PAN AMERICAN HEALTH ORGANIZATION
WORLD HEALTH ORGANIZATION

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WORKERS' HEALTH IN THE REGION OF THE AMERICAS

Among its requests, Resolution CSP23.R14 of the 23rd Pan American Sanitary Conference (1990) urges the Member States to increase the development of different institutional workers' health care arrangements in order promote the attainment of universal coverage, soliciting the support of PAHO in this endeavor.

The situation analysis determined that there are major economic and social inequities in the labor sector that have an impact on workers' health, as well as a significant institutional vacuum, particularly in health care for workers in the informal sector, who constitute more than half of the work force.

In light of this problem, PAHO has structured its actions around a comprehensive approach that is preventive, multisectoral, and participatory in nature, within the context of socioeconomic sectoral development. It has prepared the Regional Plan on Workers' Health, which sets out specific programming lines for country action and international cooperation, optimizing the use of resources to improve workers' health in the countries.

The document outlines the situation and trends, the basic features of the Plan (including the expected results), the role of PAHO and the Member States, and the suggested initiatives, as well as the fields in which the principal external actors operate.

This document was considered by the 32nd Session of the Subcommittee on Planning and Programming. The Members of the Subcommittee generally expressed their support for the preventive approach to improve workers' health. They also focused on the principal inequities in the Region in the field of workers' health.

The Committee is requested to analyze the approach of PAHO cooperation from the standpoint of the technical, economic, and political feasibility of the Plan and consider the role of PAHO and the countries in its implementation, offering its observations on possible changes and improvements that can be made.

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1. Introduction

A preliminary version of this document was considered by the 32nd Session of the SPP in March 1999. In the discussions the Subcommittee focused on the principal inequities that impact on workers' health, especially with regard to wages, child labor, and services for workers in the informal sector. It also emphasized the importance of research.

The problems affecting workers' health have been a matter of growing concern in many countries and international organizations, including PAHO/WHO. In the 1990s, this concern has intensified, particularly after the recognition of the sustainable development model as a means for meeting basic needs, improving living conditions for all, offering better protection for ecosystems, and ensuring a safer, more prosperous future. Within this context, workers' health has been addressed directly or indirectly in international, regional, and national forums, and several institutions have taken action.

The Governing Bodies of PAHO have adopted specific mandates on workers' health. Resolution CSP23.R14 (1990) of the 23rd Pan American Sanitary Conference, among others, urged the Member States to increase the development of different institutional workers' health care arrangements in order to promote the attainment of universal coverage. The United Nations Conference on Environment and Development (UNCED, 1992) noted the need for protecting health and safety in the workplace. The International Labor Organization (ILO) has incorporated the concept of sustainable development in its policies. The United Nations Development Program (UNDP) has affirmed the concept of human development, noting that the real objective of development should be to create an environment that enables human beings to enjoy long, healthy, and creative lives.

The Hemispheric activity that began with the Summit of the Americas (Miami, 1994) recognizes the importance of workers' health. The Declaration of Principles of the Summit states that free trade and greater economic integration are key factors for improving working conditions and protecting the environment. More recently, WHO adopted Resolution WHA49.12 (1996), endorsing the World Strategy on Occupational Health for All. The Strategic and Programmatic Orientations for the Pan American Sanitary Bureau, 1999-2002, include the priorities in workers' health for regional action. The XIII Meeting of the Health Commission of the Latin American Parliament (São Paulo, 1998) dealt specifically with the topic of workers' health. In a recent declaration, the Secretary General of the United Nations emphasized that ensuring safe and healthy work environments was a key consideration in all decisions on investment and production. He also emphasized the role of the United Nations system in developing standards, conducting research, providing technical assistance, and increasing the level of public

awareness. At the same time, the countries are making efforts to draft and execute national workers' health plans that address current needs.

PAHO, as the regional agency for health in the Americas, promotes prevention measures to protect public health, advocating the inclusion of health considerations in policy-making, increasing awareness in the public sector and among international agencies, private enterprises, and the public about workers' health problems, and promoting any other changes in policy and practice, as well as behavior, that will have a positive impact on health.

