Global changes in the economies of most developed nations have impacted the way healthcare is organized, even within largely public systems, and the working conditions of healthcare workers. Since the acceleration of globalization in the 1970s, service-sector workers in developed nations have faced high unemployment, increased skill requirements for most jobs, and a rise in non-traditional work arrangements. These secular shifts in service-sector labor markets have occurred against the background of an erosion of the welfare state and growing income inequality. As well, many healthcare systems, including Canada's, were severely downsized and restructured in the 1990s, exacerbating the underlying negative secular trends in the service sector, and worsening the working conditions for many healthcare workers. Globalization has altered the labor market and shifted working conditions in ways that have been unfavorable to many healthcare workers. Key words: globalization; healthcare workers; economy; work conditions; labor markets; employment security.

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The healthcare workplace has experienced profound changes over the past 50 years, at a time when the world economy has undergone extensive transformation under the influence of economic globalization. While health care has historically been regarded as a locally provided service, the pressures influencing the evolution of this sector in countries across the globe are best appreciated at a supranational level. This paper explores how these changes in economic globalization, characterized broadly by a much freer flow of capital relative to labor and deregulation of markets, influence the health and well-being of workers, focusing primarily on impacts on service-sector workforces in general and healthcare workforces in particular within developed high-income countries.

ECONOMIC GLOBALIZATION AND LABOR MARKETS IN HIGH-INCOME COUNTRIES

Labor markets in Europe and North America (except in the last half of the 1990s) have been characterized by historically high unemployment rates since the early 1970s. In the United States, annual average unemployment rates after 1973 have generally been at least 2% higher than those in the 1947–73 period. In most other OECD* nations, these differences were even more pronounced, as unemployment rates during the 1980s were approximately double those of the 1960s and 1970s. This means that, in general, that changes associated with economic globalization have led to much higher secular unemployment rates than at any time since the end of World War II, a factor that weakens the power of labor relative to capital in labor markets and heightens insecurity and job precariousness for workers.

Besides the generally higher levels of unemployment, the labor markets in most developed countries have shifted dramatically away from manufacturing and towards service-sector employment over the past quarter of a century. The transition to service-based economies began in the 1950s in most developed countries but its pace accelerated dramatically beginning in the mid-
1970s. And, at least in G7† countries, between 1971 and 1991, a rapid expansion of the high-tech knowledge-based segment of the service sector and much less rapid expansion and low rates of employment growth in the distributive and personal-services sub-sectors occurred4‡ (Table 1). Most of the jobs created in the distributive and personal-service sub-sectors over the past 20 years have been occupied by women and immigrants. These sub-sectors also have a high proportion of non-standard employment arrangements and tend to be non-unionized and pay relatively low wages.2,5–9

These two secular trends towards high general levels of unemployment and lower employment growth in the distributive and personal-services sub-sectors of the service sector mean that the opportunities for unskilled workers and those with the least education to gain access to, or stay in, the labor markets in many developed nations are becoming more limited. This creates particularly high risk of precarious employment for workers in the distributive and personal-services sub-sectors, where much of the non-medical workforce in health care is located.

A number of micro-structural shifts may be under way, at least in some developed nations, exacerbating these macro-structural shifts and tending to exclude or marginalize the unskilled from the labor market. In particular, researchers in the United States,10 Canada,11 and the United Kingdom12 have demonstrated an overall increase in the skill level required in jobs over the 1970s, ‘80s, and ‘90s.

For example, in the United Kingdom, the Employment in Britain survey and the Social Change and Economic Life Initiative Survey assessed workers’ perceptions of their jobs’ changes in skill requirements from 1981 to 1985 and from 1987 to 1992.12 This study demonstrated increases in self-reported skill requirements for all categories of workers during this time. In this study approximately four times as many semi- and unskilled manual workers reported increases in skill requirements in their jobs compared with workers in the professional and administrative categories.

As well as increased skill requirements within jobs, researchers in Canada have observed a trend of increasing entry barriers (increasing requirement for

high qualifications, known as “credential inflation”), particularly for unskilled jobs.13,14 For example, Holzer13 compared the qualifications required for various occupations in the early 1980s and the mid-1990s in a large study of Canadian workers. He found that the requirements for post-secondary education in unskilled manual and clerical occupations increased by 60% and 96%, respectively, compared to decreases of 3% for managerial occupations and increases of 6% for professional jobs.

