How Politics Makes Us Sick

Neoliberal Epidemics

Ted Schrecker and Clare Bambra
Durham University, UK

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Insecurity: How Politics Gets Under Our Skin

In this chapter we focus on the neoliberal epidemic of insecurity. Here we argue that neoliberalism has made the labour market and the world of work far less secure and consequently more stressful and health damaging. This insecurity manifests itself through reductions in workplace rights, job security, pay levels and welfare rights (so-called flexibility). We argue that this has led to large increases in chronic stress across the populations of many countries (and particularly in the most vulnerable groups), resulting in a myriad of chronic diseases, including musculoskeletal pain and cardiovascular disease. International comparisons are made with countries that have taken a less neoliberal political path.

Neoliberalism and the rise of insecurity

On the morning of 25 August 2014 a young New Jersey woman, Maria Fernandes, died from inhaling gasoline fumes as she slept in her 13-year-old car. She often slept in the car while shuttling between her three low-wage jobs in food service, and kept a can of gasoline in the car because she often slept with the engine running, and was worried about running out of gasoline. Apparently, the can accidentally tipped over and the vapours from spilled gasoline cost her life (Swarns, 2014). Ms Fernandes' death can also be attributed to transformations in labour markets that have been a key feature of neoliberalism over the past few decades – indeed, at least until the financial crisis of 2008, its most visible and dramatic manifestation in the high-income world. For increasing numbers of people in many countries, especially those that have travelled farthest down the neoliberal path, the transformation has turned the idea of a job that provides adequate income and security into an unattainable dream (Goos and Manning, 2007; Kalleberg, 2011).

The connections between labour market transformations and poor health operate through multiple pathways, of which the one exemplified by Ms Fernandes' death is only the most dramatic. The two most extensive reviews of scientific evidence on how new forms of work organization worldwide have affected health found a clear link between 'precarious' or 'downsized' employment and work-related illness and injury (Quinlan et al., 2001; Quinlan and Bohle, 2009). Around the turn of the millennium, journalists Barbara Ehrenreich and Polly Toynbee 'went undercover' in the US and the UK, respectively, to explore the day-to-day realities of the expanded low-wage, insecure service sector labour market that was and is a key element of those transformations (Ehrenreich, 2001; Toynbee, 2003). They described the physically demanding nature of the work and associated exposures to low-grade workplace hazards; the constant struggle to find affordable housing and the frequent unaffordability of a healthy diet, complicated by the time-consuming logistics of being poor (especially in the US context of non-existent public transport); and the particular demands of combining all these with child care and (again in the US context) lack of health insurance. Their work is a powerful reminder of how neoliberalism operates through labour markets to undermine health not only by way of the material consequences of unemployment or inadequate employment, as important and neglected as these are, but also through chronic exposure to stress that 'gets under your skin' by way of multiple biological mechanisms. These are sometimes described as psychosocial, but the appropriateness of this term can be questioned, since the relevant physiology is relatively well understood, and the implication that the issues are 'in people's heads' is thoroughly misleading.

In this chapter we first describe in greater detail the politics of labour market transformations in the two countries that are our focus, and then outline the scientific evidence base for the connection of labour market insecurity, stress and health. We conclude with a comparative focus on health, insecurity and social policy.

How political choices have led to an epidemic of insecurity

The transformation of labour markets that led to the exposures we have described began in the 1970s. Corporate managers began to shift labour-intensive production in some industries, such as semiconductors and garment manufacturing, to lower-wage locations in low- and middle-income countries (LMICs). Often, these were export processing zones (EPZs) established by the governments of those countries specifically

to attract foreign investment with the lure of tax breaks, no tariffs on imports of raw materials for export production, extremely low wages, 'flexible' employment relations, and little or no regulation of working conditions (Fröbel et al., 1980; Ross, 1997). Technological innovation underpinned this global reorganization of production (Marchak, 1991); think not only about advances in information and communications technology but also about such developments as the containerization of shipping. Reorganization was later accelerated by the incorporation of India, China and the economies of the former Soviet bloc into global trade and investment flows, which roughly doubled the size of the world's labour force (Freeman, 2007) – itself the outcome of a complex set of political choices. Statistically, the earliest and most conspicuous result was a dramatic decline in the importance of manufacturing employment throughout the high-income world, which a recent analysis finds to be an important contributor to overall increases in levels of unemployment (Kollmeyer and Pichler, 2013). As an indication of the extent of geographic shifts in the location of production and their connection with employment and income, by 2008 there were more than twice as many manufacturing workers in China (99 million) as in all the G7 countries combined, but the workers in those factories were earning US$1.36 an hour on average – approximately 4 per cent of hourly compensation costs in US manufacturing and 3 per cent of those in the Euro area (Banister and Cook, 2011).

Manufacturing employment is important in at least four other respects. First, national statistics on the decline of manufacturing employment fail to capture the far more serious localized impacts of such 'deindustrialization' (Bluestone and Harrison, 1982). Some cities in the US that had historically relied on manufacturing lost more than half of their total employment base within a relatively short period (Schrecker et al., 2012). The city of Detroit, once the centre of the North American auto industry, exemplifies the consequences, with its municipal government bankrupt and a population smaller than in 1910 and less than half its size in 1970 (Davey, 2013; Uberti, 2014). Many regions in the UK that had formerly been prosperous crucibles of industrialization, including the North East where we live and work, suffered comparable declines (see e.g. Beynon et al., 1994; the deindustrialization of the North is discussed again in Chapter 5). Even in London, as recently as 1961 a third of workers were employed in manufacturing (Wills et al., 2010, p. 32); today that number is minuscule. Second, many of the jobs in question had historically been accessible to those with limited formal qualifications – leading researchers who should know better

to characterize them, inaccurately, as 'unskilled' (Nickell and Bell, 1995). These jobs provided important access to adequate incomes for many people who now have no comparable options. Third, manufacturing workplaces were, and in some jurisdictions still are, highly unionized – making them at the same time a bastion and a target. Fourth, in contrast to the organization of work around mass production, it can be argued that the service sector – which has expanded rapidly throughout the high-income world – involves inherent tendencies to a wider dispersion of earnings, and is more amenable to the informalization of work and the growth of low-wage, precarious employment (Sassen, 2002).

On this point, not only the kinds of jobs but also the ways they are organized have changed considerably over the past few decades, with a decline in the number of standard full-time, permanent jobs and a sharp increase in flexible or precarious employment: more and more people are working on either temporary contracts or no contracts, with limited or no employment or welfare rights. In this new economy, skills, working hours, contracts, conditions, pay and location are all more flexible and precarious. The once standard full-time, permanent contract with benefits has been superseded by a number of atypical forms of employment which tend to be characterized by lower levels of security and poorer working conditions (Benach et al., 2002). Rather than being a transitory stage in an individual's employment history, atypical forms of labour are becoming the norm for many workers in the labour force of advanced capitalist economies (Virtanen et al., 2002). In an important ethnographic study of Teesside, a formerly prosperous Northern manufacturing region that is now among the most deprived in England, Shildrick et al. (2012b, p. 59) observed: 'Moving in and out of jobs, and above and below the poverty line, over a working life is... now the normal experience for many working-class people.' This 'low-pay, no-pay cycle' is not an idiosyncratically chosen example, but, rather, an instance of an international trend that economist Guy Standing, who worked for more than 25 years at the International Labour Organization, has described as the emergence of a new stratum of workers he calls the precariat (Standing, 2014). An alternative description refers to 'the swelling ranks of the employed but exposed' (Clark and Heath, 2014, pp. 80–88). The expansion of the precariat is exemplified by what are called zero-hours contracts in the UK, under which workers have no set hours of work and are not guaranteed even minimum hours from week to week.