In light of the above considerations, PAHO has analyzed the workers' health situation in the countries of the Region and has found major inequities. For example, the working-age population (WAP) (the population aged 15 to 64) in Latin America and the Caribbean has been estimated at 300 million for 1996, and the economically active population (EAP) at 201 million. Some 55% of this latter population are employed in the informal sector and 10% are farmers. Only 30% of the working population in the formal sector of nine countries of the Region receive health care, mainly through Social Security. Concerning wages, some 20% to 40% of the employed population has an income that does not cover the basic market basket. Moreover, women receive lower wages than men for equal work. Working children run additional risks in the workplace, due to their biology and social situation.

Bearing in mind the mandates of the Governing Bodies and the current situation, which involves countless actors with limited and sometimes isolated objectives; the deficiencies in workers' health care, which reflect a significant institutional vacuum at the national and international; and the trends toward change, PAHO has designed an approach to workers' health care that is comprehensive, preventive, proactive, participatory, and coordinated—an approach that will contribute efficiently to an improvement in the current situation and is expressed in the Regional Plan on Workers' Health.

The current situation and the impact of trends on the health and well-being of the working population are analyzed in greater detail below.

2. Current Situation and Impact of the Trends

2.1 *Composition of the Work Force and Work Profiles*

Estimates for 1996 put the population of the Region of the Americas at 781 million. Of this, the estimated EAP* was 351 million—that is, 44.9% of the total population, with 201 million (57.3%) corresponding to Latin America and the Caribbean and 150 million (42.7%) to the United States of America and Canada. The EAP will continue to grow in Latin America and the Caribbean, reaching an estimated 270 million by the year 2025 (a 34% increase).

Since mid-century, at different rates and to differing degrees, the countries of the Region have shifted from primary agricultural and extractive economies to relatively industrialized economies with trade and service activities, a shift that has modified work profiles. The developing countries are consequently dealing with the dual work pattern of transitional economies, marked by an increasingly differentiated work force among and within them. This work force ranges from the employees of the multinational corporations to workers in the informal sector who barely eke out a living, a situation that accentuates the social and health inequities.

In Latin America policies to promote labor flexibility in commercial enterprises, facilitated by reforms in the labor laws and in hiring regulations, have affected job stability, the work day, shifts, vacation time, and wages.

ECLAC estimates that the percentage of the population employed in the informal sector out of total nonagricultural employment in Latin America increased from 51.6% in 1990 to more than 56.7% in 1996, with the figure ranging from 38% to 64% among the countries. The new employment generated is largely inadequate. Eighty-five out of every 100 new jobs are in the informal sector. Moreover, contracting out of services and the informalization of the employment structure are seriously undermining the quality of jobs and equity in terms of access to services and the social distribution of wealth.

Employment in the informal sector is growing chiefly among traditional economic activities, consisting of small businesses (sometimes linked with medium-sized and large companies) and independent occupations that generally entail higher risks and more unstable working conditions. Added to the biopsychosocial risk factors for workers in the informal sector are the conditions of personal insecurity to which they are exposed on the

* The EAP includes people working in the production of goods and services during a specific period of time (ILO definition). It does not include workers under 15 years of age or older adults.

street and in the home. Work in the informal sector, moreover, exposes family members who directly or indirectly employed in the sector to occupational risks.

With regard to wages, it is estimated that some 20% to 40% of the employed population in Latin America receives a income lower than the minimum necessary to cover the basic market basket of goods and services. The drop in real household income as a result of the decline in the purchasing power of wages, added to inflation, open unemployment, and other factors, obliges many women and children to accept low-paying jobs that are often unstable and unsafe. Indigenous workers in the Andean Area typically earn less than other workers in the same economies.

It was estimated that 56 million women would join the work force by 1995. Women's participation in the work force rose from a rate 37% to 45% between the 1980s and mid-1990s, while men's participation held steady at 78% to 79%. Women generally work in more precarious conditions than men and receive only 71% of the wages that men receive. Also, women usually carry a double burden (paid work, plus housework), which exposes them to greater health risks.

Some 15 million children work in Latin America. One out of every five people under the age of 18 is employed, half of them between the ages of 6 and 14. In the United States the number of child workers is estimated at 4 million. In addition to the usual problems connected with poverty, malnutrition, anemia, and fatigue, children who work run the risks associated with unsafe and unsanitary conditions in the workplace.