A fourth secular trend in labor markets worldwide has been the rise in non-traditional work arrangements. Part-time positions, fixed-term contracts, shift-work, casual labor, and the proportion of workers holding multiple jobs, which have been grouped under a variety of terms including atypical, non-standard, marginal, and precarious employment, are becoming increasingly prevalent in industrialized nations.7

Estimates of the International Labor Organization (ILO) indicate that 25–30% of the world’s workers (750 to 900 million people) are employed through non-standard contracts, meaning that they work substantially less than full time but want to work more.15 The rate of growth in part-time employment has been dramatic.16 Between 1973 and 1995, part-time employment in the 21 countries included in the OECD doubled from 8.2% to 16.7%.17 By 1989, the share of part-time workers in Sweden was 24%, in the United Kingdom 22%, in Japan and the United States 18%, and in Canada 15%.14 By 1996, part-time employment in the United Kingdom had risen to 24.6% of total employment.18 These increases in part-time employment have gone hand in hand with increases in multiple-job holding, particularly for women.

Brewster et al. found variations in the types of flexible labor demands across Europe.19 A north–south divide existed in which northern European countries experienced rises in part-time labor whereas southern European countries favored non-permanent/fixed-contract arrangements.20 Fixed-term/temporary contracts accounted for 15% of paid employment in the European Union in 1998.21 Part-time, contract, self-employment, on-call, temporary, and day-labor employment accounted for nearly 30% of the American workforce by 1995.22 Non-standard employment arrangements have been particularly prevalent among young workers, who see them as a way to enter the job market.20 However, growing evidence indicates that non-standard employment arrangements are unlikely to lead to permanent positions.23

The secular trend of increased precariousness observed internationally is also found in Canada and among healthcare workers. For example, in 1953 in Canada 3.8% of the workforce was employed part-time, rising to 13.5% by 1980, and by 1997 to 19% nationwide.8,24 In the province of British Columbia, part-time employment increased from 15% in 1976 to 22% in
involuntary part-time rates spiked during the recessions of the early 1980s and 1990s, but unlike unemployment rates, which drop during recovery periods, involuntary part-time rates in Canada have settled at higher levels during recovery periods.25

In British Columbia part-time employment has grown twice as fast as full-time employment over the past 20 years. In addition, there has been an increase in employees working more than full-time, creating a polarization in the workforce such that the proportion of employees working more than 50 hours/week or less than 30 grew from 28% in 1976 to 45% in 1999.24 Likewise, the number of multiple-job holders, who string two or three part-time positions together, has risen across the country. These trends in part-time employment and multiple-job holding are similar to trends observed in other OECD nations during this time.3

Increases in multiple-job holding are particularly evident among women. For example, during the 1980s in Canada there was an 89% increase in female and a 28% increase in male multiple-job holders.9 These trends are amplified in employment sectors dominated by women.20 The health care sector is a major producer of part-time positions. For example, more than one third of nurses in the province of Ontario are employed part-time, and nursing has the fastest-growing part-time rate of any Canadian employment sectors.26

In most developed nations, the recent round of economic globalization has been marked by increased secular unemployment, increased levels of contingent and precarious employment, and a dramatic reduction in the size of the manufacturing labor force. Reduction in the manufacturing labor force and slow rates of growth in the distributive and personal-services sub-sectors, in conjunction with some evidence for upskilling within service-sector jobs and credential inflation, act to reduce opportunities for the unskilled and uneducated to enter the labor market. In the next section we review the ways in which this complex of changing labor-force dynamics may impact health.

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*Manufacturing as defined in this table excludes construction and utilities so that it more closely represents the workforce engaged in actual manufacturing processes.

LABOR MARKET CHANGE AND HEALTH

These secular changes in labor markets, which have occurred over the past quarter of a century, could impact the health of workers in several complex and overlapping ways. Healthcare workforces, in particular, in many developed nations have faced major threats of unemployment (beyond and above the secular increases in unemployment noted in the previous section) as hospital and other healthcare infrastructures have been systematically downsized in the 1980s and 1990s. As well, and in conjunction with downsizing, many of these workplaces have been restructured drastically through the introduction of new work processes, job descriptions, and technologies, a complex process that has altered work conditions, resulting in changed exposures to both physical and psychosocial hazards.

As well, this process of downsizing, technologic change, and restructuring has often gone hand in hand with the reworking of employment contracts as many healthcare workers have moved to non-standard work contracts characterized by more part-time work and, often, less access to benefits. Thus, healthcare workers who retain work in restructured workplaces may face not only new work hazards but also quite new conditions of employment. Finally, in many public health systems the healthcare workforce has been subjected to privatization and contracting out. The process of privatization and contracting out is complex and can involve all of the adverse dimensions of employment encompassed by downsizing and restructuring, includ-

*Downsizing is a common euphemism for deliberate reduction in the size of labor forces within a sector or workplace. Restructuring, often follows downsizing, as employers in many cases move to replace labor with technology. The combination of the downsizing and restructuring may be particularly devastating for workers who remain employed, as they face the loss of workmates as well as having to cope with a technologically, (and therefore often organizationally) rearranged workplace.
ing unemployment, the threat of unemployment, re-employment with altered work conditions, and reduced wages and benefits.