Such contracts also reduce entitlements to certain out-of-work benefits, and to pensions. In 2014, 1.4 million workers in the UK were on

such contracts (Seymour, 2014). These contracts are extensively used by large multinational companies such as Amazon, which have also been criticized for paying very little UK cooperation tax (BBC News, 2013). Across the European Union, temporary, insecure work accounted for an average of around 15 per cent of paid employment (an average of 16.4 per cent in the EU-15 countries and an average of 14 per cent in the EU-27 countries) before the impact of the financial crisis (Massarelli, 2009). This amounts to 19.1 million full-time temporary workers. Directly comparable data for the US are hard to find, but the number of involuntary part-time workers (those who want full-time work but cannot find it) rose from 5.7 million in 2000 to 8.9 million in 2010 (Mishel et al., 2012, p. 350), and the number of people employed through temporary help agencies doubled (to 2.7 million) between 1993 and 2013 (Clark and Heath, 2014, p. 85). Temporary work is considerably more prevalent among women than men, and among the young and immigrant populations. The gains to employers from such job insecurity include lower wages and lower associated costs such as pensions or sickness benefits: or, put more simply, higher profits. However, these benefits to employers are accompanied by adverse consequences for workers, with precarious employment characterized by low incomes, long and unpredictable hours, and (for many women) the ongoing challenge of combining work and child care (see e.g. Heymann, 2006; Ruan and Reichman, 2014). Another consequence with important implications for public policy is that most workers on involuntary part-time jobs, or on zero-hours contracts, are still counted as 'employed' for statistical purposes, thus understating the effects of neoliberalism on employment.

Although the decline of manufacturing has been evident throughout the high-income world, other transformations of labour markets have unfolded unevenly. In the two countries with which we are most concerned, the UK and the US, it is especially important to see such patterns as deindustrialization and the expansion of the precariat as the outcome of conscious decisions to pursue neoliberal agendas, as they are accompanied by the abandonment of the pursuit of full employment – once a pillar of political and economic policy, especially in the UK until 1979 (Bambra, 2011).

The monetarist pursuit of low inflation by the Thatcher and Reagan governments accepted high unemployment and its social consequences as collateral damage. Norman Lamont, the Conservative UK chancellor of the exchequer (finance minister) stated in 1991 that 'rising unemployment and the recession have been the price that we have had to pay to get inflation down. That price is well worth paying' (House of Commons, 1991). This was echoed in 1998 by Eddie George, then governor of the Bank of England, who stated that 'northern unemployment is an acceptable price to pay for curbing southern inflation' (BBC News, 1998). In Chapter 5, we examine some of the consequences of this spatially uneven distribution of the collateral damage from neoliberalization. Testifying before Congress in 1997, US Federal Reserve head Alan Greenspan commented that

> Atypical restraint on compensation increases has been evident for a few years now and appears to be mainly the consequence of greater worker insecurity, possibly owing to the rapid evolution of technologies in use in the workplace. Technological change almost surely has been an important impetus behind corporate restructuring and downsizing. Also, it contributes to the concern of workers that their job skills may become inadequate.
>
> (US House of Representatives, 1997, p. 28)

It is important to emphasize that he saw this level of insecurity as a good thing.

Labour market policies in both the US and the UK post-1979 involved attacks on the trade unions and labour standards that historically have been the main protectors of wage levels and working conditions. In the UK, legal changes initiated by the Thatcher government drastically reduced the ability of unions to organize and bargain collectively (Brown et al., 1997). The militarized response to the miners' strike was the most visible element of this strategy (Milne, 2004), but it was paralleled by a wave of privatizations that had the effect of further reducing union power (see Figure 3.1), increasing the exposure of British manufacturing to international competition. Meanwhile, the Thatcher government and all subsequent governments emphasized the financial services industry as the basis for economic growth strategies. The result was a massive shift of corporate investment offshore. Geographer Ray Hudson notes that 'Between 1979 and 1986 the UK's 40 largest manufacturing firms increased their non-UK employment by 125,000 while cutting employment in the UK by 415,000' (Hudson, 2013, p. 378). By the 1990s the newly de-unionized environment, in which average hourly manufacturing compensation was 22 Deutschmarks as against 44 in Germany and 36 in Japan, was increasingly attractive to foreign investors (Stevenson, 1995), but even the *Wall Street Journal* conceded that the new jobs were poorly paid, and emphasized

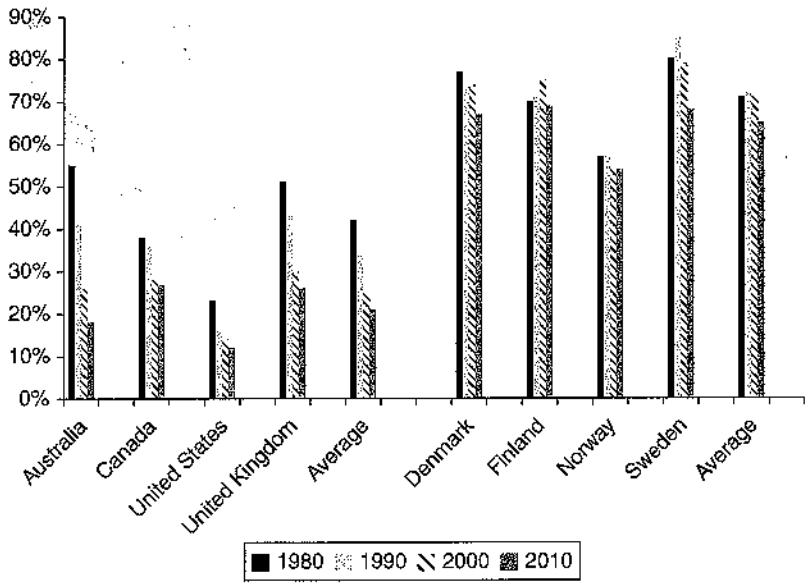

Figure 3.1 Trends in trade union density as a percentage of paid workforce, 1980–2010, in selected liberal and social democratic countries
Source: OECD (2014), http://stats.oecd.org/Index.aspx?DataSetCode=UN_DEN and Visser, J. (1990) 'Key Issues for Labour Market and Social Policies: Trends in Trade Union Membership', in OECD *Employment Outlook* (Paris: OECD), http://www.oecd.org/els/emp/4358365.pdf (accessed 20 November 2014).

the importance of 'more flexible' labour relations in attracting investment (Milbank, 1994). Famously, Labour prime minister Tony Blair campaigned on a promise to 'leave British law the most restrictive on trade unions in the Western world' (quoted in Howell, 2005, p. 176).

