The Role of Employment Relations in Reducing Health Inequalities

A MACRO-LEVEL MODEL OF EMPLOYMENT RELATIONS AND HEALTH INEQUALITIES

Carles Muntaner, Haejoo Chung, Orielle Solar,
Vilma Santana, Antía Castedo, Joan Benach,
and the EMCONET Network

The authors develop a macro-social theoretical framework to explain how employment and working conditions affect health inequalities. The theoretical framework represents the social origins and health consequences of various forms of employment conditions. The emphasis is thus on determinants and consequences of employment conditions, not on social determinants of health in general. The framework tries to make sense of the complex link between macro-social power relations among employers, government, and workers' organizations, labor market and social policies, employment and working conditions, and the health of workers. It also suggests further testing of hypothetical causal pathways not covered in the literature. This macro-social theoretical framework might help identify the main "entry points" through which to implement policies and interventions to reduce employment-related health inequalities. The theoretical framework should be approached from a historical perspective.

The Employment Conditions Knowledge Network (EMCONET) has constructed a theoretical framework to explain how employment and working conditions affect health inequalities. Given the social complexity of employment conditions, the use of theoretical frameworks helps us summarize, organize, and explain large quantities of research (1). Our framework tries to make sense of the complex link between macro-social power relations, employment conditions, and the health of workers, and suggests further testing of hypothetical causal pathways not covered in the literature. Theoretical frameworks also help identify the main

International Journal of Health Services, Volume 40, Number 2, Pages 215–221, 2010

doi: 10.2190/HS.40.2.c
http://baywood.com

"entry points" through which to implement policies and interventions to reduce employment-related health inequalities. The resulting models serve two major purposes. First, they show the origins and consequences of different employment conditions. Second, they trace the connection between political factors, employment conditions, working conditions, and health inequalities.

Our theoretical framework is divided in two complementary models: a macro-level model (see Figure 1) and a micro-level model, which is presented by Benach and colleagues in another article in this special section of the Journal (p. 223). These models visually represent the social origins and health consequences of various forms of employment conditions. In particular, the integrated framework traces the connection between a society's political and economic structure, employment and working conditions, and health inequalities. Although some models in the field of occupational health have hinted at some of these structural determinants (2), few have been explicit about them, and even fewer have integrated macro and micro determinants of work-related health inequalities. Some methodological caution needs to be exerted. The main focus of both of our models is on determinants and consequences of employment conditions, not on social determinants of health in general. Also, neither framework pretends to be a fully fledged, confirmed model. Rather, they are heuristic devices used to help simplify a complicated set of relationships and to point out the most important pathways. We should also mention that both frameworks are "static" and should be approached from historical as well as from dynamic life-course perspectives.

MACRO-LEVEL THEORETICAL MODEL

In developing our macro model (Figure 1), we followed previous attempts in recent years by the "Barcelona group" to incorporate politics and welfare state into social epidemiology (1, 3–5), health policy (6, 7), and the ensuing model from the World Health Organization's Commission on Social Determinants of Health (8, 9). The model places employment conditions in their larger institutional context, determined by power relations in the labor market, government, and civil society that fit into the global division of production of the world-system (10; see also the article by Chung et al. in this special section, p. 229), with the given historical (political, economic, and cultural) background of each society. The model also explains the effects of the distribution of political power ("power relations") on health inequalities through intermediary social mechanisms such as labor market policies (e.g., freedom of joining a union, collective bargaining) and the balance between welfare state and labor market in determining employment conditions and health inequalities. These two sets of policies are deeply intertwined. The more protection people receive from welfare state policies, the higher the level of "decommodification"—that is, the extent to which workers are able to maintain their livelihood when they find themselves unemployed (11).