2.2 Risk Profiles

Technology development has produced major transformations in the traditional forms of production, resulting in new and varied forms of hazards in the workplace. A study by Leigh, et al., demonstrates the importance of occupation as a risk factor in mortality and potential disability-adjusted life years. The study concludes that in 1990, some of the principal risk factors for mortality in Latin America and the Caribbean —occupational risks—rank seventh in terms of years of life with disability and fourth in terms of years of potential life lost (Figure 1).

In its recent publication, Health, Environment, and Sustainable Development: Five Years After the Earth Summit, WHO calls attention to exposure to risk factors in the workplace, highlighting among the principal risk factors physical overload and ergonomic risks, which affect 30% of the work force in the developed countries and from 50% to 70% in the developing countries; biohazards (more than 200 agents); physical hazards (which affect 80% of the work force in the developing and newly industrialized countries); and chemical hazards (more than 100,000 different substances used in the majority of

economic activities; these include teratogenic or mutagenic chemical substances, which are particularly harmful to maternal health and workers' reproductive health).

Social conditions and psychological stress are increasingly identified as occupational risk factors, affecting virtually the entire economically active population. The differential risks to which workers are exposed imply major inequities that disproportionately endanger the health of the poorest and most vulnerable population groups, since these are the people who hold down the riskiest, lowest-paying jobs with the least monitoring.

2.3 Profiles of Morbidity and Mortality

The social conditions of work, risks, growing social inequities, and other similar factors make the working population more susceptible to disease, more vulnerable to accidents, and more subject to burnout and physical exhaustion.

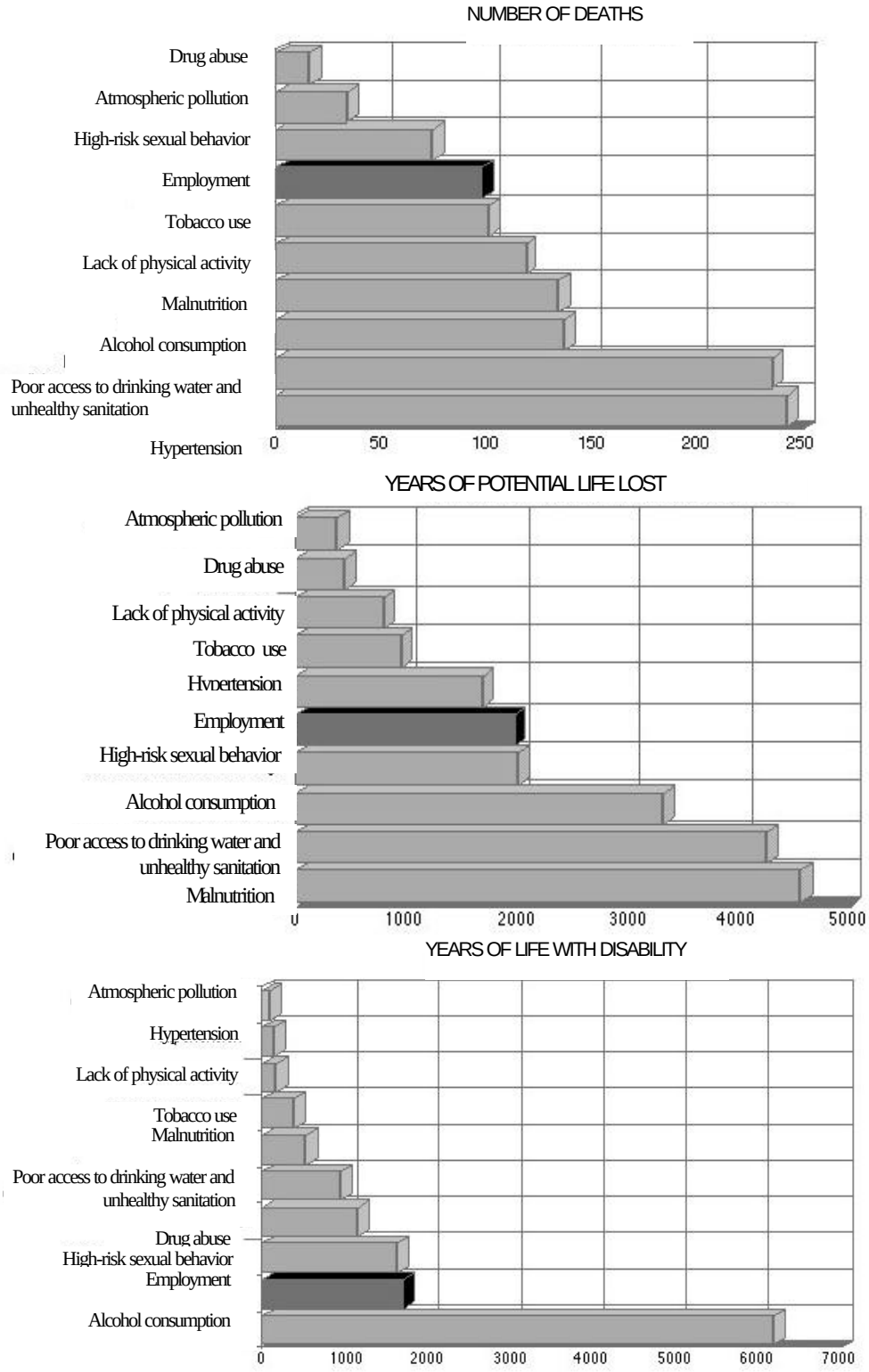
The impact of these multiple factors on workers' health gives rise to an epidemiological profile characterized by the problems typical of the traditional occupational pathologies (occupational hearing loss, acute pesticide and heavy metals poisoning, skin and respiratory diseases), side by side with others recently associated with the workplace (cancer, occupational asthma, occupational stress, cardiovascular and osteomuscular diseases, immunological conditions, and diseases of the nervous system). Also important are reemerging diseases (dengue, leptospirosis, malaria, and tuberculosis). Improvements in the diagnosis, registration, and reporting of occupational morbidity and mortality will make it possible to describe the magnitude and nature of the problem.