In the US, the Reagan government's firing of striking air traffic controllers in 1981 is sometimes seen as a watershed, but the nature of US political institutions – and the extent of state-level variation in industrial relations regimes – meant that the neoliberal transformation of labour markets unfolded more slowly and unevenly. As long ago as the 1970s, so-called right-to-work laws, which prohibit the closed shop[5] and impose various other restrictions on worker organization (Collins, 2012), had drawn the attention of Japanese investors:

> Southern wages were noticeably lower than the national average, and unions were rare.... All southern states except Kentucky had right-to-work laws on the books. Compared to the loaded packages commonly provided to the Japanese workforce, the bare-bones expectations of nonunion American labor regarding fringe benefits meant significant savings for prospective Japanese employers.
>
> (Guthrie-Shimizu, 2005, pp. 143–144)

Both domestic and foreign investment shifted to the right-to-work south east, in part as a response to Reagan-era federal defence procurement decisions (Markusen et al., 1991). Meanwhile, the real (inflation-adjusted) value of the federal minimum wage declined from US$8.38 (in 2011 dollars) in 1979 to a low point of $5.87 in 1989, and after increases in 2007 and 2008 was still only $7.25, actually below its level as long ago as 1967, and the number of workers covered by higher state minimum wages declined (Mishel et al., 2012, pp. 279–286). More recently, in what can fairly be characterized as a race to the bottom, two northern states, Michigan and Indiana, have adopted southern-style right-to-work laws in efforts to attract direct investment. Meanwhile, localized anti-union efforts by employers proliferated in a permissive legal environment (Milkman, 2008; Kalleberg, 2011, pp. 31–34). The decline of union membership in the US private sector has been precipitous, from almost 25 per cent among private sector workers in 1973 – already low in comparison with other high-income countries – to 13 or 14 per cent, depending on the source, in 2009. This was, in fact, a manifestation of a general trend – '[in] the nineteen non-Scandinavian [high-income] countries, trade union density between 1970 and 2007 declined from just under 40 percent to 23 percent' (Scharpf, 2013, p. 179), but the impact on incomes and employment relations was far less severe in jurisdictions that (for example) extend coverage of collective agreements even to non-union workers or offer strong minimum wage protections... and, in the Scandinavian countries, union density and collective bargaining coverage remained high (Figure 3.1).

A further element of the policy landscape, especially in the US but with important spillover effects because of the size of the country's economy and the reach of its transnational corporations, involved changes in capital markets and corporate decision-making that arose from the combination of recession (at the end of the 1970s) and the growing market power of institutional investors (pension funds, mutual funds and more recently hedge funds) concerned almost entirely with short-term increases in share prices (Useem, 1996; Madrick, 2012). Indicative of the impact on economic priorities is the cover of a 2003 issue of *Fortune* magazine that showed pictures of the chief executives of four major US firms; an accompanying article cheered: 'The four companies

whose CEOs are on the cover of this magazine have shed upwards of 250,000 jobs under their present leaders while creating $104 billion of new wealth' (Sherman, 1993). The author meant shareholder wealth, of course; the workers whose wealth had been diminished by the job cuts were conveniently forgotten. News headlines during the 1990s routinely announced cuts of thousands of jobs by corporations that were already profitable, but seeking to boost their attractiveness to investors; between 1992 and 1995, just ten US firms had cut almost half a million jobs (Kirk, 1995). Terms like downsizing, outsourcing (contracting out parts of the production process) and more recently offshoring became part of the everyday vocabulary (Uchitelle et al., 1996; Milberg, 2004; Grossman and Rossi-Hansberg, 2006); so did downward mobility (Newman, 1988). Although jobs were being created at the same time, they were hardly replacements but, rather, low-wage and precarious jobs in the service sector – the kinds of jobs that Ehrenreich and Toynbee were able to find, and the kind that now sustain an expanding proportion of the population in the countries they investigated, and in others.

The trends described are not inevitable, and reflect (among other influences) national, politically chosen differences in labour market policy. A major comparative study of Denmark, France, Germany, the Netherlands, the UK and the US (Gautié and Schmitt, 2010) found that in the mid-2000s low-wage work, defined as work that paid less than two-thirds the gross hourly median wage, was three times as common in the US as in Denmark, and twice as common as in France. Movement towards the US norm was clearly evident over the 1980–2005 period in some countries, such as the UK and post-reunification Germany, but not in others, although the countries in question had 'all been exposed over the last several decades to the same increases in globalization, technology, and competition within national product markets' (Appelbaum et al., 2010, p. 5). As in other studies, there was a clear and unsurprising correlation with rates of unionization and collective bargaining coverage, with 82 per cent of Dutch and Danish workers covered by collective agreements, as against the US figure of 14 per cent (Bosch et al., 2010).

The labour market transformations we have described are best thought of as an element of what political scientist Jacob Hacker (2008), writing in the US context, has described as 'the great risk shift': a process in which labour market transformations and welfare state retrenchment combine both to increase economic uncertainty and to shift responsibility for dealing with it from employers (via secure employment and funded pensions) and governments (via social safety nets like unemployment compensation) to individuals and households.

As one illustration, the chance that working-age Americans would experience a drop of 50 per cent or more in income from one year to the next more than doubled between the early 1970s and the end of the century (Hacker, 2008, p. 31). For Hacker, other indications included rising personal bankruptcy and mortgage foreclosure rates; insecurity in retirement, as defined-benefit pensions were replaced by defined-contribution plans, sometimes (as in the infamous case of Enron employees) invested in high-risk assets; and insecurity in illness, as the market-driven US health care industry systematically failed those who needed it most. On the other hand, literally trillions of dollars were mobilized in short order to bail out financial institutions that had been permitted to become too big to fail. From our political economy perspective, the great risk shift is a defining characteristic of neoliberalism, as it redistributes income and wealth upward in society while redistributing risk downward – privatizing it (Hacker, 2004) to be dealt with by individuals and households. We describe two further dimensions of this process in the remainder of the chapter. First, we expand on the argument that the great risk shift can be hazardous to your health, in ways that go beyond access to health care and the material deprivations of inadequate income. Second, we provide some cross-national comparisons of how those hazards differ across welfare regimes in the high-income world.

