organisational factors underlying exposure to hazards. The problem is that none of these three perspectives consider how power differentials determine hazardous exposures and worker vulnerability, how workers’ consent to exposure is negotiated or how the labour force is segmented by gender, class, or race, thus ignoring institutional factors (e.g., weakened regulatory processes and public policy). Many of the same limitations apply to micro-credit schemes and the voluntarist notions of corporate social responsibility that are promoted to improve health in poor countries. These perspectives only partially respond to changes in society at large.

To address this shortcoming, we provide an outline with examples of the policy entry points that we have identified according to our theoretical framework. In this framework the greatest emphasis is on structural policies and interventions. These are public health interventions that promote health by altering the structural context within which health and health inequities are produced and reproduced (Blankenship, Friedman, Dworkin, & Mantell, 2006). They are more effective because they are related to the production and reproduction of hazards from employment and working conditions, tackling the systemic problem rather than individual cases.
Power relations (changing power relations between political and economic actors in society)

Entry point A pertains to those policies and interventions that change power relations between the leading political and economic actors. The repercussions of this change affect employment conditions. Here we refer to power relations in a broad sense, not limited to the interaction of traditional political forces (for example, political parties), but including any actor that is essential for understanding the social context in a country. We include these actors because they are part of a pattern in which neo-liberal labour policies marginalise worker safeguards.

Global growth in the levels of under-employment/disguised unemployment, precarious employment, informal work and child and bonded labour has both reflected and reinforced the disempowerment of workers and their industrial and political representatives (where these exist). Even within the European Union (EU), the dominant neo-liberal discourse underpinning integration, economic development and EU enlargement has progressively marginalised the role of unions and collective regulation (Visser, 2005; Woolfson, 2007). Neo-liberalism, both as an ideology and as a set of policies, is antithetical to a strong collective voice in economic and social affairs on the behalf of workers and through which they can effectively articulate their interests. Weakened unions (Visser, 2006) cannot safeguard workers in many countries, and the policies of social democratic/labour parties have been met with decreasing success. Workers’ rights centres (including those catering to immigrants, see Cho et al., 2006), community groups, and broader social alliances (local, national and trans-national) provide a fulcrum for change. Even when fragmented, their achievements include consumer boycotts and supply chain regulation in pursuit of improved labour standards and working conditions.

Yet policy frameworks fail to address the important role played by these organisations for the sake of preserving competition. At the international level, there is a double standard in terms of the enforceability of “investor” and “worker” rights (Taylor, 2000) as well as undue corporate influence on labour law standards in poor
countries (Global Labour Strategies, 2007). In contemporary societies, political actors include political parties, trade unions, corporations, trans-national companies, banks, employer associations, NGO's, and civil society organisations. But a focus on neo-liberal policies only captures some of the interests mentioned, excluding useful welfare state provisions. For example, regarding the labour market, at the behest of workers' rights groups, minimum wage reform or modifications of the requirements for lawful dismissal have an empowering effect on workers. In terms of the welfare state, these groups would advocate social protection legislation concerning, for instance, the provision of day-care centres for children between the ages of 0 and 3 years and the right of single mothers to financial assistance or free public provision of child care. These policies have direct impact on otherwise marginalised workers', such as mothers', real insertion into workforce (Whitehead, Burstrom, & Diderichsen, 2000) [see Case study 70].

For these policies to take form, it is essential that informed and organised stakeholders be included in the policy-making process. When these groups are pushed aside, they are in very real danger of not only being ineffective but also being formally prohibited, destroying the possibility of the free association of workers. Yet the domination of policymaking by economic interests, who segment the production chains in order to stem competition, makes this a very real possibility. In this light, a useful policy intervention in entry point A would be ensuring adequate representation of small and micro-enterprises, both for reasons valid for union organising itself and because the largest share of problems relating to these businesses stems from asymmetry in negotiating power vis-à-vis large companies in a wide range of industries (Ferez, 2005; Human Rights Watch, 2002).

**Case study 70. The introduction of anti-sweatshop legislation in the U.S. - Charles Kernaghan and Barbara Briggs**

For the first time in history, anti-sweatshop legislation was introduced in 2006 in the US Congress which prohibited the import, export or sale of sweatshop goods in the US. On the heels of the National Labor Committee’s report documenting human trafficking, involuntary servitude and sweatshop labor in Jordan under the US-Jordan Free Trade Agreement, senator Byron Dorgan introduced Senate Bill S367, the Decent Working Conditions and Fair Competition Act. The bill, reintroduced in 2007 as Senate Bill S367 and House Bill HR 1992, will for the first time hold corporations legally responsible for upholding the ILO’s core worker right standards –no child labour, no forced labour, freedom of association, right to organise and bargain collectively and to decent working conditions. While the legislation will be enforced by the U.S. Customs Department and the Federal Trade Commission, it also includes an important right to private action, which allows individuals and organisations to sue corporations for violating the law. Further, the legislation would establish strict sweat-
Employment conditions (modification of employment conditions to reduce exposures and vulnerability to health-damaging factors).

Entry point B concerns policy interventions targeted at changing employment conditions to reduce, via various mechanisms, the impact of exposure and vulnerability to health-damaging factors. At present, labour standards and their implementation at both the national and international levels stand in the way of protecting workers from the adverse health effects of dangerous employment conditions. A general focus on the efficiency of the firm and sector-based economic competitiveness has created employment conditions that favour the profitability of employers rather than on any measure of social efficiency.

Approaches at the national level in some middle and low-income countries have had some success (see Case studies 71 and 72). In several cases, strong community pressure has forced better supply chain regulation to reduce the occupational health and safety problems associated with particular industries [especially agriculture, construction, road transportation, and sweatshop garment making] that rely on elaborate subcontracting networks (James, Johnstone, Quinlan, & Walters, 2007). Some cases include the integration of labour/industrial relations, occupational health and safety, and workers' compensation standards and laws, raising the broader question as to whether this historical trifurcation needs to be reconsidered.
In contrast, international efforts have been frustrated in their efforts. The ILO’s decent work agenda lacks meaningful enforcement and efficacy despite having provided a global framework for structuring policy intervention. Similarly, the quality of work policy debate within the EU has lapsed in the face of opposition on the part of employers and the importance of practicing neo-liberal economic policy. Despite these unfruitful efforts, there is a further need to consider globally enforceable supply chain laws that protect workers in both wealthy and poor countries. Voluntary codes and other manifestations of corporate social responsibility (CSR) offer a fragmented and inadequately enforced remedy which fails to empower workers/producers (including affording them key input in terms of monitoring and enforcement) or challenge the commercial arrangements and social relations underpinning poor labour standards in global production systems (Lum, 2003; Barrientos & Smith, 2007; McDonald, 2007; Newell & Frynas 2007). As of yet, little consideration has been given to policy interventions stemming practices which deteriorate occupational health and safety, such as downsizing or taxation policies that encourage the expansion of informal work or self-employment. Some countries are reconsidering or re-regulating areas of flexible employment, but contradictory socioeconomic policies and the underlying incentives for these arrangements remain largely unaddressed, highlighting the need for useful macro framework to overcome these issues (see Case study 73).

The narrow notion of efficiency within neoliberal policy discourse, which gives rise to problems and contradictions for policy-makers, needs to be questioned in favour of one that recognises broader social efficiency based on UN human development indicators and sustainability, including occupational health and safety (Lefeber & Vietorisz, 2007). Ultimately, revised labour standards need to be dovetailed with a more proactive approach towards work quality in wealthy countries and basic poverty abatement in poor countries (including the provision of food and low-cost health services). Such changes may affect both the distribution of employment conditions and their specific content. Let us illustrate this point with some examples.

A change affecting the distribution of conditions of employment would, for example, be the legalisation of temporary
employment agencies. This would in all likelihood lead to an increase in temporary contracts and, in many cases, in precarious employment. There are also examples of changes that affect the nature of employment conditions. For example, conditions of informal employment may be improved by the provision of free and universal access to health care for informal workers, independent of the social security system (Lund & Marriot, 2005). Other examples include the existence of unemployment insurance with mechanisms for sustainability, the possibility of real reinsertion into the labour market linked to such insurance in the short and medium terms (ILO, 2004), access to compensation for temporary injury, and parental leave for both parents (ILO, 2004).

Case study 71. Brazil’s movement of rural landless workers (MST). - Artur Sixto, Fernando Ferreira Carneiro and Montse Vergara Duarte

In Brazil, 45 per cent of agricultural land is held by around 1.5 per cent of population, while about half of all landowners own only about 2 per cent of all arable land (Instituto Nacional de Colonização e Reforma Agrária, 2007). About 31 million Brazilian people (18.8% of the total population) live in the countryside (Instituto Brasileiro de Geografia e Estatística, 2000). Many of them do so in scattered dwellings built within the limits of large (often huge) properties, where they are allowed to stay and obtain their own food supplies in exchange for regular or occasional paid labour. These people, known as agregados, are extremely poor and suffer high rates of psychosocial, educational and health problems caused, in part, by their working and living conditions.

In southern Brazil, during the late 1970s, the mechanisation of agriculture was already leaving thousands of poor peasants without a living, while arable land was often left unproductive within larger estates. Numerous agregados and smaller farming families could barely survive on their patches of land and began to migrate. This was the background for the appearance of a farmers’ movement towards the end of 1980 in Rio Grande do Sul, the southernmost state of Brazil, when about 600 landless families gathered to camp in an area then split between three unproductive estates. This gesture enjoyed external backing from the progressive wing of the Catholic Church (Liberation Theology and Pastoral Land Commission, or Comissão Pastoral da Terra) and some civil rights and political groups. Eventually, these families succeeded in making the government expropriate and distribute some of the land. These families then organised into a movement that was officially founded in 1984: the Movimento dos Trabalhadores Rurais Sem Terra (MST), or the Movement of Rural Landless Workers.

These days, MST is probably the largest social movement in Latin America, with around 1.5 million members. Its major achievement has been to increase the number of new landowners from a few thousand to more than 300,000 in about 2,000 settlements (See MST). Its main political and social goals are to guarantee human rights and work for all, and to distribute land and wealth more fairly. MST is also trying to introduce more environmentally sound agricultural practices by organising cooperatives and introducing alternatives, sustainable production and exchange methods. Equality is an essential principle of MST, and agrarian reform is proceeding with social and gender equality and with worker health concerns in mind. The MST has proved effective in obtaining land distribution, and also in providing social support at the community level. As a result, in addition to landless farmers, today the movement also welcomes growing numbers of migrants from urban areas in what might possibly be a reversal of rural exodus; these people believe that farming offers better living conditions and the recovery of farmer’s cultural identity.

A key legal element of MST agrarian reform is the Brazilian Constitution, which sets forth the basic principle that private property must serve a social function. Private land that is left unproductive can be claimed by landless workers under this article, as well as under Articles 184 and 186, which specifically concern expropriation. Occupation is often the first step, after which the occupants demand the land parcel’s expropriation, followed by owners taking legal action to have the landless workers evicted. Once the legal system is set in motion, quantitative criteria are used to assess land productivity and whether or not it fulfills a social function, and the dispute is settled.

The MST plans its activities and elects representatives using participatory democracy, and functions through social participation in all issues and self-governance at the local community level; however, it exists entirely outside of government institutions and political parties. All MST activities are grouped under nine sectors or collectives: Production, Cooperation
EMPLOYMENT, WORK, AND HEALTH INEQUALITIES - A GLOBAL PERSPECTIVE

and Environment; Education, Political Training and Activism; Gender; Health; Communications; Human Rights; International Relations; and Culture.

The MST health sector promotes a very broad notion of health that encompasses all aspects of life which might affect health (employment and working conditions, environment, education, nutrition, housing, access to health care, and so on). What follows are just some examples of its wide reach. The sector organises courses (up to the undergraduate level) and workshops for MST members and trains community health educators and physicians in partnership with the Ministry of Health, as well as academic and research institutions from Brazil and other countries. It has launched vaccination campaigns, an HIV/AIDS prevention program, has promoted phytotherapeutic plant groves and gardens in the communities, and has reached an agreement with the Oswaldo Cruz Foundation for funding. It has carried out preventative education in dental hygiene and nutrition and has organised activities to improve housing and quality of life in general.

Research has shown that members of MST communities (either from encampments or settlements) enjoy better health than other agricultural workers (the temporary rural landless workers and their families, called bóias-frias, or "cold meals"). The bóias-frias had a higher level of food supply uncertainty, had a lower and more irregular income on average, and higher exposure to pesticides [Carneiro et al., 2008]. The improved health of MST community members has been also attributed to a higher production of livestock, better nutrition (partly due to a greater diversity of produce), community support to the needy, and direct involvement in community decisions [Carneiro et al., 2008; see MST].

The Brazilian Health System (SUS) began its partnership with MST to prevent HIV/AIDS after validating the fact that previous work done by MST had been proved effective. The MST, like other rural social movements in Brazil, played a part in the 1998 Brazilian Health Reform, asking for improvement in public policies related to health (health education, promotion of health and access to health care) and its social determinants (employment and working conditions, nutrition, and housing and education). Formal requests to the Ministry of Health were put forward through a democratic and participatory process. An important milestone was the creation of the Grupo da Terra in 2003 by the Brazilian federal government. Grupo da Terra is a committee which includes representatives from several governmental health department units, rural social movements including the MST and other citizens at large. Among other goals, the Grupo da Terra’s mission is to serve as an instrument of communication between rural social movements and the Ministry of Health and to oversee the implementation of health policies in rural settings [Almeida Andrade & Rodrigues Nagy, 2004].

In spite of all their achievements, improving health continues to pose a daily challenge for the MST. Most communities still have difficulties accessing health care, and rural living conditions are still precarious compared to urban dwellers. The MST communities are aware of that and seek further governmental support and involvement through the SUS, as well as intersectorial commitment from different government departments (in housing and environmental issues, for instance). Avoiding violence is another permanent challenge, since encampments often produce hostile situations. Because police and landowners’ security forces carry firearms, and settlers often defend themselves with farming equipment, clashes may occur and sometimes lead to serious and even fatal injuries.

Another daily challenge for MST communities lies in finding financial resources for supplies. Still another is communication; the national press is mostly urban and suspicious or hostile to any grassroots movement with a social agenda. In spite of that, media attention of any kind is an acknowledgement of the relevance of MST activities.

Successive Brazilian governments have acknowledged that the MST is an important player in the social and political agenda. MST now enjoys a good reputation as an important tool in advancing the conditions of Brazilian peasants. The MST receives support from progressive sectors of the church, social movements, unions, sections of the urban and rural middle classes, several progressive universities, research centres and governmental organisations, national and international NGOs, and committees of solidarity with the Brazilian landless in Europe and North America [Martins de Carvalho, 2007].

The MST has acted as a catalyst, not only in the agrarian reform, but also in health and education, directly impacting governmental decisions and public policies. At the international level, it has become a leading voice, often mentioned in relation to Via Campesina. MST not only helps return land to the people, but also their voice, dignity and power to decide community issues.

References
Case study 72. Organising the informal workers around the world. - StreetNet International

The informal economy is a broad term used to describe a very large and growing sector of the global economy where the world’s working poor earn a living. The term seeks to capture the reality of the large share of the global workforce who remain outside the social institutions of full-time, secure, stable and protected jobs and, in many cases, lack any social protection. Worldwide it is estimated that informal work, broadly defined, comprises one-half to three-quarters of non-agricultural employment in middle- and low-income countries, with the highest numbers in Asia and Sub-Saharan Africa (International Labour Organization, 2002). Informal work traverses many occupations, including self-employed and own-account workers, migrant, casual, and temporary workers in an increasingly globalising world economy. The informal economy also comprises different sectors. Apart from street vendors, informal market vendors and hawkers (StreetNet’s sector), there are also waste collectors, home-based, informal transport and agricultural workers, and other occupations.

In recent years there has been substantial development in the global organisation of workers in the informal economy with the direct involvement of the trade union movement as well as in the form of a new social movement of informal workers’ organisations. StreetNet is an international federation formed in 1995 by a group of activists from eleven countries committed to increasing the visibility, voice and bargaining power of street vendors throughout the world. In 2002, this organisation was formally established in Durban, South Africa, and today dozens of organisations from all over the world are affiliated in StreetNet International, mainly from Africa, Latin America and Asia, including, for example, the Zimbabwean Chamber Informal Economy Associations (ZCIEA), the Self-Employed Women’s Association (SEWA), the National Alliance of Street Vendors of India (NASVI), the Korean Street Vendors Confederation (KOSC), the Confederacion de Trabajadores por Cuenta Propia (CTCP) of Nicaragua, and the Federacion Nacional de Organizaciones de Trabajadores No Asalariados (FNOTNA) of Mexico (see StreetNet).

StreetNet’s key objectives include the following: to promote local, national and international solidarity between organisations of street vendors, market vendors and hawkers, and stimulate the development of national alliances of such organisations; to build an information base on the numbers and situation of street vendors in different parts of the world; to organise strategies for promoting and protecting the rights of street vendors; to encourage statutory bargaining forums between street vendors and authorities at the national and local levels of government; and to promote the representation of street vendors through their representative organisations as part of, or in alliance with, national labour movements. Some of the activities of this network are the organisation of meetings, workshops, panel/public presentations, international forums and conferences, international campaigns, educational activities, policy work and training for street vendors, campaigns to identify suitable areas for litigation in various countries, and general assistance in terms of support and information. A concrete example is its work with Global Union Federations (GUFs), with a three-year programme of work in partnership with Union Network International (UNI) from 2005 – 2007 in eight francophone West African countries.

StreetNet promotes the following measures to be undertaken to improve the lives of workers in the informal economy: labour legislation, social policies, and representation. Labour legislation needs to focus on both vulnerable wage workers and own-account workers in the informal economy. Examples of policies are the provision an administrative basis for benefits such as social security schemes, development of appropriate taxation systems suitable to the particular conditions of wage workers and own-account workers, and provision of financial and non-financial support measures including legal services and skills training. Governments should develop integrated national strategies whose coverage is inclusive of workers in the informal economy. Finally, workers in the informal economy have to increase their voice through advocacy of extending existing regulatory systems to include workers in the informal economy, or through the creation of new bargaining forums (Horn, 2005; 2008).

StreetNet advocates new organisational forms and new strategies that go beyond standard activities undertaken by traditional unions, in order to develop new approaches to the workplace of workers in the informal economy and define their organising activities and strategies according to the types of workplaces where their members are working. StreetNet works
Employment, work, and health inequalities - A Global Perspective

with trade unions to develop multi-pronged organising strategies, including community-based approaches to organising, in conjunction with other “shopfloor” organising methods (Horn, 2008). The organisation of informal workers together with unions can create the collective power to influence political processes in order to improve the lives of informal workers and their families.

References

Case study 73. Can there be Flexicurity for all? - Javier Ramos and Antía Castedo

The policy concept of flexicurity has been high on the employment, social and economic agenda of EU countries and EU institutions since at least when the European Council was held in Lisbon in 2000. Indeed, the debate and policies of the 1980s revolved around the so-called “eurosclerosis” (the European incapability, vis-a-vis the US, of creating economic jobs and employment due to labour market rigidity and high social expenditures). The solutions to this situation proposed by liberal economists and politicians was the flexibilisation of labour markets, easier hiring and firing regulations, a less egalitarian wage structure and a much less generous social protection system. This approach assumed the existence of a “trade-off” between flexible labour markets and social security policies, the first being a prerequisite for economic growth and the creation of employment. In the 1990’s, however, some countries implemented labour market reforms which contradicted this view. The most cited example of this is Denmark, where a labour market reform aiming at the flexibilisation of the labour market (through, for example, easier hiring and firing regulations) was made compatible with a high, tax-financed unemployment benefits system and an active labour market policy involving obligation as well as a right to training (Madsen, 1999; 2000).

The concept of flexicurity, as shown by the Danish case, assumes that there might be a nexus, instead of a trade off, between flexibility and security. As a policy strategy, flexicurity has been defined as follows: “a policy strategy that attempts, synchronically and in a deliberate way, to enhance the flexibility of labour markets, work organisation and labour relations on the one hand, and to enhance security, notably for weaker groups in and outside the labour market, on the other hand” (Withagen & Rogowski, 2002). This definition implies that flexicurity strategies and policies are successful in a coordinated and deliberate way, e.g. during or through negotiations between social partners or between individual employers and employees at various levels.

At the European level, flexicurity is inherently linked with the European aim “to become the most competitive and dynamic knowledge-based economy in the world, capable of sustainable economic growth with more and better jobs and greater social cohesion” (Madsen, 2000). Further flexibility of employment and the labour market is being advocated in the view of the goals of economic performance, competitiveness and growth. However, the European historical compromise with preserving social cohesion and providing security to employees means that this flexibility has to be accompanied with a “new” form of security. This new form of security implies “employment security”, not “job security”, that is, the protection of the workers’ employment prospects and careers instead of the actual jobs.

The question here is whether this new economic model of a knowledge-based economy (highly productive and competitive in the global markets, with a high-skilled workforce and a highly flexible labour market), can be sufficiently inclusive regarding the most oppressed groups of the population (the low-skilled, workers over 45, immigrants, youth and women). Could innovation in low-qualified, low-cost sectors improve productivity and workers’ skills so much? Are there enough qualified jobs for all? It seems quite clear that in a context of full employment (or minimum unemployment) there will continue to be labour-intensive sectors with a low-skilled workforce, especially in the services sector. Additionally, although it is certainly speculative to foresee how likely it is that these policies could be implemented in middle-income and poor countries, the current process of globalisation, highly inspired by liberal principles of labour deregulation, privatisation of state enterprises, liberalisation of inward foreign direct investment and fiscal policy discipline, does suggest that flexicurity models are difficult to implement in emerging economies.

The concept of flexicurity is successfully being put into place in Nordic countries and Holland as the result of social dialogue and the negotiation of collective agreements. But there is no one-size-fits-all solution. A number of different
policies and interventions

Working conditions (different types of actions to modify working conditions themselves, health-related material hazards in the workplace, behaviour changes and psychosocial factors)

Entry point C covers policy interventions that aim to improve working conditions by decreasing the risk posed by unhealthy behavioural changes, material hazards in the workplace, and psychosocial forces. In other words, it is assumed that changes in working conditions will ameliorate health inequalities via these different mechanisms.

Regarding the effect on health of unhealthy behaviour and material hazards, there is evidence that job strain and an imbalance between effort and reward are exacerbated in the case of many (though not all) precarious workers. This trend implies a need for policy interventions which reshape the parameters of job demands, control and reward (Sheeran & Silverman, 2003; O'Rourke & Garrett, 2003). Poor working conditions often force workers to adopt detrimental behavioural patterns, such as consistently working long hours, which results in insufficient sleep, poor diet, fatigue, and poorer educational performance among children and student workers, and drug use among poorly paid workers. Some critics of this approach argue that the lifestyle perspective focuses on individual responsibility for protecting

Konso women are known in Ethiopia for their abilities transporting large packages of enormous volume and weight on their backs. This young woman is returning from a hard day of work at a sugar plantation. Outskirts of Konso (Ethiopia).

Source: Gabriel Brau (2007)
and promoting health through individual behaviours, such as stress management and quitting smoking, while ignoring the organisational context of those behaviours.

Research suggests that social relations and structural working conditions (including worker participation and empowerment) determine employee’s reactions to the conditions under which they work more than personal characteristics do [see Case studies 74 and 75]. Dangerous working conditions, characterised by material hazard, are risks that are common in situations of precarious employment, and the problems that arise from this are only exacerbated by a systematic pressure to not blow the whistle on dangerous workplace environments for fear of losing one’s job. One example of a policy designed to change working conditions, albeit at the micro-level, is the legal requirement for an enterprise to have trade union representatives be trained in occupational health and responsible for prevention in the workplace. This would in all likelihood bring about a reduction in occupational risks in the workplace and a decline in occupational injuries and illnesses. Thus the risk posed to worker health by both the adoption of dangerous behaviour and exposure to serious hazards is made worse by the lack of advocacy available to the worker.

The strengthening of business interests, the atomisation of companies, precariousness, short-term work, and rotation of employment do not contribute to the constitution of strong union actors. Additionally, deregulation policies and strategies increase companies’ aversion to unions and reinforce anti-union practices. Unemployment, freedom to fire workers at will, and management policies exert a powerful, social disciplining effect on workers, convincing them to give up their most basic rights, such as those to health, decent working conditions, and equity. They are forced to accept unilateral reductions in pay, extension of the workday, elimination of break periods, etc. They do not gain access to unionisation, given the expressions of hostility from employers and the fear of losing their jobs (Carnevale & Baldasseroni, 2005; Ferez, 2005).

There are many policy options that could be explored at entry point C. Regulators could impose norms defining acceptable levels of occupational risk and working conditions standards, the length of the working day, and occupational health and working environment monitoring programmes (Westerholm, 1999; Rantanen, 1999; Hogstedt & Lundberg, 1998). Another option is to launch preventive programs of screening and surveillance in the workplace, on an area basis or at the level of the workers themselves, for the early detection of health problems or high levels of exposure to work-related risk
factors (Rantanen, 1999). An even more far-ranging option is the development and implementation of specific occupational health programs aimed at workers, either in their workplaces or integrated into the public health network, or at the level of primary care (Eijkemans, 2005) (see Case studies 76 and 77).

Case study 74. Workers’ participation in the European Union. - David Gimeno

Workers’ participation may take diverse forms. Through involvement in the decision-making process regarding changes in the work that may affect them, workers can protect their rights and, for instance, enforce safety and health standards to improve their working conditions and, consequently, protect their health. Consultation, as a form of participation, is just an initial step.

International data regarding consultation is limited. Only two European Surveys on Working Conditions provide some comparability for investigating trends regarding whether, over the past 12 months, workers were consulted about changes in the organisation of work and/or working conditions. Comparable data is only available for 15 countries, which were categorised into four types (see Figure). In 1995, the highest consultation levels were reported in social democracies (56.7%), followed by liberal regimes (52.9%) and conservative regimes (45.6%), while these were the lowest in late democracies (28.5%), even below the total average (45.0%). Corresponding percentages in 2005 only changed slightly: 55.9 per cent, 44.6 per cent, 41.9 per cent, 29.1 per cent and, for the EU-15, 45.7 per cent.

Not all countries, however, followed the same pattern, and changes between 1995 and 2005 were more evident in some countries than others. The biggest changes occurred in conservative countries, with percentages in Belgium increased by 43.8 per cent, while decreasing by 43.6 per cent in Italy. In other conservative countries, except the Netherlands, consultation was reported to be lower. In the same decade, among the social democracies, Denmark showed a decrease of 18.6 per cent, whereas Sweden showed an increase of 12.8 per cent. The liberal countries reported reduced percentages in 2005 compared to 1995, with consultation decreasing by 26.2 per cent in the UK. Finally, while consultation in Greece (6.9%) and Spain (10.6%) increased from 1995 to 2005, in Portugal it decreased by 13.7 per cent.

In summary, workers in different countries exhibit distinctive levels of participation through consultation in their workplaces. Consultation is at its lowest level in late democracies, while social democracies exhibit the greatest percentages. Even so, these figures are troubling, since less than half of the workers reported having been consulted about changes affecting their work during the last year and consultation has decreased in many countries over the last decade.

Figure. Over the past 12 months, have you been consulted about changes in the organisation of work and/or the working conditions?

Case study 75. Health benefits for sex workers through empowerment. - Atanu Sarkar

Sex workers, as a group, are the most vulnerable victims of sexually transmitted diseases (including HIV/AIDS) due to the very nature of their occupation and also due to all forms of inequity, lack of negotiating power with clients to use condoms, and social stigma. Sonagachi is a red-light district in Kolkata (formerly Calcutta), India, with more than 9,000 sex workers who once had no economic independence, savings, or social security including medical services; they were also harassed by pimps, brothel owners, agents and local gang leaders. In 1992, the All India Institute of Hygiene and Public Health (AIHH&PH) in Kolkata, with the technical guidance of the WHO, started an STD intervention programme by using sex workers as peer educators (PEs). PEs soon realised that sex workers were vulnerable to STDs not because of unsafe sexual behaviour but rather for reasons due to the structure of society: power brokers within the sex industry who coerce, exploit, and oppress and a mainstream society that stigmatises sex work and sex workers and prevents them from gaining access to services otherwise freely available. From this realisation emerged the Durbar Mahila Samanwaya Committee (DMSC), a forum by and for sex workers and their children with a current membership of 65,000 sex workers throughout the state of West Bengal who also started their own cooperative bank to get rid of exploitation by moneylenders. They have been successful in compelling clients to use condoms and in preventing harassment. DMSC has been explicit about its political objective of fighting for the recognition of sex work as work and sex workers as workers, as well as a secure environment for sex workers and their children. The ownership and management of the STD intervention programme was taken over by DMSC from the AIHH&PH in 1999. An epidemiological study shows that, while less than 2 per cent of sex workers regularly used condoms in 1992, that number increased to 85.7 per cent in 2005. The prevalence of syphilis decreased from 25.4 per cent in 1992 to 4.83 per cent in 2005. While the current prevalence of HIV/AIDS among sex workers in other Indian cities ranges from 30 to 60 per cent, in Sonagachi it is only around 6 per cent.

Sources

Case study 76. A national occupational health care system integrated with primary health care: The Brazilian experience. - Vilma Santana, Marco Antônio Gomes Pérez, Maria Graça Luderitz Hoefel and Elizabeth Costa Dias

Although social protection is defined in the Brazilian Constitution of 1988 as a citizen's right and the state's duty, in reality the only realms with universal coverage are education and health care. Social insurance, such as paid retirement, and sick and maternity leaves, for instance, are social benefits limited to those who hold a formal job contract or contribute their own parcel of social security payments. Unemployment benefits (wages) are available only for those working in the formal sector of the economy. Macro-economic changes have generated new types of work arrangements (temporary work, informal work, etc) thereby leading to modifications in the workplace structure. These new forms of work arrangement leave many workers without proper benefits and protections. Most worker benefits are available only for those holding a formal category of work agreement.

According to 2004 data from the Health Ministry, more than 1 million workers are affected by some accident or illness due to work (Dias & Hoefel, 2005). In Brazil, the Unified Health System (Sistema Único de Saúde, SUS) is the only one universally accessible for all workers, regardless of their work situation. Therefore, SUS assumes a crucial social role, serving as the only public policy of universal coverage for all workers (Dias & Hoefel, 2005). In 2002, Brazil implemented a model of workers' assistance called the Network of Comprehensive Assistance for Worker's Health (Rede de Atenção Integral à Saúde do Trabalhador, RENAST). RENAST is a network developed to mediate between the Health Ministry and the State, Federal District and Municipal Health Secretariats. Its objective is to articulate, within the SUS, actions to prevent, promote and recover the health of urban and rural workers, regardless of workers' employment linkage or their type of participation in the labour market. Although workers have always been users of SUS, RENAST proposes improvements by ensuring that the SUS system functions from a workers' health perspective. The system must favour the establishment of connections, when they exist, between sickness and work, information that would be useful for eventual surveillance, preventive programs, and public policies.

Beginning in 2003, RENAST has been prioritised as the main strategy of the National Policy of Workers' Health. The network is organised hierarchically into three levels of management: federal [Ministry of Health], state [State secretariats], and municipal. Its organisation is based on an intra- and inter-sectorial structure composed of administrators and health professionals who undertake actions of promotion, prevention and surveillance in worker’s health. The most important principles guiding RENAST are: [1] comprehensive attention to workers’ health; [2] intra and inter-sector articulations; [3]
information on workers' health; [4] support for the development of studies and research; [5] permanent capacity-building in workers' health; and [6] community participation in managing actions in workers' health (MS-PNST, 2004, as cited in Dias & Hoefel, 2005). RENAST is a national network of information and health practices aiming to implement assistance, surveillance and health promotion initiatives within the SUS system, from a workers' health perspective. RENAST has 150 Worker's Health Reference Centres [CEREST] and approximately 500 Sentinel Services [for diagnosis, treatment and notification] spread throughout the whole country. RENAST’s understanding of workers' health and illness is based on the work-health-disease relationship and on the central role that work plays in people’s lives. However, the establishment of public policy priorities in the area of workers’ health is considerably handicapped by the under-reporting of work-related accidents and illnesses. In an attempt to rectify this shortcoming, the Ministry of Health established, through a regulation [Portaria 777, 28 April 2004], the reporting of work-related cases of notifiable diseases, defining the necessary criteria for their integration into the Information System for Notifiable Diseases, or SINAN-Net (Sistema Informação de Agravos de Notificação). In order to promote the application of this regulation, various protocols and procedure guides have been elaborated and published by the Ministry of Health, and staff involved nationwide have been trained. Together with countries such as Argentina, Chile, Colombia, El Salvador, Mexico, Peru and Venezuela, Brazil has developed a network for interchanging training experiences and permanent education with social organisations involved in worker’s health, known as the Continental Worker’s Health School, which in 2007 planned the training of 108 representatives of health councils and a variety of other social bodies.

In order to articulate and reinforce RENAST in Brazil’s 26 states and Federal District, and to guarantee societal participation in planning and execution of these actions, along with various other institutional initiatives related with occupational health, the Worker’s Health Technical Office also employs strategies of mass media communication. The main objective of this practice consists in sensitising the population with regard to the reality of Brazilian citizens who suffer illness or die while exercising their occupation. Working jointly with organisations specialising in health communication, programs were produced and distributed through 577 commercial and community radio stations throughout the country.

In 2006, RENAST’s implementation process was evaluated. The Worker’s Health Technical Office of the Ministry of Health promoted group meetings with administrators and representatives of SUS social control from the various regions of the country. The results show that the main activities undertaken by the CEREST are the training of health professional and representatives of social control and actions of health care and surveillance. The most commonly encountered difficulties were identified as being state bureaucracy, which makes it hard to effectively utilise available resources and political changes affecting state and municipal administrators.