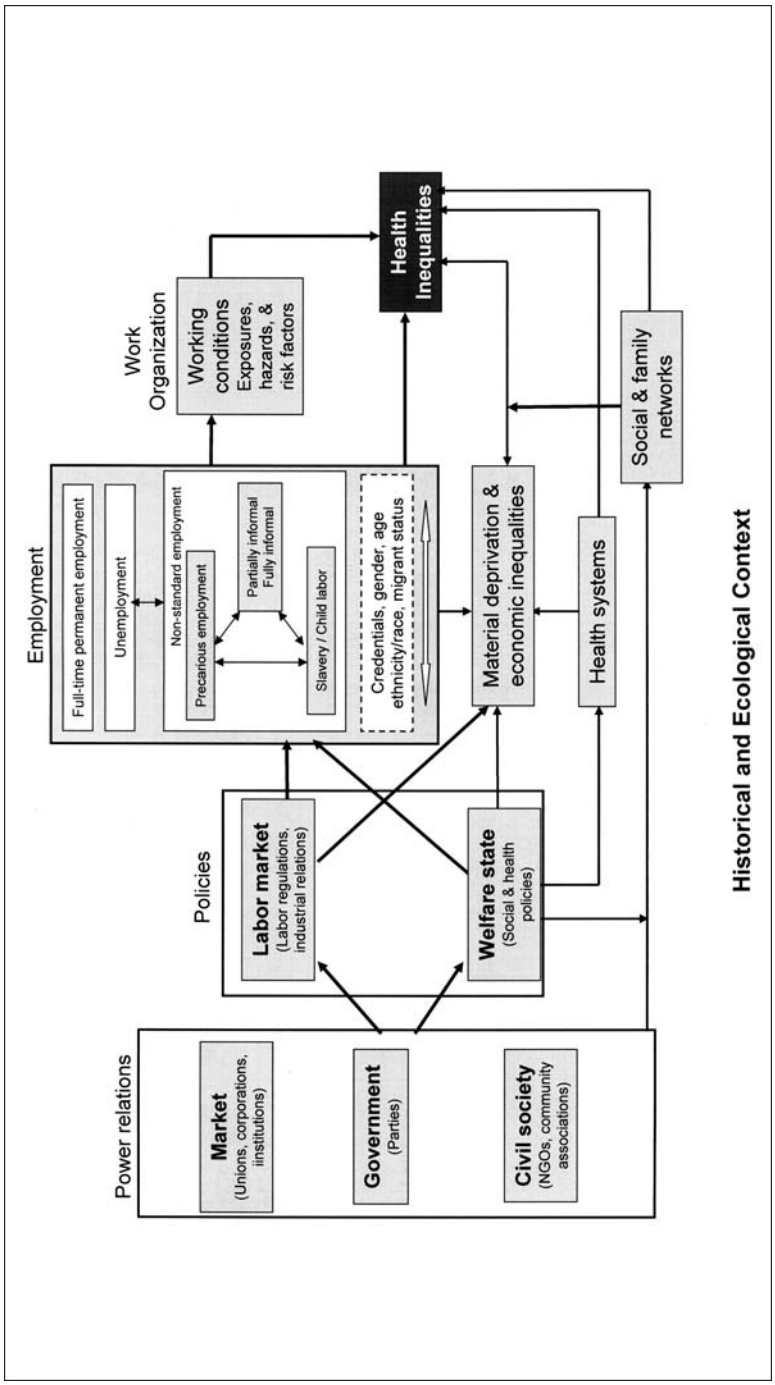

Figure 1. Theoretical framework of employment relations and health inequalities: a macro-level model. *Note:* NGOs, nongovernmental organizations.

An important determinant of employment conditions is the reciprocal relation between political power and policymaking. The balance of political power relations leads to new policies affecting the labor market and the welfare state. These new policies are a form of economic redistribution, because they change the way that the labor market functions, which in turn affects employment conditions. For example, when a "pro-labor" political party gains power, its members may implement different public policies that have different public health outcomes (5, 6, 12). Political power relations, therefore, are critical to the redistribution of economic resources and thus to the level of equality present in society, including its labor market.

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 health care, 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" (4, 13). The key causal force here is the power that government and civil society exert over the labor market and welfare state policies. Their influence over the labor market is broad-ranging, from jurisdiction extending across labor regulations to collective bargaining. With respect to the welfare state, political power-holders determine the level of distribution to be achieved by social policies (e.g., universal or means-tested). Control over both institutions is fundamental to understanding employment relations, given that workers' welfare depends both on the functioning of the labor market and on social protection policies implemented by the state. Both serve to modify social stratification and therefore social inequalities (11). In our model, "labor regulation" refers both to the specific regulation of the labor market (employment protection legislation) and to welfare state benefits related to a salaried relationship, such as health care benefits for those involuntarily leaving the labor market or income security measures for the unemployed. "Collective bargaining" refers to one of the most important means of institutionalizing labor-capital relations (14). Several studies have found that the most important factor in explaining pay dispersion is the level of wage-setting—that is, 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 labor force covered by collective-bargaining agreements are also important (14). It has been shown, for example, that a far more severe decline in the unionization rate in the United States than in Canada accounts for two-thirds of the differential growth in wage inequality between the two countries (see 8).

The next part of the model concerns the balance between welfare state and labor market. These two institutions are deeply intertwined so that a full

account of the labor market needs to consider the welfare state institutions that surround it (e.g., the public education system, unemployment benefits, poverty relief, pensions; see 15). The more protection citizens receive from the welfare state, the higher is the level of labor market "decommodification." Decommodification is gauged by the extent to which unemployed workers are able to sustain their livelihood (11). The state's welfare policies protect the work force from the labor market's notorious insecurities. Other examples of welfare state social policies are those that protect families, children, and people with disabilities. In the European Union, for example, a significant proportion of social provisions in most member states consist of benefits designed to replace or supplement earnings that individuals might not be able to secure from the labor market (16). Income replacement schemes usually take the form of three distinct kinds of provisions: unemployment benefits (based on 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 (17).