How neoliberalism gets under our skin

These new forms of labour market structure and work organization affect our health in various ways, partly through their direct material consequences on income levels and volatility but also, and relatedly, by increasing levels of chronic stress within the population. Stress gets under your skin in multiple ways that affect health. At a biological level, exposure to stress stimulates both the sympathetic–adrenomedullary and the hypothalamic–pituitary–adrenocortical systems (Bartley, 2004). Brunner (1997) uses the 'fight or flight' evolutionary response to stress to explain the biological mechanisms underpinning the body's reactions to psychosocial stressors. When the body perceives stress, in the form of an adverse environmental trigger, the sympathetic–adrenomedullary pathway is stimulated with the rapid release of adrenaline and noradrenaline. These neurotransmitters orchestrate a cascade of physiological events including, among other changes, increases in blood pressure, heart rate and the release of energy resources (Brunner, 1997). Originally this response would have been adaptive in that it would have enabled

the individual to retreat from the stressor or to fight back. In society today, however, such 'fight or flight' responses may not be possible (e.g. if the stressor is poor relations at work or stigmatization of your social group by the media), so the response ends up being suppressed. In addition, the hypothalamic–pituitary–adrenocortical system is stimulated. In simple terms, this results in the release of cortisol, a glucocorticoid hormone, which has multiple physiological effects, including the release of energy resources, suppression of the immune system and direct effects on mood (Brunner, 1997). The process of cortisol secretion involves communication between the hypothalamus and the pituitary gland (both located in the lower central part of the brain) to cause the release of adrenocorticotropic hormone in response to a stress stimulus. Adrenocorticotropic hormone subsequently induces the production and release of cortisol from the adrenal cortex (of the adrenal glands) into the blood (Bartley, 2004).

Brunner (1997) explains that activation of both the sympathetic–adrenomedullary and the hypothalamic–pituitary–adrenocortical systems is likely to be socially patterned, with differences in the magnitude and length of responses being related to individual coping resources and differential exposures to adverse environmental factors. The prolonged activation of the autonomic nervous system and neuroendocrine systems ('stress') is likely to result in reduced biological resilience over time, with measurable health consequences. The most widely used indicator of the physiological effects is allostatic load, 'the wear and tear that results' from that prolonged activation (McEwen, 1998). Allostatic load can be measured using various indicators that are commonly gathered in population health surveys and longitudinal epidemiological studies to generate allostatic load scores that have been found to predict increased risk for cardiovascular disease, among other adverse outcomes (McEwen and Seeman, 2009), and research in both human beings and primate populations continues to expand understandings of the consequences of stress and its relation to socioeconomic position or, in non-human species, position in social hierarchies (McEwen, 2012; Marmot and Sapolsky, 2014). In two especially striking studies described in more detail in Chapter 5, allostatic load scores were used to assess the biological 'weathering' effects associated with subordinate racial and gender status. In addition to the direct effects of stress, via biological responses to stress triggers, the effects of stress on health operate indirectly through changes to health-related behaviours, such as modifications to smoking patterns, alcohol consumption, dietary intake or participation in physical activity (Martikainen et al., 2004). We are cautious about placing too much emphasis on this pathway as it applies to entire national populations, because it can be difficult to identify the component of such changes that represents a behavioural response to stress that is independent of material constraints.

The prevalence of stress and stress-related illnesses has increased over time. For example, a US study found that rates of stress increased by 18 per cent for women and 24 per cent for men between 1983 and 2009 (Cohen and Janicki-Deverts, 2012). Similarly, there is evidence to indicate that stress-related disorders such as depression and anxiety have also increased during the neoliberal era, with, for example, antidepressant medication usage rising fourfold in the USA between 1988 and 2008, with more than 10 per cent of the population now receiving such medication (National Center for Health Statistics, 2011, Table 95). This trend is also evident internationally, as shown in Figure 3.2: for most OECD countries there was a doubling in the use of anti-depressant medication between 2000 and 2011. This may, of course, be attributable in part to the effectiveness of the pharmaceutical industry's marketing campaigns for these profitable products. However, the health effects of insecurity and stress are wider than that, as we explain in the next section.

Stress, work and health

One important body of research on the effects of stress on health has been conducted within workplaces. These studies have found that jobs with high psychological demands coupled with low levels of control were associated with increased exposure to stress and ill health. Psychological demands are such things as time pressure, high work pace, high workload and conflicting demands, while job control is defined as including control over workload, variety of work, and use and development of skills. This is known as the demand-control model (Karasek and Theorell, 1990; see Figure 3.3). Jobs characterized by high psychological demands in combination with low control are 'high stress' jobs because they do not enable individual autonomy and are often conducted in high pressure contexts. Work with high demands but also high control is termed 'active work', as the worker is able to manage his or her own workload and has a high degree of choice and autonomy over how the work is undertaken. Opportunities to learn new skills mitigate the stress-inducing effects of high strain in active jobs. Conversely, 'passive jobs', characterized by low demands and low control, are likely to

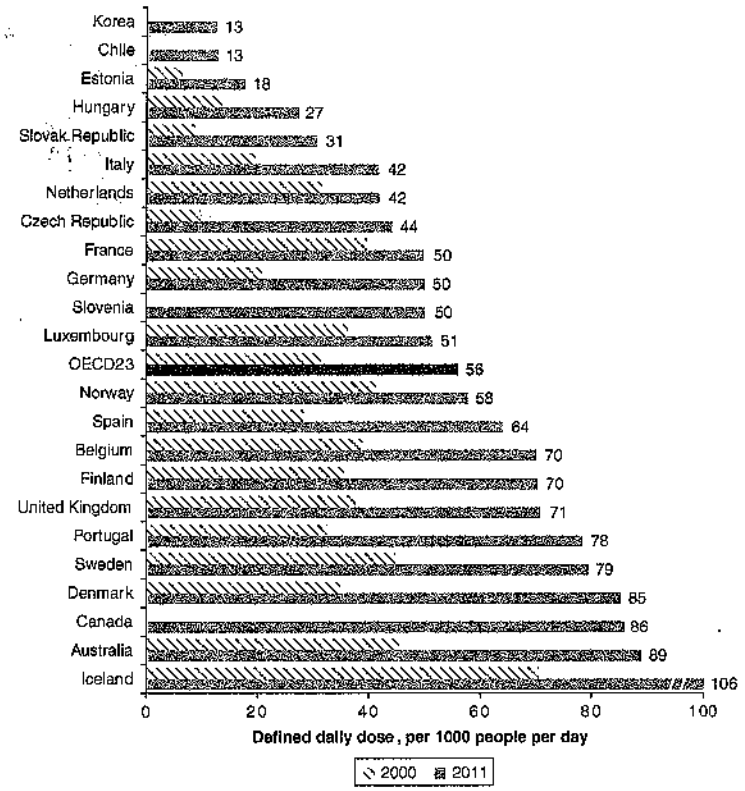

Figure 3.2 Rise in anti-depressant medication between 2000 and 2011 in the OECD countries
Source: OECD.

have fewer opportunities for learning. It has also been suggested that the presence of social support from co-workers and supervisors in the workplace might in some way moderate or act as a buffer to reduce ill-health effects (Johnson and Hall, 1988).

