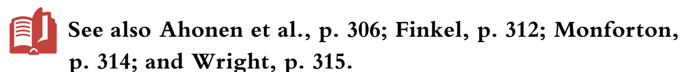
The Key Role of Work in Population Health Inequities


See also Ahonen et al., p. 306; Finkel, p. 312; Monforton, p. 314; and Wright, p. 315.

An important essay in this month's issue of *AJPH* explores why work is essential to understanding population-level health, why concepts and measures of work have been neglected in health inequities research, and how incorporating them into existing surveillance systems could expand opportunities to improve health inequity research and prevention.

Ahonen et al. (p. 306) point out that occupation largely determines income, contributes to social networks, provides social prestige, and is part of the definition of socioeconomic position, a fundamental cause of disease. Other important social determinants of health (e.g., race, ethnicity, immigration status, and gender) all affect the types of jobs people attain (occupational segregation), the hazards they face, and the amount of power they have in the workplace. For example, women and Black, Hispanic, or Asian workers can be exposed to specific work characteristics that are a "tangible manifestation of racial [and other] disadvantage" (p. 308), such as low wages, harassment, low job control, work hazards, and job insecurity. Ahonen et al. also describe how occupational safety and health (OSH) has been "separated from the larger realm of public health research and practice and fragmented through economic, social and political processes" (p. 308).

ECONOMIC, SOCIAL, AND POLITICAL PROCESSES

We agree that economic, social, and political processes are key to understanding the limited inclusion of work in health inequities research. Of central importance is the power inequity between corporations and working people. Many corporations influence health, and promote health inequity, through producing and marketing toxic substances and unhealthy products. To improve profitability, many implement stressful forms of work organization, such as contracting out, just-in-time scheduling, nonstandard shifts, excessive overtime, or "lean production," which increase psychosocial stressors such as job strain and effort–reward imbalance, all of which affects workers' health, and especially for women, the ability to balance work and care demands. Efforts to document the adverse impact of work on health confront corporate efforts to "manufacture doubt" about the science, limit funding, limit regulation, and restrict access to data (see Appendix A, available as a supplement to the online version of this article at http://www.ajph.org).

Lack of adequate funding limits the extent to which nuanced measures of work exposures are included in health surveillance systems. For example, the National Institute for Occupational Safety and Health budget pales in comparison with National Institutes of Health budgets, despite the similar costs for occupational injury and disease ($250 billion in 2007 in the United States) as for cancer or cardiovascular disease.[1]

The weakened state of US labor unions since the early 1970s has increased their challenges to successfully lobby for adequate funding for health and safety research, regulation, and enforcement. Corporate supported congressional and court challenges have resulted in few new federal OSH regulations and the rollback of critical new regulations. Countries with stronger labor movements, such as Scandinavian nations, have stronger OSH regulations, greater funding opportunities for occupational health research and education, lower workplace fatality rates, and smaller socioeconomic health disparities.

Employers, using private property rights, may refuse to participate in research studies or may resist efforts to regulate the collection of OSH data. The treatment of occupational injuries and illnesses is relegated to a dysfunctional workers' compensation system that discourages health provider and worker reporting, thus underestimating the true contribution of work hazards to health, especially chronic disease. Furthermore, our healthcare system rewards treatment rather than prevention and largely ignores the role of work in producing chronic disease.

An additional reason for the exclusion of work in health inequities research may be the social class bias of some researchers, academics, and government officials, and their reluctance to sufficiently listen to the experiences, pain, and needs of working people,[2] or to adequately fund occupational health education and research.

Finally, because the nature of work has changed in the United States, with less union density and workers' power to protect working and employment conditions, what was formerly seen as a problem faced by poorer workers is increasingly recognized as an important

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structural factor for many. In many countries, neoliberal and austerity policies have promoted contracting out and precarious employment, deepened and prolonged economic recessions, helped erode workers' rights, workers' labor unions, and financial security, and promoted ill health. The rapidly increasing rate of precarious employment in the United States and globally, through contract labor arrangements, temporary employment firms, "gig" work, and part-time employment without related benefits, such as health insurance, pensions, paid sick leave, vacations, and holidays, substantially affects the health and safety of workers, their families, and communities, and promotes inequities by type of work arrangement.

DATA LIMITATIONS

We agree with Ahonen et al. that "stronger, more detailed, and regular surveillance and research" is "vital to our ability to address health inequities" (p. 309), such as expanding and more regularly conducting the National Institute for Occupational Safety and Health Quality of Work Life survey. Currently, the small Quality of Work Life sample size (n = 1250 in 2014) makes it inadequate for detailed occupation or industry comparisons, or interrelationships of work with race, gender, or social class.

Many population health researchers have used standard socioeconomic status measures, such as education and income; however, we also recommend the use of social class concepts that describe relationships in the production process (e.g., manager, supervisor, and employee, workplace decision-making).[3] Acknowledging these relationships can contribute to solutions that go beyond improving educational opportunities or reducing income inequalities, such as the promotion of greater workplace democracy and social protection.

NEW CURRICULUM

The 2011 National Conference on Occupational Health Disparities (OHD) led to publications (see Appendix A) and the development of a 4–6 hour Work and Health Equity curriculum for undergraduate and graduate public health students, available for free download at http://losh.ucla.edu/resources-2/work-health-equity-module.

The curriculum discusses the intersection of work and working conditions with race, ethnicity, immigration status, income, and gender; how these intersections affect worker health and safety; and how unequal power in the workplace and society create health inequities. The curriculum describes efforts by unions and nongovernment organizations to improve working and employment conditions to reduce health inequities.

INNOVATIONS IN RESEARCH AND PREVENTION

Although we agree with the need to move past a narrow OHD framework, this formulation, which began close to two decades ago, was an essential first step in questioning whether traditional approaches to OSH research might miss important patterns of work-related injury and illnesses caused by gender, race, immigrant status, and job tenure. In addition, OHD research was undertaken to shed light on the most exploited worker populations, just as environmental justice research seeks to discover similar environmental health dynamics.

We agree with Ahonen et al. that the intersectionality framework may be one important pathway to advance our understanding of work and health inequities. Intersectionality theory was developed to better understand the interlocking and potentially additive or synergistic nature of social identity, social position, and systems of oppression or privilege, including gender, race/ethnicity, social class, disability status, and sexual orientation.[4] Krieger et al.[5] and several of us have incorporated intersectional approaches to study work and health in racially/ethnically diverse, low-wage work forces; for example, Choi et al.[6] assessed the impact of poor working and living conditions on obesity and obesity disparities among racially diverse urban transit workers. Several of us have also highlighted the value of integrated health protection and health promotion programs at the worksite, at state and local health departments, at community health centers, and at community-based organizations to address the needs of the low-income workforce.[7]

LOOKING FORWARD

We are heartened to see increased advocacy and action to reduce health inequities. Labor unions, worker centers, public health advocates, regulators and others are collaborating on legislation and regulations (e.g., paid sick leave or family leave, advance scheduling, safe staffing), collective bargaining, community-based research, education, and legal action. Innovative campaigns benefit a variety of worker groups, including hotel housekeepers, restaurant workers, disaster cleanup workers, nurses, domestic workers, home care workers, day laborers, nail salon workers, and car wash workers. We look forward to working with colleagues in population-based health inequities research to promote research, education, and prevention programs that incorporate the key role of employment and working conditions. AJPH

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