Reference

Case study 77. Occupational health services in Finland. - Jörma Rantanen

Since the 19th Century, industrial enterprises and some public organisations like the Finnish Railways have organised occupational health services [OHS] for their personnel. Their coverage expanded slowly during the 20th Century, and was about 30 per cent in the mid 70s. In connection with the so-called Nordic Work Environment Reform, a Special Act on OHS was passed and a statutory basis for OHS was founded. The act obligates the employer to organise services for all workers in all economic sectors, including small and micro-enterprises as well as the public sector. Self-employed workers and farmers are entitled to receive services from municipal health centres’ occupational health services. The OHS Act was renewed in 2001 to give response to new OHS needs in modern working life.

Coverage and Human Resources

Occupational health services coverage grew rapidly in the 1970s and 80s. Today, Finnish OHS coverage is one of the highest in the world, with about 85 per cent of all workers [including self-employed workers] and about 90 per cent of the workers employed by the employer being covered. Services coverage is between 90 per cent and 100 per cent for companies with 10 workers and more, while coverage decreases substantially among micro-enterprises and self-employed workers, with rates at around the 60 per cent level on average. In 2007, OHS coverage among employees was 90 per cent and among the self-employed and farmers, about 50 per cent (Manninen, 2009). About 15 per cent of the workforce employed [mainly in the micro enterprises, with less than 10 workers, a part of farmers, and single-person enterprises] are still uncovered.

There are four different models available for OHS delivery, which are strongly varied in their coverage of workers and enterprises. The two main models are OHS municipal health care units [with coverage rates of 61% and 32% for firms and workers respectively] and OHS private centers [with rates of 36% and 48% for firms and workers respectively].

Policies and Interventions
Finland has had a specialised field in OHS for doctors since the 1980s, as well as a sub-specialty for clinical occupational medicine. Occupational health nurses (OHN), physicians (OH), physiotherapists and psychologists have their own special training programmes, which qualify them for the provision of occupational health services in their respective competence areas, usually under leadership by the occupational health physician (see Table).

### Table. Human resources in Finnish Occupational Health Services.

<table>
<thead>
<tr>
<th>PROFESSION</th>
<th>MUNICIPAL OHS</th>
<th>PRIVATE OHS CENTRE</th>
<th>IN-COMPANY SERVICE</th>
<th>GROUP SERVICE</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>OHP</td>
<td>578</td>
<td>1309</td>
<td>351</td>
<td>131</td>
<td>2369</td>
</tr>
<tr>
<td>OHN</td>
<td>823</td>
<td>1220</td>
<td>444</td>
<td>147</td>
<td>2634</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>232</td>
<td>348</td>
<td>137</td>
<td>34</td>
<td>751</td>
</tr>
<tr>
<td>Psychologist</td>
<td>103</td>
<td>176</td>
<td>33</td>
<td>4</td>
<td>316</td>
</tr>
<tr>
<td>Assistant staff</td>
<td>281</td>
<td>328</td>
<td>140</td>
<td>50</td>
<td>799</td>
</tr>
<tr>
<td>Total</td>
<td>2017</td>
<td>3381</td>
<td>1105</td>
<td>366</td>
<td>6869</td>
</tr>
<tr>
<td>Number of OHS units</td>
<td>192</td>
<td>252</td>
<td>169</td>
<td>39</td>
<td>652</td>
</tr>
</tbody>
</table>

Source: Manninen, 2009

### Content and Activities

As stipulated by legislation, the content of Finnish OHS is comprehensive. Preventive activities are obligated by law and the curative services are enabled by legislation as a voluntary activity organised by the employer. Since they are well-integrated, in practice there is little difference between legally obligated and voluntary services. A special social innovation is the inclusion of promotion and maintenance work ability for workers (PWA), which was originally introduced to support ageing workers, but has subsequently been developed to cover all workers and is currently implemented in over 80 per cent of Finnish workplaces. The activities of OHS are directed towards the work environment as well as worker and work organisation. The service is carried out as a cyclic process based on the identification of service needs and the provision of responses to those needs (see Figure). Thus, the content of services may vary widely depending on the needs of the individual workplaces still meeting the requirements set by legislation.

### Figure. Process description of comprehensive occupational health services (WE= Work Environment, WA= Work Ability, OD= Occupational Diseases, WRO= Work Related Diseases).

### Financing

The total costs of OHS in Finland amounts to 459 million euros per year. On average, it costs 257 euros per worker per year, with great variation between economic sectors, service provider and company size. The employer is primarily responsible for organising and
Policies and Interventions

Policies and interventions

Financing OHS for employees. Provided that the OHS Act is followed, the employer is entitled to reimbursements from the Social Security Institution (SSI) of up to 60 per cent of incurred OHS costs from preventive activities and 50 per cent from curative activities. Funding for reimbursements is collected from the legislation-based work income insurance fee, which is paid by the employers.

Monitoring and Inspection

OHS information and surveillance systems include several regular national surveys. Among these are the triennial OHS survey in Finland, the triennial PMWA Barometer, Triennial Health and Work in Finland Survey, the Ministry of Labour’s annual Work Life Barometer and the Working Conditions Survey (which is conducted in connection with household surveys by Statistics Finland every 7 years). The annual OHS SSI statistics provide information on activities and the costs of services. Statistics on occupational diseases and occupational accidents are available annually. The Occupational Safety and Health Inspectorates supervise the employer’s organisation of occupational health services, usually by checking the contract made by the employer with the service provider. OHS content monitoring, as regards medical aspects, professional competence and OHS personnel activities, is controlled by the Ministry of Social Affairs and Health as well as the State Provincial Health Authorities. The SSI’s reimbursement criteria and practices also serve the monitoring of both service costs and content [Rantanen, 2006].

Future developments

A national programme, in the form of the 2004 Government Resolution OHS 2015, includes ten key lines for the development of occupational health services. The implementation of the key lines has continued steadily, but some of the prerequisites have changed substantially as a consequence of changes in the structures of economies, as well as changes in the health services systems. There is a shift in the balance between various service provision models towards a growing share of private OHS centres, with a consequent commercialisation. Recently, discussion has been started on the need to more effectively control the external service providers, with particular emphasis on maintaining priorities in preventive and work-environment-oriented activities.

Conclusion

Over the past 30 years, the Finnish OHS has been developed on a statutory basis and with wide societal consensus as part of the welfare state’s social dimension. Service coverage has developed positively but levelled off in the early 1990s to a level of 85 per cent of the total employed population. The combined prevention, promotion and curative content is found feasible, productive and relevant, particularly in terms of the promotion and maintenance of work ability (PMWA) of ageing workers. The 2001 amendment to the OHS Act added a number of new elements to its content, such as the PMWA strategy, follow-up and assessment of workers’ personal work-load, OHS quality management and continuous evaluation and self-assessment. High coverage and comprehensive content have been achieved with reasonable costs. Evaluation studies of the Finnish OHS system show both a positive health impact and positive cost-effectiveness. For example, the continuation at work of the ageing workers has been extended by an average of one year since the PMWA interventions were introduced.

References


Ill-health (reducing the unequal social consequences produced by physical and mental illness)

Entry point D concerns those policy interventions designed to cushion the different social and financial consequences of a change in or loss of health [see Case study 78]. Workers who suffer from work-related ill-health have varying degrees of access to workers’ compensation and social security. There is often limited recognition given to occupational diseases and mental illness under such schemes, and often a limited scope for rehabilitation or return-to-work assistance.

In wealthy countries, workers’ compensation and social security schemes need to be reconfigured to ensure that all injured workers are covered (including self-employed and all
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foreign-born workers), that access of vulnerable workers (like the precariously employed, young, old, and female workers) is safeguarded and that far stronger incentives are put in place to encourage the re-employment of workers after injury (especially in the case of vulnerable groups like agency workers) [see Case studies 79 and 80]. In most low-income countries, the workers’ compensation and social security net needs to be extended to include all workers, including those in the informal sector, to provide even a minimum level of protection. Such protection was introduced in currently wealthy countries 100 years ago, when these countries were poorer than they are today.

In that time, the policies have grown deeper and more effective. There is no reason that a similar process could not occur in poor countries. At the very least, government policies should aim to protect these workers and their families from starvation or malnutrition. In both wealthy and poor countries, community-based schemes could assist workers suffering an illness to return to the workforce. An illustrative example is provided by policy interventions that provide benefits or rehabilitation for people with chronic illnesses or lasting injuries from occupational accidents. These benefits and services offset some of the financial and social consequences of the illness or accident (Bellaby, 1999; Graham, 2005). Other policy options include occupational reinsertion programmes for people in marginalised positions or occupational re-training programmes to learn new skills and find employment.

We must reiterate here that health inequalities stem from a variety of causes and intermediate mechanisms. For the same reason, there are also a multitude of possible interventions. Without a doubt, strengthening workers’ organisations is a key factor for achieving greater equity and justice in employment conditions. However, the issue goes beyond this. Interventions and policies are needed to address shortcomings in the system of labour relations, which at its core involves control over how the economic fruits of labour are distributed (Muntaner & Lynch, 1999). For this reason, it seems neither possible nor tolerable to continue accepting labour markets that generate vast inequities and that function as engines driving an increasing concentration of income, while at the same time placing the responsibility for reducing these inequities entirely on the state through redistributive social policies that attempt to palliate the damage created by labour market structures (Berlinguer, Falzi, & Figa-Talamanca, 1996; Loewenson, 2004; Laurell, Noriega, Martínez, & Villegas, 1992) [see Case study 81].
Case study 78. The global employment costs of the HIV/AIDS epidemics. - EMCONET*

In 2006, an estimated 36.3 million people of working age were living with HIV/AIDS, the vast majority of them in sub-Saharan Africa. In countries hit hardest by the epidemic, the disease’s relentless advance is slowing economic and employment growth, thus jeopardizing efforts to reduce poverty, and create new jobs, especially for youth.

A recent study has analysed the impact of the HIV/AIDS epidemic in 43 countries that have greater than 1% HIV/AIDS prevalence, and in which sufficient data exists to estimate losses in economic and employment growth. This made it possible to arrive at an estimate of the annual cost to the global economy in terms of curtailed job growth (ILO 2006). Among those of working age, in addition to the 24.6 million labour force participants living with HIV/AIDS, 11.7 million more people who are engaged in some form of productive activity, often women in the home, are now living with the virus. Forty-three countries heavily affected by HIV/AIDS lost on average 0.5 percentage points in their rate of economic growth every year between 1992 and 2004 due to the epidemic, and as a result forfeited 0.3 percentage points in employment growth. Among them, 31 countries in sub-Saharan Africa lost 0.7 percentage points of their average annual rate of economic growth and forfeited 0.5 percentage points in employment growth. This produced a global employment shortfall of 1.3 million new jobs every year, of which 1.1 million were lost annually to sub-Saharan Africa.

The impact of the epidemic is particularly severe for children and youth whose lives, hopes and future are blighted directly or indirectly by HIV/AIDS. Globally, nearly 2.3 million children live with AIDS and there are an estimated 15 million AIDS orphans. When children in worst-affected countries do reach working age, they face a severe shortage of legitimate job opportunities. Unemployment for young people considered to be of working age is two to three times as high as for their adult counterparts. This puts young people at risk in terms of poverty but the report also highlights the increased risk of exposure to HIV of large numbers of unemployed youth in resource-poor settings. Consequently, young people account for half of all new HIV infections. An estimated 5,000 to 6,000 young people, age 15 to 24, acquire HIV each day. In 2005, more than 3 million labour force participants worldwide were partially or fully unable to work because of illness due to AIDS, and three-quarters of them lived in sub-Saharan Africa. Globally 41% of the labour force participants living with HIV are women, and in sub-Saharan Africa, the proportion is even higher at 43%.

The epidemic is having a severe impact on the future global labour force. Often the epidemic propels children into work too early because their parents are sick or have died and a means of income is needed. Child labour puts children at risk, robs them of education and can lead to work that makes them more vulnerable to acquiring the virus themselves.

Yet a range of rights-based legal instruments have seen widespread ratification that would eliminate the worst forms of child labour if vigorously enforced, and limit access to underage children for purposes of work in order to keep them in compulsory education. A rapid assessment study by the ILO in Zambia in 2002 estimated that HIV/AIDS increased the child labour force between 23 and 30%. A survey in Uganda in 2004 found that over 95% of children living in AIDS-affected households were engaged in some type of work. Sixteen percent of the working children—mostly girls—worked both day and night. In addition, girls are more likely than boys to stay at home and look after ill parents or younger siblings, thereby foregoing education. Girls face greater risks than boys of being sexually abused and acquiring HIV at their workplace, particularly through prostitution and other types of sexual exploitation. A lack of opportunities for decent work can compel women and men to work under precarious and un-regulated conditions. They are at increased risk for HIV when these conditions expose them to the virus. Studies often show that the majority of men and women who resorted to the sex industry for their livelihoods began sex work in their teens or early twenties. These factors interact, and according to the most recent data, young people account for half of all new HIV infections. Moreover, the majority of young persons who are living with HIV do not know that they carry the virus, especially in resource-poor settings.

Illness, lack of access to anti-retroviral treatment (ARVs), and mortality losses to the labour force are jeopardizing the ability of worst-affected countries to lift themselves out of poverty. Without increased access to ARVs, cumulative mortality losses to the global labour force are expected to continue to increase from 28 million estimated for 2005 to 45 million projected by 2010, over 64 million projected for 2015, and nearly 86 million anticipated by 2020. Increased access to ARVs could mitigate the projected losses for the next five years by 14%, and avert between 20% and 25% losses for the future. These numbers serve as a powerful incentive to target the workplace as a major entry point to achieving universal access to ARVs.

* Based on the 2006 ILO report on the impact of HIV/AIDS on the world of work

Source
Case study 79. Workers’ compensation in New York state. - The National Economic and Social Rights Initiative

New York State’s Workers’ Compensation Board (WCB) was created in 1914 to ensure the right to health and economic security for the quarter of a million workers in the state who become injured on the job each year. It protects employers from employee lawsuits and severely limits the constitutional right to access the courts in cases of negligence and malfeasance by employers. In exchange, workers are promised no-fault coverage for injury, access to medical treatment, death benefits, and wage replacement.

In practice, the WCB does not meet its responsibility to protect the human rights of workers. Instead, workers are forced to prove their need for benefits in a grossly unbalanced match against powerful insurance companies and lawyers. Early in the process, workers are forced to go to insurance-company-paid doctors who assess whether a worker has been injured on the job. In conflict with medical ethics, these doctors, misleadingly called Independent Medical Examiners (IMEs), frequently go to great lengths to deny claims and give false diagnoses. Too often, the process turns into a bureaucratic and procedural nightmare, where workers are humiliated, stigmatised and subjected to investigations that violate their right to privacy.

Very little of this process is shaped by objective medical review or public health considerations. Indeed, the WCB is rife with unjustified delays in access to medical care and wage replacement, rejection of legitimate injuries, obstacles for non-English speakers, and inadequate rates of compensation. The strain on workers can be extremely severe. Many workers develop new mental or physical problems as a result of their experiences before the WCB, for which they might never receive support. With limited resources and unable to work, these workers and their families face hunger, extreme insecurity, and a heavy burden of guilt that they are no longer providing for their families. Essentially, workers begin with sickness and injury and often end up sicker and more injured, creating a devastating impact on human dignity and well-being. There are cases where workers facing these hardships have committed suicide. Even the WCB’s stated goal of resolving cases in eighteen months is not a reasonable period of time for workers who often have no other source of support or medical care, and frequently the formal hearing process takes much longer. During this period, workers are unable to take care of their basic needs. Some workers suffer several decades through unfathomable delays to resolve claims. These dangerous delays, coupled with procedural abuses sometimes involving dozens of hearings, may coerce workers into accepting inadequate settlements once their resources and energy are thoroughly exhausted.

Workers may lack medical care while awaiting a decision from the WCB. In particular, private insurers will not cover injuries that should be covered by workers’ compensation. While some doctors accept patients hoping that the WCB will ultimately cover care, the long delays make it increasingly less likely that physicians will continue with this arrangement. In such cases, a worker may have to wait until eligible for public assistance or Medicaid in order to get care while the case is pending. Many physicians drop out of the system, making appropriate care unavailable in some areas of the state or for certain disabilities.

It is not uncommon for workers to spend their last dollars on out-of-pocket medical expenses. Pressured by debts and lawyers who want to settle cases quickly, some give up long-term medical coverage in exchange for a modest lump sum settlement not adjusted for inflation and arbitrarily approximated to what they might have collected for life. Sometimes out of sheer desperation, workers resume working while still injured, resulting in further injury and complicated multiple claims for workers’ compensation.

Workers who win their cases still have difficulty making ends meet because New York State’s workers’ compensation rates have not increased since 1992. At $40 minimum and $400 maximum per week, they are among the lowest in the nation. A small fraction of workers receive maximum benefits. Some receive less than the minimum, because of income and level of injury. These low-level benefits are hard to explain given that New York spends more per claim than almost any other state in the system. The resources, however, are spent delaying claims and denying medical care and support, rather than ensuring the health and security of workers with injuries. Workers are often forced to attend dozens of hearings with little or no explanation. Non-English-speaking workers have even more trouble accessing information because they are unable to understand what is being said at proceedings. Additionally, the WCB judges and even the workers’ own lawyers often exclude or silence them, and question their credibility in offensive and degrading ways. The testimony of doctors working for insurance companies is used to falsely accuse workers of fraud and deception. Indeed, despite the fact that the workers’ compensation system has an extraordinarily low rate of fraud, insurance companies do all they can to stigmatise workers with injuries, characterizing them as lying, lazy, or crazy. Claimants have been told by insurance companies that serious injuries, such as toxic chemical exposures, are “all in their head,” while legitimate and sometimes life-threatening claims are routinely denied.

Becoming injured on the job should not strip workers of their right to health and economic security. Currently, the WCB lacks the procedural fairness to protect these rights. In short, workers’ compensation programs must be
better integrated into the overall health system and administered with a focus on health and effective mechanisms to protect the rights of workers. Workers with injuries often demonstrate a fierce desire to contribute to their families and communities. They have a right to the support and care necessary to heal and become an active part of society.

**Source**  

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**Case study 80. Workers’ compensation systems and the needs of women workers.** - Katherine Lippel

Workers’ compensation systems were largely designed to be wealthy (or well-funded), with a full-time male breadwinner in mind. The first systems were designed in European countries at the end of the nineteenth century, and European models were exported, with or without adaptations, both to North America and Australia, and to many poor countries in Central and Latin America and Africa. While some European countries have revisited their disability insurance systems to ensure support for all people with work disability (Pennings, 2002), in a majority of countries, disability insurance is restricted to workers’ compensation for work-related injury. In many countries the basic premises of the initial legislation have never been questioned.

Initially, legislation was designed to provide income support to accident victims, and later to some occupational disease victims, and the beneficiaries contemplated by policy makers were those injured while working, in formal contractual arrangements, in primary or secondary sector industries, and their widows.

Women’s participation in the formal paid labour force has increased dramatically since the early twentieth century, but these changes have not led to policy adaptations. Occupational health and safety and compensation policies often apply with difficulty to work in the service sectors, or to precarious employment, where women are disproportionately present (Vosko, 2006). Because women’s work is often undervalued, this has repercussions when they are injured. Stereotypes with regard to women’s work include the belief that women’s work is easier and lighter than men’s and that it is thus unlikely that women’s working conditions cause injury and disease, thus access to compensation may be more difficult for women (Lippel, 2003). These stereotypes have also been used to justify inattention to women’s work in the scientific literature, so that evidence documenting the hazards of women’s work is under-researched or poorly researched, and this in turn has repercussions for policies on prevention (Messing & Stellman, 2006; Messing et al., 2003).

Those who do have access to coverage are often confronted with regulatory and policy obstacles regarding disability associated with musculo-skeletal or mental health disorders, which are prevalent among women workers because of the highly repetitive nature of their work and the psycho-social risk factors to which they are frequently exposed.

Many systems currently in place fail the precariously employed, because they do not adequately compensate temporary or part-time workers, home-based workers, or those holding multiple jobs. Most also fail to provide compensation for the consequences of workplace injuries that affect the ability to do unpaid reproductive work, which disproportionately falls on the shoulders of women throughout the world.

**References**


Case study 81. People with disabilities and health inequalities in Australia and New Zealand. - Paula Veciana and Joan Benach

Disability is not something individuals have. What individuals have are impairments that may be physical, sensory, neurological, psychiatric, intellectual or of other types. Disability is thus the process which happens when one group of people create barriers by designing a world only for their way of living, taking no account of the impairments other people have. Along with other citizens, disabled people aspire to have good employment and working conditions. However, they also face huge barriers to achieving the employment and work that so many take for granted. These barriers are created when a society is built that takes no account of the impairments other people have (Ministry for Disability Issues, 2001).

It is estimated that between 4 and 20 % of the world’s population have a disability, depending on the definitions and study methods that are used (Metts, 2004). Disability can be defined from many perspectives which result not only in different estimates but also in different understandings, concepts and policies regarding disability. Impairment indicators give lower estimates on the extent of disability than those figures which are based on the functional definition. For instance, in Chile a household survey that used functional indicators maintained that 21.7% of households had a member with a disability, while a study using impairment indicators resulted in a figure of 5.3%.

Disabled people belong to the most vulnerable, poor and excluded groups and have fewer assets and means to escape from poverty. People with disabilities make up 15-20% of the poor in low income countries (Etwan, 1999). Out of the 1.3 billion people who are extremely poor, approximately 260 million have disabilities (i.e., about 43% of the world’s population have some disability). Most disabilities are strongly related to poverty and unsafe living and working conditions. Malnutrition causes 20% of disabilities, accidents/trauma/war 16%, infectious diseases 11%, non-infectious diseases 20%, congenital diseases 20%, others (including ageing) 13%. Lack of access to medical care and rehabilitation leads to worsening limitations on activity. These, in turn, combined with social stigma, discrimination and physically inaccessible living environments, tend to generate a process of exclusion from participating in employment, social life, schooling, and vocational training. In the end, it results in a life-long exclusion from mainstream society.

Many specific groups are recognized to be at risk of inequalities in health including prison inmates, asylum seekers, the homeless, and people with physical and mental disabilities. Particular sub-populations of Australia, such as people with disabilities, are more likely to be living in disadvantage, and are more likely to lack access to social, geographic and economic resources for good health and wellbeing. The state of Victoria is located in the south-eastern corner of Australia and is the smallest mainland state in area. It is also the most densely populated and urbanised. About 20% of people living in Victoria report having a disability, ranging from 19% among people born in Australia to 40.8% among people born in Southern and Eastern Europe [Australian Bureau of Statistics, 2004a, cited in VicHealth, 2008]. The relationship between health and disability is complex, as it is influenced by the complications of the disability itself, the impact of functional limitations associated with the disability, and by broader social and economic conditions experienced by people with disabilities. There is also variability in the extent and nature of disability. Nevertheless, it is widely accepted that this group is ‘deserving of attention in its own right from the perspective of health as well as disability’. People with disabilities have been found to have demonstrably poorer access to the social and economic resources required for health, experiencing higher rates of unemployment (9% compared with 5% for the general population), lower rates of workforce participation (53% compared with 81% in the general population), lower average incomes, and higher social isolation. Additionally, there is strong evidence that people with disabilities face barriers to accessing health care services, and have lower rates of participation in illness prevention programs. Only 52.25% of people with a disability rated their health as good, very good or excellent, compared with 85.4% of all Victorians (VicHealth, 2008).

In New Zealand, the "New Zealand Disability Strategy" promoted by the Minister for Disability Issues has postulated a number of actions to provide opportunities in employment for disabled people including the following points: to provide education and training opportunities to increase the individual capacity of disabled people to move into employment; to enable disabled people to lead the development of their own training and employment goals, and to participate in the development of support options to achieve those goals; to educate employers about the abilities of disabled people; to provide information about career options, ways to generate income, and assistance available for disabled people; to investigate longer-term incentives to increase training, employment and development opportunities for disabled people; to ensure a smooth transition from school to work; to investigate the requirements of the ILO Convention on Vocational Rehabilitation and Employment, with a view to ratification; to encourage the development of a range of employment options recognising the diverse needs of disabled people; to ensure disabled people have the same employment conditions, rights and entitlements as everyone else has, including minimum wage provisions for work of comparable productivity; to make communication services, resources and flexible workplace options available; to operate equal employment opportunity and affirmative action policies in the public sector; to investigate a legislative framework for equal employment opportunities across the public and private sectors; to ensure disabled people have access to economic development initiatives; to encourage staff and service organisations (for example, unions) to appoint or elect disabled people as delegates and members of their executives (Ministry for Disability Issues, 2001).
Policies and Interventions

9.5. A TYPOLOGY OF INTERVENTIONS ON EMPLOYMENT DIMENSIONS

Table 14 presents a typology according to employment dimensions and entry points A, B, C and D. The typology is a way of conceptualising different types of policy options aimed at the reduction of health inequalities for specific employment dimensions at various policy entry points.

While this typology helps to organise interventions into different groups, in practice some encompass more than one entry point or employment dimension. For example, the establishment or integration of occupational health services in the primary health care of the public health system (as recently undertaken in Brazil) affects entry points C and D (and arguably A as well, if it has indirect effects on worker mobilisation) and a number of employment dimensions. A second example along similar lines involves policies designed to restrict precarious employment, which can affect health outcomes for both precarious and non-precarious workers (i.e., by limiting job insecurity and spill-over effects).

Full-time permanent employment

The health inequalities portrayed in this book are produced by the previously described employment and working conditions, that is, those which are part of the full-time, permanent employment contract. In many countries, especially wealthy ones, this situation continues to be the most commonly found labour market relationship. However, as we have shown, neo-liberalism has substantially decreased its prevalence. In light of these circumstances, it is critical that policies designed to reduce employment-related health inequalities include this dimension.

One of the causes of these health inequalities is the increased resort to management and personnel adjustments undertaken by companies as they grow, mature and face changing market conditions.

References


**Table 14.** Typology of policies and interventions at the national level for employment dimensions to reduce health inequalities, stratified by main entry points.

<table>
<thead>
<tr>
<th>ENTRY POINT</th>
<th>FULL-TIME STANDARD EMPLOYMENT</th>
<th>UNEMPLOYMENT</th>
<th>PRECARIOUS EMPLOYMENT</th>
<th>INFORMAL EMPLOYMENT</th>
<th>CHILD LABOUR</th>
<th>SLAVERY AND BONDED LABOUR</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Provide incentives for unionisation and collective bargaining</td>
<td>Policies to promote full employment (more emphasis on full-time and secure employment)</td>
<td>Limit temporary contracts</td>
<td>Legislation and land reforms</td>
<td>Strengthen enforcement/sanctions</td>
<td>Legislation, effective enforcement and punishment of beneficiaries (including those at peak of subcontracting networks)</td>
</tr>
<tr>
<td></td>
<td>Provision of quality/safe work</td>
<td>Strengthen employment component in poverty reduction programs (e.g., micro-credits)</td>
<td>Provide incentives for unionisation and collective bargaining</td>
<td>Provision of informal workers organisation</td>
<td>Provision of food for attending school programs</td>
<td>Sanctions on governments that tolerate slavery/bonded labour (e.g., trade access &amp; investment penalties) with incentives for those who seek to eradicate the practices</td>
</tr>
<tr>
<td></td>
<td>Central policy objective (not subordinate to economic policy)</td>
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<tr>
<td></td>
<td>Universal access to public education</td>
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<tr>
<td></td>
<td>Legislation / Minimum wage (poverty)</td>
<td></td>
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<tr>
<td></td>
<td>Income redistribution through progressive tax system and social services</td>
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<tr>
<td></td>
<td>Avoid wage discrimination (gender, race, employment status),</td>
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<tr>
<td></td>
<td>Promote policies towards upward social mobility</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>Create incentives and sanctions for reduction of employment violations</td>
<td>Promotion of unemployment insurance</td>
<td>Regulatory controls on downsizing, subcontracting and outsourcing (including supply chain regulation)</td>
<td>Develop legislation and regulation on informal employment</td>
<td>Conditional cash transfer programs (e.g., for food, education and immunisation)</td>
<td>Anti slavery/bonded labour law/enforcement mandated internationally (target penalties for non-compliance)</td>
</tr>
<tr>
<td></td>
<td>Incentives to promote working time flexibility (e.g., work-life balance)</td>
<td>Develop active labour market policies (e.g., interventions to facilitate access to employment among women, young and older workers)</td>
<td>Integrated minimum labour standards (industrial relations, OHS and workers’ compensation)</td>
<td>Create incentives and sanctions for reduction of employment violations in informal economy</td>
<td>Civil society mobilization against worst forms of child labour (e.g., consumer boycotts)</td>
<td>Strengthen law enforcement agents (special agents to interdict and prosecute practices e.g., NAPTIP in Nigeria)</td>
</tr>
<tr>
<td></td>
<td>Regulate downsizing/job insecurity and outsourcing</td>
<td>Re-evaluate retention of rural area services/agricultural activities on basis of employment and sustainability (environmental and health effects)</td>
<td>Promote regulation to avoid employment discrimination of foreign born, migrants and other vulnerable workers</td>
<td>Establish worker or community health centre network or integration activities to worker in the primary care of the public health system</td>
<td>Civil society mobilization against slavery (e.g., consumer boycotts)</td>
<td></td>
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<tr>
<td></td>
<td>Laws placing limits on use of ‘atypical’ employment</td>
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<tr>
<td></td>
<td></td>
<td>Strengthen public capacity for regulation and control regarding employment conditions</td>
<td>Steepen public capacity for regulation and control regarding employment conditions</td>
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<tr>
<td></td>
<td></td>
<td>Impose externality assessments on labour market flexibility, competition policies</td>
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</tbody>
</table>

Source: Prepared by the authors
**Table 14 (continuation).** Typology of policies and interventions at the national level for employment dimensions to reduce health inequalities, stratified by main entry points.

<table>
<thead>
<tr>
<th>ENTRY POINT</th>
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<th>CHILD LABOUR</th>
<th>SLAVERY AND BONDED LABOUR</th>
</tr>
</thead>
<tbody>
<tr>
<td>C</td>
<td>Strengthen enforcement of OHS legislation (e.g., inspectorate)</td>
<td>Include OHS component in employment creation programmes</td>
<td>Include OHS in subcontracting and outsourcing (including supply chain) regulation</td>
<td>Include OHS dimension on micro-credits</td>
<td>Education and awareness raising of health consequences of child labour</td>
<td>Education and awareness raising of health consequences of slavery and bonded labour</td>
</tr>
<tr>
<td></td>
<td>Expand coverage OHS prevention</td>
<td></td>
<td>Expand coverage of OHS services (temporary workers, self-employed, small business)</td>
<td>Expand coverage by OHS legislation and services (intersectoral)</td>
<td>Develop special programs to prevent hazardous child labour</td>
<td>Slaves and bonded labour deemed to be protected by OHS laws notwithstanding legal status</td>
</tr>
<tr>
<td></td>
<td>Strengthen prevention in social security and insurance mechanisms (public and private)</td>
<td></td>
<td>Include OHS in regional trade agreements</td>
<td>Develop minimum OHS standards and regulation for progressive improvements</td>
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<tr>
<td></td>
<td>Include occupational health dimension in collective bargaining (e.g., right to know)</td>
<td></td>
<td>Regulate to avoid double standards and occupational hazard dumping</td>
<td>Increase coverage with basic occupational health services</td>
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<tr>
<td></td>
<td>Promote worker's participation and action of safety representatives to prevent occupational hazards / stimulate worker's participation and enforcement of legislation</td>
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<tr>
<td></td>
<td>Create inter-sectoral OHS policy for full coverage</td>
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<tr>
<td></td>
<td>Train and sensitise health care providers</td>
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</tbody>
</table>

| D           | Expand coverage (access, quality, cost-eficiency, rehabilitation) of occupational diseases and injuries (include mental illness) | Special re-training programmes to assist employment re-entry of disabled workers | Expand coverage and effective implementation of workers' compensation or national illness insurance (e.g., self-employed, undocumented and migrant workers) | Provision of basic income/anti-poverty support for injured and their dependents | Provision of basic income/anti-poverty support for injured | Provision of basic income/anti-poverty support for injured |
|             | re-training programmes to assist employment re-entry of disabled workers | | | | | |
|             | Universal access to health care / include occupational health in Primary Health Care | | | | | |
|             | Establish information centers or networks for injured workers | | | | | |
|             | Increase capacity of health system to recognize and treat occupational diseases and injuries | | | | | |
|             | Create adequate solidarity finance mechanisms to cover compensation and treatment for all | | | | | |
|             | Deemed cover for undocumented immigrant/guestworkers, child and bonded labour under workers' compensation/social security laws | | | | | |

**Source:** Prepared by the authors
conditions and a globalised economy. Just as downsizing/restructuring, outsourcing, and privatisation have contributed to the growth of temporary work and self-employed subcontractors, they have also affected the health and well-being of the workers who continue to hold nominally secure jobs. Repeated rounds of downsizing and restructuring in large public and private sector employers have contributed to increased job insecurity and workers’ concerns that their commitment will not be reciprocated. This is also exacerbated by the weakening of legislative or union-based collective protection in wealthy countries (see Case study 82). These changes often entail increased workloads and intensity as well as changes to jobs and work processes (such as multi-tasking).

There is now a substantial body of evidence confirming that workers who ‘survive’ downsizing suffer from stress and other adverse occupational health safety effects. Reduced staffing levels and increased workloads may contribute to premature burnout by professional workers. Reduced staffing may also affect the health and wellbeing of others, such as hospital patients (see Case study 83). Downsizing and the growth of precarious employment can also affect the working conditions of all workers in particular industries as a result of increasing work intensity or specific spill-over effects. For example, the presence of temporary and part-time workers can lead to an increased administrative, training, or supervisory load on full-time permanent workers. Alternatively, work intensity may increase as a result of competition for work between precarious and permanent workers in the same labour market. One example is the case of competition between self-employed and employee truck drivers.