Workplace studies of the demand-control-support model have found that job control is an important determinant of health. High stress jobs lead to increased risk among employees of cardiovascular disease, including heart disease and stroke; increased risk of unhealthy behaviours, including poor diet, physical inactivity, heavy drinking and smoking; and obesity, musculoskeletal disorders such as back pain, and mental ill health, including depression, anxiety and emotional exhaustion (Bambra, 2011, pp. 81–87, 91–95). High stress jobs also

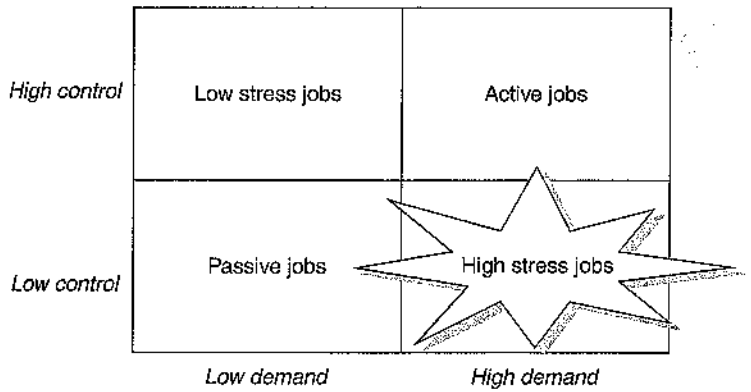

Figure 3.3 Visual representation of Karasek's model of job strain
Source: Adapted from Karasek and Theorell (1990).

contribute to health inequalities, as low job control accounted for approximately half of the social gradient in coronary heart disease in the Whitehall II study (Marmot et al., 1997; see Box 3.1).

Box 3.1 The Whitehall studies

The Whitehall studies, named for the street in London where much of the British civil service is located, are two large longitudinal studies of British civil servants set up to investigate (in the first instance) inequalities in coronary heart disease (CHD). Whitehall I, which began in 1967, followed 17,530 male civil servants; Whitehall II, which began in 1985 and at the time of writing (2014) is ongoing, is following 10,308 male and female civil servants. The original study decisively undercut the prevailing view that higher rates of CHD were experienced by high-status professionals and managers, and, in fact, found an 'inverse social gradient' in which risks for low-grade clerical workers were more than twice as high as for senior managers. Both Whitehall studies have subsequently identified similar inverse gradients across a broad range of adverse health outcomes. In other words, the person most likely to suffer adverse health effects is not the stereotypical hard-charging executive or ambitious professional, but, rather, the man

Box 3.1 (Continued)

or woman (and many such jobs are disproportionately held by women) working in a care home, serving food in a restaurant, cleaning or staffing a call centre – the kinds of jobs Ehrenreich and Toynbee found in their investigations, and on which millions of people now rely for survival. The Whitehall studies are also significant because serious material deprivation was almost certainly not an issue for most of the people studied; in other words, they make it possible to isolate the physiological effects of such psychosocial variables as position in a hierarchy. This said, they almost certainly understate the extent of the inverse socioeconomic gradient in health among the population as a whole: to assess this, we would need a study that included (in the case of London) not only civil servants but also building cleaners and fast food employees working on zero-hours contracts, and perhaps also investment bankers as well as civil servants.

A further set of stresses is associated with the spread of insecure employment. Job insecurity is associated with a number of adverse health outcomes, including worse rates of self-reported health, mental ill health and high blood pressure, as well as higher rates of smoking, drinking and unhealthy diet (Bambra, 2011, pp. 111–117). People in temporary employment also have higher mortality rates than those in secure employment, and poor-quality work with little security can be as damaging to health as unemployment (Benach and Muntaner, 2007). For example, one Australian study found that poor-quality jobs with low security, low marketability and high job strain were associated with poorer health when compared with work with few or no stressors (Broom et al., 2006). As suggested earlier, multiple mechanisms are probably at work here, and it is difficult to disentangle them.

Many workers on insecure contracts cycle from precarious work into unemployment – the 'low-pay, no-pay cycle' (Shildrick et al., 2012b) – thus augmenting the negative consequences for health. Working conditions have arguably become more stressful, and therefore more harmful to health, during this period of neoliberal ascendancy. Even before the financial crisis, workers in OECD countries reported substantial increases in working long hours and especially in work intensity between 1995 and 2006 (OCED, 2009, Annex 2).

Worklessness, unemployment and health

A second way in which neoliberal economic insecurity gets under our skin is via worklessness and unemployment. Worklessness refers to 'the unemployed' (defined as those out of work but looking for work), as well as those who have never worked and those who are deemed unable to work (e.g. due to ill health). The evolution of the term and its more frequent use within policy discourses, particularly in the UK, since the late 1990s reflects the emergence of neoliberalism in advanced economies and specifically the demise of full employment as a policy objective. In North America, 'unemployment' (usually defined with reference to official figures that may exclude a substantial number of the workless) is a more common term.

From the late 1940s until the mid-1970s, the advanced economies of the West experienced something close to full (male) employment, broadly understood as either official unemployment rates of less than 3 per cent or employment rates of over 80 per cent of the working-age population. There were, of course, periods of unemployment during the early post-war years, but these were cyclical, following the boom and bust of patterns of the economy (e.g. the early 1960s in the UK): in periods of economic growth there were jobs for all, while in periods of recession there was an increase in unemployment. To a large extent this cyclical pattern ended with the economic crisis of the 1970s and the subsequent rise of neoliberal economic models. The point here is simply that this overtly ideological policy change has led to the emergence of *structural* worklessness – long-term, permanent and non-cyclical lack of jobs – as a key characteristic of neoliberal economies.

At the same time, there was an expansion relative to the early post-war period in terms of those (e.g. women, lone parents) for whom work was expected, or required as an alternative to falling behind economically. At the time of writing, Elizabeth Warren is a US senator. Circa 2004, when still an academic, she pointed out that *all* the growth in median family income in the US between the 1970s and 2004 occurred because two-earner households had become the norm (Warren, 2007). Conversely, families with only one earner (including in particular those headed by single women) were falling behind, in relative terms. Meanwhile, as part of the neoliberal project to shrink the state (Chapter 1), neoliberalism has reduced the support provided to people when they are out of work – a level of support that varies widely among high-income countries (Scruggs and Allan, 2006); this variation underscores our emphasis on the importance of politics. For example, as an instance

of the great risk shift, in the UK the percentage of an average production worker's wage that would be replaced by unemployment benefits (the unemployment replacement rate) for one earner supporting a partner and two children declined from 69 per cent in 1971 to 36 per cent in 1990, although increasing slightly under Labour governments post-1997. For a single worker with no dependents, the decline was more dramatic: from 54 per cent in 1971 to 20 per cent or less in every year post-1997 (Scruggs et al., 2014). These figures apply only to those workers who are eligible for benefits; a further issue involves eligibility for compensation, which varies widely among countries and, in some cases, has been one of the more conspicuous casualties of neoliberalism. In Canada, one of the more dramatic neoliberal retrenchments of social policy was a 1996 tightening of the eligibility criteria for the national program of unemployment insurance, such that 'the proportion of unemployed Canadians who actually receive[d] regular insurance benefits dropped dramatically, from 83 per cent of unemployed Canadians in 1980 to only 42 per cent in 1997' (Prince, 1999, p. 181).