For the past few decades, most wealthy countries have experienced some reduction of social safety nets for the unemployed, job losses in the public sector, a growth in job insecurity and precarious employment, a weakening of regulatory protections, and the historical reemergence of an informal economy, including home-based work and some child labor (8, 18). On the other hand, in poor countries, reliance on neoliberal economic policy has resulted in even lower levels of labor standard laws, reduced social security safety nets, very limited workers' compensation, and highly exploited vulnerable workers (8, 17). Therefore, the employment conditions in our model include full-time permanent employment, but also unemployment, precarious employment, informal employment, child labor and slavery, and bonded labor (see Figure 1).

CONCLUDING REMARKS

We need to consider the difficulties inherent in establishing a macro model of employment conditions and health inequalities that might be suitable for nations across the globe (i.e., in high-, low-, and medium-income countries; see Chung et al.'s article, p. 229). But our assertion is that our macro model allows sufficient generality and flexibility to be applied at different levels of aggregation (national, regional, local) and across positions in the world-system. Ultimately, the macro model, its constructs, relations, and indicators, are contingent upon

specific historical contexts (e.g., informal work may signal precariousness in wealthy countries but extreme poverty in poor countries (17, 19).

Acknowledgment — This work was supported by the CIBER Epidemiologia y Salud Pública (CIBERESP), Spain.

Note — The members of the EMCONET network who contributed with ideas to the content of this article during various meetings are Carlos H. Alvarado, Francisco Armada, Yucel Demiral, Chamberlain Diala, Magdalena Echeverría, Gerry Eijkemans, Sharon Friel, Anne Hammarström, Mary Haour-Knipe, Shengli Niu, Marco António Gomes Pérez, Michael Quinlan, Javier Ramos, Hernán Sandoval, Atanu Sarkar, Amit Sen Gupta, Meera Sethi, Walter Varillas, Laurent Vogel, and Mariana Wagner.

REFERENCES

1. Muntaner, C., et al. The social class determinants of income inequality and social cohesion. *Int. J. Health Serv.* 29:699–732, 1999.
2. Landsbergis, P., et al. Lower socioeconomic status among men in relation to the association between job strain and blood pressure. *Scand. J. Work Environ. Health* 29:206–215, 2003.
3. Navarro, V., et al. The importance of the political and the social in explaining mortality differentials among the countries of the OECD, 1950–1998. *Int. J. Health Serv.* 33:419–494, 2003.
4. Navarro, V., and Muntaner, C. *Political and Economic Determinants of Population Health and Well-Being: Controversies and Developments.* Baywood, Amityville, NY, 2004.
5. Navarro, V., et al. Politics and health outcomes. *Lancet* 368:1033–1037, 2006.
6. Chung, H., and Muntaner, C. Political and welfare state determinants of population health. *Soc. Sci. Med.* 63:829–842, 2006.
7. Chung, H., and Muntaner, C. Welfare state matters: A typological multilevel analysis of wealthy countries. *Health Policy* 80:328–339, 2007.
8. Employment Conditions Knowledge Network (EMCONET). *Employment Conditions and Health Inequalities: Final Report to the WHO Commission on Social Determinants of Health (CSDH).* World Health Organization, Geneva, 2007.
9. Solar, O., and Irwin, A. Social determinants, political contexts and civil society action: A historical perspective on the Commission on Social Determinants of Health. *Health Promot. J. Austr.* 17:180–185, 2006.
10. Wallerstein, I. M. *The Modern World-System, Vol. I: Capitalist Agriculture and the Origins of the European World-Economy in the Sixteenth Century*. Academic Press, New York, 1974.
11. Esping-Andersen, G. *The Three Worlds of Welfare Capitalism*. Princeton University Press, Princeton, NJ, 1990.
12. Navarro, V., and Shi, L. The political context of social inequalities and health. *Int. J. Health Serv.* 31:1–21, 2001.

13. Navarro, V. *The Political Economy of Social Inequalities: Consequences for Health and Quality of Life*. Baywood, Amityville, NY, 2000.
14. Lewin, D. (ed.). *Contemporary Issues in Employment Relations*. Cornell University Press, Ithaca, NY, 2007.
15. Esping-Andersen, G., and Regini, M. *Why Deregulate Labour Markets?* Oxford University Press, New York, 2001.
16. Erne, R. *European Unions: Labor's Quest for a Transnational Democracy*. Cornell University Press, Ithaca, NY, 2008.
17. Heymann, J. (ed.). *Global Inequalities at Work: Work's Impact on the Health of Individuals, Families, and Societies*. Oxford University Press, New York, 2003.
18. Pórtes, A., et al. *The Informal Economy: Studies in Advanced and Less Developed Countries*. Johns Hopkins University Press, Baltimore, 1989.
19. Kalleberg, A. Non standard employment relations and labour market inequality. In *Inequalities of the World: New Theoretical Frameworks, Multiple Empirical Approaches*, ed. G. Therborn. Verso, London, 2006.

Direct reprint requests to:

Carles Muntaner
R386-Health Science Building
155 College Street
Toronto, ON M5T 1P8
Canada

carles.muntaner@utoronto.ca