Overall, these changes have not been addressed by existing labour standards. While the occupational health and safety laws of some countries require risk assessment/control and consultation when employers make changes to work practices that could affect occupational health and safety, implementation has usually been minimal, leaving even those workers in conditions of full-time employment vulnerable to differential health outcomes.

Unemployment

The devastating health consequences of unemployment have been well-established by research since the 1930s. As documented elsewhere in this book, unemployment has profound long-term
Policies and interventions

Case study 82. Unions and safety representatives are good for worker’s health. - María Menéndez and Joan Benach

Historically, workers have organised in trade unions to strengthen their efforts at improving employment conditions such as contracts, working hours, wages, working conditions, social security, and workplace health and safety. In the face of neo-liberal globalisation, trade unions are still one of the most effective tools for ensuring good health and safety at work (Johansson & Partanen, 2002). Extensive research (mainly conducted in Canada, Australia, the United States, and especially in the United Kingdom) shows that workplaces where trade unions are present are safer, thus improving occupational health outcomes (Milgate, Innes, & O’Loughlin, 2002; Walters, 2006). Participation of unions and the workforce at different levels can have a considerable salutary effect in changing health and safety in the workplace. For instance, unions dramatically increase enforcement of Occupational Safety and Health Acts, and unionised workplaces are much more likely to have a Health and Safety Committee and to have undergone a management safety audit in the previous year than non-unionised workplaces. Unions ensure that their safety representatives are better-trained in health and safety than employers. Moreover, unions often realise the risks long before management does. For example, it was unions that highlighted the dangers of asbestos and campaigned for a ban many years before the government introduced one. Unions also unearthed the risks posed by many hazardous chemicals and were the first to raise major concerns over high levels of stress or violence in the workplace (Trades Union Congress, 2004). The work of trade unions, through their empowered role for purposes of consultation and participation, often leads to higher levels of compliance, lower workplace injury rates and ill-health problems, and better health and safety performance (Walters, 2006). Good employers recognise the benefits that unions can bring. Today there is a strong need to support trade unions in their efforts to promote health for all workers, especially in the case of workers with the most hazardous employment and working conditions.

References

There is now a union in our factory. Before workers were forced to do overtime but now this is voluntary and the management respects the law. Also before if workers were sick they were not allowed to leave the factory. Now they can take sick leave.”


Effects on the health of individuals and communities, increasing the burden placed on health services and exacerbating health and welfare inequalities in society (see Case studies 84 and 85). In both wealthy and poor countries, there is a need for policy frameworks and new economic systems that actively promote full employment.

In wealthy countries, changes in macro-economic policy, social security and unemployment benefits have increased financial and other burdens on the unemployed, the hidden unemployed (discouraged job-seekers, including many older workers and women), the under-employed (a growing group, including older workers, seeking more hours or more regular work) and encouraged often marginal forms of self-employment (Bruce & Schuetze, 2004).

While labour market flexibility is typically seen as a means of reducing unemployment and its serious health consequences, research on the adverse health consequences of prolonged precarious employment questions the idea of a net health benefit to the community (Broom et al., 2006). Intermittent employment (with periodic bouts of unemployment) is also especially debilitating (Clarke, Lewchuk, de Wolff, & King, 2007), adding to the need for better unemployment reduction policies in the wealthy world.
In poor countries without extensive unemployment insurance, the extent of unemployment is often poorly recorded. Moreover, underemployment is extensive and often disguised by minimal forms of self-employment in the informal sector. In parts of Africa, malnutrition and other health effects of extreme poverty result from labour market exclusion or minimal contact. The magnitude of the problem, however, means that the health effects of hidden unemployment and intermittent work are better understood in poor countries than in wealthy ones. In Latin America, the regional urban unemployment rate fell from 9.5 per cent in the first three quarters of 2005 to 9.0 per cent in the same period of 2006. Although this further decline in unemployment is positive, it is still far from the rate of 7.3 per cent reached in the early 1990s. In 2006, an estimated 17.5 million people were unemployed in Latin America’s
urban areas, and youth unemployment rates are between 1.7 and 2.2 times higher than the total unemployment rate. While more difficult to accurately measure, the health-related effects of unemployment in the poor world are much more pronounced, demonstrating further the need for adequate unemployment policy.

**Case study 84. Social safety nets and the health of the job insecure and unemployed.** - Eunice Rodríguez and Kathryn E. Lasch

For decades, a wealth of research on the health effects of economic insecurity has provided important evidence about the mental and overall health effects of job instability and unemployment. Researchers have begun to document that the unemployed and job-insecure, however, fare differently in different countries in terms of health outcomes. A key factor in understanding the divergent findings in different countries is the distribution of socioeconomic resources and the level of social benefits and institutional support available to unemployed people.

Economic support during times of job insecurity and unemployment tends to ward off negative health effects. In countries with more generous income maintenance systems, such as the Netherlands (Hurd & Kapteyn, 2003), there is a smaller impact of wealth and income on subsequent health deterioration than in other Western countries with less generous social safety nets. In industrialised countries, high unemployment levels combined with low unemployment benefits are associated with high infant mortality rates (Wennemo, 1993). Conversely, the infant mortality rates in Japan and in Scandinavian countries were lower than expected, given their levels of economic development. Existing data suggest that in industrialised countries, better social security for vulnerable groups is associated with better levels of health. Especially disturbing, given growing inequality in some countries, is the evidence showing that spending on social insurance against income loss is lower in countries with highly skewed income distributions (Moene & Wallerstein, 2001). Rigorous documentation of the health impacts of social intervention is just beginning to accumulate, and there is a need to further study the protective health effects of social intervention.

The ways in which income is redistributed during times of unemployment and job insecurity affects health outcomes. Research in the United States and other Western countries has uncovered differences in health outcomes between groups of unemployed individuals, based on the types of benefits that they receive (e.g., entitlement, means-tested). While receiving entitlement benefits buffers the impact of unemployment on health, means-tested benefits do not attain the same level of health maintenance (Rodríguez, 2001). Furthermore, receiving unemployment compensation appears to decrease the likelihood of body weight changes and alcohol abuse, factors known to be related to more dismal health outcomes. Some means-tested programs, such as food assistance programs, have also been found to be beneficial. For example, food assistance programs had a modifying effect on food insecurity, which can lead to depression and obesity in girls (Jones, Jahns, Laraia, & Haughton, 2003).

Within countries, unemployment has a greater impact among ethnic minorities, not only because the rates are much higher, but also because the duration of unemployment is longer and, often, reemployment means loss of income and status relative to one’s former job. For example, at the beginning of 2007 the period of unemployment for white men and women in the United States was on average 15.5 and 15.3 weeks respectively (with a median of 8.3 weeks), while African-American men and women were unemployed for an average of 22 and 20 weeks respectively (with a median duration of 10.8 and 11.6 weeks). It is unclear whether the existing levels of unemployment benefits and other welfare programs are as beneficial for minority groups as they are for the majority of citizens. If the special needs and circumstances of significant minority groups are not considered appropriately, potential health-protective interventions, such as specific social security programs, could fall short of reaching the goal of decreasing social and health inequalities.

**References**


Case study 85. Imprisonment and labour market inequality in the United States. - Bruce Western

For fifty years, from 1925 to 1974, the U.S. rate of imprisonment hovered around 100 per 100,000 of the population. A stunning expansion of the penal population began in 1975 as the imprisonment rate grew over the next thirty years (see figure). By 2005, the imprisonment rate had increased fivefold. If inmates in local jails are added to the count of the penal population, the United States registers the highest incarceration rate in the world, far exceeding the penal populations of Western Europe, and beating its closest rivals, South Africa and Russia. Because the penal population is mostly drawn from young economically disadvantaged men, incarceration rates are now extremely high among those under age 40 with little schooling, and racial minorities. Around a fifth of young black men with just a high school education were in prison or jail by 2005. High rates of incarceration at a point in time add up to large cumulative risks of imprisonment over the life course. Among black men born in the late 1960s, around 1 in 5 have served time in prison for felony conviction, exceeding the number who will serve in the military or graduate from college with a four-year degree (Petit & Western, 2004). The concentration of high rates of incarceration among young, low-skilled, minority men had two kinds of effects on inequality in the U.S. labor market. First, prison and jail inmates are not included in the population surveys that are commonly used to measure unemployment and other indicators of economic well-being. Official statistics thus provide an optimistic picture of the economic status of groups with high incarceration rates. For example, the U.S. Current Population Survey indicated that 37 percent of black men in their twenties were out of work in 2004, but 50 percent were jobless if prison and jail inmates are included in the population. Studies show that, after adjusting for the growth in the penal population, young black men obtained no benefit from the economic expansion of the 1990s, even though standard labour force data showed increases in employment and wages. These ostensible improvements in economic status among young black men were artefacts of the growth in imprisonment. After release from incarceration, ex-prisoners face high risks of unemployment and low wages compared with similar workers who have not been to prison. Estimates from survey data suggest that incarceration reduces hourly wages by around 15 percent, as well as increasing unemployment, shortening job tenure, and dampening the rate of wage growth. The negative effects of incarceration on the labor market appear mostly due to the stigma of a criminal conviction. Survey data show that employers are much more willing to hire high school dropouts or welfare recipients than criminal offenders. Audit studies have sent teams of fake job applicants to apply for real jobs in which one applicant presents evidence of a criminal record. Although the applicants have the same level of schooling, dress similarly, and act similarly in job interviews, employers are only half as likely to respond positively to these presenting a criminal record. Because incarceration has become so common among young, poorly-educated and minority men, and because serving time in prison reduces economic opportunity, the penal system has emerged as a new and important source of social and health inequality in the United States. For example, young men and women returning home from New York City jails faced challenging life circumstances. Fifteen months after release, only about a third of the participants held formal jobs and many of them were still using drugs, and reported mental health problems, and had high rates of emergency room care and hospitalization (Freudenberg, Daniels, Crum, Perkins, & Richi, 2005).

References

Source: U.S. Census
Precarious employment

Other parts of this book have pointed to extensive evidence on the adverse health effects of precarious employment in poor and wealthy countries, across a broad spectrum of different policy settings. Downsizing and job insecurity affects the health and well-being of workers in social democratic Norway or Sweden, just as it does in neo-liberal USA or post-communist China. Even comparatively speaking, comprehensive labour standards and social protection regimes (in countries where unions have retained influence) have been unable to do more than mitigate the consequences of ill-health, since the growth of insecure and contingent work arrangements either bypass or undermine these protective regimes (Bernstein, Lippel, Tucker, & Vosko, 2005; Johnstone & Wilson, 2006). The growth of precarious employment has further debilitated the ailing workers’ rights advocacy groups (such as workplace committees and health and safety representatives) and unions and their involvement in shaping and regulating the working environment. (Baugher & Timmons Roberts, 2004; Johnstone, Quinlan, & Walters, 2005) (see Case studies 86 and 87).

In wealthy countries, government responses to these problems have been belated and fragmented. Policy interventions have generally involved amending occupational health and safety and minimum labour standard laws, codes and guidance material, adding contractual obligations (e.g., occupational health and safety provisions in government tender standards), strategic enforcement campaigns, industry-specific packages (e.g., tripartite agreements dealing with small builders and subcontractors in construction), and the establishment of (often union-backed) roving safety representatives (e.g., the Swedish regional safety representatives system; see Walters, 2004).

In most poor countries, limited laws, shortfalls in regulatory resources, weak or repressed unions, and a political climate not conducive to enforcement inhibits the implementation of basic standards, let alone recognition of the difficulties associated with precarious labour (Balzano, 2004; Baumecker & de Faria, 2006). Research indicates that temporary foreign workers and undocumented immigrants are especially vulnerable to exploitation. They are further used by employers to fracture regulatory standards (even where bilateral agreements, protocols or multi-country directives exist, like Saudi Arabia and the European Union) and can be denied access to workers’ compensation when injured (Guthrie & Quinlan, 2005; Woolfson & Sommers 2006).

Large-scale international workers movements may sometimes represent a serious challenge to essentially closed national welfare state regimes (Freeman, 1986). Yet, in the context of neo-liberal-inspired reductions in worker entitlements, it is possible that an underclass of foreign-born workers will become entrenched in this precarious class position across generations. In the international merchant marine, for
example, the widespread use of “flag of convenience” registration to evade minimum labour and safety standards and engaging crews from poor countries under insecure and grossly inferior wages and working conditions has, together with reduced manning levels, compromised occupational health and safety (Smith, 2006). Competitive work arrangements, pressure on precarious workers, restructuring and under-staffing have also been linked to increased bullying and more overt forms of occupational violence although more research is required (Snyder, 1994; Mayhew et al., 2004).

The insecure and erratic work hours and earning streams associated with contingent work can further affect non-labour activities (such as arranging childcare, family needs and leisure), budgeting, and the accumulation of pension entitlements—a potentially serious issue for older workers (Aronsson, Daliner, Lindh, & Goransson, 2005; Artazcoz, Benach, Borrell, & Cortes, 2005; US General Accounting Office [GAO], 2006; Wegman & McGee, 2004). The full extent of these and other externalities (such as the cost of taxation policies that encourage self-employment in wealthy countries or placing additional burdens on formal sector employment in poor countries like Brazil) is unknown, and they seldom appear to be factored into the evaluation of policies concerning employment and working conditions.

With regard to self-employment, it is critical to distinguish those workers who work for themselves as individuals (sometimes with the support of family members) who are often referred to as “own-account self-employed”, and those self-employed persons who are de facto employers. The former are generally economically dependent (many are subcontractors) and enjoy few legislative protections in terms of their employment conditions. A growing number of these workers have been “converted” from employees to self-employment as a result of business strategies.

**Case study 86. Subcontracting. - Michael Quinlan**

Production in the global economy is composed of an increasingly complex network of contractual arrangements or supply chains. Modern business practice, especially amongst large corporations, depends heavily on the outsourcing of production of goods and services to other firms or distant locations (including internationally). Outsourcing occurs through a variety of subcontracting arrangements, including the provision of labour-only services (agency work) and partial or complete supply of services and goods. Subcontracting can be multi-tiered, involving numerous steps between the producer of a good or service and the ultimate client. Subcontractors include other firms, small businesses and self-employed workers. International studies have overwhelmingly found that subcontracting leads to a deterioration of occupational health and safety (Quinlan, Mayhew, & Bohle, 2001). Multi-tiered subcontracting has also contributed to a number of major industrial disasters such as the explosions at the Phillips 66 Pasadena petrochemical complex in the United States in 1989 and the AZF chemical factory in Toulouse, France, in 2001 (Loss & Le Deaut, 2002). The OHS risks linked to subcontracting include financial/cost-cutting pressures on subcontractors, disorganisation/fracturing of OHS management, and inadequate regulatory controls (Johnstone, Quinlan, & Mayhew, 2001). The legal framework, government and industry response to these issues varies widely and has generally been fragmented and inadequate. Governments have recently begun to explore supply-chain regulation as a means of addressing the risk-shifting associated with complex subcontracting networks. The organisation at the pinnacle of the supply chain often exercises substantial control over the parties it engages to perform tasks. This control manifests itself in the financial dependency of subcontractors (for future work) and in the terms of contractual arrangements between the outsourcing firm and its suppliers to secure quantity, quality, timeliness and price and to allocate regulatory risks. Unlike social protection laws, this private regulatory control effectively spans international borders. Nonetheless, government regulation of these contractual arrangements, covering each step and focusing responsibility at the top of the supply chain,
Case study 87. Poor workers in US agriculture.

Modern day slavery around the world is ongoing and systematic in some sectors of the economy within the United States. In Florida, significant numbers of workers are in slavery and/or forced labour at any given moment in the agriculture industry. Indeed, in the last decade, there have been six successful federal government criminal prosecutions in Florida for forced labour and slavery resulting in up to fifteen-year prison terms and the freeing of over 1,000 workers. In addition, there are ongoing cases under investigation by the Department of Justice.

Forced labour and slavery are driven by the economic and legal context in which farmworkers find themselves. These violations are enabled by discriminatory and inadequate labour laws, failure to ensure basic economic and social rights and increasingly concentrated buying power, which has driven down wages and fuelled inhumane working conditions. In no other sectors in the US, outside of agriculture and domestic work, do employers have as much power over their employees. Farmworkers have long been excluded from the country's most basic labor laws, including the National Labor Relations Act (NLRA), which means farmworkers can be legally fired for collective bargaining efforts. Farmworkers are also excluded from portions of the Fair Labor Standards Act (FLSA), which regulates issues like minimum wage and overtime pay. There are also restrictions on immigration visas for farmworkers, which enable abuse. In particular, the H2-A visa increasingly used by farmworkers to work legally in the US has no employer portability; in other words, it is valid only for the existing employer. This hampers workers from protecting themselves against abuses, leaving them no options other than illegal work or returning home to where there may be no viable work and where they may not be able to pay off the sizeable debt accumulated to come to the US. All of these components working together clearly enable human rights violations.

Farmworkers are among the poorest, if not the poorest, labourers in the United States economy. When legal, they earn roughly $7,500 per year, which is far below the national poverty line. Undocumented workers often earn less than half of that. Wages are kept low through illegal withholding of pay, enabled by inadequately enforced federal and state wage protection regulations. Farmworkers also generally earn less than the legal minimum wage because they are not compensated for time spent travelling between fields and harvests, time waiting for fields to dry before picking, and time waiting for crops to ripen. In addition, farmworkers' wages have not changed significantly in over twenty-five years. Adjusted for inflation, this is a 65 per cent drop in income in the last quarter decade.

Farmworkers rarely receive overtime pay. Besides not being adequately compensated for their time, workers often do not have a choice as to whether they want to work overtime. They do not generally receive benefits such as health insurance, sick leave, vacation pay, and pensions. The number of farmworkers who do have access to either benefits from their employers or contribution-based and needs-based services has never been large and has been declining. Farmworkers' lack of access to health insurance means they lack information about medical services, confront long travel times to medical facilities from their isolated labour camps, face language barriers and often encounter hostility from employers reluctant to report workplace injuries or illnesses. The failure to ensure farmworkers basic economic and social rights is also reflected in the substandard housing they inhabit. Workers often have no telephones, no cars, and neither heat nor air conditioning in the shacks and trailers they inhabit. Overcrowding is both common and severe. Twelve to fifteen people, or roughly three families, may live in a single-wide trailer, hanging sheets as dividing walls. Far from being cheap, a trailer such as the one just described can rent for up to $1,200 per month. Shacks can rent for upwards of $200 a week, a square-footage rate approaching Manhattan's, one of the highest rent districts in the US.

Source
Informal employment

The informal sector is a step below precarious employment in terms of vulnerability. Although an informal economy exists within wealthy countries (and may be growing), informal employment is predominantly a feature of low- and middle-income countries such as China, where it has grown rapidly to account for over 25 per cent of the workforce, and is especially predominant among women (Cooke, 2006) (see Case studies 88 and 89). In some African countries, such as Ghana, the majority of workers are engaged in the informal economy. The danger of the informal sector in the production of health inequalities is the fact that both workers and dominant practices remain very difficult to monitor.

The economic pressure, deprivation, and lawlessness surrounding much informal economic work exposes workers to an array of heightened risks including poor mental health, physical over-exertion, and exposure to sexual harassment and violence (prevalent amongst domestic workers and street vendors) (Nunes & Theodoro, 2006). The problem is that informal labourers and the informal labour market as a whole remain largely invisible to OHS statistics. Moreover, the existence of such a substantial informal sector corrodes the regulatory protection of the formal sector because there is no universality to minimum labour standards. More important still, the informal sector can be used as an alternative source of supply (through outsourcing) by local or foreign firms seeking to evade regulatory standards (Dwyer, 2006; Baumecker & de Faria 2006; Beltrao, 2006).

To combat this usurpation, informal workers have occasionally sought to organise in order to protect themselves. Despite their efforts, social marginalisation and workplace isolation make organisation problematic and these bodies have, on occasion, been shunned by unions more concerned about restricting membership than acknowledging the informal economy. Nonetheless, groups of informal workers mobilise in the social, industrial and political spheres to demand dignity and rights from employers and push to create broad alliances in order to pressure governments to adopt food production and redistributive policies and alleviate poverty, rather than prioritising export crops.

As we mentioned before regarding the informal economy, child and bonded labour governments must assume the policy space to ensure that resources are directed to achieve equitable access to health care, that poverty reduction is a priority and that health is treated as a human right and not as a WTO/IMF-approved outcome of the marketplace (Labonte & Schrecker, 2007). As Tokman (2007) has argued with regard to Latin America, the informal economy can be incorporated into the modern sector to address social exclusion and achieve near-universal social protection.
Case study 88. Self-employment. - Michael Quinlan

The own-account self-employed (those who work for themselves as individuals, as distinct from those who employ others) cover a wide diversity of workers, ranging from professionals with scarce expertise to vendors and workers performing highly repetitive physical tasks (in cleaning, construction, forestry and fishing). Some self-employed provide goods or services for a wide array of clients, but many operate in dependent subcontracting networks. The self-employed include highly vulnerable workers such as child street vendors (in poor countries such as Ghana) and undocumented foreign construction workers (in wealthy countries such as Italy). Historically, there has been a divide in wealthy countries between self-employed workers and employees with respect to social protection, the former being largely excluded from unions, collective agreements/minimum labour standards, and workers’ compensation (though not OHS laws). Regulatory gaps have been exacerbated by the growth of elaborate supply chains and by corporations like FedEx converting their employees into independent contractors (Coppelman, 2007). In some countries governments have sought to combat these practices (e.g., by redefining employees), while unions have sought to enroll self-employed workers (Pernicka, 2006). In poor countries, self-employed workers—including many workers in the informal sector—are often uncovered even by OHS laws. There is evidence that the economic vulnerability of self-employed workers—intense competition for work, long hours and low pay—can adversely affect OHS in industries such as road transport, construction, and agricultural harvesting. The combination of self-help associations and the provision of micro-credit has been promoted as a way of mitigating poverty and health problems amongst self-employed and other informal sector workers, especially rural women (or indeed moving them into gainful self-employment), in poor countries. However, research evaluating such programs has yielded ambiguous or mixed results (Ahmed, Chowdhury, & Bhuiya, 2001; Barboza & Barreto, 2006). Several studies question whether micro-credit is a means of empowering women or otherwise economically and socially vulnerable workers (Bhuiya, Sharmin, & Hanifi, 2003; Parmar, 2003) while others suggest that collective organisation by these workers is the more powerful effect improving economic, emotional, and physical work-life conditions [Hill, 2001; Thorp, Stewart, & Heyer, 2005]. Contingencies in the capacity of groups to organise or to exert political pressure or countervailing influence at the bottom of a supply chain and the underlying assumptions of micro-credit programs with respect to economic behaviour suggest that self-help and micro-credit are, at best, partial remedies to the vulnerability of workers in poor countries. At worst, they represent an approach compatible with the dominant neoliberal policy paradigm whereby workers increasingly assume the burden of economic risks, which legitimizes the failure of governments to address the health consequences of economic and social subordination in the labour market (Rankin, 2001).

References
Child labour

Child labour remains both pervasive and concentrated in the informal economy of poor countries in Africa, Latin America, and elsewhere, and the conditions of some of these workers may have worsened (Quinlan, Mayhew, & Bohle, 2001). It has also re-emerged as an issue in wealthy countries (7% of Australian children aged 5-14 work; Australian Bureau of Statistics, 2007). Child labour is most prevalent in conjunction with precarious employment (temporary and seasonal jobs and home-based work) and numbers are found in high-risk industries such as agriculture, which has caused governments to reconsider their child labour laws (GAO, 2007; Kruse & Mahony, 2000; Mourell & Allan, 2005). Like their poor country counterparts, a number work the bottom of elaborate supply chains or subcontracting networks, such as
home-based garment making (Mayhew & Quinlan, 1999) [see Case studies 90 and 91]. Thus supply chain regulation, especially at the international level, offers opportunities to mitigate the damaging health outcomes of child labour. Since child labour is largely a response to poverty, the establishment of minimum wages that ensure a decent standard of living and the provision of food for attending school programs [as done in one state in India] represent other policy interventions.

**Case study 90. Reducing child labour in Brazil: A successful experience.** - Vilma Santana and Mariana Wagner

Child labour in Brazil became the focus of attention of social policies in the 90s, when statistics showed a 2.2 per cent average yearly increase between 1970 and 1990. Approximately 29 per cent of individuals from 5 to 17 years of age were in the labour force in 1996, representing around 8 million child labourers (International Labour Organization, 2003). Studies show that most of the activities they performed endangered their biological, physical, emotional and social development, and are known as having increased risks for health and safety (Roggero, Mangiaterra, Bustro, & Rosati, 2007). The growing number of street kids in the 90s, most of them involved in illegal activities, called for the attention of the government and international institutions, which elaborated a new law intended to protect the interest and rights of children and adolescents. In 1992, Brazil signed the International Programme on the Elimination of Child Labour (IPEC), and in recent years a remarkable advance in the fight against child labour has been observed. The Child Labour Eradication Program (PETI) was created in 1996 based on a heavy dissemination of knowledge about the illegal nature of child labour and the broad social mobilisation of civil society, non-governmental organisations, and the various levels of government. The reduction of children in the labour market caused an expressive increase in school enrolment, around 10 per cent a year since 1995, reaching 96 per cent in 2006 throughout the country (Ferro & Kassouf, 2005). However, since permanence at school was low due to the spread of family poverty, the Bolsa Escola Programme was also created. This programme determined a minimum income for each family that kept their children attending school under the guidelines of conditional cash transfer policy. Evaluations of the Bolsa Escola revealed that it could lead to distortions because the amount of transfer depend on the number of children, but it has been successful by reducing the average work-time of children of 6 to 15 years of age by 3 hours per day, rural and urban areas, of families with income below the minimum wage (Ferro & Kassouf, 2005). More recently, this programme was replaced by the Bolsa Família, which is based on conditional transfer. From 1995 to 2005, the proportion of working children from 5 to 15 years of age dropped from 13.7 per cent (5,147,964 children) to 7.8 per cent (2,934,724 children), a 43 per cent decrease in 10 years (Fórum Nacional de Prevenção e Erradicação do Trabalho Infantil, 2006). Domestic employment, the most common job of girls, was outlawed for children below 16 years of age. Since 2006, the Unified Health System (SUS), a state network of universal health care coverage, has been implementing a protocol to identify child labour cases in the primary health care facilities and developing special prevention programmes from the Workers’ Health Referral Centres, which comprise the National Network of Workers Health Care. At the moment, most of the actions performed focused on training over 4,500 health workers from the SUS and the Health Ministry is offering a distance-learning course specifically on the prevention of child labour at the national level. Ten Brazilian states are already performing a mandatory notification of occupational injuries among children and adolescents, which started in 2007.

**References**


Slavery and bonded labour

Although legalised slavery is relatively rare nowadays, millions of men, women and children in poor countries are still forced to work under various forms of debt bondage or contractual servitude, which government authorities tolerate (see Case studies 92 and 93). Even more clandestine forms of debt bondage are used against some undocumented foreign workers in wealthy countries. As noted, while the clandestine nature of forced labour makes its health effects difficult to assess, the violation of human rights and the health inequities it entails justify stringent attention. Like the worst forms of child labour, the combination of poverty, unscrupulous labour agents, and regulatory corruption are critical to the survival of forced labour. Policy interventions must target all three to have any chance of success.

In addition to the essential need for action by poor countries’ governments, such measures could be encouraged through a reward-penalty incentive system funded by the wealthy countries with whom they trade. Finally, it should be recognised that, historically speaking, slavery existed as one extreme in a spectrum of labour arrangements between unfree, semi-free and free labour (other categories included...
prison labour and indentured workers) and the growth of individualistic and “contractualist” employment regimes in wealthy and poor countries provides the means to reintroduce greater subordination in the employment relationship (Hay & Craven, 2004).

## Case study 92. Forced labour among indigenous communities in the Peruvian Amazon

The Amazon region has a diversity of indigenous communities that is greater than almost anywhere else in the world. Currently, the estimated indigenous population in the Amazon is 982,289 (4.43% of the total population of the Amazon region), which includes 59 ethnic groups and 16 linguistic families (Instituto Nacional de Estadística e Informática, 1993). Since first contact with occidental culture, these groups have suffered internal pressures, struggles and removals. Although they have different territorial and demographic characteristics, all groups suffer from discrimination, marginalisation, exclusion and poverty. As a result, some groups have voluntarily chosen isolation. Nevertheless, most Amazon territory has always been related to other adjacent cultures; consequently, ethnic groups have not been as isolated historically as is sometimes assumed.

Indigenous groups, like any other society, have economies that can be: 1) capitalist, which look for opportunities in regional markets and remunerate work; 2) quasi- or pre-capitalist, in which a significant part of production is not directed to markets but to subsistence, and whose production is based on their own perceived needs; or 3) prehistorical, very remote from urban centres and mostly made up of a network of other indigenous communities who exchange products. It is currently estimated that 5 per cent of indigenous people are part of groups which are not in contact with the non-indigenous world, though some of these groups have voluntarily isolated themselves, having in the past been more integrated. On the other end of the spectrum, some indigenous people are completely integrated into the dominant culture.

For centuries, indigenous people of the Amazon have been characterised by their great autonomy and a complex culture that relied largely on the relationship with the natural world. Since pre-Columbian times, Amazonian societies have looked to the forests for their food, building materials, medicines, spiritual guidance and trade products. This relationship with the forest has persisted through the economic and social cycles of the past two centuries, including different economic periods: the missionary period of 1780-1860, the rubber boom of 1860-1915, intensive timber exploitation between 1920 and 1960 and the oil boom from 1960 to the present. However, in the last decades, pressure on their territories has dramatically increased. By the end of the twentieth century, global neo-liberal structural adjustments have imposed a large ecological and social impact on the Amazon indigenous, whose survival is threatened by the over-exploitation of their natural resources and the invasion of their territories. Additionally, in many cases these activities not only involve the destruction of natural resources, but also extortion, threats, and enslavement of entire indigenous communities, including non-contacted or isolated groups.

Members from native communities market their surplus from hunting and fishing, and exchange them for basic foodstuffs like rice, salt, sugar, oil and rifle cartridges, drugs or other basic tools. Indigenous people gather products in the forest and give them to a local merchant, fixed or travelling, as payment for goods previously received. Consequently, they are required to assume a long-term debt with the local merchant or the master, and to give the merchant most of their production, which further subjects them to merchant-imposed conditions. This is actually a covert form of slavery, but it frequently goes unnoticed since it takes place on a small scale and on the margins of society and because, on the surface, it seems to involve an exchange of goods. These activities have been strongly encouraged by larger regional markets and those in the business of exploiting natural resources, such as timber and fauna. Although these markets have existed since colonisation, the modern capitalist systems augment their impact in the region. Traders benefit from scarce knowledge of the external commercial system, the product value in urban markets, and the inexperience of indigenous people. Traders or landowners are able to convince them to work to pay off previously acquired debts, and as indigenous products are continually devalued, the debt only increases. In this situation of long-term indebtedness, they may be forced to move illegal encampments set up by landowners, who further entrap them in a cycle of debt and servitude, which can be passed from one generation to the next. This scenario is often accompanied by illegal and clandestine activities of resource extraction.

Only recently, the Peruvian government has recognized the scenario described above as forced labour. There are currently an estimated 33,000 indigenous people in situations of forced labour in the Peruvian Amazon, especially in those regions with isolated communities and overexploitation of timber (Bedoya Garland & Bedoya Silva-Santiesteban, 2005). The recognition of these activities as forced labour is an important advance, since only a few years ago they were only considered “poor working conditions.” As a result of ILO reports (Bedoya Garland & Bedoya Silva-Santiesteban, 2005), Peru has set up...
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the Action Plan for the Eradication of Forced Labour to control illegal extracting activities, and to educate and train
employers, workers, estate civil servants, NGOs, scholars and Peruvian citizens in general. But reforms must continually be
revised and implemented at a legislative and institutional level. Several international associations against slavery and pro-
indigenous communities have recognised the work of the Peruvian government, but they have also raised alerts about the
difficulty of implementing these antislavery measures, such as lack of financial support and human resources (Anti-Slavery
International, 2006). While regulation, inspection and criminalisation activities are necessary, rehabilitation is also required
for all people involved in forced labour. The Amazon indigenous communities affected by forced labour suffer from not only
restriction of freedom and privacy, but also the destruction of their habitat, resources and life patterns, which are vital to the
daily subsistence of most indigenous communities.

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Case study 93. Close to slavery: guest worker program in the United States. - Mary Bauer

In his 2007 State of the Union Address, the President of the United States called for legislation creating a “legal
and orderly path for foreign workers to enter our country to work on a temporary basis.” Doing so, the president said,
would mean “they won’t have to try to sneak in.” Such a program has been central to Bush’s past immigration reform
proposals. Similarly, recent congressional proposals have included provisions that would bring potentially millions
of new “guest” workers to the United States. What George Bush did not say was that the United States already has a
guest worker program for unskilled laborers—one that is largely hidden from view because the workers are typically
isolated both socially and geographically. Before we expand this system in the name of immigration reform, we should
carefully examine how it operates. Under the current system called H-2, a program created in 1943, revised by
Congress in 1986 and administered by the U.S. Department of Labour, employers brought about 121,000 guest
workers into the United States in 2005, approximately 32,000 for agricultural work and another 89,000 for jobs in
forestry, seafood processing, landscaping, construction and other non-agricultural industries. These workers are not
treated like “guests,” however. Rather, interviews with thousands of workers and dozens of legal cases show that they
are systematically exploited and abused (The Southern Poverty Law Center, 2007). Unlike U.S. citizens, guest workers
do not enjoy the most fundamental protection of a competitive labour market: the ability to change jobs if they are
mistreated. Instead, they are bound to the employers who “import” them. If guest workers complain about abuses,
they face deportation, blacklisting, or other retaliation. Federal law and U.S. Department of Labour regulations
provide some basic protections to H-2 guestworkers, but they exist mainly on paper. Government enforcement of their
rights is almost nonexistent. Private attorneys typically won’t take up their cause. Guestworkers who come to the
United States are routinely cheated out of wages, forced to mortgage their futures to obtain low-wage, temporary
jobs, held virtually captive by employers who seize their documents, forced to live in squalid conditions and denied
medical benefits for injuries. The current program is shamefully abusive in practice, and there is almost no
enforcement of worker rights. Guestworkers are usually poor, powerless people who are lured here by the promise of
debt jobs. But all too often, their dreams are based on lies, their hopes shattered by the reality of a system that
treats them as commodities. They’re the disposable workers of the global economy. The federal government has
failed to protect them from unscrupulous employers, and most cannot obtain private legal assistance to enforce their
rights through the courts. The structure of this system creates unequal power between employer and worker, which
leaves the worker in a dangerously vulnerable position. The H-2 should not serve as a model for immigration reform,
but in fact should be overhauled if allowed to continue. As part of the reform of the broken U.S. immigration system,
Congress should eliminate the current H-2 system entirely or commit to making it a fair program with strong worker
protections that are vigorously enforced.