Studies have consistently shown that unemployment increases the chances of poor health (Bambra and Eikemo, 2009). Empirical studies from the recessions of the 1980s and 1990s have shown that unemployment is associated with an increased likelihood of morbidity and mortality, including higher rates of poor mental health and suicide; all cause and specific causes of mortality; self-reported poor health and limiting long-term illness; and risky health behaviours, particularly problematic alcohol use and smoking (Bambra, 2011, pp. 102–111). As suggested by our earlier discussion, unemployment and precarious employment are also important causes of the within-country health inequalities that we discuss at greater length in Chapter 5.

A UK study found that recently unemployed young men were twice as likely to visit a GP for depression and anxiety as those in work (Montgomery et al., 1999a). Similarly, in terms of suicides, a study of young men in Scotland conducted in the 1980s found that the risk of suicide was double (Platt, 1986), while attempted suicide is ten times more likely in unemployed young men than in those in employment (Dorling, 2009). Other causes of death are also more common among the unemployed. For example, a study that examined the impact of loss of employment during the early 1980s recession on mortality among middle-aged British men found that the unemployed were twice as likely to die as those who remained in work (Morris et al., 1994). This included deaths from cardiovascular disease and cancers. The negative effects of unemployment on health are also evident in studies of self-reported

health and long-term illnesses, with, for example, a study of UK men (Bartley and Plewis, 2002) finding that the unemployed were twice as likely to have a long-term health problem. Data also suggest that unemployment increases risky health behaviour. This is particularly the case among young men. For example, a study of British young men found that the unemployed were three times more likely to smoke or drink heavily than men who had never been unemployed (Montgomery et al., 1999b).

Unemployment is associated with poverty and social exclusion, and it tends to be concentrated among those with lower incomes, education or skills. The importance for health inequalities was demonstrated (Popham and Bambra, 2010) in an English study which found that more than 80 per cent of health differences between the most affluent and the least affluent people in the English workforce is due to unemployment: 6 per cent of men living in owner-occupied housing reported ill health compared with 19 per cent of men in social rented housing – a difference of 13 points. Once differences in employment status were taken into account, this difference reduced to three points, a reduction of over 80 per cent. Another study found that regional differences in unemployment – such as between the North and the South of England – also explained regional differences in levels of poor health (Moller et al., 2013).

Two pathways explain how unemployment results in poorer health: the material consequences of unemployment (income loss) and the psychosocial effects of unemployment (e.g. relative deprivation as a result of income loss, stigma, isolation and loss of self-worth). On the first point, especially over the longer term the unemployed suffer substantial income losses and the material consequences of unemployment. Around one in four unemployed men report feelings of shame related to unemployment (Bambra, 2011, p. 107), and an Italian study of factory workers who were made redundant found that their mental health got worse even though they were still given 100 per cent of their wages for the first six months of unemployment (Rudas et al., 1991). In the longer term, though, the unemployed suffer from a greatly reduced income, and many unemployed people live in relative poverty. In the UK, for example, against a background of rising prices for such essentials as food and transportation, circa 2013 out-of-work benefits for single adults covered only 38 per cent of the cost of a Minimum Income Standard developed by the Joseph Rowntree Foundation, and for households with children only 58 per cent (MacInnes et al., 2013, p. 24). For some of those out of work, in the UK and elsewhere, the consequences are even

more grave, and are compounded by the cuts in other benefits described in Chapter 4.

Ill health itself is also a cause of worklessness. 'Health-related worklessness' is a term used to refer collectively to people who are out of work on a long-term basis (in the UK, over four weeks) due to a chronic illness or disability (Bambra, 2011, pp. 131–146). A disability in this context is defined as an illness or impairment that limits the usual activities of daily living, including work ability. Neoliberalism breeds vicious cycles. A study of trends in the UK (see Figures 3.5 and 3.6) has shown that the percentage of men reporting poor health has increased from 7 per cent of the working population in 1978 to 11 per cent in 2004, and for women this has increased from 11 per cent to 13 per cent. This was accompanied by a threefold increase in health-related worklessness, from 2 to 7 per cent for men and from 2 to 6 per cent for women during the same time period (Popham et al., 2012). This is hardly surprising, since poor health is a significant risk factor for job loss. For example, European and US studies have found that people who developed chronic health problems while in employment were twice as likely to become workless within a four-year period as those who remained healthy (McDonough and Amick, 2001; Schuring et al., 2009). In the US, where health insurance coverage, at least until recently, was closely tied to employment and even those with insurance often find it inadequate, a vicious cycle of special importance involves untreated illnesses related to loss of insurance coverage following job loss, creating a health poverty trap (frequently including personal bankruptcy) that can be extremely difficult to escape (Abelson, 2009; Dwyer, 2009; Himmelstein et al., 2009).

In most Western countries, long-term health-related worklessness carries an entitlement to receipt of financial support from the welfare state in the form of sickness and disability pensions or, in the case of the UK, incapacity-related benefits. Rates of receipt of these health-related benefits have increased over the last 30 years – and have become a feature of neoliberal structural worklessness. For example, in the UK the number of people who claim health-related benefits has increased from 0.5 million recipients in 1975 to 2.6 million in 2014 – around 7 per cent of the UK working-age population (Gabbay et al., 2011). Post-2010, the Conservative-led government in the UK initiated major and often dishonest efforts to reduce the cost of such benefits, which we discuss in more detail in Chapter 4. Across the Organisation for Economic Co-operation and Development (OECD) countries, around 6 per cent of the entire working-age population receive such benefits (OECD, 2009).

The most common causes of long-term sickness absence are musculoskeletal disorders (such as back pain), stress and mental health problems (especially depression and anxiety) (Bambra, 2011, p. 133). Internationally, mental health problems account for a third of new disability claims across OECD countries. Health-related worklessness contributes to health inequalities, as it varies by gender, education and region (Bambra, 2014):

- The employment rates of women (50 per cent) with a health condition or disability are lower in the UK than for men with similar levels of ill health (60 per cent).
- Health-related job losses are more likely among the least educated.
- There are substantial geographical inequalities in health-related worklessness, with rates highest in areas which have experienced rapid deindustrialization and the loss of manufacturing jobs.

Spatial variation in health-related worklessness is illustrated in Figure 3.4. This uses Standardized Illness Ratios, in which 100 represents the national average incapacity-related benefit recipient rate. Areas with values above 100 have of incapacity-related benefit receipt rates above the national average. These areas are depicted by dark grey and black shading. Areas with values below 100, shown by white and pale grey shading, have rates below the national average. Looking at data in this way shows that the receipt of incapacity-related benefits is concentrated in the de-industrialized areas of the North East of England and South Wales, as well as in former manufacturing centres such as Manchester and Liverpool. These areas are all shaded black, with receipt rates at least 50 per cent higher than the national average. Regional differences in worklessness rates contribute substantially to regional differences in health inequalities and to health inequalities between regions – as we discuss further in Chapter 5 (Bambra and Popham, 2010).