In California, in the United States, information on the 10 reportable disease has been consolidated and correlated with the 10 occupational diseases and accidents (Figure 2). Especially noteworthy is the magnitude of the most frequent occupational diseases compared to the diseases requiring compulsory notification.

The International Labour Organization (ILO) has estimated that 36 occupational accidents occur every minute in Latin America and the Caribbean, and that approximately 300 workers die each day as a result of these accidents. It also notes that nearly 5 million accidents occur annually, and that of these, 90,000 are fatal.

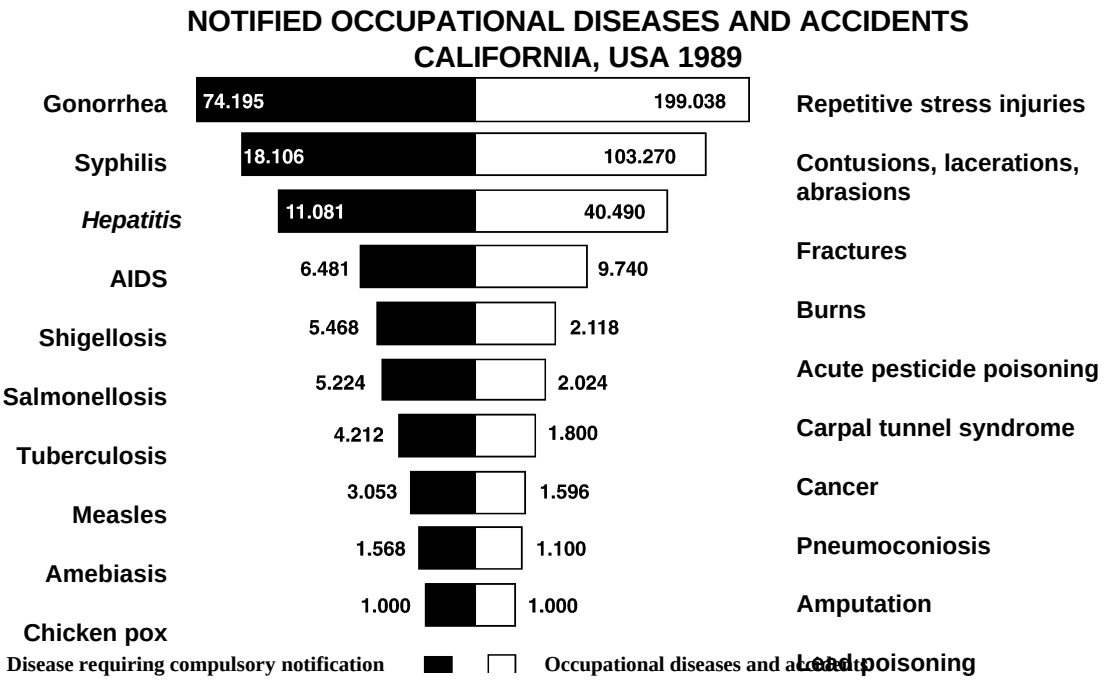
With regard to occupational diseases, WHO estimates that barely 1% to 5% of cases are reported in Latin America and the Caribbean, since only cases resulting in disability subject to indemnification are recorded. The traditional occupational diseases most reported in Latin American and the Caribbean are occupational hearing loss, acute pesticide and heavy metals poisoning, skin diseases, and respiratory diseases.