Downsizing:

A large body of evidence indicates that the threat of unemployment is extremely harmful to health. The earliest research examining the link between health and employment status appeared in the midst of mass unemployment during the 1930s. The most powerful available research designs for studying the impact of threat of unemployment are found in plant-closure studies, mainly of blue collar workers. Twenty plant-closure studies have been conducted, mainly in the United States and in Scandinavian nations and mainly with male blue-collar workforces, although, using the Whitehall civil service cohort, Ferrie et al. investigated the impact of threatened job loss on white-collar employees. Results from these studies demonstrated that workers facing an imminent threat of unemployment had elevated blood pressure and increases in depression and anxiety, increased visits to general practitioners (GPs), increased symptoms of coronary heart disease, worse mental health and greater stress, increased psychological morbidity and increased GP visits, decreased self-reported health status and an increase in the number of “health problems,” as well as an increase in the family problems, particularly financial hardship, compared with “control” workers in factories not exposed to the threat of unemployment. This is powerful evidence, with the potential for health selection bias removed, that increased threats of unemployment have major adverse health impacts.

Restructuring

There is a growing body of literature linking restructuring to adverse health outcomes. Workers who remain employed in workplaces as they go through downsizing in combination with restructuring (i.e., survivors) may also face unique threats to health. For these survivors of the downsizing/restructuring process several studies have shown that they experienced reduced job satisfaction, reduced organizational commitment, and greater stress. Two of these studies determined that a downsizing process followed by a restructuring that was perceived as “fair” had a positive impact on survivors’ attitudes to their jobs and commitment to their employers. Two other studies showed that blue-collar workers and technicians were more likely to perceive the downsizing process as unfair compared with supervisors and managers.

As workplaces downsize and restructure the survivors often face drastically new technologies, work processes, and new physical and psychosocial exposures such as reduced autonomy and increased work intensity, changes in the characteristics of social relationships; shifts in the employment contract; and, changes in personal behaviors (such as lifestyle factors including diet, smoking, alcohol consumption, exercise, and sleeping patterns).

Trust is at the core of the psychological contract between workers and employers. Downsizing followed by restructuring may violate workers’ sense of trust, with the result that the employer’s expectations regarding loyalty also may not be met. It is difficult to develop a sense of trust among employees in workplaces undergoing restructuring. Indeed, introducing new managerial strategies such as “total quality management” (TQM) while also pursuing general organizational change and downsizing seriously compromises the effectiveness of these programs. These results have also been found in manufacturing facilities that have moved to lean production methods.

Restructuring may also involve contracting out all or some of the work. A Danish study of stress among bus drivers whose jobs were both restructured and contracted out showed increased levels of urinary cortisol and elevated blood pressure among study participants. In this study both self-reports and objective physiologic measures of stress were used, providing solid evidence that restructuring in combination with contracting out can lead to prolonged stress.

Finally restructuring may result in direct changes to employment contracts. Because the latter often involve de-unionization or otherwise reduced influence and power of the worker in relation to the employer, the level of control over and ability to alter or improve the new restructured physical and psychosocial conditions of work may be limited. Thus, the direct effects of restructuring through altered work conditions may be exacerbated if they occur in conjunction with new contractual arrangements that limit the power of workers to alter the newly restructured workplaces.

Non-Standard Work Arrangements

There is growing international evidence that workers in jobs with non-standard employment contracts have higher rates of occupational injury and disease than workers in full-time stable employment. Several studies have linked non-standard employment with increased rates of injury, high levels of stress, low job satisfaction, and other negative health and well-being factors. For instance, the literature confirms that injury and fatality rates are at least twice as high for self-employed and contract workers as for full-time employees. These part-time and contingent jobs are increasingly located in the growing distributive and personal-services sub-sectors. Because these sub-sectors are most accessible for workers with little education and low skills, the most vulnerable sections of the labor
force will be increasingly exposed to non-standard employment arrangements.