Health-related worklessness has emerged as a relatively new phenomenon over the 30-year period of neoliberal ascendancy (Chapter 1). There are debates as to whether this type of worklessness reflects a genuine increase in poorer health among certain social groups or whether it is a form of 'hidden unemployment' (Beatty and Fothergill, 2005; Bambra, 2011, pp. 145–150). In our view, there is evidence for both arguments, and, like many other candidate explanations for health inequalities, they are not mutually exclusive.

In terms of hidden unemployment (a term coined by Beatty and colleagues, 2000), the rapid increase in health-related benefit claims across

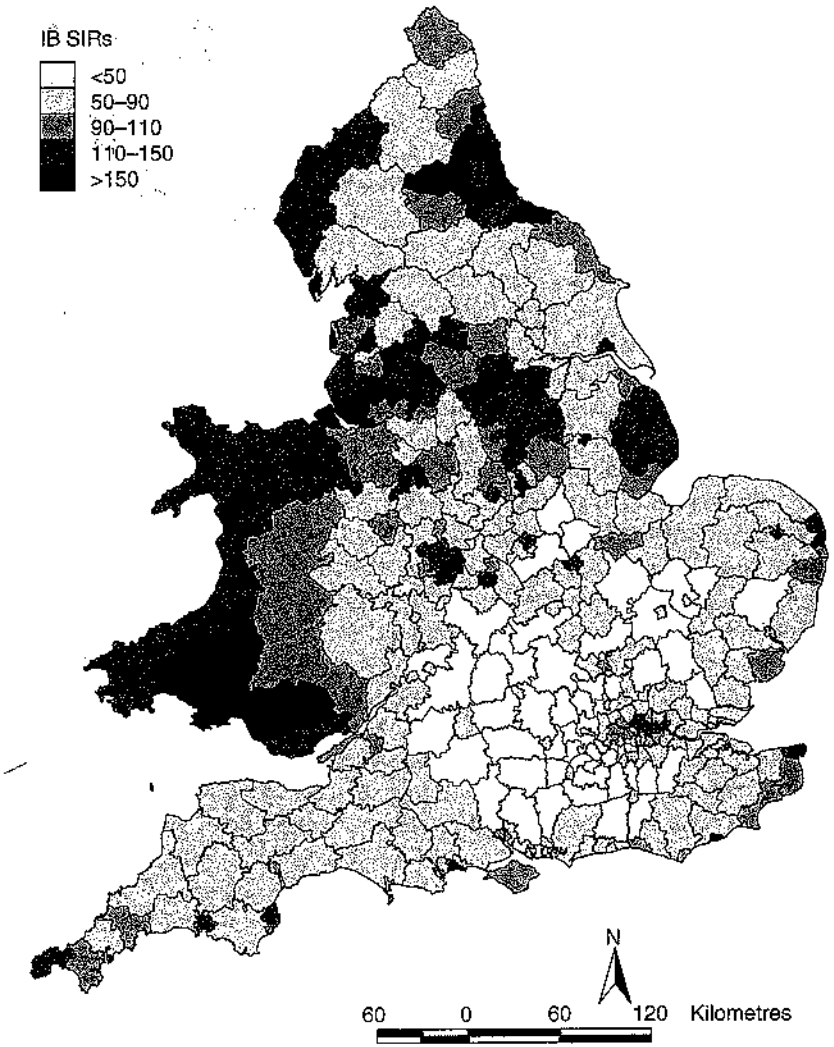

Figure 3.4 Standardized illness ratios of incapacity benefit claims by local authority, England and Wales

Source: Reproduced from Norman, P. and Bambra, C. (2007) 'The Utility of Medically Certified Sickness Absence as an Updatable Indicator of Population Health'. *Population, Space and Place, 13*, 333–352, with permission from the publishers, John Wiley & Sons.

the OECD in the 1980s and 1990s coincided with similar decreases in the numbers in receipt of unemployment benefits (Figures 3.5 and 3.6), suggesting substitution between the two types of benefit schemes (OECD, 2009). This perception is also supported by the geographical distribution of health-related worklessness, which is skewed towards the de-industrialized areas. These areas lost thousands of jobs when their main industries, such as the coal, steel and shipping industries, were closed in the 1980s and 1990s, and, in the absence of a policy of full employment, there has not been sufficient replacement work in these localities. In the UK, Conservative governments also actively encouraged a transition to sickness benefits in these communities as a way of reducing the unemployment rate. By way of example, Beatty and colleagues (2007) estimate that the 'real' level of unemployment in the UK in 2007 was 2.6 million, compared with only 0.9 million claiming

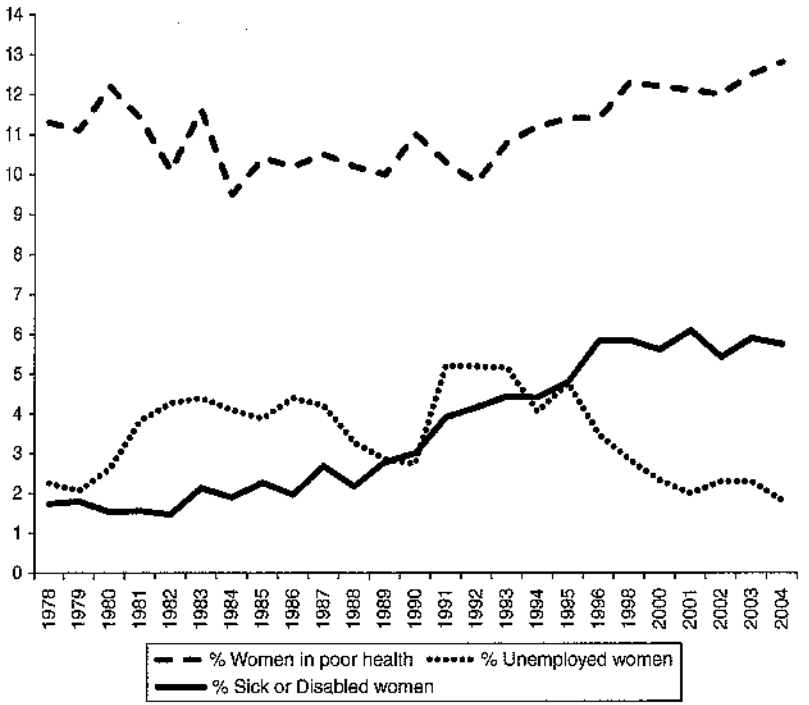

Figure 3.5 Percentage of women unemployed, workless due to ill health or disability or in poor health, UK, 1978–2004

Source: Data from Popham et al., 2012.