Figure 1*



* Ref. Leigh J. et al. Occupational Hazards. In: Murray, C.J.L., López, A.D., eds. Quantifying global health risks: The burden of disease attributable to select risk factors. Cambridge, Massachussetts: Harvard University Press; 1996

Figure 2



Sources: 1. Division of Labor Statistics and Research. Work Injuries and Illnesses. California, 1989. San Francisco Department of Industrial Relations, 1989.
2. Centers for Disease Control, Summary of Notifiable Diseases, United States, 1989. Morbidity Mortality Weekly Report 1989,38(54)

Leigh's studies on occupational mortality and morbidity in the United States estimate that roughly 2% to 8% of all cancers are of occupational origin and that 10% to 30% of all types of lung cancer in men can be attributed to occupational exposure. In addition, some 5% to 10% of morbidity from cancer, cardiovascular, cerebrovascular, and chronic obstructive pulmonary diseases in workers aged 25 to 64 are work-related. In Latin America and the Caribbean, chronic work-related diseases (such as cancer, cardiovascular and osteomuscular diseases, and neurobehavioral disorders) are not registered as such.

2.4 *Cost of Accidents and Occupational Diseases*

The available information on the cost of occupational accidents and occupational diseases usually comes from Social Security and includes the cost of health care and pensions for disabilities or death. The cost of occupational injuries and diseases in the

sectors not covered by Social Security is not known; this burden falls on workers and their families and increases demand in the health services.

In Costa Rica, where the National Insurance Institute alone is responsible for managing occupational risks and covers 56% of the country's work force and 84.3% of the salaried population, the direct cost (care and indemnification for occupational injuries and diseases) and the administrative cost for 1995 was US$ 50 million. This amounts to nearly 0.6% of the gross domestic product (GDP), not counting the indirect costs or the costs for the workers not covered.

Estimates in Bolivia and Panama for 1995 yield figures of 9.8% and 11% of GDP, respectively, for occupational injuries and diseases. The ILO estimates the cost of occupational accidents at as much as 10% of the GDP of the developing countries and has calculated that if the countries reduced this figure by half, they could pay their foreign debt. In the United States it was estimated that in 1992 the direct cost ($65,000 million) plus the indirect cost amounted to $171,000 million, with the cost of occupational accidents $145,000 million and the cost of occupational diseases $26,000 million. These latter two figures are considered to be underestimated.

3. Implementation of the Regional Plan on Workers' Health

The basic principles of PAHO technical cooperation in workers' health are Pan Americanism and equity. Technical cooperation responds to the mandates of the Governing Bodies of PAHO and, in particular, to the strategic and programmatic orientations (SPO) on workers' health. It is consistent with the recommendations of UNCED, the objectives of the ILO, and the commitments of the Summits of the Americas and other international organizations.

Concerning the situation of workers' health, PAHO has taken the initiative to fill the enormous gap that currently exists and promote the adoption of a comprehensive approach grounded in the basic principles that guide the action of the Organization, through the Regional Plan on Workers' Health.

The Plan emphasizes the need for national leadership and the important role that the international, regional, and subregional organizations, as well as other institutions, play in the application of a common approach to carry out synchronized interventions and optimize the available resources on behalf of the countries. Also required are the cooperation and participation of employers and workers alike, who with their actions must help to ensure health, safety, and well-being. Groups of experts, individuals from various sectors and disciplines, and the majority of the countries of the Region were involved in the preparation of the Plan. It has also benefited from the conclusions and

recommendations of national and international forums, as well as the national plans for workers' health.

The Plan is conceived as a frame of reference for the countries for the preparation of plans, policies, and programs geared to improving working conditions and worker's health. It is also designed to promote and orient international cooperation, as well as horizontal cooperation among countries, agencies, and institutions, both national and international, with a view to optimizing the available resources. Furthermore, given the changing situation in the countries and the Region, the Plan is a dynamic and flexible instrument that can be adapted to new situations and trends.