However, workers with non-standard part-time/casual contracts are also less likely to be entitled to workers' compensation. And workers who are covered have been found less likely to make claims for fear of losing their jobs.67 Workers who have non-standard employment contracts are at greater risk from occupational health hazards from hazardous work intensification motivated by economic pressures, inadequate training and poor communication caused by institutional disorganization, inadequate regulatory control for non-permanent employees, and the inability of workers to organize to protect themselves.60

According to Park and Butler,61 compensation systems do not deal well with highly mobile workers employed through non-standard contracts. For example, in the case of a cumulative trauma claim, where the symptoms developed slowly over time and across several employers, determining where an injury occurred and who is responsible is much more difficult than it is for stable workers in standard employment contracts.61

Other studies confirm these findings. Morris62 found that temporary employees at a medium-sized U.S. manufacturing worksite were two to three times more likely to incur injuries than permanent employees in the same workplace. The vulnerability of temporary employees was exacerbated by the perception among these workers that the reporting of work injuries could lead to loss of employment or loss of the chance to get hired on as a permanent employee. These concerns resulted in underreporting of injuries among workers, while the agencies responsible for these temporary workers along with the managers at the worksite expressed apprehension that temporary workers exaggerate workplace injuries, since they were less supervised and had the opportunity to mislead their employers in order to access benefits.62

The financial risk to workers in non-standard employment with inadequate workers' compensation coverage may be exacerbated by low wages as well as less access to benefits, salaries, training, and promotions compared with workers, even at the same worksite, who have standard employment contracts.62 Also, because bankers and credit agencies lend money based on the assumption that people have standard employment, in its absence, the ability to obtain credit and bank loans, find housing, and make pension arrangements may be compromised for workers in non-standard employment.63

Another of the health challenges for precarious workers is that they often lack access to employer-sponsored benefits such as extended health, dental, and pension coverage. These workers are also less likely to have access to employee assistance programs.62

Workers in non-standard employment may be less likely than other workers to address health and safety concerns in the workplace. Aronsson’s64 study of Swedish workers showed that workers with short-term contracts were less likely to voice concerns over environmental issues in the workplace. They were also less likely to be knowledgeable about environmental issues, and they received less health and safety training. These results differed by gender, age, sector, and industry.

Finally, in an international review of the literature on occupational health and contracting out, Quinlan, Mayhew and Bohle65 found that of 29 studies on contracting out and home-based work, 23 demonstrated adverse health effects. These authors describe how competitive tendering policies among government agencies in Australia led to deterioration in the management of contractor safety.65 In order to handle growing occupational health and safety concerns and potential liabilities, the Australian government had to produce a special guide on OHS management for contractors.

CONCLUSION

The labor history of much of the 20th century was a struggle to reduce labor-force precariousness over conditions of work. Movements to establish living wages, regular work hours, and regulated conditions of employment were won in hard-fought battles between workers and employers. By mid-20th century, particularly for male workers, and particularly in large industrial sectors, some control over the terms and conditions of full-time permanent employment with associated job benefits had been gained.66

However, the past quarter of a century has seen a growth in precarious employment even for workers in the sectors that had attained the most stable, full-time, and best-protected conditions of work. For workers who have always been on the periphery, the erosion of employment standards in the traditionally most stable employment sectors has further weakened their position in the labor market. These labor market shifts towards greater precariousness may have adverse health impacts. Research indicates that precarious employment, because it exposes workers to greater job insecurity, less task-level and generalized levels of control over work, less social support at work, and less access to benefits and greater financial insecurity, may through complex interconnected pathways lead to serious adverse impacts on health in working populations.

This may be a particular problem in healthcare workforces. In most developed countries, large segments of the healthcare workforces work in publicly funded healthcare systems. Just as men made employment gains in many of the blue-collar industrial sectors in the 1950s and 1960s, so women, with the acceleration of female labor force participation in the 1970s, began to make real employment gains in the service sectors within publicly funded systems such as education and health care. However, increasingly, as the healthcare sectors in many
developed countries faced budgetary rollbacks in the 1980s and 1990s, downsizing and restructuring resulted in closing of hospitals, renegotiation of conditions of employment, and increasing contracting out, particularly of functions seen as "non-medical."

As well, in many countries functions formerly conducted within public healthcare systems faced pressures to privatize, resulting in growing job insecurity among those facing the threat of privatization and precarious employment, particularly among staffs in nursing homes and community and home-care workers. Ironically, these trends are occurring as healthcare systems in most developed countries move away from their traditional focus on hospital-based care towards models of care in smaller institutions located in the community and towards models of home care. Thus, at the very time they are needed most, the almost completely female, and in many developed countries, immigrant-dominated workforces that staff nursing homes and other community and home care face major deterioration in their working conditions as their jobs become more precarious.

In addition, these changes in the labor force have occurred against the backdrop of an unprecedented rollback of welfare state and unemployment benefits in most developed countries. More restrictive labor markets, particularly for the unskilled, in combination with lower welfare and unemployment benefits, increase the likelihood that precarious employment will be accompanied by greater financial strain and greater threat of financial strain than in the past, when benefits were more generous, potentially exacerbating the relationship between precarious employment and ill health.

In conclusion, globalization had altered the labor market in a way that has been particularly unfavorable to a large segment of the healthcare workforce. There is increasingly reason to be concerned about the health of these workers, unless the current trends can be reversed.

References


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