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9.6. ASSESSING POLICY INTERVENTIONS

While evidence indicates that the employment conditions identified in this book exert profound effects on health, we cannot meet these challenges through simple policy solutions. Rather the complex and dynamic nature of employment conditions, and the range of specific country contexts, call for an array of policy interventions operating at different levels (see Case studies 94 to 99). Nonetheless, they must all take note of the trends uncovered in this book, such as avoiding the harmful side-effects of neo-liberal policies on work arrangements in both poor and wealthy countries. Drawing on an array of sources, this chapter has identified a series of policy interventions that can address these challenges, many of which have already been implemented (albeit often on a minor scale).

Our ability to evaluate interventions is limited by the comparatively recent nature of some changes to employment conditions, the even more recent nature of some remedies (such as supply chain regulation) and the more general paucity of research on the effectiveness of interventions (Bambra, Egan, Thomas, Petticrew, & Whitehead, 2008; Egan et al., 2007; Egan, Bambra, Petticrew, & Whitehead, 2009). Nonetheless, many of the policies identified make intuitive sense because they are directed at those characteristics (economic deprivation, disorganisation, disempowerment and regulatory failure) that, as evidence suggests, cause the problems (for a parallel analysis see Labonte & Schrecker, 2007). Policy interventions also need to be informed by an understanding of gender effects, since some employment conditions disproportionately marginalise women (Artazcoz, Borrell, Cortès, Escriba-Aguir, & Cascant, 2007). As noted elsewhere in this book, evidence on the effectiveness of some current, internationally-promoted interventions, such as corporate social responsibility and micro-credit, is ambiguous (Blowfield, 2007). On the other hand, available evidence indicates that less-publicised measures, such as food or income support for the poor, has alleviated the incidence of child labour in countries like Brazil.

The aforementioned tables and discussions place considerable emphasis on infrastructure (poverty alleviation, universal education and public health facilities, government inspectorates) and regulation (international standards and agreements, laws and enforcement). This is because governments and their agencies are in a position to provide comprehensive standards and laws, as well as enforce them. These policies also set a framework for community expectations, thus influencing other actions and giving them a dramatically more far-reaching scale than more targeted policies.
Interventions may also occur at the employer/organisational level and the job/task levels.

Even so, while interventions related to employment conditions may occur at the organisational and job/task level, employment conditions can be restructured (perhaps more so than working conditions) at the societal/regulatory level. Voluntary measures by employers or corporations have a role to play, but are too fragmented to reshape employment conditions and lift standards generally. The same applies to union and community activities, although unions can generalise collectively negotiated protections (nationally and internationally) and, as evidence from poor countries attests, community actions can act as an important adjunct or impetus to government measures. Historically, government action, often in response to community pressure, has set minimum social standards.

Mandating standards or enacting regulation has little effect without adequate, supportive infrastructure and rigorous enforcement. Evidence of the failure of existing regulations to protect vulnerable workers, even in wealthy countries (Lipscomb, McDonald, Dement, Schoenfisch, & Epling, 2007), generally reflects a failure of enforcement rather than an argument against the regulatory option. Likewise, the failure to enforce labour standards in poor countries results from political and social decisions, not economic necessity (Brown & O’Rourke, 2003). On the other side of the coin, however, the combination of pressure from unions and social communities plays a vital role in ensuring government action, something well-illustrated by the prolonged struggle to ban asbestos and recent actions to address children kidnapped and forced to work in brick-making in the Shanxi and Henan provinces in China (Sydney Morning Herald, 2008). As was true in the past (MacDonagh, 1977), evidence attesting to the effectiveness of new policy and regulatory measures addressing the OHS threats of employment conditions will only accumulate slowly, and will further involve a process of trial, error and refinement in the context of ongoing community pressure.

Fundamental questions also need to be asked about how employment conditions best serve the long-term health and well-being of the global community. Leaving the health consequences of employment conditions as an afterthought or “downstream” consideration in trade, commercial transactions, business practices and industrial relations will simply perpetuate the problems identified in this book. Enforceable standards (with effective sanctions) are essential at the national and international levels,
along with economic and health policies designed to alleviate poverty in poor countries. At the same time, those employment arrangements that deliver healthier and better quality working conditions must also be pursued centrally and be well integrated with other policies aimed at ameliorating public health inequalities (Stahl, Wismar, Ollila, Lahtinen, & Leppo, 2006; Labonte & Schrecker, 2007).

Policies and Interventions

Case study 94: ISTAS’ participatory approach to the psychosocial work environment to reduce health inequalities in Spain. - Salvador Moncada i Lluis, Clara Llorens Serrano, Fernando Rodrigo, Ariadna Font Corominas and Ariadna Galtés

The Spanish psychosocial work environment combines poor psychosocial working conditions (e.g., 14.5% and 17.6% of workers in high strain in 1995 and 2000 respectively), elevated exposures to psychosocial hazards (e.g., high prevalence of exposures to low influence, low possibilities for development, low control over working time and high job insecurity) and large occupational health inequalities (e.g., poor mental health outcomes are associated with precarious employment arrangements) (Moncada, Llorens, Gimeno, & Font, 2007; Benach et al., 2007). Historically, main causes of the unhealthy Spanish psychosocial work environment include lack of awareness on occupational health problems, employers’ resistance to attaining healthier workplaces via the implementation of organisational changes, the weakness of unions with low density levels and sometimes a lack of concern for health and safety issues, the deregulation of working conditions within an economic structure with many small- and medium-size firms in which, due to the international division of labour, competitiveness is increasingly based on precarious working conditions stemming from labour management practices characterised by employer demands of high availability regarding working time and employment arrangements, as well as Taylorism (see Case study 59) and the presence of a number of “myths” (e.g. that “stress” would be directly linked with individual personality issues or that we lack valid methods for assessing psychosocial hazards). The implementation of the Spanish Health and Safety Act in 1996, however, represented an opportunity to highlight psychosocial hazards, making it mandatory for employers to evaluate and prevent workplace occupational hazards, as well as to recognise the participatory rights of health and safety representatives. In 2008, the 70,000 union health and safety representatives constitute a key workplace organisation asset for improving occupational health (Menéndez, Benach, & Vogel, 2008; 2009).

The Union Institute of Work, Environment and Health (ISTAS) is a non-profit, self-managed technical trade union foundation supported by the Spanish Trade Union Confederation “Comisiones Obreras” (CC.OO.) whose aim is to improve working conditions, occupational health and safety and environmental protection in Spain. A concrete example of the ISTAS approach is action to improve the psychosocial work environment. ISTAS uses a participatory strategy that empowers workers and helps safety representatives provoke changes in work organisation, pressuring employers to negotiate and thus improve the psychosocial work environment and workers’ health. One of the key ISTAS activities is to provide safety representatives with an adequate level of information, training and advice, so they can implement preventive interventions in the workplace [García, López-Jacob, Dudzinski, Gadea, & Rodrigo, 2007]. The overall strategy includes eight general steps that are summarised below.

1. Promote actively union’s participation to endorse primary prevention, that is, the trade union decision to work towards developing the highest level of participatory rights in workplace health and safety in order to achieve prevention at the source. This includes proposals regarding bargaining and co-management in all phases of the prevention process.

2. Develop alliances and collaborative agreements with scientific, administrative and technical institutions, including national (e.g. Spanish Universities, Occupational Health and Safety Institutes, and Regional Governments) and international (the Danish National Research Centre for the Working Environment) institutions.

3. Adapt a valid and participatory method for assessing workplace psychosocial hazards. ISTAS adapted the Copenhagen Psychosocial Questionnaire (CoPsoQ) [Kristensen, Hannerz, Høgh, & Borg, 2005] in cooperation with other institutions (see above), attaining a valid, reliable and practical method for analysing psychosocial workplace hazards in Spain - COPSOQ (ISTAS21) [Moncada, Llorens, Navarro, & Kristensen, 2005; Moncada, Llorens, Font, Galtés, & Navarro, 2008]. Although a complete evaluation is still in process, it is estimated that no less than 2,000 firms are already using this scientific, participatory, action-based approach. All ISTAS materials are of public domain, including information on ISTAS21. Also, it is estimated that around 15,000 downloads have been made from ISTAS web site.

4. Promote specific workplace experiences. Risk assessment processes were implemented in 50 Spanish workplaces in order to adapt the ISTAS21 (COPSOQ) prevention processes to the Spanish context. In all cases, three-party working teams (i.e. managers, occupational health professionals and workers’ representatives) were established.

5. Achieve agreements with labour authorities. An agreement was reached so that the Catalan Government established...
the ISTAS21 method as a reference for the assessment of psychosocial hazards in the region of Catalonia. A Technical Note of Prevention (NTP, a technical reference bookmark in Spain) was also issued by the National Institute of Occupational Health and Safety.

6. Communicate and share the experience with workers’ representatives. A strategy to “socialise” the experience to workers’ representatives was settled using a “cascade” design. The first phase was “learning by doing”. Thus, working together with safety reps, trade union heads and trade union occupational health consultants, experiences at the firm level were used to develop trade union guidelines and tools that are helpful for workplace action. After these guidelines, ISTAS developed materials for the training of trade union occupational health consultants (who later provided technical support to workers’ reps at the firm level) and training of safety representatives. This strategy helped to socialise and multiply these experiences.

7. Gain trust among occupational health experts and researchers and OH professionals. Previous steps (particularly steps two through five), allowed for substantial increases in the general awareness and technical legitimacy of the ISTAS21. The Catalan Society of Occupational Safety and Medicine, for example, awarded this method as the best research project in occupational health (Moncada et al., 2005). Public funding from the Spanish National Plan of Research and Development was obtained further on and the methodology is currently being used by most important Spanish preventive services.

8. Evaluate and learn from experience. Workshops were made to analyse the feasibility of what has been learned through interventions and analytical research in an on-going dynamic learning process with university researchers, health and safety professionals from private firms and administration, trade unionists, workers’ representatives and trade union occupational health consultants. In October 2007, for example, the 5th ISTAS meeting on Occupational Health gathered around 300 persons, including union leaders, workers’ health and safety representatives, occupational health professionals and managers to discuss preventions to be taken (ISTAS, 2007). A total of 42 intervention experiences were presented and conclusions were issued (Moncada & Llorens, 2007).

ISTAS’s work could be seen as a form of knowledge activism as defined by Hall in the sense that what ISTAS does is to work in both technical (scientific and social) trade union arenas in order to strategically collect and use technical, scientific and legal knowledge to empower worker health and safety representatives at the company level.

References

Case study 95. Argentina’s worker-occupied enterprises. - Marcelo Amable

The appearance of workers’ cooperatives in Argentina can be traced back to the economic crisis that affected the country in 2001. During the years of military rule in Argentina in the late 1970s, there was a profound change in the patterns of capital accumulation. Under the auspices of the International Monetary Fund (IMF), the influx of transnational capital redefined the traditional functions of the state and market-oriented reforms dismantled the strong labour unions that had been in place since the Perón era. This model of economic growth peaked in the 1990s, but the full effect of the social inequality it had caused wasn’t seen until the crisis in December 2001, when the country defaulted on $600 million in bond payments and investors fled the country.

In 1974, before the military dictatorship took office, the top 10 per cent of income earners received five times the income of the bottom 10 per cent. By 1991, it was a factor of 15, and by 2003, 44 (Ranis, 2005). In addition, as a result of the crisis, it is estimated that between 2001 and 2003 an average of 1,000 companies were closing every day; in 2003, 2,680 firms closed in the city of Buenos Aires alone (Gambina, 2003). The situation was critical for those workers who lost their jobs, since they were not entitled to any monetary compensation, and the crisis made it almost impossible to find another job. As these new social, cultural and economic experiences spread throughout the country, citizens and workers began to try new ways of resisting and surviving.

One of these strategies was to occupy former companies that had been closed down. Although there is no accurate registry, according to several sources, the number of companies as of 2003 was between 120 and 170, using a total of about 10,000 to 15,000 workers (Saavedra, 2003; Arévalo & Calello, 2003). These recovered companies very often adopted a new form of employment relations, where hierarchical structures were rejected in favour of more egalitarian regimes of income distribution, according to workers’ tasks and responsibilities. It is estimated that this has been the case for 90 per cent of the total number of recovered enterprises. The economic activities and products of these companies vary greatly, ranging from food processing and refrigeration to iron, steel, wood, transportation or textiles. The companies vary from small restaurants to large factories and are located mainly in the urban areas of the country, sites of past industrial development.

The need to share experiences and look for common strategies stimulated the creation of various organizations such as MNER, MNFRT, ANTA, FACTA and FENCOOTER* (Saavedra, 2003; Arévalo & Calello, 2003). These organisations differ with respect to their type of ownership: while some organisations support the creation of cooperatives whose benefits help generate more activities, others prefer to be owned by the state under workers’ control, with benefits for the community. The legal situation of the companies is not yet well defined. Currently, many of them have obtained judicial permission to rent or temporarily use facilities or machinery, although the situations are also diverse.

Some problems have emerged. For instance, creditors, suppliers and banks are claiming the debts of the previous owners, now that the companies have new capital. A second challenge is that the recovered companies have little start-up capital to initiate or to maintain the development of their productive activities. In fact, they drag along debts from the previous owners, for example with the social security system, and they have limited access to the credit market (Arévalo & Calello, 2003). Thus, even if successfully re-started, company profits might not end in the workers’ hands. Because of these drawbacks, changes in the conditions of production and technology are not easy to implement. Nevertheless, the businesses are run with increased worker control. Often there is a reduction in the intensity of the tasks because the control and monitoring of the owners have disappeared. With better employment relations and conditions, workers’ quality of life improves. Therefore, these experiences constitute an interesting case to follow.


References

Case study 96. Venezuela: A new phase in the Bolivarian revolution? Promotion of forms of collective ownership. - Rodolfo Magallanes

Since the end of 2004, Venezuela appears to have initiated a new phase characterised by the increased radicalisation of the objectives of socio-economic transformation and promotion of forms of property ownership alternative to individual private property. In this context, the "Líneas Generales del Plan de Desarrollo Económico y Social de la Nación 2007-2013" (General Outline of the National Economic and Social Development Plan, 2007-2013) aims to contribute to defining the actions with a new endogenous development model, with the following objectives (Ministerio del Poder Popular para las Comunas y Protección Social, 2005):

- Question the predominance of individual lucrative interest as the axis of production, rewarding collective interests and wellbeing.
- Promote new social relations in production.
- Stimulate adoption of new styles of living and consumption.
- Democratic planning of the economy, rejecting market anarchy and favouring the satisfaction of collective needs.

The creation of cooperatives and of a form of association oriented towards production, known as Empresas de Producción Social (Social Production Enterprises) are the mechanisms promoted by the government to implement the new model of development. In June 2006, there was a total of 131,581 cooperatives registered in the country. Of these, nearly three-quarters are oriented towards the services sector. The majority of cooperatives have between five and ten members. This system of cooperatives has revealed certain limitations, such as the possibility of corruption, limited spheres of action (as many of them have a minimum number of members and are more oriented towards generation of services than towards production), difficulties for state control, or reproduction of hierarchical relationships. The government has opted for complementing these organisational forms with other mechanisms, over which it can exercise greater control and guarantee compliance with the model of society it is promoting.

The main instrument used to achieve the government’s objectives for transforming the mode of production and promoting new forms of property ownership are the new Social Production Enterprises. These are “economic entities dedicated to the production of goods, services and work, free of social discrimination in the work place, in which there are no privileges associated with hierarchical position, and where there is substantial equality between members”. Furthermore, they “would be based on participative planning under a regime of state ownership, collective ownership, or a combination of the two” (see PDVSA). The program encourages participating firms to adopt an attitude of social co-responsibility, according to which they must contribute to solving certain social needs in the social context in which they are situated. The main client of the Social Production Enterprises is the state, mainly the state oil company, PDVSA.

From a critical perspective, government actions destined to change the production model and form of ownership, however, reveal certain contradictions, giving the appearance of being guided by ideological and party-oriented reasons. Thus, the government refers to a strategy for constructing a “socialism for the 21st century”, while at the same time its actions form part of a government strategy to increase its chances of remaining in power, the most visible aspect being the way in which these actions are accentuated in the face of elections (e.g., the constitutional referendum). There is a notable absence of competitive mechanisms that raise efficiency and ensure better quality results, and also of any participation by non-governmental actors in directing these programs. Furthermore, the difficulty of obtaining any information about government execution of these plans does not contribute to transparency or control of public actions.

However, there is a perceptible change in the quality of public administration, with a significant incorporation of historically excluded sectors of society as benefactors, revealing improvements in the global distribution of the country’s income and in the quality of life. These aspects are associated with a reduction in levels of malnutrition, related in turn with a decline in poverty, particularly extreme poverty (Salmerón, 2007)

References
**Case study 97. Employment relations and health inequities in South Africa. - Yogan Pillay**

South Africa is designated as a middle-income country, yet it has high levels of unemployment (between 30-40%). It also has a large and growing sector of people who are informally employed. This situation has led to the characterisation of South Africa as having two economies: one in which workers have formal employment, which is relatively well paid and largely organised by labour unions, and the second economy, which includes both the informally employed and the unemployed. This situation is further complicated by the history of apartheid (segregation) of the country, with white South Africans being advantaged relative to black South Africans.

This reality has several consequences: black South Africans have the worst health outcomes while whites have outcomes that are similar to those living in high income countries. Black South Africans make up the overwhelming majority of the working class and are in the second economy, while the majority of white South Africans are in formal employment; most whites can and do use the private health sector (where per capita spending is about R8000 per year) while the majority of South Africans use the public health sector (where per capita health expenditure is at R1000). This means that race and class for the most part overlap in South Africa.

The post-apartheid governments (elected since 1994) have adopted a very progressive constitution with a Bill of Rights that guarantees certain rights to all citizens, among them the right to receive fair treatment in employment, the right to shelter and access to health services. In line with the Constitution, the country has implemented a number of policies to level the playing field between white and black South Africans. These include employment equity targets (to ensure that both the state and private sector employ more black South Africans), broad-based black economic empowerment, minimum salaries for workers in certain sectors (agricultural and domestic work in particular), the removal of user fees for primary health care through the public health sector and public hospital services for pregnant and lactating women, children under six and people with disabilities.

The policies referred to above have produced mixed results. Employment equity targets have been met in the public sector but not fully realised in the private sector. The private sector appears to focus more on the bottom line (profits) than on transformation targets. Given the historically inferior education provided to black South Africans, there is a small pool of highly qualified and skilled black South Africans, especially women, which has resulted in high mobility and rapid upward mobility for a few. However, in a speech on 11 September, 2006, which launched the sixth report on employment equity, the Minister of Labour said that “the overall picture remains bleak. If we continue at this pace we would most probably reach equitable workplaces only in forty to fifty years from now.”

The process of black economic empowerment has been criticised for not being broad-based, as evidenced by the fact that a few black South Africans have become enormously rich and that the same individuals appear to be involved in most of the attempts by white capital to sell equity to black South Africans. The South African Communist Party has been critical of some of the consequences of black economic empowerment, as noted by its general secretary, who argued that “our attempts to build an effective developmental state are perversely undermined by relations between business and the political elite, and by the depletion of senior public sector posts by private companies ‘meeting’ BEE employment targets” (Nzimande, 2006).

The goal of raising the earning capacity of the working class by setting minimum wages and instituting unemployment benefits for domestic workers has been largely welcomed, but it has had the unintended consequence of making it economically difficult for lower-middle class South Africans to employ domestic assistance. Hertz (2005) found that, while between 2002 and 2004 wages rose by almost 20 per cent as a result of the implementation of a minimum wage policy for domestic workers, the employment levels of women as domestic workers fell 10 per cent (full-time) and 12 per cent (part-time). However, male employment increased by 14 per cent (full-time) and 15 per cent (part-time) employment.

In summary, attempts by the post-apartheid South African government to improve the lot of the working class, and black South Africans in particular, have had mixed results. What is clear, however, is that the private sector continues to elevate profit and wages over employment while still “meeting” BEE targets.

**References**


**Case study 98. Employment, political relations and unfair trade: The case of coffee in Ethiopia. - Tadesse Meskela, Joan Benach and Carles Muntaner**

With over 500 billion cups consumed every year, coffee is one of the world’s most popular beverages. Coffee is not, however, just a drink but also one of the world’s most important primary commodities, generating annual sales of over 80 billion dollars per year in the global market. Coffee grows in more than 50 countries, and the production of coffee employs millions of people around the world through its growing, processing and trading. In Brazil alone, where almost a third of all the world’s coffee is produced, over 5 million people are employed in the cultivation and harvesting of over 3 billion coffee plants; it is much more labour-intensive than alternative forms of agriculture in the same regions, such as sugar cane or cattle-raising, as it is not subject to automation and requires constant attention. Poor African countries such as Burundi, Uganda and Ethiopia are particularly dependent on coffee. For Ethiopia, with a population of over 75 million people and an economy based mainly on agriculture (more than 40% of the GDP and 80% of exports), coffee is the largest...
export, generating over 65 per cent of all export revenue. Ninety-five per cent of Ethiopia’s coffee production comes from small-holder coffee farmers, and 15 million people in the country depend on coffee for a living. Although coffee is vital to the economy and survival of countries such as Ethiopia, the control of coffee production involves producers, middlemen exporters, importers, roasters and retailers, while the pricing is decided in conference rooms and on stock exchange floors in some of the world’s wealthiest cities by companies, speculators and economic institutions. The coffee industry has a commodity chain with coffee collectors and suppliers who purchase coffee directly from small farmers below market price, keeping a high percentage for themselves. Roasters have the highest profit margin in the commodity chain. Large roasters normally sell pre-packaged coffee to large retailers, such as Maxwell House, Folgers and Millstone. Coffee reaches the consumers through cafes and specialty stores selling coffee, of which approximately 30 per cent are chains, and through supermarkets and traditional retail chains. Supermarkets and traditional retail chains hold about 60 per cent of the market share and are the primary channel for both specialty coffee and non-specialty coffee.

Large coffee estates and plantations often export their own harvests or have direct arrangements with a transnational coffee processing or distributing company. Under either arrangement, large producers can sell at prices set by the New York Coffee Exchange. These large plantations generally pay workers extremely low wages and offer poor working conditions. The world coffee market is dominated by a few multi-national corporations: Kraft General Foods (owner of Maxwell House and other brands), Nestle, Proctor & Gamble (owner of Folgers and other brands) and Sara Lee (owner of Chock Full O’Nuts and Hills Brothers). Despite the persistent poverty of most coffee producers, the multi-national companies have high profit margins with annual sales that in some cases are larger than the GDP of coffee-export dependent countries. With no restrictions on international investments, corporations force countries to compete against one another in a race to the bottom, lowering wages in order to maintain business. The corporate products that have the lowest price and highest profitability on the world market win out, often devastating the economies and communities in smaller, poorer countries. Most coffee is traded by speculators in New York City, who trade up to ten times the amount of coffee that is actually produced each year. The World Trade Organization (WTO), with its policies of free trade and trade liberalisation, has also had a significant impact on coffee prices and small coffee producers. The International Monetary Fund (IMF) and the World Bank have privatised public businesses and removed restrictions on foreign ownership in many poor countries, who sign the IMF agreements in order to prevent default on international loans. Signing the IMF agreement also includes a pledge of new loans from private international lenders. As a result, the Gross National Income in sub-Saharan African countries has been devastated, and Africa’s share of world trade has decreased: over the last 20 years, it has fallen to one per cent, and seven million people in Ethiopia are now dependent on emergency food aid every year.

An increase in price regulation, supply control and fair trade initiatives might help to solve the unfair trade of coffee. Fair Trade certification is a rapidly growing international system designed to guarantee that products from low-income countries are being produced under just and sustainable conditions, benefiting the people producing them. Fair Trade Labelling Organizations (FLO) International is the international umbrella organisation which sets international Fair Trade standards, and has an independent body, FLO-Cert, to monitor and certify producer organisations and importing organisations. There are now well over 50 different products imported from poor countries under Fair Trade Certified conditions, including coffee (the first product to be certified), tea, sugar, fruits, grains, spices and sport balls. Fair Trade guarantees farmers a fixed minimum price for their coffee, which can be as much as two or three times the unsubsidised market price. Fair Trade also eliminates the middle-men exporters involved in the coffee trade, who often pay farmers below market rates and then sell at the rates set by the New York Coffee Exchange, pocketing the excess money for themselves. In recent years the production and consumption of Fair Trade coffee has grown, as some local and national coffee chains have started to offer Fair Trade alternatives. A key aspect of the Fair Trade system is its economically beneficial trade relationship. Producers are assured a minimum price that is based on the costs of production, not the low and volatile market price. Along with higher prices, the Fair Trade system creates a more direct and stable relationship between producers and buyers. At the level of production, coffee farmers and their democratically organised cooperatives must follow Fair Trade regulations to ensure that they are operating in a fair and sustainable manner. Fair Trade improves not only the working conditions for coffee farmers, but also those of seasonal and temporary labourers working on the farms. The condition of women tends to improve with Fair Trade, as they are paid equally to men and given benefits such as maternity leave and free health care, like most hired labourers, and benefits negotiated in collective agreements for producers. Many studies have shown that Fair Trade coffee has a positive impact on the communities that grow it, greatly improving the well-being of small-scale coffee farmers and their families, and providing access to credit and external development funding, as well as greater access to training, thus giving them the ability to improve the quality of their coffee. Ethiopian farmers capture a greater share of retail prices, families are more stable than those not involved in fair trade, their children can attend school and Fair Trade ensures that there is clean water and a health unit in their village. Fair Trade has created a direct relationship between producer and consumer and has enabled consumers, retailers and roasters involved in Fair Trade to establish relationships that go beyond just buying and selling.

Sources
Case study 99. Potential explanations for the recent positive trends in employment conditions in Brazil. - Vilma Santana

Informal work has grown in Brazil between 1992 and 1999, when it became 56 per cent of the labor force. This was worse in the countryside, where some municipalities had up to 70 per cent rates of informal jobs (Instituto Brasileiro de Geografia e Estatística [IBGE], 2007). Several hypotheses about the potential causes of this situation have been debated by academics and government officials, who considered informality as a major drawback for productivity and economic growth. A number of economic reasons have been raised (Pochman, 2000; Barros & Mendonça, 1996; Mckinsey & Company, 2004) such as high taxes to hire and maintain a formally employed worker, bureaucratic difficulties and high taxes to register small firms, which would encourage small entrepreneurs to keep their business illegally unregistered and employees not legally hired. Indeed, for each formally hired worker in Brazil, taxes are 100 per cent of the corresponding wage, one of the highest rates in the world. There are also complaints about the high burden of presumed workers’ privileges that are rights assured by the Labor Law enacted in the late 1940’s. Although there has been too much pressure to reduce workers’ protection such as job stability, indemnities for unjustified firing and labor-related taxes, there has also been organised resistance by labour unions and social movements against these proposed changes. Between 1999 and 2008, without any important change in labour legislation, taxation policy or social insurance norms or coverage, there has been a minor but steady decrease in the country's informal employment rate (see Figure). During this time, there has been a historical strengthening of social policies focusing on the poor. Thus, among the social initiatives focusing mainly the extreme poor are educational incentive programmes and, for creating small firms, cash transfer programmes such us the Bolsa-Escola, and a national programme against child labour. More recently, there was a reduction of the interest rate and an expansion of credit, increasing internal consumption and demand, which boosted economic production. Cash transfer programmes apparently played an important role for the increase of internal consumption. Along with the decrease of informal jobs, there have been other positive changes regarding employment conditions and income distribution. Unemployment also fell from 12.1 per cent to 8.5 per cent between 1999 and 2008.

The Brazilian economy has been growing and social inequalities have been falling steadily, as shown by a decrease in the Gini Index. National population-based surveys have also shown that the proportion of the extreme poor and that of the working poor are falling, although the latter is doing so on a smaller scale. No major changes in the labour law occurred during this time. This provides evidence that, without the flexibility of workers’ rights or tax reduction, it is possible to change a scenario of unjust employment conditions and improve economic growth. In spite of the moderate improvement in employment conditions, the current poor indicators of occupational health and safety reveal not only the need to establish stronger policies to keep improving employment conditions for both informal and formal workers, but also the need of interventions to substantially improve working conditions and the effective application of existing norms and regulations.

Figure. Proportion of informal jobs in Brazil [1992-2004].*

Source: Pesquisa Nacional por Amostra de Domicílios (PNAD, IBGE).

*Definition of informality: (workers without formal contracts + own account workers) / (protected workers + workers without formal contracts + own account workers)

References
Epilogue: 
the economic crisis

"The man who possesses no other property than his labour power must, in all conditions of society and culture, be the slave of other men who have made themselves the owners of the material conditions of labour. He can only work with their permission, hence live only with their permission."

Karl Marx
THE IMPACT OF THE RECENT ECONOMIC CRISIS

Although neo-liberalism and the deregulation of the financial sector have barely been criticised in public health (Muntaner, Lynch, & Smith, 2001; Benach & Muntaner, 2005), the magnitude of class inequalities and the rate at which they have increased have been fuelled by 30 years of these policies. In 2008, the melt-down in the financial sector, which arose from speculative investment practices (themselves a symptom of much deeper structural problems), rapidly impacted the economies of both rich and poor countries. While the exact extent and likely length of the economic recession are still unknown, it is now being acknowledged as the greatest upheaval since the Great Depression of the 1930s. In our own view, parallels with the Great Depression, such as significant levels of unemployment and large-scale human misery, will only grow stronger as events unfold. The economic crisis is relevant to the issues presented in this book on a number of grounds.

First and most obviously, the global economic crisis is contributing to a growth of unemployment (and under-employment) and employment arrangements that we have identified as health-damaging in this book. The economic crisis that came to the world's forefront in September 2008 has dramatically increased the number of unemployed people. In its most recent Key Indicators of the Labour Market (KiLM) (ILO, 2009a), the ILO projected that global unemployment could increase by up to 61 million people between 2007 and 2009, while the number of vulnerable workers and those at risk of slipping into poverty could increase by 108 million and 222 million respectively. The negative social, economic and health impacts of these changes will be greatest in poorer countries, where few of the working age population can afford not to work, there is little or no income support or welfare, and often heavily indebted governments have been least able to fund labour market stimulus packages (Cazes, Verick, & Heuer, 2009: 10). According to the ILO, the number of working poor may rise to up to 1.4 billion, or 45 per cent of all the world’s employed, while the proportion of people in vulnerable employment could rise considerably to a level of 53 per cent of the employed population (ILO, 2009a; 2009b). Even neo-liberal agencies like the Organization for Economic Cooperation and Development (OECD) have been obliged to continuously revise their estimates of global unemployment upwards in an effort to appear relevant and informed. By March 2009, the OECD was predicting unemployment would approach double-digit figures amongst its 30 rich country members by 2010 (O’Neil, 2009). In the US, overall unemployment reached 9 per cent by March 2009 (and far exceeded...
this in states like California, with about 11%, and Michigan, with 14%, in July of 2009.

Apart from the growth of unemployment, the economic downturn is also leading to downsizing and restructuring, as employers “respond” to falling demand or seek to re-align cost pressures (Quinlan & Bohle, 2009; Cazes et al., 2009). It is also likely that flexible and insecure work arrangements, the growth of which marked the so-called prosperity phase prior to 2007, will continue to grow. In Japan, temporary workers have already begun losing their jobs (and associated housing benefits) with some of its largest corporations, like Toyota, leaving a vulnerable core of “permanent workers”. Like in the Depressions of the 1890s and 1930s, intermittent employment (serial bouts of short-term employment and unemployment) are likely to become more common. Presenteeism/longer hours and other forms of work intensification will also grow as workers try to retain their jobs. Irregular working hours will also continue to grow, perhaps at an accelerated rate (Quinlan & Bohle, 2009).

The myriad of small subcontractors in elaborate supply chains throughout rich and poor countries are also beginning to suffer and, in their case, just as in the case of agency labour, not even a dismissal notice will be required; simply the closing of a contract will do (Quinlan & Bohle, 2008). It is also possible, and indeed likely in our view, that work will shift even further to the informal sector, and practices like child and forced labour will become even more difficult to control as poverty deepens (Bureau of International Affairs, 2009). The impact of unemployment and precarious employment in the so-called emergent economies is already severe, especially those unable or unwilling to embark on (short-term) government stimulus packages.