Implementation of the Plan requires a joint effort on the part of the countries, the international organizations, bilateral agencies, and other interested parties.

The Plan presents objectives, strategies, and lines of action within the following four program areas in order to consolidate the preventive approach:

- *Program area No. 1: Quality of Work Environments*. The principal approach for improving the quality of the work environment is primary prevention. This requires strengthening the countries' capacity to anticipate, identify, evaluate, control, and eliminate risks in the environments in which workers labor and live. Secondary prevention activities related to the early detection of adverse environmental impacts and tertiary prevention activities linked with physical and social rehabilitation are also considered important.

– *Program area No. 2: Policies and Legislation on the Regulatory Policy Framework*. Action in this area implies strengthening the countries' capacity to set policy and draft legislation on workers' health through ongoing situation analysis, within the context of sectoral reform, integration, and globalization; strengthening the capacity to develop legal instruments to support technical surveillance standards; integrating this work area into the national health, social security, and labor plans, and the national development plans, as well as consideration of these plans in the regional and subregional development processes.

– *Program area No. 3: Promotion of Workers' Health*. This implies promoting the adoption of a positive work culture in the countries, including implementation of the health promotion strategy, using a healthy workplaces approach to the work environment; emphasis on positive aspects of work and the personal growth and development of workers to promote individual and community action by improving the physical, psychosocial, economic, and organizational work environment. This should be carried out

in coordination with activities to promote primary environmental care, healthy municipios, and other similar initiatives to create healthy spaces.

– *Program area No. 4: Comprehensive Workers' Health Services*. This area includes strengthening the countries' capacity to expand the coverage and access of workers to comprehensive health services that include health promotion, disease prevention, care, and physical and social rehabilitation. Comprehensive health services based on the primary health care strategy should be integrated or coordinated with the national and local health systems and implemented by multidisciplinary teams.

In general, developing the program areas of the Plan involved application of the six functional approaches that constitute the basis for describing the cooperation strategy:

(a) mobilization of resources (this includes financial, material, human, information, political, and institutional resources);

(b) dissemination of information;

(c) training;

(d) development of policies, plans, and standards;

(e) promotion of research;

(f) direct technical assistance.

3.1 *Role and Activities of PAHO*

As resources permit, PAHO will continue to provide cooperation to the countries to strengthen national capacity in the field of worker's health, particularly to implement aspects of the Plan for national application. In particular:

- it will promote the mobilization of human, financial, and material resources;

- it will promote and collaborate in the strengthening of institutional networks in scientific and technical, as well as policy, areas;

- it will promote and collaborate in the planning and programming of activities at the national level;

- it will promote the participation and collaboration of international organizations and other external actors in Plan activities;

- it will emphasize interprogrammatic and interdivisional cooperation within PAHO, as well as horizontal cooperation among countries, employing a regional and subregional approach;

- it will promote information systems on workers' health in the countries at the regional and subregional level;

- every four years it will report to the Governing Bodies of the Organization on PAHO cooperation activities, within the context of the implementation of the Plan;

- it will report on workers' health conditions in the Region for inclusion in the publication *Health in the Americas*.

3.2 *Initiatives and Leadership of the National Governments*

The success of the Plan at the country level depends on the leadership and initiatives of the national governments in the following areas:

- sectoral, intersectoral, and interinstitutional action to ensure that the countries act together with a common purpose to improve workers' health;

- determining the areas of international cooperation in which this type of support can be most effective for the country.

Some of the specific activities suggested for the national governments are:

- to establish intersectoral coordination with the ministries, the private sector, the labor sector, nongovernmental organizations, local governments, international agencies, and other actors;

- to develop and implement effective policies and national laws and to adopt national standards for the programs in health promotion, disease prevention, care, and rehabilitation directed toward workers;

- to develop the capacity of workers as a community to understand the link between working conditions and health, developing the capacity of local authorities, promoting community participation, and supporting local initiatives.

3.3 *Areas of Action of the International Organizations and Other Actors*

At the global level several actors are directly or indirectly involved in workers' health. The number varies according to the geographical region, the degree of industrialization, the nature of the problem, and other factors. A list of regional actors is gradually being drawn up, particularly those that are being incorporated into the Plan.