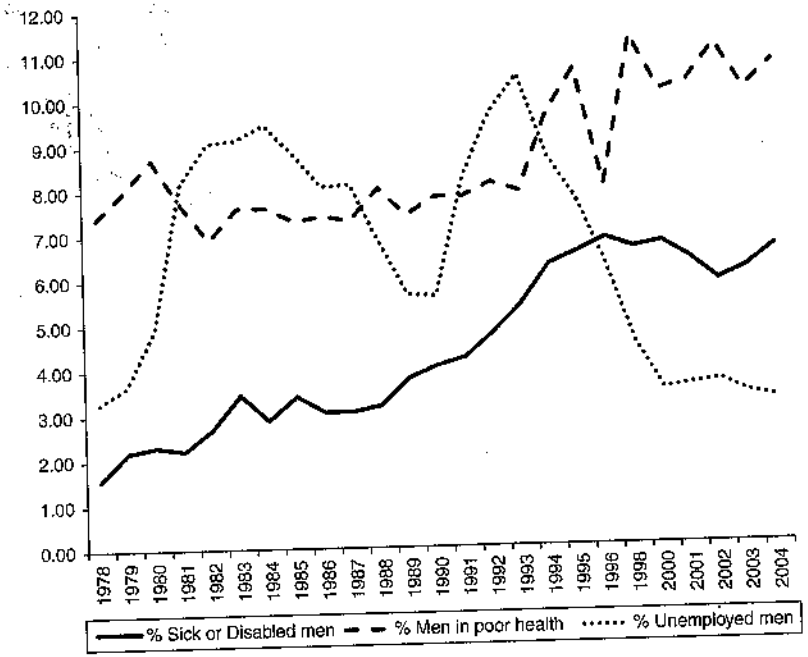

Figure 3.6 Percentage of men unemployed, workless due to ill health or disability or in poor health, UK, 1978–2004
Source: Data from Popham et al., 2012.

unemployment benefit (Jobseeker's Allowance), as they estimated that around 40 per cent of health-related benefit recipients would have been in work under full employment.

So, we argue that it is a case of both increased ill health (particularly mental ill health) *and* hidden unemployment leading to the explosion of health-related worklessness under neoliberalism as: (1) work-related ill health (particularly mental ill health) has increased as a damaging social by-product of neoliberal economic insecurity, the intensification of work and the epidemic of stress; and (2) the abandonment of full employment as part of the economic restructuring of neoliberalism and the subsequent rapid deindustrialization of certain regions has meant that for many areas there are simply no jobs to be had (hidden unemployment), which, in turn, can lead to an increase in ill health. This is a vicious cycle, one that is very much a feature of a neoliberal economics that puts profits before people and places.

Cross-national comparisons of the insecurity epidemic

Patterns in the distribution of stress, work insecurity and worklessness do not follow a universal international pattern. In this section, we draw on previous comparative work on national employment patterns, labour markets and social policies to provide a further basis for assessing the connections between neoliberalism and health. We show that in the most neoliberal countries stress has a worse effect on health than in those countries that are less neoliberal, while the health penalty of unemployment, and the unemployment penalty of ill health, is also higher in more neoliberal countries. This is because countries that have not been as much affected by the politics and economics of neoliberalism – largely the social democratic countries of northern Europe – have a more extensive regulatory state, which provides a better context within which to work as well as stronger support for those out of work. Stress and insecurity develop within a wider economic, political and social context.

First, the prevalence of stress is significantly higher in the most neoliberal countries and lower in the least, as the workplace is more regulated (particularly in Sweden or Norway). For example, a study of 12 European countries found that levels of workplace stress were higher in the more neoliberal UK (i.e. levels of low control at work were higher) than in the social democratic countries of Denmark and Sweden (Dragano et al., 2011).

Second, the effects on health of stressful work environments are also reduced in these countries, as, for example, workers with low job control in the UK were more than 2.5 times more likely to report depression, compared with only a 1.7 times higher likelihood in Denmark and Sweden (Dragano et al., 2011).

Third, the health effects of job insecurity or unemployment are also much less pronounced in the least neoliberal countries, as their more extensive social security systems improve the ability of individuals to cope with stressful events (Bartley and Blane, 1997). European research has shown that, while in all countries unemployed people report higher rates of poor health than those in employment, inequalities between the employed and the unemployed are largest in the most neoliberal countries (Bambra and Eikemo, 2009). For example, in 2011 the replacement value of out-of-work benefits in the UK for a single worker with no dependents was just 18 per cent and for a worker with dependents just 45 per cent, as compared with 60 per cent or higher for both categories

in Sweden (Scruggs et al., 2014), and benefits were means tested and subject to strict criteria for eligibility assessment.[6] Fourth, less neoliberal countries, such as Finland, have smaller inequalities in stressful working conditions than more neoliberal countries, such as the UK, potentially resulting in smaller health inequalities among the workforce (Sekine et al., 2009).

Fifth, the onset of ill health is more likely to result in worklessness in more neoliberal countries. In Europe, health-related worklessness is lowest in the social democratic welfare states (an average of 38 per cent) and highest in the most neoliberal countries: in the UK 50 per cent and in Ireland 64 per cent of people with a health problem are workless. Continental European countries have an average worklessness rate of 48 per cent, while in southern Europe it is around 52 per cent (van der Wel et al., 2012). In all countries, worklessness rates are particularly high among people who have both a health problem and low education. However, the study found that the employment rates of those with a health problem and low education are higher in countries that invest in active labour market policies, have higher levels of income equality and provide more generous welfare benefits (van der Wel et al., 2012).

Like the comparisons of labour market policy cited earlier, these observations underscore the importance of political choices. In the aftermath of the financial crisis that began in 2008, a variety of protections against the health consequences of insecurity are under renewed attack in the name of austerity and deficit reduction. The nature of that attack, its ideological connections with neoliberalism and the consequences for health are the topic of the next chapter.

4

Austerity: How Politics Has Pulled Away Our Safety Net

David Stuckler and Sanjay Basu (2013) introduce their book on austerity and its health consequences with the case of a stroke-paralysed man with limited ability to walk who was cut off disability benefits by Atos Healthcare, a corporation given a contract by the Conservative-led UK government to cut its benefit costs by (re)assessing applicants, with abundant subsequent evidence of inadequate performance that eventually led to the end of the contract (Ramesh, 2013; Wintour, 2013; Butler, 2014a; Syal, 2014). This example captures three dimensions of the neoliberal turn in social policy: the perceived imperative of cutting costs; the presumption of undeservingness applied to benefit claimants, in contrast to the corporate recipients of public subsidies; and the privatization of core public service functions that have serious consequences for the daily lives of their clients (Seabrook, 2013). Here we first describe the origins of the crisis in neoliberal policies of deregulation that left financial markets to 'do their thing', and then examine the impacts and politics of the austerity programs that have represented the neoliberal response to the crisis. We end the chapter with a provocative comparison with development policies that advanced neoliberalism outside the high-income world.

The financial crisis of 2008: The opportunity for the austerity epidemic

The basic facts about the financial crisis that spread across the world in 2008 are now familiar. The policies that made it possible, and perhaps inevitable, began decades earlier, but the sequence of events began in 2007, as investors became concerned about the quality of the high-risk or subprime mortgages that had been packaged ('securitized') and