Second, as has been demonstrated, all the employment conditions described in this book are associated with serious adverse health outcomes for workers, their families and their communities. Therefore any global growth in these conditions will entail an exacerbation of these problems. Further, if history is any guide, as this economic crisis unfolds, working conditions will deteriorate, profoundly so even for those who manage to remain in employment, albeit holding precarious or informal jobs. There is nothing especially novel in these predictions. An examination of earlier global depressions in the 1890s and 1930s will provide ample evidence of these effects, through government inquiries from the time and even media reports. What is likely to be novel is the scale of the disaster and the number of countries affected. This looming
crisis in public health will provide a clear testament to the failure of “free market” economics in delivering social well-being.

Third, even leaving aside health effects, these changes in employment conditions will lead to increased social inequality, including lower wages. As is noted in this book, these changes will also have important effects on population health. Governments in rich countries responded to the economic crisis by, amongst other things, providing massive bail-out packages to large banks and financial institutions that became enmeshed in, and indebted by, speculative investment in highly “engineered” but, at best, hard to value investment products like collateralized debt obligations (CDOs). Ordinary taxpayers will foot the bill for these packages long into the future, especially as large corporations have become so adept at “massaging” government subsidies and minimising their own tax exposure through the use of tax havens, promotion of regressive consumption taxes, transfer pricing and the like, leaving the tax burden largely with workers. In a further irony, the major beneficiaries of massive bail-out packages were the very organisations and advocates of big business who had extolled the free market and eschewed government intervention (apart from hidden industry subsidies and wealth transfers from the public sector, such as those achieved through privatisation). Now as economies “appear” to recover (note the short-lived stock market recovery in 1931) the same interest groups are vigorously opposing new regulation or extensions of social protection to the poor. In essence, the poor who suffered from the excesses of the past decade are now asked to save those who engineered and benefited from these excesses, while the underlying causes remain unaddressed.

Fourth, the impact of the global economic recession is likely to heavily impact migrants and foreign guest-workers, since they are among the most deprived workers. While there is still limited empirical evidence, a number of negative effects of the global economic crisis on migrants and migration have been recently summarised (International Organization for Migration [IOM], 2009). Firstly, there are restrictions on new admissions of migrant workers and non-renewal of work permits. Secondly, there are massive job losses in employment sectors sensitive to economic cycles such as construction and manufacturing, as well as financial services, retail and travel- and tourism-related services, thus affecting migrants in these sectors. Thirdly, in some countries there are reports of reductions in wages or non-payment, fewer working days and opportunities for overtime available and worse working conditions,
all of which are likely to affect migrant workers due to their weaker bargaining power. Fourthly, newly arrived migrants or precarious migrant workers are not eligible for many social benefits and therefore are likely to risk particular hardship upon loss of employment. Fifthly, there are growing instances of discrimination and xenophobia against migrant workers, who are mistakenly perceived as “stealing” local workers’ jobs, particularly in low-skilled sectors of the labour market. Sixthly, there is an increase in the return of unemployed migrants to their countries of origin, where they are also likely to face high unemployment and poverty, constituting a potentially disruptive element to economic and social stability at home. There has been a significant reversal of rural-urban internal migration in countries like China, where millions of migrants have returned to their villages because of lay-offs in the manufacturing sector in urban centres resulting from the steep fall in export demand. Finally, the crisis is expected to impact male and female migrant workers differently, especially in affected sectors of the economy dominated by one gender (such as construction, in which men predominate, and manufacturing, of which one example is the textile industry, in which women are overrepresented). Job losses and worse working conditions for migrants are likely to disproportionately impact migrant women, who are overrepresented in the informal, low-skilled and unregulated sectors of the economy (e.g., domestic work and care work). For women, return could mean losing economic independence and, for families, a reduction in income due to the end of remittances.

Fifth, it is also likely that, as is already the case with the environmental crisis and climate change, the very same businesses and associated interest groups and lobbyists that brought about this debacle will argue that the health inequalities related to employment conditions and other social determinants of health cannot be addressed until the global economic crisis is resolved. In a similar vein, the same neo-liberal interest groups (and neo-liberal agencies like the World Trade Organization [WTO] and the OECD) are now arguing that maintaining and, indeed, extending “labour market flexibility” (a euphemism for precarious employment) is essential to “saving” jobs and re-initiating economic growth. Thus, contrary to any careful assessment of the evidence, a critical part of the problem is redefined as the solution.

Sixth, the contention that we cannot afford to deal with health inequalities in the present climate, though it will undoubtedly exert significant pressure on governments, represents not only a morally bankrupt position (why should those whose health has been
compromised by the flexible work arrangements so advocated by these same interests now be asked to carry the burden for that same interest groups’ own failings?) but also a misreading of the causes of the problem. As an ILO report (2008) highlighted, the growth associated with the latest phase of “globalisation”, including the use of flexible work arrangements and the like, has not contributed to a generally narrower socio-economic inequality. Quite the reverse has happened. Further, the current economic crisis and its adverse effects on inequality are not an aberration but a direct outcome of the current economic system, which is based on neo-liberal ideology. Any assessment of the socio-economic effects of unfettered markets must include the boom/bust cycle that accompanies such a system. Therefore waiting for better times to resolve these issues would be a bootless exercise in futility (even ignoring the fact that the situation will actually deteriorate in the meantime). Again, the 1890s and 1930s provide important lessons. In both cases, the problems of exploitation, escalating wealth inequality and speculation began before the depression. They were resolved by the combination of social mobilisation and government action including war, not by the recovery of market forces.

Seventh, as just implied, such an argument fails to acknowledge the role that the pursuit of the policies that increased socio-economic inequality within both rich and poor countries contributed to this very economic crisis. In other words, the preferred solution is actually the cause of the problem. Since the mid 1970s, the Keynesian accord in socio-economic policy, which had been applied in rich countries after the Second World War, was progressively abandoned in favour of neo-liberal policies, which argued that deregulated markets were the best mechanism for achieving prosperity and public welfare. Keynesianism, it was argued, had failed to address stagflation (simultaneous inflation and unemployment). Note, however, how “free market” economists now remain remarkably silent when their preferred solution also delivered stagflation and a recession looming into depression. The elements of neo-liberal policy are sufficiently well-known and need not be repeated in detail here, but they included privatisation, outsourcing/competitive tendering for government services, de-collectivised/de-centralized industrial relations, an attack on and neutering/refashioning of government regulation, and the promotion of flexible work arrangements, balanced budgets (with profound effects on government service provision), tax cuts for the rich and risk being shifted away from governments and towards individuals (who are now required to invest for their own retirement
As has been well-documented, this ideological philosophy dominated the decision-making of governments and key agencies such as the WTO, IMF and World Bank. Further, desperation to save the unfettered market system still marks these agencies’ interventions. Indeed, the authority of the IMF was bolstered by a quadrupling of its funding at the April 2009 G-20 meeting. In supporting fiscal stimulus and government bailout for both financial and industrial capital (disproportionately favouring the former), the IMF has indicated that countries will need to restructure their long-term expenditures in order to meet this burden. Thus, the IMF has indicated that countries like Australia will need to examine the generosity of their welfare regimes while, for poor debtor countries, IMF loans will entail planned shrinkages in government expenditure and wage cuts (Hudson, 2009). In essence, interventions are not addressing income and wealth inequalities and ordinary working people and taxpayers are being asked to pay the price for decades of corporate excess and unfettered markets.

A point lost in the current debate around the economic crisis is that Keynesianism did not simply entail fiscal management (something that has now been re-embraced) but also critical redistributive mechanisms such as full employment, government services aimed at protecting the poor, progressive tax regimes and the like. In sum, however imperfectly, Keynesianism sought to manipulate social inequality to some degree in order to address the profound economic instabilities that arose from an unregulated market system and from capitalism in general. The newer regime, on the other hand, concentrated wealth in the hands of a few, while income levels for workers often stagnated and, in wealthy countries at least, high levels of personal debt were increasingly used to sustain consumption (something markedly different than the situation during the Great Depression and which is likely to exacerbate the effects of the present crisis). Furthermore, current efforts at fiscal stimulus largely ignore the need for redistributive mechanisms. Pumping money into banks that still refuse to lend, since they cannot trust other financial institutions [why would they, as more evidence of ever-greater debt burdens unfolds?], or into the automobile and other industries in order to save jobs (which it won’t, since burgeoning wealth inequality and income and job insecurity imply that consumption will continue to contract) are responses that will not resolve the problem. Indeed, the latter was tried and failed during the Great Depression. More recently, the same strategy has been tried in Japan and failed. As was already noted, thus far the vast majority of interventions assist capital and ask the poor to pay
for this. In sum, far from addressing inequality, current intervention packages will largely serve to extend it.

Finally, the lessons to be drawn from the above two paragraphs are important. Not only have the notions of self-correcting markets and limited government intervention conspicuously failed, but inequality needs to be a central component to redressing the current crisis. Employment arrangements should be a critical redistributive mechanism and not a source of further exploitation and harm to workers’ health. Fundamental change is required in thought and in action. Unfortunately, it is doubtful that governments will recognise these realities before the level of immiseration associated with the current crisis is too manifold to ignore due to pressure from social movements.

A PREMISE FOR THE END OF THE ECONOMIC CRISIS

The current systemic crisis of the economy has not only revealed the instability of capitalism, but also the weakness of conventional economic theory, which the majority of policies developed in recent decades are based on. Contrary to what is usually thought, it would not be considered correct to openly state that neo-liberalism has been characterised by attempts to undertake a process of massive economic deregulation. Institutional economics taught us long ago that the market cannot exist or operate without rules (such as property rights, sanctions, incentives, job conditions, requirements for developing production processes, etc.) dictated by a public sector that regulates its functioning. Thus, inevitably, the efficiency or profitability of the market economy depends on the institutional framework that defines and regulates the market itself. Thus, though obscured by neo-liberal rhetoric about deregulation and reduction of the state’s role in the economy, what has actually occurred has been a powerful intervention by the public sector in order to defend the interests of a dominant class or group. In other words, what was established was an institutional framework on an international scale that strongly favours rich countries and the most powerful companies and social classes. Examples of this are the international regulations on trade relations promoted by the WTO, regulations in favour of the liberalisation of movements of capital, spurring processes of financialisation, or the so-called "Washington Consensus", which forces poor countries to take measures such as privatisation of public services, budget cuts, reduction of social expenditure and so on. Moreover, to avoid those cases in which state regulation might not be favourable to their interests, the dominant
groups have imposed self-regulation on the sector (Corporate Social Responsibility) or the privatisation of certain public information and supervisory functions through the use of auditors and rating companies, thus avoiding democratic meddling in their economic authoritarianism. Hence, given that the crisis will eventually end, an important premise would be to ascertain the criteria with which economic activities will be regulated, what goals will be pursued, what the [more or less democratic] institutional framework under which such things will be decided will look like and, particularly, whose interests will be furthered by the outcome of this intervention [see Case study 100].

Case study 100. The crisis as an opportunity to change the economic model. - Óscar Carpintero

Reorganisation of property ownership and the financial system in an “economy of acquisition”

One of the balsams used to placate criticism of the neo-liberal rules of the game has been to claim that their application promoted economic growth. However, going beyond the serious shortcomings of the GDP as an indicator of population well-being, growth in the production of goods and services hides a vast, planet-wide process of wealth and corporate asset acquisition. Large-scale extraction of riches in the form of energy and non-renewable raw materials has meant that rich countries have ceased to be “production” economies and have instead become economies of “acquisition”. To do so, they have used two powerful instruments: international trade and the financial system. The former allows over 2,000 million tons of energy and raw materials annually, a quantity which increases yearly, to flow away from the rest of the world and into rich countries. The latter reinforces the acquisitive nature of “developed” economies [Naredo & Valero, 1999; Carpintero, 2005], since the financial world also has an impact on economic assessment, thus redistributing both the financing and purchasing power of economic agents with regard to not only goods but also companies and territories. Thus, along with the cheap importation of energy and raw materials, over the last two decades there has been an increase in acquisitions of companies that extract and export energy and raw materials destined for rich countries. These countries’ transnational companies, thanks to the liberalisation of international financial markets, have taken advantage of successive waves of transnational mergers and acquisitions in order to gain control of a large part of the world’s corporate assets, leading to a vertiginous and unprecedented planet-wide reorganisation of property ownership.

A global analysis of foreign direct investment (FDI) shows that such investment is mostly a matter of the acquisition or simple purchase of existing companies (either between rich countries, or between companies from rich and poor countries) and not of investment in installations or economic activities that create employment and increase production and income in the host country. The last decade has seen a growth of investment in extractive industries in poor countries, where levels of FDI stocks are consequently very high. Some examples include Nigeria (74% in extraction mining), Botswana (68%), Bolivia (70%), Venezuela (almost 40%), Chile and Argentina (each around 30%) [United Nations Conference on Trade and Development, 2007]. Moreover, trans-national companies control mining extraction and commercialisation completely in countries such as Mali, Tanzania, Guinea, Botswana, Gabon, Namibia, Zambia and Argentina, and have very high levels of control in Colombia, Peru and Chile. In fact, the expansion of the so-called “new economy” has largely been possible due to the acquisition of company assets in sectors closely related to the utilisation and commercialisation of natural resources [examples include electricity, gas and water production and distribution or oil extraction and refining industries], as well as the fact that Africa and Latin America have supplied strategically important minerals needed by the new information and communications technologies [Carpintero, 2004]. For instance, the large-scale manufacture and consumption of computer monitors, hard discs, cellular telephones, electronic components, integrated circuit boards, condensers and so on would not have been possible without the gold, platinum, palladium, rhodium, ruthenium, iridium, tantalum, columbium, and magnesium mined in Africa (between 65% and 75% of imports of these substances going to OECD countries). It should also be pointed out that the rich countries themselves, in order to control poor countries’ natural resources, provoke or prolong wars and conflicts (for example, oil drives conflicts in Nigeria, Coltan in the Democratic Republic of Congo; Klare, 2003). Many times, a large part of this process has been financed thanks to so-called “finance money” [Naredo, 2000], thus giving companies enormous power and control in establishing the rules of the game, which tend to increase social inequalities.
The need for a new economic model

The obvious had to be emphasised because it had been long ignored” remarked Nicholas Georgescu-Roegen, one of the founding fathers of ecological economics (Georgescu-Roegen, 1972). The present economic crisis obligates us to remember and rethink many things. For example, we need profound changes in approaches to and theories for analysing economy-nature-society relationships as well as changes in the model of production and consumption by industrialised societies and in the rules of the game which make it all possible. From a theoretical perspective, the conventional economic approach cannot continue to turn its back on contributions formulated by alternative consumption and production theories. We must learn a theory of economic behaviour that goes beyond *Homo economicus*, and we must learn from the ecological economists who, for many years, have been pointing out that the production of goods and services cannot ignore thermodynamics or ecology and thus hide aspects such as energy, raw materials, the generation of residuals and environmental impact. This would allow us to see beyond the myths about growth and the GDP, which have become the supreme objective of economic policy, and beyond conventional economics which, by hiding behind a smoke-screen of economic activity, eludes the socio-ecological costs of the physical process of producing goods. Moreover, the limitations of economic growth strategies ought to help us re-consider redistributive policies such that rich countries reduce their control and appropriation of energy, raw materials and the generation of residuals, thus freeing up resources and environmental space to let poorer countries and their peoples work and live in a healthy, just and dignified manner. “Living well on less” is possible (Linz, Riechman, & Sampere, 2008). We have the necessary instruments to carry out an economic-ecological reconversion in the industrialised societies. However, we also require political power to be capable of instituting new rules of the game, new criteria for the regulation of economic-ecological-social activity; political power must also be able to change the goals serving the present institutional framework which, through powerful academic, social and media-related indoctrination, manages to make private interests appear to be public ones. As it does not seem reasonable to expect a resolution of the crisis from the institutional framework and economic agents which provoked it, this situation has a touch of that golden opportunity we were waiting for to change the course of the economy, to give it a new, more socio-ecologically equitable and just direction, with a corresponding impact on social and health inequalities.

References


PUBLIC POLICIES AND SOCIAL IMPACT

Since they are, to a large extent, the result of the workings of the social organisation of production processes, the origins and impact of economic crises are not phenomena that we can analyse in an economically “isolated” way. The roles of institutions and the particular organisation of markets are fundamental not only to understanding the generation of the crisis and its costs, but also its consequences for employment conditions, quality of life and health, not to mention their different distribution among social groups. Thus, the social impact of the current economic crisis will vary depending on what policies are adopted as well as the institutional changes these policies generate. For the critical schools of

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Case study 101. Economic crisis, public policy and social impact - Albert Recio

The current economic depression began as a crisis in the housing and financial markets and has put many of the world’s banking institutions in a seriously difficult situation. The central role played by the financial sector in the functioning of the globalised economy has meant that the current crisis spread rapidly to all economic activities. To a certain extent, we are dealing with a crisis model that is already prefigured by recent “regional” episodes such as the financial crises in Mexico, Russia, East Asian countries or Argentina, among others, all of which can help us understand the impact of the current crisis. Governmental responses to the crisis have centred on avoiding the collapse of the financial system through massive transfers of public funds to banks in order to avoid bank failures and provide liquidity to the economic system as a whole. The result of these operations is still not clear, although things seem to suggest that the former will be easier to achieve than the latter (Stiglitz, 2002; Harvey, 2005; Álvarez et al., 2009).

Governments have applied similar subsidies, in varying forms and levels, to other key economic sectors (for example the automotive industry), either as subsidies to industrial sectors or as public investment plans. The results of these huge transfers of public funds represent a considerable short- and medium-term public debt, not only due to transfers of funds to the private sector, but also to the decline in tax revenues. If economic recovery were rapid, it is possible that this deficit could be reduced due to a rise in revenues. However, a rapid recovery is not assured, and the volume of transfers seems to suggest that the deficit will not easily be reduced. Therefore, the question is to know what responses to these high public deficits will be. There are two ways to reduce deficits: increasing taxation or reducing expenditure. The former often requires acceptance of profound changes in the distribution of income, changes which the wealthier social sectors have refused to accept in recent years, arguing that raising taxes discourages spending and investment. In fact, some governments have implemented tax cuts as a measure to increase demand. Therefore, it may happen that the end of the crisis will be accompanied by cuts in public expenditure.

Public expenditure cuts impact employment conditions and life in general in a variety of ways although, logically, their specific impact depends on what is cut and by how much. In the first place, budget cuts affect public employment through direct staff cuts or substitution by outsourcing services, or through the generation of temporary public sector jobs. In terms of employment, the impact may therefore be either quantitative (adding to general employment problems) or qualitative, through substitution of quality jobs by others with lower wages and worse conditions. The social impact can only be considered acceptable when there is a public sector that is too large due to clientelism. However, if these cuts or worsening conditions affect relevant public sector services, the negative social impact could be enormous. The “flip-side” of this problem is that public expenditure cuts can directly affect the population’s health and living conditions. Their impact would differ depending on whether cuts are in transfers of public funds or in public services. In the former case, the broad effect would be the impoverishment of sectors affected by the cuts. In this case, unless they only affected a parasitic minority, the cuts would affect lower-income social sectors such as the retired or unemployed. A fall in income undoubtedly has an influence on expenditure (for example in groceries), which in turn affects the population’s health. In the case of cuts in services, their effect depends on each particular case. It should be pointed out that, usually, these cuts involve both the elimination of services and introduction of, or increases in, charges payable in order to obtain them. In all cases, the lower income sectors are the ones which suffer most from cuts of this type, since they cannot afford to pay for private services, nor, at times, charges for public services. It is well-known that problems in accessing health services, education or public transport have a notable effect on the general living conditions and health of the population. Moreover, the negative impact also has a gender-related component which should be stressed, since women are still responsible for the basic nucleus of social reproduction activities. Thus, the cuts directly affect their incomes, their work-load or both. In high-income countries with an ageing population in need of a higher level of care, reduction in public expenditure could generate a situation of true social crisis. (Standing, 2002; Held & Kaya, 2007)

One of the most common and important social effects of economic crises is the rapid increase in unemployment and its impact on the living and health conditions of working populations. One of the direct ways this impact operates is through the generation of greater economic uncertainty, which relates to processes of extreme poverty and social exclusion that, in turn, lead to breaks in careers, considerable psychological stress and mental health problems, among other negative effects. Unemployment also indirectly influences the working population by increasing the pressure to which workers are subjected in their jobs. Thus the threat of losing a job becomes a powerful disciplinary mechanism against the work-force, which increases according to the degree to which unemployment becomes a phenomenon of masses.

Massive unemployment due to the crisis can lead to different dynamics in the economy which are equally harmful for health and living conditions. In a world of economies that are very open to outside influences, there is always a temptation to consider that stimulation of demand ought to come from the foreign market, that is, from competition. When this view prevails, generally social rights (fair wages, job security, unemployment benefits, etc.) are seen as more of a restraint on growth than as a positive social value. For the sake of competitiveness, the denial of a variety of social rights is promoted and leads to a rise in economic insecurity that is particularly suffered by workers who are exposed to greater international competition or those who, in the internal market, undertake intensive manual tasks.
economic thinking, unemployment levels are merely a result of the workings of the economic system as a whole. However, for the line of thought that is dominant in political institutions and academic circles, unemployment is a problem specific to the labour market. Thus, unemployment becomes a justification for applying structural reforms in the labour market, which usually include cuts in the duration or level of unemployment benefits (since such benefits are assumed to reduce efforts to seek employment), reductions of job security (to improve flexibility and stimulate private investment) and measures aimed at decentralising collective negotiation. The impact of these policies affects not only individual rights but also the possibility of collective action, an aspect which is crucial to both achieving improvements in social standards and to guaranteeing that regulations and collective agreements are respected (Case study 101).

A NEW POLICY AGENDA

Neo-liberalism has so embedded itself in the decision-making of governments that most policy-makers can no longer grasp the proactive role that government can play at the national and international levels, in terms of social and economic development. Instead, the role of government has been limited to boosting private markets and, in times of crisis, responding to the lobbying of powerful special interest groups, while the pleas of unions and other

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groups representing the vulnerable are largely drowned out. Even in the current crisis, the space of government intervention is unduly restricted, generally to supporting businesses deemed too big to fail or using markets as remedial devices (as is the case with bail-out packages for failed banks or dealing with climate change through carbon-based trading schemes). This needs to change.

The broad framework for critical changes aimed at securing a more sustainable and healthy workforce and society are clear.

First, inequality of income and wealth need to be addressed at both the national and international levels. Forms of employment that accentuate economic inequality (including precarious employment, informal work and child labour) also perpetuate broader social and health inequalities. For example, unemployment and precarious employment have cascading effects on housing quality, nutrition, the education of children and social interaction. In areas of concentrated deprivation, providing secure and reasonably remunerated work is a precondition for urban renewal. Far from being an impediment, initiatives that address sources of inequality, including employment conditions, are an integral part of addressing the current economic, environmental and climate-related challenges facing the world. Government investment in more effective and environmentally sustainable infrastructure, including education, research, transportation, health care, energy (including the manufacturing of new technologies), food production and urban environments, can be used to simultaneously create quality work and healthier work, while undertaking the essential restructuring that unfettered markets and neo-liberalism have failed to deliver. Promoting this form of development in poor countries and re-orienting trade can avoid current dilemmas, wherein scarce health care workers are plundered from Africa by rich countries, domestic food production is sacrificed for export goods, cocoa and soccer balls are produced by child labour, trade in dangerous products (like asbestos and unsafe food) is not regulated and “dirty” forms of manufacturing or recycling are shifted to poor countries.

Second, effective action needs to be taken to minimise if not eliminate work arrangements known to be harmful (precarious employment, informal work, slavery, child labour and forced labour) through devices like legislation, income transfers and empowering groups that represent the vulnerable. Integrated minimum labour standards and regulation (like supply chain regulation) are necessary to combat evasive tactics at both the national and international levels. Trade cannot be divorced from health and labour standards and arrangements safeguarding the latter need to
be an integral part of international commerce (Labonte & Sanger, 2006a; 2006b). Counter-claims that labour flexibility is the only way in a global economy are simply determinist and ahistorical. Work arrangements such as insecure employment, the informal sector, child labour and indentured/forced labour have been successfully addressed in the past.

Third, promoting “quality” work needs to be a central policy objective for governments and multi-national bodies such as the European Union (EU). At an EU presidency conference held in Belgium in 2001, such an effort was made only to be quickly stymied by neo-liberal opponents. This effort needs to be revived and extended. Again, this process requires clear policy and regulatory guidance and must include unions and community groups as key decision-making participants. Work plays a central role within communities and the provision of meaningful and healthy work will not occur if left entirely to the market, especially given the influence exerted by large corporations within it. Similarly, the potential synergy between creating “green” jobs and healthier jobs (discussed below) requires conscious social intervention. Unions in Europe and elsewhere have advocated socially constructive employment creation in the area of green jobs that also targets disadvantaged or displaced groups such as youth from deprived areas or unemployed older workers (Syndicats et Changement Climatique, 2009; Sydney Morning Herald, 2009). However, they have also warned that “green” jobs need not be healthier or safer unless the latter are integrated into the policy framework, including regulatory protection and provision for union or community input and monitoring (Hazards, 2009).

In terms of implementing this framework, we already have enough evidence to point to the broad direction of policy changes and the ways of implementing them. Any discussion of employment policies needs to take account of the serious environmental, climate and population challenges we have mentioned. In March 2009, the UK government scientist warned that by 2030, a global population of over 8.3 billion would mean a 50 per cent increase in demand for food and energy and a 30 per cent increase in demand for water. The result will be serious shortages in all three, with the United Nations Environment Programme predicting widespread water shortages in Africa, Europe and Asia (McGourty, 2009). These predictions do not take into account the impact of global warming (United Nations Intergovernmental Panel on Climate Change, 2007; 2008) on temperature, rainfall patterns, sea levels (inundating low-lying land) and the melting of key glaciers (most notably those in the Himalayas.
feeding major rivers in China and other populous parts of Asia. An economic and social system is subordinate, not super-ordinate, to the biosphere. In a world facing the exhaustion of its finite resources, environmental degradation on a hitherto unimagined scale and catastrophic humanity-induced climate change, the dominant model of economic growth (based on a presumption of limitless resources and measures of wealth/production/consumption that take no account of sustainability, environmental impacts or scarce resources) needs to be fundamentally refashioned. The refashioning will need to entail a sustainable model of economic growth and social advancement as well as associated changes to food production, manufacturing, energy generation, transportation and urban living. It will also require changes to the dominant business model and the education of management, which privilege "shareholder value" and short-term profits over the building of long-term wealth and a more collaborative and mutually beneficial engagement with workers and the community. The economic crisis has begun the process of questioning neo-liberal economics and current management and business models, and research and debate on the generation of alternative approaches that are based on a concept of sustainability are growing in fields as disparate as ergonomics and finance or management (see, for example, Khurana, 2007; Genaidy, Sequeira, Rinder, & A-Rehim, 2009).

Although meeting the combination of environmental, climatic and economic/employment restructuring challenges will adversely affect some industries and activities – industries which will resist changes for this reason - it will also lead to new areas of growth and "green" jobs. A number of examples illustrate this.

With regard to energy generation, a shift away from an overarching dependence on fossil fuels towards a greater use of renewal forms of energy (wind, wave or tidal, solar, thermal and, selectively, hydro) will create new jobs in manufacturing and operations. Most of these renewable energy forms are more amenable, local/regional or even household applications, which increase flexibility and self-sufficiency in power generation and are at a scale that is more applicable to poor countries (especially if initial construction costs are subsidised by wealthier countries). Jobs associated with these changes can be used to both create meaningful employment opportunities and address health inequalities (Pollin & Wicks-Lim, 2008). For example, youth in deprived urban or rural areas can be trained and employed in the installation and maintenance of solar panels for buildings and houses or in the installation and maintenance of water tanks and...
reservoirs, especially in more arid regions. In the USA, the Sierra Club has joined with unions and other agencies to develop a host of green job opportunities along these lines (see Sierra Club, 2009). Again, these opportunities apply to both rich and poor countries.

Similar arguments can be applied to food production. Beyond the disastrous economic consequences of poor countries substituting export commodities for food production (which even the IMF recognises now), food security and the relative costs and benefits of localised production for some food items require a reconsideration of food sourcing and production which will generate employment (existing examples include reactivating unused urban space, a process already pioneered by some community groups in the UK). Changes to agriculture aimed at minimising dust and soil erosion, encouraging natural pest predators, re-vegetation/re-forestation, as well as measures to ensure clean water, water table remediation, water recycling and waste recycling, should re-emerge as important areas of employment in both poor and rich countries, thus addressing both the threats of environmental degradation and climate change and establishing more sustainable production systems. Again, research and development in association with technologies appropriate to achieving this can be undertaken and shared by both poor and rich countries.

With regard to transportation, the shift away from active, healthy forms of land transport such as walking and riding bikes, river and canals and railroads towards road transport for both people and freight, which has taken place since World War II, has led to a mix that is inefficient (even in an economic sense, once full road costs are calculated), land hungry, unsustainable and causes pollution (Buehler, Pucher, & Kunert, 2009; Genter, Donovan, & Petrenas, 2009; McGimpsey, Havermann, & Sutcliffl, 2009). A combination of economic pressure, deregulation, hidden subsidies and failure to invest in rail infrastructure has resulted in the expansion and restructuring of road freight transport involving bigger trucks and elaborate subcontracting leading to work intensification and contingent pay that has had negative effects on both public and occupational health (Saltzman & Belzer, 2007; Belzer, 2009; Christopherson & Belzer, 2009). Solutions include a substantial extension and upgrading of freight (such as heavy rail) and passenger transport (which includes heavy rail, light rail and subways), as well as the establishment of multi-modal centres to interface with short-haul trucking. As in Europe, high-speed rail will also present an effective alternative to...
short-haul air travel in more populated areas and routes. Reversal of hazardous policies and employment practices in the road transport industry is also part of this change (for examples see Quinlan & Sokas, 2009).

A need for significant changes also looms for maritime transport. A US scientific study indicating that the world’s 100,000 commercial ships, which are often poorly designed or reliant on low-grade fuel and generally operate under “flags of convenience” with little regulation, poor safety conditions and exploited crews (Parliament of the Commonwealth of Australia, 1992), produce almost half as much particle pollution as the world’s 600 million cars (Ogilvie, 2009). The shipping industry itself is a significant contributor to pollution and climate change (Lack et al., 2008; Dalsoren et al., 2009) and this doesn’t include the loss of ships, regular and sometimes catastrophic oil spills and the like (Parliament of the Commonwealth of Australia, 1992). Addressing this issue requires a major reconsideration of shipping technology and port facilities as well as the actual costs of what is transported and of the regulation and employment practices used by the industry (which artificially deflate real costs to users and clients, the industry, those employed by it and the community at large). In some areas, like the transportation of bulk waste materials for recycling and some foodstuffs, a shift towards localised processing and production will create greener employment opportunities, without losing a re-engineered global shipping industry.

The reconfiguration of transportation and other social and economic infrastructure needs to be viewed in a context where neo-liberal policies (de-regulation, balanced budgets, privatisation, public-sector productivity targets, and lower income tax revenues) have commonly resulted in a failure to adequately maintain, renew or upgrade publicly-provided infrastructure, including bridges, railway networks, hospitals, water and sewage systems and power generation and distribution. The result is often an ageing and inadequate infrastructure that is in urgent need of renewal (National Research Council, 2009). Even where critical infrastructure is provided by the private sector, there can be significant issues with replacing and safeguarding ageing power plants (such as many nuclear power stations in the USA). It is by no means clear that private sector reinvestment in infrastructure will match long-term planning needs in an uncertain environment (or that communities and government won’t be pressured to subsidize or risk-insure such ventures) or that the long-term environmental costs will be met by the private sector. In short, neo-liberal policies

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View of the mining site of Lovozero, which today is over 95% abandoned. 470 miners still work day and night shifts to extract titanium, niobium and tantalum in the site of Lovozero (~600m deep, 30km of tunnels). It lies in the middle of the tundra in the Murmansk region (Russian Federation). Source: © ILO/M. Crozet [2006]
have undermined the capacity of governments to provide essential infrastructure, while private provision of essential public infrastructure raises additional policy dilemmas likely to lead to suboptimal solutions. Overall, in many if not most countries, there are significant shortfalls in infrastructure that need to be addressed. While this constitutes a major challenge, it also accentuates the potential for a relatively rapid, sustainable reconfiguring of transportation systems, power generation and the like, once the neo-liberal paradigm is discarded in favour of more socially inclusive policy settings.

In terms of the specific actions that need to be taken to simultaneously address the economic crisis, unhealthy employment conditions, environmental degradation and climate change the following points can be made.

At the global and regional (for example, the EU) level, there is a need for governments to agree on a new economic and social infrastructure. Most notably, new and existing agreements on international trade and commercial arrangements will need to be re-engineered so that minimum labour, health, environment and climate protections become an integral part of them (with a gradual raising of standards over time). This will not only overcome the disarticulated and health-damaging discourse that presently occurs but also provide a powerful economic incentive for all countries to join (something that is completely absent from present arrangements). The global restructuring will also require that international agencies responsible for health and labour standards (WHO and ILO) have a direct and meaningful input into these deliberations (matched with real sanctions, unlike the largely ineffectual collaborative efforts of the past [Rosentock, Cullen, & Fingerhut, 2005]. It will also require a fundamental restructuring or, if this proves impossible, the replacement of key international agencies governing economic infrastructure, such as the WTO, the IMF, the OECD, and the World Bank, shifting away from the neo-liberal agenda that currently dominates towards one based on sustainable economics and including sufficient expertise in health, labour and social issues in order to facilitate more balanced judgements and more ample discourse with the ILO and WHO. The same applies to agencies directing economic, trade and commercial arrangements at the regional level [for example, neo-liberal policy remains dominant within the European Commission and NAFTA]. Furthermore, global campaigns based around
communities and workers (including reconfigured networks of solidarity, strategic campaigns and alliances of informal and formal workers [Wahl, 2008], and global supply chain regulation provide the basis for synergistically addressing the health (both workers’ and public) and environmental standards of elaborately outsourced production and service delivery [Nossar, 2007]).

At the national, provincial and local levels, governments, empowered community organisations, unions and more progressive elements of the business community can play a critical role. However, such an endeavour would require a significant reconfiguration of the points of departure that have long dominated mainstream views and led us to the current economic situation. Because the assumptions that guided neo-liberal policy became so entrenched in public discourse, the free-market ideology has been able to disguise itself within it as “common sense” or, even more dangerously, a system bearing something akin to a set of natural laws. As a result, any interventions by community organisations, unions and governments have been viewed by overt, tacit and unknowing defenders of neo-liberal policy as interferences with natural processes.

This has never been the case and, as we have seen, the “invisible hand” of the market often wears a glove that has been paid for by the public. While the economic crisis has spelled out that this fact is no longer a secret, it is not the only assumption embedded in the neo-liberal ideology that has been demonstrated as limited, false or dangerous. As the next case studies illustrate (Case studies 102 and 103), the free market has proven to be systematically more free for some than it is for others.

At the broad policy level, governments need to adopt the right to relatively secure and decent work as well as quality, sustainable work (with appropriate benchmarks) as core principles. In 2001, as part of its efforts toward quality of work benchmarking and enhancement, the European Foundation for Improvement in Living and Working Conditions [Eurofound] produced a measurable set of occupational health indicators which were comparable to environmental “green” indicators. These could be incorporated into this process. At a broader global level, further modification of indicators developed as part of the ILO’s (2009c) decent work agenda, which already include a number of indicators of work and life quality, provide another mechanism for policy development in rich and poor countries.

Other ways of implementing change at the national level include not just a broad legislative mandate, but the incorporation of these
requirements into public sector employment practices and making these principles a condition for government funding for infrastructure and other “green” initiatives. Governments can also provide support (i.e., in terms of legal recognition), facilitation and incentives to encourage communities, unions and the like to pursue initiatives designed to simultaneously improve working, living and environmental conditions in the workplace, industry and community levels. Community groups and unions can also take the initiative. There are successful examples of past collaborative community and union struggles over health and environmental issues (such as the “green bans” imposed by Australian construction unions in the 1970s) and, more recently, there has been growing evidence of these mobilisations (Quinlan & Sokas, 2009).

Case study 102. Globalisation and labour - Michael H. Belzer

Globalisation, from the perspective of workers and their unions, involves the deregulation of labour relations. Just as deregulation of industries like trucking weakened the role of institutions and subjected the industry to intense market forces, the ideology of globalisation has meant replacing institutions protecting labour conditions more generally – removal of the “safety net” – with competitive labour markets (Belzer, 2000; Preface and Chapter 1).

Workers’ rights to organise unions for their self-protection, to take wages out of competition, have also been attenuated directly by growing limitations in the right of freedom of association. In the United States, legal decisions favouring property rights over human rights, accompanied by political regimes hostile to workers, have contributed to drastic deunionisation (Dannin, 2006). Combining deunionisation with the competitive markets resulting from deregulation has caused workers’ bargaining power to collapse in industry after industry, with truck drivers and airline pilots suffering the same fate.

Finally, the ideology of free trade and the development of regional free trade zones like the North American Free Trade Agreement (NAFTA) have predictably pitted workers in wealthy countries against those in poor countries, to the detriment of both. The World Trade Organization has wrought this scheme globally in response to the free market ideology (though not necessarily the science) of neoclassical economics (Samuelson, 1948; 1949) without recognising that the distribution of gains between workers and capitalists, as well as between poor and wealthy countries, may not be equal (Baumol & Gomory, 1996; Gomory & Baumol, 2000). Advocates of radical free markets dwell on growing average wealth and avoid talking about distribution, so they have declared success even after history has demonstrated that median wealth has declined as average wealth has increased [Mishel, Bernstein, & Allegretto, 2006].

The increasingly unequal distribution of income and wealth initially fuelled a boom over the last three decades, but the contradiction inherent in that unequal development finally brought about the collapse of the global economy and an unwinding of the wealth created during the boom. While ordinary workers fall into destitution, the unequal distribution of the gains of the past 30 years means that they had less to lose. The ranks of increasingly impoverished workers now reach well into the middle and professional classes, threatening to spark a reaction that could provoke a re-examination of the Washington Consensus.

There are some indications of a growing union response. This includes community-union alliances in both poor and rich countries, which are developing international networks as part of their campaigns. Some international union federations like the ITF are also trying to develop campaigns targeting the spread of precarious employment, including the development of global supply chain regulation. In the healthcare sector, unions in different countries (such as Australia and the USA) have run essentially parallel campaigns to combat the adverse effects of staffing level cuts in hospitals on public and workers’ health. Beyond this, as already implied, there is a need for labour standards and worker input to be reinserted into the global infrastructure that governs economic relationships.
“Feminist economics”, as it is currently known, has its roots in the 19th century when, coinciding with the first wave of feminism, pioneering women in this line of thought demanded the right of women to have a job, thereby denying the job and wage inequalities between the sexes (Perdices de Blas & Gallego, 2007). From the decade of the 1960s onwards, a second wave of feminism took place that was characterised by the impulse provided by feminist theory as an independent and innovative body of thought. That time was characterised by strong methodological and epistemological criticism of existing economic traditions, along with new theoretical elaborations and empirical analyses (Pérez, 2006). The aim was to construct an economy by integrating and analysing the realities of women and men, using living and working conditions as a basic principle. Concepts, models and paradigms traditionally used by economics were reformulated, new categories and theoretical frameworks elaborated. However, feminist economics is not based on a single, monolithic theoretical construct. In what follows, we review some of the more relevant themes and proposals of recent decades.

All schools of economic thought have centred their interest on processes of goods production, which are analysed as autonomous processes, independent of any other type of work. Caring for human life is displaced to the domestic setting and understood to be a private responsibility of the family (read: the women), thus having no relationship with the economy. The most significant contribution of feminist economics has undoubtedly been the break away from traditional economic demarcations, which restrict economics to monetary and market issues, and the recovery of housework and caring as a fundamental part of the processes of production, reproduction and life. This crucial methodological rupture permits the establishment of a complete change of perspective in economic analysis. Feminist economics thus centres on human life, and peoples’ living, employment and working conditions, with all their various dimensions and subjective aspects; this means recognising and making visible the work of caring, recovering a feminine experience without which neither life nor the market would even be possible (Picchio, 1996). A focus of this type helps make the deep structural relationship between the process of producing goods and the process of social reproduction visible, permitting the establishment of relationships between time and money, and paid and unpaid work, as well as highlighting the fact that market work owes its existence to the performance of caring work.

The proposal of this new analytical framework also necessarily implies a revision of concepts, particularly that of work. The aim is to recover an idea of trans-systemic work distinct from that performed in capitalist society, which incorporates other activities occurring outside the market as an economic category, especially housework and home-based caring (Folbre, 2001). This reconceptualisation of work is accompanied by an analysis of women’s work. The various dimensions of housework and caring are studied in terms of their relation to paid market work and to the precariousness specific to female employment, thus revealing the limitations of the various theories used to analyse women’s work in the economy. At the same time, since they only represent the market economy, employment statistics and macro-economic indicators are questioned and information sources dealing with the feminine experience are elaborated.

Studies on “gender and development” focusing on countries that are not fully industrialised have shown that neo-liberal policies, and in particular structural adjustment policies, have modified the relationships between the market goods, production settings and the home, with more responsibility for family survival falling on the latter. This implies increased costs, a situation aggravated by the redefinition of the public sector in favour of the private. More recently, there has been discussion of the specific effects of globalisation on women’s living, working and employment conditions (Beneria, 2005). Perhaps the most interesting aspect of these studies is their theoretical framework, which centres analyses on the emerging global contradiction between the extending power of capital and mechanisms of social reproduction, with unpaid housework being included in this process.

References
Another notable aspect tackled recently by feminist economics involves so-called “gender budgets”, public budgets with a gender perspective or sensitivity (Elson, 1998). Traditionally, public budgets have been elaborated taking into account only the visible side of the economy, without recognising unpaid housework and caring. This has prevented them from considering that women and men are situated in different social positions and that, as a result, the effects of budgetary policies are not neutral, but indeed differentiated by sex and gender. A gender-sensitive budget recognises the social and economic structure which determines the different needs, privileges, rights and obligations of women and men in society; it makes the differentiated contributions of each to the production of goods and services visible and, in particular, attaches value to the caring work performed by women. A budget of this type forces a reappraisal and re-elaboration of priorities and the re-orientation of programmes and policies.

The conjunction between new data that are becoming available and the elaboration of gender budgets has led to the development of new, non-andocentric indicators of “wellbeing” which try to account for living and working conditions in their various dimensions. In this way, they recover the feminine experience and consider the various social processes, both market-related and otherwise, in an integrated manner (Carrasco, 2007). We must emphasise that the idea of human wellbeing is a complex, multi-dimensional concept which cannot simply be reduced to the level of income. It is highly related with living conditions as well as the physical, intellectual and relational experiences of individuals in a particular context and under certain conditions. It also includes aspects that are fundamental to the development of human life such as the satisfaction of needs for direct bodily, emotional and affective care, all of which are developed in the home.

One field of study that is strongly related to the living and working conditions of women and men is that of health and quality of life. In this case, the aforementioned aspects are partly reflected by inequalities in the health of women and men in relation to their differing positions in society. These differences are closely related with the types of work people do, such as full-time housework, the possible existence of “double roles”, greater or lesser opportunities for organising one’s own leisure time, income levels, harassment and violence directed at women, and so on. Health status, in turn, has consequences for other areas of life. For example, enjoying better health opens the door to greater chances to participate in job-related social activities, leisure time activities, social and political involvement, etc.

Finally, it is important to mention that feminist economics recognises that, in addition to sex or gender inequalities, there are other axes of inequalities which cut across society a way that provoke inequalities between women themselves, basically based on ethnic and social class differences. Take, for example, the social inequalities present in the labour market, where precariousness has less impact on better-qualified, native women, or in the home setting, where women with a higher socio-economic level can afford to have part of their household’s domestic and caring burden covered by paid workers, typically poor foreign women.

References
Conclusions & recommendations

“It may be just for a human being to set foot on the Moon, but it would be more just still if the great countries, at least symbolically, set foot on Earth and realised that millions of people are hungry, have no work, no culture.

I also consider quite just this utopia which speaks of a 21st century human being, a human being with a different vision, another scale of values. A human being who is not solely motivated by money. A human being who understands that, fortunately, there is another way for his or her intelligence to exercise all its creative force.”

Salvador Allende

“Unless the poor of the world agitate for themselves to be heard, there will be no changes in their circumstances.”

Vandana Shiva
11.1 CONCLUSIONS

The need to discern employment-related concepts

Employment relations, employment conditions and working conditions are different yet interrelated concepts.

Employment relations are the relationships between buyers and sellers of labour, as well as the practices, outcomes and institutions that emanate or impinge upon the employment relationship. In wealthy countries, employment relations are often subject to the provisions of the law or a hiring contract, while in middle-income and poor countries most employment agreements are not explicitly subject to any formal contract, and a high proportion of total employment is in the informal economy.

At the global level, main employment conditions derived from employment relations include five main dimensions: unemployment, precarious employment, informal employment, child labour, and slavery/bonded labour.

Working conditions can be divided into physical, chemical, biological and social exposures. Simply put, material working conditions constitute the physical, chemical, biological and ergonomic work environment, while work organisation involves psychosocial relations, management and control, satisfaction, the tasks performed by workers and the technology being used. Working conditions also include hierarchy and power relations, the participation of workers in decision-making and social and occupational discrimination.

Power differences are embedded in employment relations

Power relations in negotiation between trans-national corporations, businesses, employers and workers’ associations are unequal. An important component of employment relations are the power relations between employers and employees and the level of social protection that employees can count on. Thus, public efforts at improving the health inequalities produced by employment relations must take into account the power differences among employers, workers and government. Employment relations therefore reflect the different relations of power over the production, appropriation and distribution of the fruits of labour by those who hire labour (employers and managers) and those who sell labour (workers).

Much of the history of employment relations has been characterised by unequal power and conflict between labour and capital, the former being represented mainly by unions, who demand higher wages,
shorter hours, and better working conditions through strikes, as well as social movements, and the latter being represented by corporations and businesses, who resist those demands through firings, lockouts or court injunctions.

A **more equitable balance of power in employment relations** is needed in most parts of the world to create fair employment growth, improve health and reduce health inequalities. Historically, worker participation has been associated with the development of collective labour rights, the labour movement and the policies and labour markets developed by modern welfare states. The degree of control and participation that workers have is thus not only a key factor for promoting a more egalitarian decision-making process within the firms, but also a “protective factor” of workers’ health. The state must take responsibility to **ensure the real participation** of less powerful social actors.

Historically, health inequalities emerging from power inequalities between capital and labour are partially reversed when **democratic institutions** allow the latter to modify laws which reverse the distribution of social determinants of health in the population.

**International and national** enforceable standards (with effective sanctions) are essential, along with economic and health policies designed to alleviate poverty in low-income countries. In an increasingly globalised capitalist economic system, the political, economic and cultural decisions of a handful of institutions and corporations have a powerful effect on the daily lives of millions of people worldwide, setting up labour standards, occupational health and safety regulations and union protections, among other important social determinants of health. Many **corporations** are creating unfair employment and working conditions throughout the production chain, yet they remain invisible most of the time. The market in itself cannot be expected to regulate employment and working conditions fairly, nor does it include among its objectives the protection of the population’s health.

The **state** bears a fundamental role in the reduction and mitigation of the negative health effects caused by inappropriate employment and working conditions. This can be achieved with social policies and workers’ full and real participation. Countries whose governments favour fair employment and decent work policies also tend to have better health indicators and lower health inequalities. The state should **guarantee** health and work as human rights, along with access to fair employment and decent work. Today, very few countries have developed specific policies for integrating employment-related policies into economic and social policies.
The primacy of fair employment and decent work

The concept of fair employment needs to be distinguished from that of decent work, with fair employment reflecting the need to redress unequal power relations embedded in employment relations.

The achievement of fair employment requires that serious action be taken on the following dimensions: (1) freedom from coercion, which excludes all forms of forced labour such as bonded labour, slave labour or child labour; (2) job security, in terms of contracts and safe employment conditions; (3) fair income, that is, enough to guarantee an adequate livelihood relative to the needs of society; (4) job protection and the availability of social benefits, including provisions that allow for harmony between working life and family life, and retirement income; (5) respect and dignity at work, so that workers are not discriminated against because of their gender, ethnicity, race or social class; (6) workplace participation, which allows workers to have their own representatives and negotiate their employment and working conditions collectively within a regulated framework; and (7) enrichment and lack of alienation, where work is not only a means of sustenance but, to the extent possible, an integral part of human existence that does not stifle the productive and creative capacities of human beings.

International political and public health institutions should recognise fair employment and decent working conditions as universal human rights. Unless guaranteeing fair employment is recognised as a priority by public health agencies and international regulatory institutions, health inequalities in the workplace are unlikely to be reduced. Action is needed to work towards the development of global social protection that guarantees fair employment and decent work for all citizens, all over the world.

The links between employment conditions and health inequalities

Health inequalities derived from employment are closely linked to other kinds of social inequalities, including inequalities in wealth, political participation and education. Through the regulation of employment relations, main political actors can not only redistribute resources affecting social stratification, but also have an impact on the life experiences of different social groups, including opportunities for well-being, exposure to hazards leading to disease and access to health care.
The concept of fair employment is informed by a public health perspective in which just employment relations, via various employment conditions (i.e., full-time permanent employment, unemployment, precarious employment, informal employment, child labour, and slavery and bonded labour), are a prerequisite for poverty reduction, health promotion and health inequalities reduction.

In middle-income and poor countries, estimates of unemployment are between three to seven times higher than in rich countries. Youth comprise nearly half of the world’s total unemployment. Compared to adults, youth are more than three times as likely to be unemployed. Other groups at high risk of being unemployed include workers without credentials, single mothers, ethnic minorities and recent immigrants.

Worldwide, the working poor (i.e. people living below the US2$ poverty line) constitute a large fraction of the employed labour force (around 1.4 billion people), the majority being women. The largest burden of precarious workers is overwhelmingly located in low-income countries, especially in Africa south of the Sahara. Over the past three decades, precarious employment relations have largely increased in wealthy countries, the largest burden also being born by younger workers, workers with low credentials, women, ethnic minorities and immigrants.

Over the past two decades, informal employment has grown in most low- and middle-income countries. In these countries, between half and three-fourths of workers are informally employed. Informal employment still comprises a wide range of production and distribution of goods and services in wealthy countries.

Children are among the most affected by these global labour market inequities. More than 300 million children (aged 5-17) are economically active, more than two-thirds are child labourers, and far more than one-third are engaged in hazardous work. The proportion of children in the labour market in the group of low-income countries shows a large variation, with the highest levels found in Africa south of Sahara as well as in Asian countries. Although much lower than in middle-income and poor countries, child labour, slavery, trafficking and bonded labour are still present in high-income countries.

Between 12 and 28 million people are victims of slavery globally, the majority of whom are in Asia. At least 2.4 million people (mostly women and girls) are in forced labour as a result of human trafficking.

The conditions under which people work have a direct or indirect impact on their health. Employment conditions are an antecedent of working conditions that can affect health either directly or through
Employment, work, and health inequalities - a global perspective

these. Also, indirect inequalities derived from employment and working conditions are closely linked with increased health inequalities in injuries, chronic diseases, ill-health and mortality. Every day, about 1,000 workers die due to their working conditions and 5,000 workers die due to work-related diseases. Work-related deaths, including injuries but also caused by cancers, cardiovascular disease, and communicable diseases, are estimated at about 2 million annually.

Most health hazards at work are related to the social class, gender, ethnicity, race, age and migrant status of workers. The worse the social position, the higher the risk is of having an unhealthy job. Moreover, the negative effects of work-related health hazards are often reinforced by environmental hazards and risky behaviours.

The world is divided into different types of labour markets according to national income and the countries’ political economies. Different labour market types reflect differing roles of the state and the amount of power of labour institutions in promoting fair or unfair employment relations. Wealthy social democratic countries enjoy the most salutary forms of employment relations, while low-income, non-egalitarian countries present the most health-damaging forms of employment relations.

The uncovering of the specific pathways between employment conditions, working conditions and health should be contextualised for each country based on its economic, political and cultural and technological characteristics.

There is an emerging body of evidence on the impact of employment relations on health at the macro-social (population-) level of analysis. In wealthy countries, labour-related institutions such as union density, collective bargaining coverage and social movements favouring solidarity are associated with better population health indicators. In middle-income countries, labour market characteristics, such as the proportion of working poor or gender inequality, are significantly associated with worse population health.

Unemployment, precarious employment and informal employment are well-known for their association with poverty and unfavourable health indicators. It is difficult to distinguish between poverty, hazardous working conditions, precarious employment and informal employment conditions. There are strong links both between informal and formal employment, and between the ways both affect health inequalities. A large informal employment sector affects the way working conditions are regulated, decreasing the level of enforcement of norms and legislation created to protect
workers. While labour institution indicators are scarcely recorded in low-income countries, labour market characteristics such as the size of the informal sector, the proportion of working poor and gender inequality are strongly correlated with worse population health.

Employment conditions are proximal determinants of material deprivation and working conditions. Employment conditions have a strong effect on chronic diseases and mental health via multiple psychosocial factors such as job insecurity, "life-style" behaviours, and direct physio-pathological changes.

Employment conditions, such as precarious employment, bonded labour, slavery and child labour share some common pathways, such as domination and lack of autonomy at work, but may also be characterised by specific pathways (e.g., child labour leading to low physical growth and compromising cognitive development).

Gaps in knowledge

Many employment and work-related health inequalities are socially invisible or neglected. Comparisons across countries are difficult, given the diversity of forms of employment and working conditions and the ensuing barriers to reaching universally standardised definitions. Empirical evidence concerning the impact of employment relations on health inequalities is particularly scarce for poor countries, small size firms and rural settings.

There are few initiatives regarding the use of indicators intended for the surveillance and monitoring of employment and working conditions, as well as their relationship with health and health inequalities. International and national health information systems lack data on employment relations and health. This problem is particularly acute among low- and middle-income countries. Two examples of this are the lack of comparable data on informal employment and the health-related consequences of forced labour.

Governments and health agencies should establish adequate surveillance information systems and research programmes in order to gather public health data associated with fundamental employment conditions, and all forms of precarious employment and work, giving attention to the singularities of each context, e.g., focusing on production chains to reveal the role of international corporations, the relationships between formal and informal economy or the role of the state and health and social protection coverage.
There is a lack of theoretical and empirical work on the mechanisms and explanations linking employment conditions to poor health outcomes. For example, more longitudinal empirical research and reviews are needed relating to issues such as the mechanisms mediating between employment dimensions, their interrelationships and several health outcomes. Most studies of employment dimensions should stratify by social class, gender, age, ethnicity, race and migration status. There is also a need to investigate externalities and spill-over effects on the health of other workers, families, children and the community.

Another important area in need of further research is the evaluation of employment policies and other employment interventions to reduce health inequalities. While much more research is essential, enough is currently known for effective public health action.

11.2 RECOMMENDATIONS

Cross-cutting proposals

While interventions on employment conditions need to be conducted at the organisational and job level, “upstream” action on employment and working conditions (especially through labour market regulations, social policies and workplace standards) is expected to be more effective in reducing health inequalities and should be the key focus of action. Leaving the health consequences of employment conditions as an afterthought or “downstream” consideration in trade, business practices or public health interventions will perpetuate the existing health inequalities caused by unfair employment and the lack of decent working conditions.

General strategies combining policies at different entry points (power relations, employment, working conditions and ill-health workers) need to be specified and contextualised for each territory (international, country/region, urban/rural local areas), condition, and population. Specific recommendations on policies and interventions should be tailored according to the typology of countries developed in this study, as well as by the specific characteristics of each country, region and territory.

To achieve better employment and working conditions, public economic, social and health policies and interventions require the implementation of integrated inter-sectoral actions and programmes, where policy-makers, government, workers and community organisations need to be actively engaged.
Efforts to reduce social inequalities in health should be understood, in general, as part of global and local integrated economic and social policies and, in particular, of specific public health and occupational programmes and interventions. Examples of interventions include universal access to public education, legislation on living wage, income redistribution through progressive tax systems and social services, avoidance of gender, racial and ethnic wage gaps and other forms of discrimination, and protection of the right to organise and collective bargaining. Evidence of the failure of existing regulations to protect vulnerable workers, even in wealthy countries, generally reflects a failure of enforcement rather than an argument against the regulatory option.

The health sector should take on an important role in the achievement of health equity for workers and their families. It can do so by including discussions about economic development models, labour market policies, regulations on employment and working conditions and evidence of their impact on the health of workers and their families.

International institutions, governments and political parties, unions, and civil society associations favouring fair employment relations are key actors in implementing effective policies leading to the reduction of employment-related health inequalities. Nevertheless, a crucial issue to consider is the need to expand the participation of workers and unions, as well as the participation of social movements based on social class, gender, race, ethnicity, migration or other social relations affecting employment conditions.

Given the relative lack of information available on the effectiveness of labour market interventions in the reduction of health inequalities, it is crucial to search for actions based on the most sound theoretical frameworks, such as the realistic approach used in this book. As expressed recently by the WHO’s Commission on Social Determinantes of Health, it is necessary to progress towards surveillance systems that include the determinants of health and health inequalities. Development of information systems that include health and health equity among workers is critical to this end, together with follow-up and impact on policies and programmes for mitigating and reducing health inequities among workers. It is necessary, then, to carry out studies that facilitate the knowledge and use of the employment indicators most adequate for surveillance and monitoring of health inequalities. There is also an urgent need to expand the evaluation and monitoring of policies and interventions in the short-, mid- and long-term, especially in low-income countries, small-size firms and rural settings.
Training and education on the links between employment relations and health inequalities is urgently needed in public health studies and research programs. Special emphasis is needed on workers’ health and employment conditions, directed both at health professionals and workers. Additionally, there is also a strong need to develop communication and dissemination campaigns among the lay population concerning employment and working conditions as key social determinants of health inequalities.

For each of the four main entry points identified (see below), there is a need to identify the most effective level (international, national/regional, and local), type of employment dimension and actor involved.

ENTRY-POINTS

Entry point A refers to any change in power relations, especially related to labour market conditions and social policies, which can occur between the main political and economic actors in a society.

General recommendations

International regulatory agencies should influence governments to put more emphasis on full-time permanent employment and the adoption of fair employment policies. For example, the United Nations, the International Labour Organization and other international agencies dealing with the rights of workers should have the leadership and power to influence the adoption of fair employment practices among member countries.

- Legislation, effective enforcement and punishment of beneficiaries of slavery and bonded labour (including those at the peak of subcontracting networks).
- Developments of international campaigns to raise awareness about sex traffic targeting potential victims, and provision of support and protection to those who are seeking help.
- Sanctions on governments that tolerate slavery or bonded labour (e.g. trade access & investment penalties) with incentives for those who seek to eradicate the practices.

Governments should lead national policies devoted to full employment and the national and international law enforcement of fair employment standards.

- Increase public spending and investment in social policies and social protection.
- Regulation of the labour market via protective legislation (wages, benefits and working conditions).
• Support and incentives to reduce precarious employment and informal work
• Support and incentives to reduce child or bonded labour (such as provision of food programmes for children attending school).
• Provision of quality and safe work environments as a central policy objective (not subordinate to economic policy) limiting temporary contracts and precarious jobs.
• Strengthening the employment component in poverty reduction programmes.
• Legislation, effective enforcement and punishment of beneficiaries and sanctions on governments that tolerate slavery or bonded labour and any form of exploitative labour.

Voluntary measures by employers/corporations have a role to play but are insufficient and too fragmented to reshape employment conditions and lift standards generally.

The role and participation of unions, social movements and grassroots community groups is crucial. Unions can generalise collectively negotiated protections (nationally and internationally) and, as evidence from poor countries attests, community actions can act as an important impetus to government measures.
• Provide incentives for unionisation and collective bargaining, as well as support the collective organisation of informal workers.
• Develop policies that increase the rights and participation of unions and workers in general, eliminating anti-union legislation or other forms of institutional discrimination of workers’ organisations.
• Implement policies, legislation and measures for land reform and against capitalist speculation.

Examples:
• Policies of Social Democratic Governments in Northern Europe. Development of more just redistributive economic policies as well as social policies on social protection which reduce social inequalities.
• Cooperatives in Colombia, India, Venezuela and Mozambique.
• Development of non-capitalist economic production built on economic solidarity with new forms of collective, social and public property, alongside private ownership.
• Landless movement in Brazil and rural South Africa. Pressure on land reform and against capitalist speculation.
Entry point B refers to modifications of employment conditions that reduce exposures and increase vulnerability to health-damaging factors.

General recommendations

The public capacity for regulation and control of employment conditions must be strengthened and full employment policies promoted in order to reduce the health inequalities associated with unemployment, precarious employment and informal work.

Economic development policies and programmes should be promoted mostly in middle- and low-income countries, taking into consideration the offer of formal job posts, thus assuring social sustainability and unemployment reduction.

- Develop active labour market policies (e.g., interventions to facilitate access to employment among women, young and older workers), unemployment insurance and measures to incentivate fair employment and deepening social inclusion. Implement measures to counter discrimination.
- Develop employment policies tailored for young and old workers in poor, middle-income, and rich countries.
- Provide incentives to promote working time flexibility (i.e., work-life balance).
- Promote regulations to avoid employment discrimination of foreign-born, migrant and other vulnerable workers.
- Reinforce laws against forced labour, child labour and other forms of labour exploitation.

Governments should help to respect the right of workers to be unionised by hindering firms’ retaliation.

- Provide government policies, legislation and incentives that give more power to workers.
- Remove anti-union laws and practices (e.g. Colombian and Ecuadorian flower industry) and increase the rights of workers and unions.

Support collective arrangements for production based on solidarity, as exemplified by the so-called solidarity economy.

- Support worker co-management in manufacturing plants and popular participation with communal and other councils funded and supported by the government (e.g., Venezuela).
• Develop policies and incentives that facilitate the participation and involvement of social class, gender-, and ethnicity-based social movements.

Support the creation of precarious and informal workers’ organisations based on relevant shared features such as occupation (domestic workers, taxi drivers, etc.), workplace location (farmers’ markets, streets), conditions such as being a migrant worker and production chains (food industry chain composed of small agricultural farmers to international trade corporations). These organisations, like labour unions, will strengthen precarious and informal workers and make their interests and needs politically visible.

• Develop policies and legislation that reduce insecurity in the labour market, and provide more stability for temporary employment jobs and precarious and informal employment.

• Regulatory controls on downsizing, subcontracting and outsourcing (including supply chain regulation) and laws placing limits on the use of precarious employment.

• Development of policies targeting the reduction of informal business, such as special taxation gradients for unregistered small and home-based firms.

• Expand social security to provide fair wages and more social protection to workers in the informal economy and to home-makers.

• Develop legislation and regulations for informal employment, creating incentives and sanctions for the reduction of employment violations in the informal economy.

Government-led national industrial policies devoted to full employment, enforcement of fair employment standards and universal education are necessary to eliminate child labour.

• Development of programmes to raise parents’ awareness about the social and health problems caused by child labour and, when applicable, conditional cash transfer programmes to poor families with school-age children.

• Support civil society mobilisation against the worst forms of child labour (e.g., consumer boycotts).

Enforce controls to eliminate slavery and human trafficking. Supporting land reform in poor countries can potentially reduce slavery, which is most common in areas of rural land conflicts.

• Anti slavery/bonded labour law and enforcement must be mandated internationally [with target penalties for non-compliance].
• Strengthen labour law enforcement agents (like special agents to interdict and prosecute practices, e.g., NAFTIP in Nigeria).
• Civil society mobilization against slavery (e.g., consumer boycotts).

Examples:
• The Programme for the Eradication of Child Labour in Brazil (PETI). Develop policies and legislation that eliminate child labour.
• Development of Occupational Health Workers’ Councils ("Consejos Obreros de Salud Laboral") in Venezuela. Governmental policies and legislation to give more power to workers. Subsidies for cooperatives in Venezuela (equal power, equal pay).

**Entry point C** relates to actions modifying working conditions such as health-related workplace material hazards, behaviour changes and psychosocial factors.

**General recommendations**

Governments and firms must provide workers with the tools to participate in the analysis, evaluation and modification of health-damaging work exposures.
• Include occupational health component in employment-creation programmes.
• Include occupational health in subcontracting and outsourcing (including supply chain) regulation.
• Strengthen prevention in social security and insurance mechanisms (public and private).
• Include occupational health in regional trade agreements.
• Regulate to avoid double standards and occupational hazard dumping.
• Develop minimum occupational health standards and regulation for progressive improvements.
• Education- and awareness-raising of health consequences of child labour.
• Develop special programmes to prevent hazardous child labour.
• Expand occupational health coverage to apprenticeship wherever this is not already case.
• Education- and awareness-raising of the health consequences of slavery and bonded labour.
• Slaves and bonded labourers must be deemed protected by occupational health laws notwithstanding legal status.

Health and health equity among workers should be a matter of public health, hence they should be guaranteed to working people independent of their conditions of employment. Here the strategy and model of primary health care has a capacity and a responsibility to reach these sectors with preventive and curative interventions, as well as support for reinsertion into work.

• Provision of universal health care coverage, including occupational health and safety programs integrated into primary health care, especially family health care programmes.
• Expand coverage with basic occupational health services through occupational health legislation and services (intersectoral occupational health policy).
• Establish worker health centre networks or integration activities for workers in the primary health care sector of the public health system.
• Opening of Occupational Health Offices to monitor occupational diseases.
• Development of occupational training programs that include occupational health and safety contents, targeting informal workers and social movements.
• Strengthen enforcement of occupational health legislation (e.g., inspectorate).

Unions play a fundamental role in reducing employment and work-related health inequalities. Unions can generalise collectively negotiated international or national protections.

• Include occupational health dimension in collective bargaining (e.g., right to know).
• Expand coverage of occupational health services (include temporary workers, self-employed, small business).

Social movements and grassroots community activities may play a fundamental role towards the goal of reaching fair employment. Evidence from some countries attests that community actions can act as an important adjunct/impetus to government measures (e.g., living wage campaigns in targeted US cities).
Cooperative models of organisation and production management based on solidarity need to be emphasised and their impact evaluated in comparison to individual bank loans.
- Include occupational health dimension on microcredits.

Mobilisation of savings and credit extension might be a beneficial strategy for reducing poverty in some regions for some households. However, its effects on health inequalities needs to be evaluated rigorously before any definite conclusion can be adopted with confidence.
- Promote worker’s participation and the action of safety representatives to prevent occupational hazard. Stimulate worker participation and enforcement of legislation.

**Examples:**
- Social Production enterprises in Venezuela and Argentina. They include more worker control, provide the same wage for everyone, and ten per cent profits are channelled by law towards improving surrounding communities.
- Development of the Union Institute of Work, Environment and Health (ISTAS), an applied research model for promoting the improvement of working conditions, occupational health and safety and environmental protection in Spain through the empowerment of health and safety representatives.

**Entry point D** relates to different types of interventions which may reduce the unequal consequences of ill-health and psychopathological change.

**General recommendations**

Governments and firms must provide workers with the tools to reduce the impact of ill-health.
- Universal access to health care including occupational health in primary health care.
- Establish information centres or networks for injured workers.
- Increase the capacity of the health system to recognise and treat occupational diseases and injuries.
- Create adequate solidarity finance mechanisms to cover compensation and treatment for all, including workers in the informal sector.
• Deemed coverage for undocumented immigrants and guest-workers, child and bonded labour under workers’ compensation/social security laws.
• Expand coverage (access, quality, compensation, rehabilitation) of occupational diseases and injuries (including mental illness).
• Effective rehabilitation programmes to assist disabled workers.
• Special re-training programmes to assist employment re-entry.
• Stronger legal obligations on employers to re-engage injured workers (including agency workers).
• Expand coverage and effective implementation of workers’ compensation or national illness insurance (e.g., self-employed, undocumented and migrant workers).
• Provision of basic income/anti-poverty support for the injured and their dependents.
• Introduction of special rehabilitation programs.
• Integrated minimum labour standards (industrial relations, OHS and workers’ compensation).
• Create institutional mechanisms to allow for society’s participation in health and social protection policies and programmes (e.g., social participation in the Unified Health System across all levels of the organisational structure in Brazil, and participatory democracy in Barrio Adentro, in Venezuela).

Examples:
• Integration of occupational health into the primary healthcare activities of the public health system (Brazil).
• Combined social movement/state moves to establish community-based support for injured informal workers and their families in regions of Brazil and elsewhere.
• Community and regulatory intervention measures for improving return-to-work options for workers in small business (including incentives/penalties, information provision and sharing return-to-work options amongst a number of small employers) in Denmark, Canada, Australia and elsewhere.
• Integrated minimum labour standards (including workers’ compensation entitlements) and provisions (including contractual track mechanisms and rebuttable presumption, to target the top of supply chains) to provide injury coverage to home-based clothing workers in Australia. There have been efforts to make this a more generic model for homeworkers.
Independent community-based advice, medical and legal support services for injured workers such as those found in parts of Canada. Workers’ (including self-employed) cooperatives (in middle-income and poor countries), workers’ health centres, and women’s community health centres provide another vehicle for this.
Appendix
A.1. GLOSSARY ON EMPLOYMENT AND WORKING CONDITIONS

Employment concepts developed in this book represent an attempt to conceptualize employment conditions in ways that relate employment to other institutional structures such as family, work organization, and social safety nets. Employment conditions may influence health by creating uncertainty and stress regarding income and social support, which have consequences for employment security and general well-being. Some of these concepts have already been published in specialised journals, others appear for the first time.

Bonded labour. Debt bondage was first defined in Article 1 (a) of the UN Supplementary Convention on the Abolition of Slavery, the Slave Trade and Institutions and Practices Similar to Slavery [1956] as: “the status or condition arising from a pledge by a debtor of his personal services or those of a person under his control as security for a debt, if the value of those services as reasonably assessed is not applied towards the liquidation of the debt or the length and nature of those services are not respectively limited and defined”. The 1956 Supplementary Convention specifies that debt bondage is a practice similar to slavery. The Convention’s definition clearly distinguishes bonded labour from a normal situation in which a worker accepts credit for whatever reason and then repays the amount by working. In the latter situation the repayment terms are fixed and the capital sum borrowed is only subject to reasonable interest rates (Anti-Slavery International & ICFTU, 2001). In bonded labour cases these safeguards do not exist, as the terms and conditions are either unspecified or not followed, leaving the bonded labourer at the mercy of their employer or creditor. In these circumstances bonded labourers can be forced to work very long hours, seven days a week for little or no wages. The employer may also adjust interest rates or simply add interest; impose high charges for food, accommodation, transportation or tools; and charge workers for days lost through sickness. In such cases workers may not have been told in advance that they will have to repay these expenses. Bonded labourers may take additional loans to pay for medicines, food, funerals or weddings resulting in further debt.

Reference

Child labour. International organisations share a common understanding of a child as any person under 18 years of age. However, there is no consensus about the definition of child labour. For instance according to UNICEF, child labour affects children below 12 years of age working in any type of economic activity, or those from 12 to 14 years of age engaged in occupational duties that are not considered “light work” (see US Funds for UNICEF, 2010). For the ILO, child labour is defined according to its effects. Therefore, it represents work activities that are mentally, physically, socially, or morally harmful and affect schooling. In 1999, the ILO
Recommendation No. 190 and Convention No. 182 defined the worst forms of child labour as those involving slavery or compulsory labour, prostitution, pornography, human trafficking, war, drug dealing or trafficking, or any illicit activity (ILO, 2009). There are also recommendations concerning hazardous occupations for children, such as those involving toxic chemicals and carrying or lifting heavy loads, among others.

References

Contingent employment. Contingent employment refers to work with unpredictable hours or of limited duration (Polivka & Nardone, 1989; Bergström, 2001). Work may be unpredictable because jobs are structured to be short-term or temporary, or because hours of work vary in unpredictable ways. The US Bureau of Labour Statistics has adopted the first part of this definition (short-term or temporary work contracts) as its definition of contingent employment, and has considered the second part (unpredictably variable hours) as an alternative employment arrangement, a strategy for increasing the flexibility of work assignments (Polivka, 1996). Workers are in contingent employment when they are working on limited-duration contracts, working through temporary work agencies or on call. One related development of particular interest is the evolution of firms specialising in the placement of temporary workers. This industry has grown dramatically in recent years and was a substantial proportion of job growth in the US during the 1990s (Smith, 1997). Some self-employed workers may be considered to be in contingent employment, since their working hours or terms may be unpredictable. Part-time jobs are not included in this definition because they are not necessarily limited in time, nor do the hours vary. Several reasons exist for public health to be concerned with contingent employment relations (Benach, Benavides, Platt, Diez-Roux, & Muntaner, 2000). Contingent workers are often marginalised at work, have fewer training and promotion opportunities, less predictable and lower incomes, fewer pension benefits and, in countries such as the US where health insurance is primarily derived from work, are less likely to have health insurance (Smith, 1997; Hipple & Stewart, 1996). Also, in a variety of ways, contingent work is covered less by government regulations regarding workplace safety and social safety nets (Bergström, 2001; Quinlan, Mayhew, & Bohle, 2001). Nevertheless, some workers may seek temporary work to satisfy personal needs for flexibility. For others, temping may provide a transition from unemployment to employment with a standard work contract, although many temporary workers would prefer more regular work schedules (Bergström, 2001; Smith, 1997).

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**References**


**Decent work.** The concept of decent work was first introduced by the International Labour Organization in 1999, who defined it as "opportunities for women and men to obtain decent and productive work in conditions of freedom, equity, security and human dignity" (Anker, Chernyshev, Egger, Mehran, & Ritter, 2003). Decent work is the ILO’s converging focus for four strategic objectives: the promotion of rights at work, employment, social protection, and social dialogue.

**Reference**


**Dignity.** Dignity refers to the ability to establish a sense of self-worth and self-respect, and to possess a social presence that is worthy of respect from others. Positively, dignity is attained through noble action, steadfast loyalty to one’s group, or enduring great suffering (Hodson, 2001; Lamont, 2000). Dignity is often connected to issues of class and ethnic identity. It is also rooted in pride in one’s daily work or in one’s ability to support a family and participate in the community. The idea of dignity has two different meanings—the first is that people have a certain inherent dignity as a consequence of being human; the second is that people earn dignity through their actions (Meyer & Parent, 1992; Castel, 1995). In the workplace, dignity can be violated by mismanagement or by managerial abuse; it can be protected by acts of resistance.


**References**


Employment conditions. Employment conditions are the conditions or circumstances under which a person is engaged in a job or occupation. Very frequently this involves an agreement or relationship between an employer who hires workers and an employee who offers his/her labour power. While the employer generally has the intention of creating profits, the employee contributes to the enterprise with labour, usually in return for payment of wages. Specifically, an employee is any person hired by an employer to do a specific job. In Western countries, employment conditions are often subject to the provisions of law, with the need to perform a job under a hiring contract. In these societies, governments are often the largest single employers, yet most of the work force is employed in small and medium businesses in the private sector. In poor countries however, agreements are not explicitly subject to any contract, and informal sector employment constitutes a high proportion of total employment (ILO, 2000). In a given company, employees may work under different conditions of employment. Some are full-time and permanent workers who receive a guaranteed salary, while others are hired for short term contracts or work as temps or consultants. The latter differ from permanent employees in that the company for which they work is not their employer, but a temp agency or consulting firm. It is important to distinguish independent contractors from employees, since the two are treated differently, both under the law and in most taxation systems.

Reference

Employment protection. Employment protection refers to regulations concerning both hiring (e.g. rules favouring disadvantaged groups, conditions for using temporary or fixed-term contracts, training requirements, etc.) and firing (e.g. redundancy procedures, mandated prenotification periods and severance payments, special requirements for collective dismissals and short-time work schemes). The OECD uses the term employment protection legislation (EPL), which refers to all types of employment protection measures grounded primarily in legislation, court rulings, and collectively-bargained conditions of employment or customary practice (OECD, 1999).

Reference

Employment relations. The individual and collectivist aspect of power relations at work that describe the relations between buyers and sellers of labour and all the behaviours, outcomes, practices and institutions that emanate or impinge upon the employment relationship (Benach et al., 2010).

Reference
Employment security. While job security represents the ability to remain in a particular job, employment security represents the likelihood of being able to remain in paid employment, even if this is a succession of jobs.


Fair employment. While in recent years the term "decent work" has been a guiding axis for the ILO’s work, in EMCONET we have also felt the need to establish a definition of what can be understood as the ultimate goal, in moral terms, concerning employment quality. According to the ILO, decent work means "productive work in which rights are protected, which generates an adequate income, with adequate social protection. It also means sufficient work, in the sense that all should have full access to income-earning opportunities" (ILO, 2005). Proceeding from this definition, we propose the term "fair employment", which includes seven different dimensions. The first of these is employment in the absence of coercion, or freely chosen work. This excludes all forms of exploited labour such as bonded labour, slave labour or child labour. Second, employment that provides the worker with security (this dimension relates to the types of contract, e.g., permanent, full-time contracts) as well as the existence of safe working conditions. The third dimension, income, requires that workers’ wages are fair (i.e., in accordance with relative earnings in society with respect to occupation, skills, gender or other individual characteristics) and sufficient for an adequate livelihood relative to the needs of that society. The fourth dimension is protection. This represents the availability of social benefits, including provisions that allow conciliation between working life and family life. Fifth, respect/dignity, requires that workers are not discriminated against because of their gender, race or social class. Sixth, the dimension of participation requires that workers are allowed to have their own representatives and negotiate their working conditions with employers within a regulated framework. Finally, the seventh dimension deals with personal enhancement and absence of alienation so that work is not a means of subsistence but rather, as far as possible, an integral part of human existence which helps to develop people’s creative and productive capacities.

Reference

Flexible labor market. A flexible labour market is one in which employees are no longer expected to deliver competence in a single job, but to possess multiple generic skills adaptable to changing employer demands.

Forced labour. Although the older form of slavery was abolished by enforcing laws, a newer form of forced labour has emerged. The actual distinction between newer and older versions of forced labour is slight. When an individual is forced to work against his or her will, under the threat of violence or some other form of punishment, their freedom is restricted and a degree of ownership is exerted over them. The ILO defined forced labour in its 1930 convention as “all work or service which is exacted from any person under the menace of any penalty and for which the said person has not offered himself voluntarily” (ILO, 2005). Penalties include economic penalties, non-payment of wages or loss of wages accompanied by threats of dismissal if workers refuse to do overtime beyond the scope of their contract or of national law. Apart from penal sanctions, the penalty might also take the form of a loss of rights and privileges, or even extreme forms such as physical violence and death threats. It also includes threats to denounce victims to the police or immigration authorities and other administrative authorities when employment status is illegal. Many victims enter forced labour situations initially of their own accord, albeit through fraud and deception on the part of the employers, only to discover later that they are not free to withdraw their labour. Forced labour cannot be equated with low wages or poor working conditions, nor does it cover situations of pure economic necessity, such as when a worker feels unable to leave a job because of the real or perceived absence of employment alternatives. Forced labour represents a severe violation of human rights and a restriction of human freedom, as defined by the ILO conventions on the subject and in other related international instruments intended for slavery, practices similar to slavery, debt bondage or serfdom (ILO, 2010a; ILO, 2010b).

References

Full-time permanent employment. Traditionally this term means a "regular job". In general, the so-called standard employment relationship has been defined as a full-time job, year-round, with unlimited duration, and benefits, the basic conditions of which (working time, pay, social transfers) are regulated to a minimum level by collective agreement or by labour and/or social security law. The full-time nature of the job, its stability, and the social standards linked with permanent full-time work are the key elements in this definition. Typically, a full-time employee is someone who is scheduled to work at least 35 hours per week: work lasts about eight hours a day, five days a week and forty-eight weeks of the year with four weeks of paid leave. Often, welfare and retirement plans will restrict eligibility based on the number of working hours and full- or part-time status (Bosch, 2004).

Reference
Informal economy. Although it varies from country to country, a sizeable proportion of economic activity takes place in an informal economy. What makes these activities informal is that they are not reported to the government authorities that measure and regulate the formal economy. Exchange in the informal economy is either for cash or barter, since these do not create records that can be tracked by authorities. Some activity in the informal economy would still be illegal even if the income or the transactions were reported. Work in the informal economy poses considerable health risks because the working conditions are unregulated and workers do not enjoy benefits. The informal economy undermines social welfare systems because production in the informal economy is untaxed. Synonyms for the informal economy include underground, hidden or irregular economy (Losby et al., 2002).


**Reference**


Informal employments and informal jobs. Non-regulated placement in the labour market usually involves an informal arrangement between the employee and employers [informal employment] or self-employment [informal jobs], and hence does not imply a market exchange of labour, but of products or services. Informal employment and informal jobs prevail in the informal economy but non-formal job contracts may occur in legal, registered firms (Harding & Jenkins, 1989). In several countries, workers’ entitlement to social benefits such as paid retirement, sickness or maternity leaves and access to health care are dependent on the possession of a formal job contract (Williams & Windebank, 1998). There are also employment guarantees for formally employed workers, such as legal limits on work-hours, compensations for firing, and so on, which are not available to informal workers. Therefore, informal employment is a particular type of precarious job because it expresses a sub-standard form of placement in the labour market (Santana & Loomis, 2004). Besides a lack of social benefits, workers engaged in informal employment or informal jobs tend to have low salaries, high turnover, lack of security, poorly-defined work-hours and limited unionisation.

**References**


**Job discrimination.** This term describes what happens when work-related decisions are based on ascribed characteristics such as sex, age, race, ethnicity or social class, rather than on individual merit, qualifications or performance. Social epidemiological analyses of discrimination require conceptualising and operationalising diverse expressions of exposure, susceptibility and resistance to discrimination. Clearly, individuals and social groups can be subjected simultaneously to multiple-and interacting-types of discrimination (Krieger, 2000).


**Job insecurity.** Much work on the concept of job insecurity has been carried out by Hartley and colleagues, who define it generally as the discrepancy between the level of security a person experiences and the level she or he might prefer (Hartley, Jacobson, Klandermans, & Van Vuuren, 1991). Some researchers limit the concept of job insecurity to the threat of total job loss while others extend it to include loss of any valued condition of employment (Greenhalgh & Rosenblatt, 1984).


**Labour market policies.** Labour market policies mediate between supply (jobseekers) and demand (jobs offered) in the labour market, and their interventions can take several forms. There are policies that contribute directly to matching workers to jobs and jobs to workers (public and private employment services, job search assistance, prospecting and registering vacancies, profiling, providing labour market information), or enhancing workers’ skills and capacities (e.g. training and retraining), reducing labour supply (e.g. early retirement, supporting education), creating jobs (public works, enterprise creation and self-employment) or changing the structure of employment in favour of disadvantaged groups (e.g. employment subsidies for target groups) (ILO, 2003). “Active” labour market policies (ALMPs) are policies that provide income replacement and labour market integration measures to those looking for jobs, usually the unemployed, but also the underemployed and even the employed who are looking for better jobs. Active policies concern labour market integration. “Passive” policies are those that are concerned with providing replacement income during periods of joblessness or job search. Indeed, active support for labour market integration is the main thrust of ALMPs. Broadly
speaking then, passive policies correspond to social transfers that are not conditional upon joining a training or work programme, although they usually include job search provisions that are increasingly enforced and which correspond to an active element in passive policies. In contrast, active policies are contingent upon participation in such programs in order to enhance labour market (re)integration. Typical passive programs are unemployment insurance and assistance and early retirement. Typical active measures are labour market training, job creation in the form of public and community work programs, programs to promote enterprise creation, and hiring subsidies. Active policies are usually targeted at specific groups facing particular difficulties with respect to labour market integration. These groups include younger and older people, women, and particularly hard-to-place individuals such as the disabled. In part, ALMPs are an answer to the criticism that pure income replacement policies might entail disincentives to work once unemployment is of longer duration.

**Reference**

**Non-standard work contract.** A non-standard work contract is defined relative to an employment standard. Standards are usually set nationally and define what it means to be in full-time, year-round, permanent employment with benefits. Non-standard employment fails to meet standards along any of these dimensions. Examples of non-standard employment are any part-time, seasonal, home-based, contingent or informal work. Nonstandard work is typically characterised by reduced job security, lower compensation and impaired working conditions (Benach, Muntaner, Benavides, Amable, & Jódar, 2002).


**Reference**

**Outsourcing.** Outsourcing is a strategic switch to using external suppliers to carry out activities previously handled by internal staff and resources. Outsourcing may include the creation of durable partnerships and the organisation of supply chains. This process can be especially sensitive for workers and their communities when it entails moving production from developed to developing countries. Outsourced work may also go to independent contractors, self-employed workers, or home workers. Displaced and outsourced workers may be faced with reduced wages, longer working hours, problems in worksite management, inability to organise or protect themselves, a failure of established regulatory procedures, and the shifting of work to unregulated firms or sites (Quinlan, Mayhew, & Bohle, 2001).
Precautionary employment. This term has been used to signal that new forms of work might reduce social security and stability for workers (Benach, Benavides, Platt, Diez-Roux, & Muntaner, 2000; Bielinski, 1999). Flexible, contingent, non-standard, temporary work contracts do not necessarily provide an inferior status as far as economic welfare is concerned. Precautionary employment forms are located on a continuum, with the standard of social security provided by a standard (full-time, year-round, unlimited-duration, with benefits) employment contract at one end and a high degree of precariousness at the other. Precautionary employment might also be considered to be a multidimensional construct defined according to dimensions such as temporality, powerlessness, lack of benefits and low income (Rodgers, 1989; Amable, Benach, & González, 2001). Historically, precautionary employment was once common but declined in what are now the developed economies with increased government regulation and the increased political influence of organized labour, as well as changes in technology that favoured more stable work relationships. Currently, precautionary employment is becoming more common in developed economies and is widespread in developing economies (Quinlan, Mayhew, & Bohle, 2001; Bielinski, 1999).


References


**Slavery.** Millions of men, women and children around the world are forced to lead lives as slaves. Although this exploitation is often not called slavery, the conditions are the same. People are sold like objects, forced to work for little or no pay and are at the mercy of their "employers". According to Anti-slavery International, a slave is someone who is forced to work through mental or physical threat, owned or controlled by an "employer" (usually through mental or physical abuse or threatened abuse), dehumanised, treated as a commodity or bought and sold as "property", and/or physically constrained or has restrictions placed on his/her freedom of movement. Examples of slavery include bonded labour, early and forced marriage, forced labour, slavery by descent, trafficking and the worst forms of child labour (Anti-Slavery International, 2010).

**Reference**


**Social distribution of unemployment.** Unemployment is by no means randomly distributed in the economically active population (Sinfield, 1981; Stern, 1979). It is always more prevalent among less privileged social groups. Much routine manual labour is inherently insecure, such as working on building sites, road construction, seasonal agricultural work, etc. Ethnic minority groups often suffer a high risk of unemployment due to discrimination by employers. Once a person has suffered a spell of unemployment, they are known to be at higher risk of a more insecure work history. A large proportion of time spent in unemployment is experienced by a relatively small proportion of the working population, either as long-term unemployment or as repeated spells (Westergaard, Noble, & Walker, 1989; White, 1991; Daniel, 1990). The gender distribution of unemployment is rather difficult to assess. According to official figures for the late 1990s, there are large national variations. In the UK, the unemployment rate for women was under half that of men, while in Norway and Finland rates were almost equal, and in Italy and Spain unemployment was up to twice as prevalent among women as it was among men.


**References**


**Social insurance.** Social insurance is one form taken by unemployment benefits, specifically the "contributory" form. Under social insurance, citizens pay a premium while they are working, and employers often pay into the fund as well. This is used to finance benefits when an employee is out of work. Only those who are "paid up" are eligible for this type of benefit.
Trafficking. Human trafficking is a transnational form of organised crime involving the recruitment, transportation, transfer, harbouring or receipt of persons by means of the threat or use of force or other forms of coercion. This includes abduction, fraud, deception, the abuse of power or of a position of vulnerability or giving or receiving payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation includes, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs. Traffickers normally use either an implicit or explicit threat of violence, which can be directed at the migrant or at their family back in the country of origin to ensure that the migrant does the work as instructed. Traffickers may also confiscate the migrant’s identity or travel documents to control their movements and ensure that they do not try to escape (Anti-Slavery International & ICFTU, 2001). Those migrant workers who have been trafficked or who do not enjoy a documented immigration status are particularly at risk of being subjected to forced labour because they are afraid that if they go to the authorities to make a complaint or to seek protection they will be deported. Typically the migrant will not know the language or country to which they have been brought and will have no money to live on let alone pay for a return ticket home. Migrant workers in this position are clearly working against their will under the menace of reprisals from the trafficker and therefore meet the criteria of forced labour set out in ILO convention No. 29.

Reference

Unemployment. The meaning of this term varies in each country. In the UK there have been many definitions that have changed over time to suit the political purposes of governments. Some of the most common definitions are listed under separate headings. Roughly speaking, the unemployment rate is the proportion of all individuals of working age in a given area who do not have a job and are actively seeking one. It often leaves out large numbers of people who would like to work but are prevented from even looking for work, such as many people with long-term illness who could work if working conditions were better and parents who could work if child care services were adequate.

Welfare state policies. Welfare state policies are policies aimed at protecting citizens’ welfare. They relate to several policy sectors, such as health or education. Typical welfare state policies are social protection policies. Expenditure on social protection includes the following areas: sickness/health care, invalidity/old age, survivors, family/children, unemployment, housing and social exclusion (Navarro & Quiroga, 2005).

Reference

Work-family conflict. Work-family conflict is a form of inter-role conflict in which the role pressures from the work and family domains are mutually incompatible in some respect, causing considerable personal and organisational problems (Hage & Powers, 1992). Two main hypotheses regarding gender differences in domain sources conflict have been suggested: domain flexibility and domain salience. The domain flexibility hypothesis predicts that the work domain is a greater source of conflict than the family domain for both women and men. The domain salience hypothesis predicts that the family domain is a greater source of conflict for women than the work domain, and the work domain is a greater source of conflict for men than the family domain. Women may experience more role conflict as a result of the simultaneity of their multiple roles (Hall, 1972). Along with gender, some family domain pressures (such as the presence of young children and spouse time in paid work) and work domain pressures (such as number of hours worked per week) are associated with work-family conflict. Although the influence of multiple roles (such as employee, spouse and mother) on women’s health has been examined, results are not consistent. The contradictory findings in the literature may be attributable to the number or the type of roles occupied, as well as the nature of particular roles. Thus, job-related exposures may differ by employment, social class and marital status, as well as by the family demands associated with these roles (Artazcoz, Borrell, & Benach, 2001). The degree of control that people have to negotiate in stressful situations also seems to be critical (Fenwick & Tausig, 2001).


References
**Work intensification.** Work intensification involves increased pressure at work from colleagues or workmates, managers or supervisors, and the sheer quantity of work (Burchell et al., 1999).


**Reference**


**Working class power.** Power is the ability to make what one wants to happen, even over the resistance or opposition of others. There are numerous sources of working class power under capitalist production relations, but they often involve having collective control over generalised resources such as money, organisations, political parties and communications media. Some sources of working class power are situation-specific, such as having access to information networks, a particular position in an organisation, or possessing collective control over particular natural resources. Other sources of power, such as ideological charisma, are personal even though they are expressed via working class organisations (social democratic parties or unions). Social class power is manifest through political processes in government policy, in the actions of labour and working class parties.


**Working conditions.** General conditions of work determine peoples’ experiences at work in many ways. Minimum standards for working conditions are defined in each country, yet the large majority of workers, including many of those whose conditions are most in need of improvement, are excluded from the scope of existing labour protection measures. In many countries, workers in cottage industries, the urban informal economy, agriculture (except for plantations), and small shops, as well as local vendors, domestic workers and homeworkers are outside the scope of protective legislation (ILO, 2005). Other workers are deprived of effective protection because of weaknesses in labour law enforcement. This is particularly true for workers in small enterprises, which account for over 90 per cent of enterprises in many countries, with a high proportion of women workers. An explicit definition incorporating the causal relationship between work and health is the one given by the Spanish National Institute of Work, Health and Safety, which defines working conditions as “the variables which define the carrying out of any given task as well as the environment in which it is carried out, determining the health of the workers in a threefold sense: physical, psychological and social” (Benavides, Castejón, Mira, Benach, & Moncada, 1998). Main types of hazards in the workplace include physical, chemical, ergonomic, biological, and psychosocial risk factors.
A.2. TYPOLOGY OF COUNTRIES

A.2.1. METHODS

Data sources and variables

In developing countries (i.e., semi-peripheral and peripheral), we used variables measuring inequality and poverty in the labour market as a whole (i.e., regardless of whether they were formal or informal), and workers’ wage levels. We constructed indicators of labour market characteristics as two-factor scores composed of three variables, each measured at two different times. The first labour market score measured inequality in the labour market through three standardized variables: the ratio between male and female workers of estimated earned income (incr1999, incr2003); the gap in levels of labour-force participation between female and male workers (lfp1997, lfp2003); and the employment-to-population ratio (epr1997, epr2003). The second factor score quantified poverty and income levels in the labour market, also using three standardized variables measured twice: percentage of children in the labour market (chldl1997, chldl2003); percentage of workers that are poor (wkpr1997, wkpr2003); and average income level (aveinc1999, aveinc2003). For core countries, we used unionisation rate and employment protection legislation (EPL) indices, developed by the OECD, to measure the security and flexibility of the labour market. We used the mean EPL index for regular workers and temporary workers, for the years 2000-2003 (2000-2004 for Germany and Portugal).

Health outcomes were downloaded from the WHO Statistics Information System (WHOSIS) website (WHO, 2010). We used the mean values over the period 1997-2004. Variables and sources are given in Table A1.

Table A1. Labour market variables used in the typology of countries.

<table>
<thead>
<tr>
<th>VARIABLES</th>
<th>YEAR</th>
<th>SOURCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour market variables</td>
<td>Core</td>
<td>Union Density (logarithmic)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Employment Protection Legislation (EPL) indices</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- EPL index for regular workers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- EPL index for temporary workers</td>
</tr>
<tr>
<td></td>
<td>Average of 2001-2003</td>
<td>OECD</td>
</tr>
<tr>
<td></td>
<td>(2000-2004 for Germany and Portugal)</td>
<td></td>
</tr>
<tr>
<td>Semi-periphery and Periphery</td>
<td>Labour market inequality factor score (labeq)</td>
<td>1997 and 2003</td>
</tr>
<tr>
<td></td>
<td>- Estimated earned income ratio between male and female workers (incr)</td>
<td>1999 and 2003 for incr and aveinc</td>
</tr>
<tr>
<td></td>
<td>- Labour force participation gap between female and male workers (lfp)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Employment to population ratio (epr)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Labour market poverty factor score (labpov)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Percentage of children in labour market (chldl)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Percentage of workers that are poor (wkpr)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Average income level (aveinc)</td>
<td>KILM</td>
</tr>
<tr>
<td>Health outcomes</td>
<td>2002 or 2004</td>
<td>WHOSIS</td>
</tr>
</tbody>
</table>

Statistical analyses

World-Systems classification

For the classification of countries based on their position in the world-system, we used Gross National Product per capita (GNPpc) for the year 2000, generated through the World...
Bank's Atlas Method (adjusted by exchange rate). Figure A1 shows three clear groups of countries and the cut-point log10 of GNPpc (Babones, 2005). Then we re-categorised countries based on our knowledge and perception of their position in the world-system. For example, oil-rich countries were categorised as core countries based on income level. However, their function as a provider of oil does not qualify them as core countries, which usually occupy high value-added sectors such as finance and banking (Arrighi, 2003). We have also categorised East-Asian countries into the semi-periphery, because of their relative dependence on US hegemony and integrated industrialisation with Japan and the US.

**Figure A1. Three Positions in the World-System (year 2000, smoothing=0.15).**
**Structure of the World-Economy Analytical Tool**
Salvatore Babones
University of Pittsburgh
* All values are expressed as 1995 US Dollars

<table>
<thead>
<tr>
<th>Year</th>
<th>Sample:</th>
<th>Smoothing kernel:</th>
<th>Income series:</th>
<th>Weighting:</th>
</tr>
</thead>
</table>
| Troughs in Distribution | Log10 | Value
| Trough 1 midpoint | 3,275 | $1,884 |
| Trough 2 midpoint | 3,925 | $6,414 |
| Peaks in Distribution | Log10 | Value
| Peak 1 midpoint | 2,675 | $473 |
| Peak 2 midpoint | 3,425 | $2,661 |
| Peak 3 midpoint | 4,375 | $23,714 |
| COUNTRIES included: | 102 |
| POPULATION (millions): | 5,024 |

Table A1: Countries by National Income Level

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**Factor scores and cluster analyses**
For semi-peripheral and peripheral countries, we constructed 2 labpov and labeq factor scores, using the variables listed under each factor name in Table A1. Factor analyses were conducted using a principal components method, and the reliability of the score was measured by Cronbach's alpha. Finally, factor scores were constructed using the regression method. Using this factor score, we conducted a series of hierarchical cluster analyses to generate clusters of countries. This was achieved using Ward’s method of measuring squared Euclidean distance.

For core countries, we used 3 standardised variables listed in Table A1 to generate clusters using Ward’s methods. Analyses were conducted using STATA version 10.0.

**Descriptive analyses of labour market variables and bivariate association with various health outcomes**
We calculated descriptive statistics of standardized labour market variables and factors by position in the World System and later by labour market clusters. The bivariate association of labour market variables and factors with various health outcomes was also calculated to analyse the relationship between labour market characteristics and health outcomes.
Bivariate associations with percentage of GNP from the informal sector

To compensate for the fact that we did not use any informal sector indicator in this analysis, we examined the bivariate associations between the explanatory variables, various health outcomes and the variable “percentage of GNP produced from informal sector.”

A.2.2. RESULTS

Originally our dataset included a total of 210 countries, which was comprised of 38 core, 61 semi-peripheral and 111 peripheral countries. Due to missing data-points, 144 countries out of 210 were categorised into labour market clusters (21 core, 42 semi-peripheral, and 71 peripheral countries). Data from a total of 79 (53 peripheral and 26 semi-peripheral) countries were used for the analysis of the informal sector.

Descriptive analyses

The descriptive statistics of explanatory variables are given in Table A2. Mean values of variables that were used to generate labour market inequality scores (labeq) were similar between semi-peripheral and peripheral countries. However, variables used to generate labour market poverty factor scores (labpov), such as percentage of child labour, percentage of working poor, and average income, show large discrepancies between the two positions in the World System. In Figure A2, we present the relationship between the two factor scores. We can see that the positive correlation between them is more pronounced in peripheral countries compared to semi-peripheral countries.

Figure A2. Relationship between two factor scores (Quadratic).
<table>
<thead>
<tr>
<th>VARIABLES</th>
<th>CORE</th>
<th>SEMI-PERIPHERY</th>
<th>PERIPHERY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>S.D.</td>
<td>Mean</td>
</tr>
<tr>
<td>Revealed</td>
<td>2.11</td>
<td>0.38</td>
<td>2.19</td>
</tr>
<tr>
<td>Revealing</td>
<td>2.05</td>
<td>0.50</td>
<td>2.03</td>
</tr>
<tr>
<td>Reformer</td>
<td>2.17</td>
<td>0.42</td>
<td>2.56</td>
</tr>
<tr>
<td>Reaction</td>
<td>2.28</td>
<td>1.73</td>
<td>2.81</td>
</tr>
<tr>
<td>Incr 1989</td>
<td>58.02</td>
<td>12.08</td>
<td>40.66</td>
</tr>
<tr>
<td>Incr 1989</td>
<td>64.68</td>
<td>12.00</td>
<td>40.66</td>
</tr>
<tr>
<td>KgWRP</td>
<td>-5.60</td>
<td>4.95</td>
<td>-0.38</td>
</tr>
<tr>
<td>gprWRP</td>
<td>66.57</td>
<td>10.64</td>
<td>64.21</td>
</tr>
<tr>
<td>gprWRP loader</td>
<td>69.22</td>
<td>7.02</td>
<td>47.23</td>
</tr>
<tr>
<td>Labour (cont.)</td>
<td>0.88</td>
<td>0.77</td>
<td>0.11</td>
</tr>
<tr>
<td>Direct 1977</td>
<td>0.06</td>
<td>0.15</td>
<td>0.09</td>
</tr>
<tr>
<td>Direct 1983</td>
<td>0.055</td>
<td>0.13</td>
<td>0.01</td>
</tr>
<tr>
<td>wrpr 1977</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>wrpr 1983</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>anronic 2003</td>
<td>28.494</td>
<td>20.95</td>
<td>46.60</td>
</tr>
<tr>
<td>Labour (cont.)</td>
<td>-1.20</td>
<td>0.10</td>
<td>-1.09</td>
</tr>
</tbody>
</table>

Table A2: Descriptive statistics of labour market variables by the labour market cluster.
Bivariate associations between factors and health outcomes are calculated by position in the World System (Table A4). Overall EPL score correlated highly with both EPL for regular workers (coef.=0.84; p-value=0.000) and EPL for temporary workers (coef.=0.92; p-value=0.000). The correlation between EPL-regular and EPL-temporary was less pronounced (coef.=0.54; p-value=0.011). The union density was not significantly associated with any EPL values. The two labour market factor scores, labpov and labeq, were significantly associated with each other (coef.=0.48; p-value=0.000) only in peripheral countries.

All EPL indices and union density are significantly associated with under-5 mortality rate, infant mortality rate, and neonatal mortality rate in core countries. In addition, union density is significantly correlated with the low birthweight rate and potential years of life lost due to communicable disease. Factor scores, especially labpov, showed highly significant associations (p-value=0.000) with most health outcomes. In both peripheral and semi-peripheral countries, labpov factor scores were significantly associated with longer life expectancy in males and females, healthy life expectancy (HALE) in males and females, a higher probability of dying (male and female), higher under-5, infant, neonatal, and maternal mortality rates, low birthweight rate, more potential years of life lost due to communicable diseases (both sexes) and fewer potential years of life lost due to non-communicable diseases (both sexes). Mortality from cancer and injury and potential years of life lost from injury were significantly correlated with labpov in peripheral countries only. The labeq factor score in peripheral countries shows a similar pattern, and is significantly correlated with the same health outcomes except for low birthweight rate. In semi-peripheral countries labpov is only correlated significantly with cancer mortality.

In Figure A3 and A4, we illustrate the correlation between male and female HALE and two factor scores. The distribution of labeq is relatively more disperse and random compared to labpov. We can see the pattern of negative correlation between labeq and HALEs only in peripheral countries, and it is still more disperse than the pattern between labpov and HALEs, as would be predicted from Table A4.

**Construction of factor scores and association with health indicators**

We present Cronbach’s alpha values for measuring the reliability of factors and loadings of each variable in Table A3. All indicators used to construct factor scores show high factor loadings, and thus high Cronbach’s alpha scores, 0.934 and 0.913 for labeq and labpov, respectively.
Table A3. Labour market factor scores, constituting variables, loadings, and reliability coefficient (Cronbach’s alpha).

<table>
<thead>
<tr>
<th>FACTOR</th>
<th>VARIABLES</th>
<th>FACTOR LOADINGS</th>
<th>CRONBACH’S ALPHA</th>
</tr>
</thead>
<tbody>
<tr>
<td>labeq (labour market inequality factor score)</td>
<td>incr99 Estimated earned income ratio between male and female workers, year 1999 (standardized)</td>
<td>0.889</td>
<td>0.934</td>
</tr>
<tr>
<td></td>
<td>incr03 Estimated earned income ratio between male and female workers, year 2003 (standardized)</td>
<td>0.877</td>
<td></td>
</tr>
<tr>
<td></td>
<td>lfp97 Labour force participation gap between female and male workers, year 1997 (standardized)</td>
<td>0.937</td>
<td></td>
</tr>
<tr>
<td></td>
<td>lfp03 Labour force participation gap between female and male workers, year 2003 (standardized)</td>
<td>0.912</td>
<td></td>
</tr>
<tr>
<td></td>
<td>epr97 Employment to population ratio, year 1997 (standardized)</td>
<td>0.810</td>
<td></td>
</tr>
<tr>
<td></td>
<td>epr03 Employment to population ratio, year 2003 (standardized)</td>
<td>0.787</td>
<td></td>
</tr>
<tr>
<td>labpov (labour market poverty factor score)</td>
<td>chldl97 % child labour, year 1997 (standardized)</td>
<td>0.926</td>
<td>0.913</td>
</tr>
<tr>
<td></td>
<td>chldl03 % child labour, year 2003 (standardized)</td>
<td>0.930</td>
<td></td>
</tr>
<tr>
<td></td>
<td>wrkpr97 % working poor, year 1997 (standardized)</td>
<td>0.893</td>
<td></td>
</tr>
<tr>
<td></td>
<td>wrkpr03 % working poor, year 2003 (standardized)</td>
<td>0.884</td>
<td></td>
</tr>
<tr>
<td></td>
<td>aveinc99 Average income level, year 1999 (standardized)</td>
<td>-0.794</td>
<td></td>
</tr>
<tr>
<td></td>
<td>aveinc03 Average income level, year 2003 (standardized)</td>
<td>-0.771</td>
<td></td>
</tr>
</tbody>
</table>

Figure A3. Scatterplots of male and female healthy life expectancy and labour market poverty factor score (labpov).
Table A4. Zero-order correlation between labour market indicators and selected health outcomes.

<table>
<thead>
<tr>
<th></th>
<th>CORE</th>
<th>SEMI-PERIPHERY</th>
<th>PERIPHERY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>EPLL</td>
<td>EPLREG</td>
<td>EPLTEM</td>
</tr>
<tr>
<td>Standardized EPL-index for all workers (eplall)</td>
<td>Coef. 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>P-value</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obs.</td>
<td>21</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standardized EPL-index for regular workers (epreg)</td>
<td>Coef. 0.8361</td>
<td>1.0000</td>
<td></td>
</tr>
<tr>
<td>P-value</td>
<td>0.0001</td>
<td></td>
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</tr>
<tr>
<td>Obs.</td>
<td>21</td>
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</tr>
<tr>
<td>Standardized EPL-index for temporary workers (epitem)</td>
<td>Coef. 0.9152</td>
<td>0.5443</td>
<td>1.0000</td>
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<tr>
<td>P-value</td>
<td>0.0001</td>
<td>0.0107</td>
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<tr>
<td>Obs.</td>
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<tr>
<td>Standardized union density, logarithmic (uden)</td>
<td>Coef. 0.0050</td>
<td>0.0462</td>
<td>-0.0249</td>
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<tr>
<td>P-value</td>
<td>0.9830</td>
<td>0.8423</td>
<td>0.9146</td>
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<tr>
<td>Labour market poverty factor score (labpov)</td>
<td>Coef.</td>
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<td>1.0000</td>
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<tr>
<td>P-value</td>
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<td></td>
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<tr>
<td>Obs.</td>
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<td>Labour market inequality factor score (labeq)</td>
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<td>P-value</td>
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<td>0.7509</td>
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<td>Obs.</td>
<td>42</td>
<td>42</td>
<td>71</td>
</tr>
<tr>
<td>Life expectancy at birth (years), Males</td>
<td>Coef. -0.1296</td>
<td>-0.0957</td>
<td>-0.1264</td>
</tr>
<tr>
<td>P-value</td>
<td>0.5756</td>
<td>0.6800</td>
<td>0.5851</td>
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<tr>
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<td>21</td>
<td>21</td>
</tr>
<tr>
<td>Life expectancy at birth (years), Females</td>
<td>Coef. 0.1875</td>
<td>0.1359</td>
<td>0.1882</td>
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<tr>
<td>P-value</td>
<td>0.4158</td>
<td>0.5569</td>
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<td>21</td>
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<tr>
<td>Healthy life expectancy (HALE) at birth (years), Males</td>
<td>Coef. 0.0116</td>
<td>0.0535</td>
<td>-0.0193</td>
</tr>
<tr>
<td>P-value</td>
<td>0.9603</td>
<td>0.8177</td>
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<tr>
<td>Healthy life expectancy (HALE) at birth (years), Females</td>
<td>Coef. 0.2766</td>
<td>0.2652</td>
<td>0.2301</td>
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<tr>
<td>P-value</td>
<td>0.2248</td>
<td>0.2452</td>
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<tr>
<td>Probability of dying per 1 000 population between 15 and 60 years (adult mortality rate), Males</td>
<td>Coef. 0.2794</td>
<td>0.1472</td>
<td>0.3182</td>
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<tr>
<td>P-value</td>
<td>0.2200</td>
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<tr>
<td>Probability of dying per 1 000 population between 15 and 60 years (adult mortality rate), Females</td>
<td>Coef. -0.3910</td>
<td>-0.3259</td>
<td>-0.3593</td>
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<tr>
<td>P-value</td>
<td>0.0797</td>
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<td>0.1097</td>
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<tr>
<td>Probability of dying per 1 000 live births under 5 years (under-5 mortality rate)</td>
<td>Coef.</td>
<td>P-value</td>
<td>Coef.</td>
</tr>
<tr>
<td>--------------------------------</td>
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<td>EPTEM</td>
<td>UDEN</td>
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<tr>
<td>Coef.</td>
<td>-0.4764</td>
<td>-0.4809</td>
<td>-0.3775</td>
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<th>Infant mortality rate (per 1 000 live births)</th>
<th>Coef.</th>
<th>P-value</th>
<th>Coef.</th>
<th>P-value</th>
<th>Coef.</th>
<th>P-value</th>
<th>Coef.</th>
<th>P-value</th>
<th>Coef.</th>
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<td>EPTEM</td>
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<td>LABLEQ</td>
<td>LABPOV</td>
<td>LABLEQ</td>
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<tr>
<td>Coef.</td>
<td>-0.6012</td>
<td>-0.5948</td>
<td>-0.4847</td>
<td>-0.6120</td>
<td>0.7184</td>
<td>-0.1668</td>
<td>0.7498</td>
<td>0.3302</td>
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<tr>
<td>Obs.</td>
<td>21</td>
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<table>
<thead>
<tr>
<th>Neonatal mortality rate (per 1 000 live births)</th>
<th>Coef.</th>
<th>P-value</th>
<th>Coef.</th>
<th>P-value</th>
<th>Coef.</th>
<th>P-value</th>
<th>Coef.</th>
<th>P-value</th>
<th>Coef.</th>
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<tr>
<td>Coef.</td>
<td>-0.4824</td>
<td>-0.4757</td>
<td>-0.3908</td>
<td>-0.4500</td>
<td>0.7411</td>
<td>-0.2172</td>
<td>0.6161</td>
<td>0.1890</td>
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<table>
<thead>
<tr>
<th>Maternal mortality ratio (per 100 000 live births)</th>
<th>Coef.</th>
<th>P-value</th>
<th>Coef.</th>
<th>P-value</th>
<th>Coef.</th>
<th>P-value</th>
<th>Coef.</th>
<th>P-value</th>
<th>Coef.</th>
<th>P-value</th>
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<td>LABPOV</td>
<td>LABLEQ</td>
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<tr>
<td>Coef.</td>
<td>0.1163</td>
<td>0.0368</td>
<td>0.1506</td>
<td>-0.2070</td>
<td>0.5474</td>
<td>-0.2263</td>
<td>0.7830</td>
<td>0.4549</td>
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<tr>
<td>Obs.</td>
<td>21</td>
<td>21</td>
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<table>
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<tr>
<th>Newborns with low birth weight (%)</th>
<th>Coef.</th>
<th>P-value</th>
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<th>P-value</th>
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<th>Coef.</th>
<th>P-value</th>
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<td>LABPOV</td>
<td>LABLEQ</td>
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<tr>
<td>Coef.</td>
<td>0.0346</td>
<td>-0.0212</td>
<td>0.0860</td>
<td>-0.7089</td>
<td>0.3780</td>
<td>-0.2035</td>
<td>0.4504</td>
<td>-0.1431</td>
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<tr>
<td>Obs.</td>
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<td>20</td>
<td>20</td>
<td>22</td>
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<table>
<thead>
<tr>
<th>Age-standardized mortality rate for Cardio-vascular diseases (per 100 000 population)</th>
<th>Coef.</th>
<th>P-value</th>
<th>Coef.</th>
<th>P-value</th>
<th>Coef.</th>
<th>P-value</th>
<th>Coef.</th>
<th>P-value</th>
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<td>LABPOV</td>
<td>LABLEQ</td>
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<tr>
<td>Coef.</td>
<td>0.1848</td>
<td>0.1598</td>
<td>0.1639</td>
<td>0.1991</td>
<td>0.1073</td>
<td>-0.0676</td>
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<td>Obs.</td>
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<table>
<thead>
<tr>
<th>Age-standardized mortality rate for Cancer (per 100 000 population)</th>
<th>Coef.</th>
<th>P-value</th>
<th>Coef.</th>
<th>P-value</th>
<th>Coef.</th>
<th>P-value</th>
<th>Coef.</th>
<th>P-value</th>
<th>Coef.</th>
<th>P-value</th>
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<td>UDEN</td>
<td>LABPOV</td>
<td>LABLEQ</td>
<td>LABPOV</td>
<td>LABLEQ</td>
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<tr>
<td>Coef.</td>
<td>-0.0580</td>
<td>-0.0576</td>
<td>-0.0479</td>
<td>0.0070</td>
<td>-0.1720</td>
<td>0.5584</td>
<td>0.2658</td>
<td>0.3244</td>
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<td>23</td>
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<table>
<thead>
<tr>
<th>Age-standardized mortality rate for Injuries (per 100 000 population)</th>
<th>Coef.</th>
<th>P-value</th>
<th>Coef.</th>
<th>P-value</th>
<th>Coef.</th>
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<td>LABLEQ</td>
<td>LABPOV</td>
<td>LABLEQ</td>
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<tr>
<td>Coef.</td>
<td>-0.0382</td>
<td>-0.2068</td>
<td>0.0941</td>
<td>0.1994</td>
<td>0.2365</td>
<td>0.1729</td>
<td>0.4882</td>
<td>0.2301</td>
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<td>Obs.</td>
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<table>
<thead>
<tr>
<th>Years of life lost to injuries (%)</th>
<th>Coef.</th>
<th>P-value</th>
<th>Coef.</th>
<th>P-value</th>
<th>Coef.</th>
<th>P-value</th>
<th>Coef.</th>
<th>P-value</th>
<th>Coef.</th>
<th>P-value</th>
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<td>EPTEM</td>
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<td>LABLEQ</td>
<td>LABPOV</td>
<td>LABLEQ</td>
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<td>Coef.</td>
<td>-0.2319</td>
<td>-0.3367</td>
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<td>0.0686</td>
<td>-0.1033</td>
<td>-0.1682</td>
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<td>21</td>
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<table>
<thead>
<tr>
<th>Years of life lost to communicable diseases (%)</th>
<th>Coef.</th>
<th>P-value</th>
<th>Coef.</th>
<th>P-value</th>
<th>Coef.</th>
<th>P-value</th>
<th>Coef.</th>
<th>P-value</th>
<th>Coef.</th>
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<td>LABPOV</td>
<td>LABLEQ</td>
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<tr>
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<td>0.1297</td>
<td>-0.1987</td>
<td>-0.3796</td>
<td>0.5949</td>
<td>-0.1654</td>
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<table>
<thead>
<tr>
<th>Years of life lost to non-communicable diseases (%)</th>
<th>Coef.</th>
<th>P-value</th>
<th>Coef.</th>
<th>P-value</th>
<th>Coef.</th>
<th>P-value</th>
<th>Coef.</th>
<th>P-value</th>
<th>Coef.</th>
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<td>LABPOV</td>
<td>LABLEQ</td>
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<tr>
<td>Coef.</td>
<td>0.2022</td>
<td>0.1658</td>
<td>0.1884</td>
<td>0.1387</td>
<td>0.5920</td>
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</table>

Bold: p-value<.1 for core countries and p-value<.05 for other countries, to account for the small sample size in core countries.
Figure A4. Scatterplots of male and female healthy life expectancy and labour market inequality factor score (labeq).

Labour market inequality factor score (labeq), standardized

- Females: Fitted values, female HALE vs. labpov
- Males: Fitted values, male HALE vs. labpov

Table: Core Semi-peripheral Peripheral Total

<table>
<thead>
<tr>
<th>Healthy life expectancy (years)</th>
<th>Core</th>
<th>Semi-peripheral</th>
<th>Peripheral</th>
<th>Total</th>
</tr>
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</tbody>
</table>
Country clusters

Table A5 shows the regional distribution of clusters. Core countries are Western and Southern European countries; semi-peripheral countries are mostly East Asian and East European countries, as well as Latin America, with a couple of African countries; peripheral countries are predominantly African and South East Asian countries, with some Caribbean countries.

Core countries

The cluster analysis of EPL indices for regular workers and temporary workers and the union density in core countries resulted in 4 different types of labour markets. We present these findings in Figure A5 with the x-axis representing union density and the y-axis representing the EPL indices. Of the two EPL indices, the smaller is that of temporary workers. Nordic countries (Sweden, Finland, Denmark, Norway), Belgium, and Italy constitute a cluster where both EPL scores are in the medium range and relatively similar to each other, but with significantly higher union density compared to the rest of the countries analyzed. France, Spain, Portugal, and Greece have the most protection for regular workers and comparatively low protection for temporary workers, with the difference being relatively large. These are countries with low to medium union density, but with high collective bargaining coverage (not shown in this graph). There is another layer of countries beneath these, with medium protection for both full time and temporary workers but with a large difference between these two classes of workers. This group includes South Korea, Poland, Hungary, Japan, Netherlands, Czech Rep., Slovak Rep., and Austria. The last group is comprised of liberal countries (the US, New Zealand, Australia, Canada, UK, Ireland) and Switzerland, with low protection for both regular and temporary workers and with small differences between the two.

We merged the second and the third groups together and created three clusters of labour markets [Table A5], which approximate the three worlds of welfare capitalism (Esping-Andersen, 1990). Among countries usually categorised as corporatist conservative, Belgium fell into the social democratic labour institution cluster and Switzerland into the liberal labour institution cluster in this analysis. Japan and Southern European countries (Portugal and Spain) were categorized into corporatist conservative labour institutions, whereas Italy was grouped with Nordic countries. Based on the widely-accepted typology, we named them social democratic labour institutions, corporatist conservative labor institutions, and liberal labour institutions, respectively. As observed from Figure A5, the social democratic labour institution cluster presents high average union density (62.28%) combined with medium EPL for both regular (2.05) and temporary (2.17) workers. Corporatist conservative labour institution countries show low union density (22.01%) with high EPL for both regular (2.83) and temporary (2.55) workers. Liberal labour institution countries on average show low union density (24.78%) with very low EPL for both regular (1.22) and temporary (0.63) workers.
Table A5. Country clusters by labour market characteristics and position in the World-System.

<table>
<thead>
<tr>
<th></th>
<th>More Equal</th>
<th>Labour Market</th>
<th>Less Equal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CORE</strong></td>
<td>Social Democratic Labour Institutions</td>
<td>Corporatist Conservative Labour Institutions</td>
<td>Liberal Labour Institutions</td>
</tr>
<tr>
<td></td>
<td>Belgium, Denmark, Finland, Italy, Norway, Sweden</td>
<td>Austria, Germany, France, Greece, Japan, Netherlands, Portugal, Spain</td>
<td>Australia, Canada, Ireland, New Zealand, Switzerland, United Kingdom, United States</td>
</tr>
<tr>
<td><strong>SEMI-PERIPHERY</strong></td>
<td>Residual Labour Institutions</td>
<td>Emerging Labour Institutions</td>
<td>Informal Labour Market</td>
</tr>
<tr>
<td></td>
<td>The Bahamas, Croatia, Czech Rep, Hong Kong, Hungary, Jamaica, South Korea, Latvia, Lithuania, Poland, Russia, Singapore, Slovak Rep, Slovenia, Thailand, Uruguay</td>
<td>Argentina, Brazil, Chile, Colombia, Costa Rica, Ecuador, Fiji, Kuwait, Malaysia, Mexico, Panama, Paraguay, Peru, South Africa, Trinidad and Tobago, Venezuela</td>
<td>Bahrain, Belize, Botswana, El Salvador, Lebanon, Oman, Saudi Arabia, Tunisia, Turkey</td>
</tr>
<tr>
<td><strong>PERIPHERY</strong></td>
<td>Post-Communist Labour Market</td>
<td>Less Successful Informal Labour Market</td>
<td>Insecure Labour Market</td>
</tr>
</tbody>
</table>

Figure A5. Mean EPL for regular workers and temporary workers vs. mean union density, OECD countries.
**Semi-peripheral countries**

Cluster analyses of labour market inequality and poverty factor scores resulted in 3 clusters each in semi-peripheral and peripheral countries (Table A5). The first cluster of semi-peripheral countries consists of mostly East Asian countries and Eastern European countries. Both of these regions are marked by an emphasis on industrialisation and thus incorporation of rural workers into urban industrial centers (Cook, 2007; Haggard & Kaufman, 2008). Massive growth in urban working populations has necessitated the development of labour contracts, but these are not as strongly regulated as in core countries. The relationship between the workers, companies and governments was often partially democratic and embedded in labour institutions, but at the same time was more authoritarian than in core countries. For this reason we named this cluster the “marginal labour institutions” cluster.

The second cluster includes mostly middle income (Argentina, Chile, Mexico) and more stable (Costa Rica) Latin American countries, South Africa and Kuwait. These countries underwent limited industrialization with stagnated economic development and hence did not incorporate as many rural populations as in the first cluster (Cook, 2007; Haggard & Kaufman, 2008). Nevertheless, the jobs available in urban centers attracted immigrants from rural areas and adjacent countries into cities, producing massive urban slums and large informal sectors. Therefore we call this cluster the “emerging labour institutions” cluster.

The last cluster of semi-peripheral countries includes countries where industrialisation has lagged due to civil wars and other crises, with the majority of their national income deriving from oil exports, with a tendency towards authoritarian governments. Labour markets in these countries are largely composed of informal sectors, and thus informal contracts. Therefore, we named them the “informal labour market” cluster. We used the term “labour market” instead of “labour institution” to signify the informal nature of labour contracts in these countries.

**Peripheral countries**

The first cluster of peripheral countries consists of mostly former communist countries. This makes them similar to the semi-peripheral countries. The developmentalist and universalistic tendencies (Cook, 2007; Rosenstein Rodan, 1943) of the ex-communist countries have enabled them to distinguish themselves from the rest of the peripheral region through industrialisation and relatively less poverty.

The third cluster of peripheral countries is composed of the world’s poorest countries. This cluster is marked by a significantly higher labpov score when compared to the rest of the peripheral region. These countries suffer from long term wars, natural disasters and epidemics, to the extent that the nation-state cannot function. We named this the “insecure labour market” cluster.

As a result, the second cluster of peripheral countries included relatively diverse countries in the peripheral region that are not as homogenous as the post-communist labour market, but also not as devastated as the insecure labour market type. We named this cluster “less successful informal labour market”, following the informal labour market label used in semi-peripheral countries.
Labour market institutions and health outcomes

In Figure A6, we present box plots of population health indicators by labour market clusters. More egalitarian labour market clusters tend to exhibit better health outcomes compared to their counterparts in the same position in the World System. The outstanding exception is potential years of life lost due to non-communicable diseases (Table A6), which shows a positive relationship with labour market equality, i.e., more labour market equality results in more potential years of life lost due to communicable diseases.

Bivariate association of percentage of GNP from informal sector

Results from this analysis are shown in Table A6. The variable %Gnp from informal sector is highly significantly correlated with all variables used to construct the labpov factor score.

To summarise, our analyses of the relationship between labour market indicators and health revealed that labour market flexibility correlates significantly with maternal and child health (MCH) indicators; union density was significantly correlated with low birthweight rate in addition to the MCH indicators that were associated with EPL-indices. Poverty in the labour market ("labpov") correlated significantly with most health outcomes in both semi-peripheral and peripheral countries; and inequality in the labour market "labeq" (gender inequities and employment-population ratio) correlated significantly with most health outcomes only in peripheral countries.

Regarding the analyses of labour market clusters, our core country clusters of labour markets parallel the welfare state regime types. In core countries, we supplemented EPL-indices (a proxy for flexibility) with union density (a proxy for security) to better characterise the labour market types. In semi-peripheral country clusters, the level of industrialisation is the most powerful determining factor of population health. In peripheral countries, the determining factor is the stability of the nation-state rather than labour institutions.

Table A6. Correlation of the size of informal economy with labour market indicators and factor scores

<table>
<thead>
<tr>
<th></th>
<th>GNP GENERATED FROM INFORMAL ECONOMY, % OF TOTAL GNP (IGENP)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ZERO-ORDER CORRELATION COEFFICIENT</td>
</tr>
<tr>
<td>stlabeq (standardised)</td>
<td>-0.0026</td>
</tr>
<tr>
<td>incr1999</td>
<td>0.0126</td>
</tr>
<tr>
<td>incr2003</td>
<td>-0.0678</td>
</tr>
<tr>
<td>lfpr1997</td>
<td>0.0152</td>
</tr>
<tr>
<td>lfpr2003</td>
<td>-0.0217</td>
</tr>
<tr>
<td>epr1997</td>
<td>0.1080</td>
</tr>
<tr>
<td>epr2003</td>
<td>0.0620</td>
</tr>
<tr>
<td>stlabpov (standardised)</td>
<td>0.6086</td>
</tr>
<tr>
<td>chldl1997</td>
<td>0.3692</td>
</tr>
<tr>
<td>chldl2003</td>
<td>0.3620</td>
</tr>
<tr>
<td>wrkpr1997</td>
<td>0.4249</td>
</tr>
<tr>
<td>wrkpr2003</td>
<td>0.4363</td>
</tr>
<tr>
<td>aveinc1999</td>
<td>-0.6935</td>
</tr>
<tr>
<td>aveinc2003</td>
<td>-0.6916</td>
</tr>
</tbody>
</table>
Figure A6. Health indicators by country clusters and labour market characteristics.

a. Male and female healthy life expectancy (HALE)

b. Maternal and child health indicators
c. Male and female adult mortality rate

<table>
<thead>
<tr>
<th>Region</th>
<th>Core</th>
<th>Semi-peripheral</th>
<th>Peripheral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Females</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Core: Social democratic, Corporatist, Liberal
- Semi-peripheral: Residual, Emerging, Informal, Post-Communist, Less Successful, Informal
- Peripheral: Insecure

d. Years of life lost due to communicable and non-communicable diseases

<table>
<thead>
<tr>
<th>Region</th>
<th>Core</th>
<th>Semi-peripheral</th>
<th>Peripheral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communicable</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-communicable</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Core: Social democratic, Corporatist, Liberal
- Semi-peripheral: Residual, Emerging, Informal, Post-Communist, Less Successful, Informal
- Peripheral: Insecure

Legend:
- Blue: years of life lost to communicable diseases (%)
- Red: years of life lost to non-communicable diseases (%)
1. INTRODUCTION

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Full-time permanent employment

Unemployment

Precarious employment

Informal employment

Child labour

Slavery and bonded labour

Social class
Employment, work, and health inequalities - a global perspective


Gender


Age


**Ethnicity**


**Migrant status**


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3.1. METHODS AND STRATEGIES


4. THEORETICAL MODEL


4.1. MACRO STRUCTURAL FRAMEWORK


Employment, work, and health inequalities - a global perspective


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5.1. WEALTHY COUNTRIES


6. LABOUR MARKETS AND WELFARE STATES: A COUNTRY PERSPECTIVE

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6.2. SELECTED COUNTRY CASE STUDIES

Sweden


Germany


Spain


Bundesregierung der Bundesrepublik Deutschland. (2005). Lebenslagen in Deutschland-der zweite armut-und reichtumsbericht der bundesregierung (p. 6; p. 18; pp. 19-20; p. 31; p. 37).
artizipation.pdf

Spain


Canada


United States


EMPLOYMENT, WORK, AND HEALTH INEQUALITIES - A GLOBAL PERSPECTIVE


South Korea


Russia


Argentina


Brazil


Chile

**Employment, work, and health inequalities - A global perspective**

**Venezuela**


**El Salvador**


**Turkey**


**Bolivia**


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India


Nigeria


Sri Lanka


Ethiopia


**Haiti**


**Cuba**


7. EMPLOYMENT RELATIONS AND HEALTH INEQUALITIES: A CONCEPTUAL AND EMPIRICAL OVERVIEW

7.1. Power relations


7.2. Labour regulations and labour market


7.3. Employment conditions

Full-time permanent employment


**Unemployment**


Gilmore, A. B., McKee, M., & Rose, R. [2002]. Determinants of and inequalities in self perceived health in Ukraine. *Social Science and Medicine, 55*(12), 2177-2188.


**Informal employment**


Employment, work, and health inequalities - a global perspective


Child labour


Slavery and bonded labour


7.4. Working conditions


Employment, work, and health inequalities - A global perspective


Occupational injuries


Work-related hazards and outcomes


Workplace Psychosocial stressors


8. Employment Conditions and Health Inequalities: Pathways and Mechanisms

8.1. Macro-sociological employment relations and the health of nations: Empirical evidence


8.2. Employment conditions

Full-time permanent employment


Unemployment


Roberts, H., Pearson, J. C., Madeley, R. J., Hanford, S., & Magowan, R. Unemployment and health: The quality of social support


**Precarious employment**


Employment, work, and health inequalities - A global perspective


Informal employment


REFERENCES


Child labour


8.3. Working conditions

Working conditions and health, pathways and mechanisms


Material working conditions


**Psychosocial working conditions**


EMPLOYMENT, WORK, AND HEALTH INEQUALITIES - A GLOBAL PERSPECTIVE


Pathways between working conditions and socio-economic health inequalities


Differential exposure to adverse working conditions


Borg, V., & Kristensen, T. S. (2000). Social class and self-rated health: Can the gradient be explained by differences in life style or work environment? Social Science and Medicine, 51(7), 1019-1030.


Sarkar, A., Muntaner, C., Chung, H., & Benach, J. (2009). The Employment Conditions Network final report is a political,
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Anti-neoliberal and welfare state move. Indian Journal of Medical Research, 130(1), 93-94.


Effect modifiers of the health effects of adverse working conditions


**Employment conditions and working conditions**


Gaps in knowledge

9. POLICIES AND INTERVENTIONS

9.1. The need for a political perspective


Navarro, V. (2007). Neoliberalism as a class ideology; or, the political causes of the growth of inequalities. International Journal of Health Services, 37(1), 47-62.


9.2. Macro policies and health: an historical perspective


9.3. Employment-related international policies and actors


Nossar, I. (2007). The scope for appropriate cross-jurisdictional regulation of international contract networks [such as supply chains]. Presented at ILO/International Meeting of Labour Inspectors, April 17, Toronto, Ontario, Canada.


### 9.4. Employment-related policy entry points to reduce health inequalities


### Power relations [changing power relations between political and economic actors in society]


Employment, work, and health inequalities - a global perspective


**Employment conditions (modification of employment conditions to reduce exposures and vulnerability to health-damaging factors)**


**Working conditions (relates to different types of actions to modify working conditions themselves, health-related material hazards in the workplace, behaviour changes, and psychosocial factors)**


**Ill-health (reducing the unequal social consequences produced by physical and mental illness)**

9.5. A typology of interventions on employment dimensions

Unemployment


Precarious employment


Informal employment


EMPLOYMENT, WORK, AND HEALTH INEQUALITIES - A GLOBAL PERSPECTIVE

Nunes, C., & Theodoro, M. Work and health in the informal sector: Domestic work and street commerce. OSH and Development, 8, 61-70.


Child labour


Slavery and bonded labour


9.6. Assessing the effectiveness of policies / challenges / developments


10. EPILOGUE: THE ECONOMIC CRISIS


Ogilvie, F. (2009, March 9). Shipping pollution more than a drop in the ocean. ABC News.


Quinlan, M., & Bohle, P. (2008). Under pressure, out of control or home alone? Reviewing research and policy debates on the OHS effects of outsourcing and home-
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**ACRONYMS AND ABBREVIATIONS**

AIDS - Acquired Immunodeficiency Syndrome  
BMI - Body Mass Index  
CSR - Corporate Social Responsibility  
CSDH - Commission on Social Determinants of Health  
EPZ - Export Processing Zone  
EU - European Union  
KILM - Key Indicators of the Labour Market  
DALYs - Disability Adjusted Life Years  
GATS - General Agreement on Trade in Services  
DC - Demand-Control  
ECA - Epidemiologic Catchment Area  
ECLAC - Economic Commission for Latin America and the Caribbean  
EMCONET - Employment Conditions Network  
EPL - Employment Protection Legislation  
ERI - Effort-Reward Imbalance  
Eurofound - European Foundation for the Improvement of Living and Working Conditions  
EUROSTAT - Statistical Office of the European Communities  
FAO - Food and Agriculture Organization  
GCIM - Global Commission on International Migration  
HALE - Healthy-adjusted Life Expectancy  
HIV - Human Immunodeficiency Virus  
GDP - Gross Domestic Product  
ICFTU - International Confederation of Free Trade Unions  
ICSE - International Classification of Status in Employment  
ILO - International Labour Organization  
IMF - International Monetary Fund  
IOM - International Organization for Migration  
IPEC - International Programme on the Elimination of Child Labour  
NAFTA - North America Free Trade Agreement  
NGO - Non-Governmental Organization  
OCDE - Organization for Economic Cooperation and Development  
OPEC - Organization of the Petroleum Exporting Countries  
REACH - Registration, Evaluation and Authorisation of Chemicals  
SEP - Socio-economic Position  
SME - Small and Medium Enterprise  
UN - United Nations  
UNDESA - United Nations Department of Economic and Social Affairs  
UNDP - United Nations Development Programme  
UNICEF - United Nations Children’s Fund  
UNRISD - United Nations Research Institute for Social Development  
WB - World Bank  
WHO - World Health Organization  
WTO - World Trade Organization
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Over the last two decades, research in public health and occupational health has gradually broadened its field of study to cover employment conditions and their relationship with health, and more recently with inequalities.

However, the studies conducted have hardly analysed the situations of low and middle income countries, the causes of inequalities, or the policies which help to improve health and reduce inequalities, among other topics. This book, the origin of which was the report produced in 2007 by the Employment Conditions Network (EMCONET) as part of work for the World Health Organisation Commission on the Social Determinants of Health, provides a broad view of how employment conditions affect inequalities in health among workers all over the world. This study presents a conceptual framework which helps in understanding the causes and consequences of employment conditions on health and quality of life in widely differing economic and political contexts, presents a classification of countries in terms of their labour market, describes very diverse labour market situations and the health problems of workers through an extensive number of ‘case studies’ and, among many other topics, analyses the current economic crisis, identifying the institutional and political changes necessary to reduce inequalities in health.

This book is intended for specialists in public health, health inequalities, and occupational health, as well as researchers in political and social sciences, and activists and members of unions and social movements, and in general, for those interested readers without specialised prior knowledge of these topics.