SUBMISSION FROM PROFESSOR CLARE BAMBRA

This submission is based upon C. Bambra (2011) *Work, Worklessness and the Political Economy of Health*, Oxford, Oxford University Press. This book examines the impact of working conditions on health and wellbeing as well as on health inequalities.

1.0 Executive summary

1.1 This evidence submission is based on the findings of Professor Clare Bambra's extensive research into work and health, with a particular focus on her 2011 book *Work, Worklessness and the Political Economy of Health*.

1.2 Professor Bambra has researched work and health for over 12 years – examining how working conditions contribute to public health and health inequalities.

1.3 From a public health perspective, 'bad' quality jobs are those that entail exposure to poor physical, psychosocial or contractual working conditions. 'Good' quality jobs are those that offer better working environments.

1.4 The health effects of low quality jobs are multiple and extensive ranging from musculoskeletal pain through to mental ill health and heart disease.

1.5 The Scottish Government can improve low quality work by increasing workplace health and safety inspections, examining the feasibility of further work place regulations (e.g. regulating the psychosocial work environment), developing and improving guidance for employers, banning zero-hours contracts, regulating other forms of insecure work, implementing a living wage and/or re-examining the contribution basis of work-related benefit and pension entitlements.

2.0 Background

2.1 Clare Bambra (PhD) is Professor of Public Health Geography, and Director of the Centre for Health and Inequalities Research, Durham University. She is an elected Academician of the Academy of Social Sciences and a Fellow of the Royal Geographical Society and the Royal Society of Public Health. She contributed to the Marmot Review of Health Inequalities in England (2010) and Europe (2013); and was a panel member of the Public Health England commissioned report on health equity in the North of England: Due North (2014). She was a member of the NICE guidance development group on incapacity benefit and sickness absence.

2.2 Professor Bambra has researched how work impacts on public health for almost 15 years. She has also conducted a number of systematic evidence reviews of what employers and policymakers can do to improve working conditions and thereby improve the health and wellbeing of workers.

3.0 Evidence: What makes a job 'good' or 'bad'?

3.1 From a public health perspective, job quality (whether a job is 'good' or 'bad') is determined in relation to (a) physical working conditions, (b) psychosocial working conditions, and (c) contractual conditions (including job security, rights at work and pay levels).

3.2 Jobs that require exposure to adverse physical working conditions or adverse psychosocial conditions and those that offer poor terms and conditions, insecurity, few rights at work or low pay, are all, from a health perspective, 'bad' quality. Such working conditions all have negative health consequences.

3.3. In contrast, 'good' quality jobs entail few exposures to adverse physical working conditions, a positive psychosocial environment and good terms and conditions, rights at work and levels of pay that enable a decent standard of living. These jobs, on average, have better health effects.

3.4 This classification into 'bad' and 'good' jobs is done on the basis of the health effects of different working conditions – explored more fully in section 4.

4.0 Evidence: What are the health impacts of low quality jobs?

4.1 The health effects of low quality physical working conditions:[1]

4.1.1 There is clear occupational health evidence that the adverse physical working conditions that characterise low quality jobs – exposure to hazardous materials, physical environmental factors, and ergonomic hazards - can have important negative health effects.

4.1.2 Workers with *exposure to chemical hazards* in the workplace such as lead, cadmium, mercury, asbestos etc have a higher likelihood of developing respiratory diseases and some cancers.

4.1.3 *Environmental factors* such as noise levels or exposure to vibrations are also associated with adverse health outcomes. For example, workers who are regularly exposed to harmful noise levels can develop hearing loss or tinnitus, fatigue, or sleep disturbance and there are also associations (via psychosocial pathways) to heart disease. Vibrations (e.g. from pneumatic tools) are associated with musculoskeletal disorders.

4.1.4 Adverse *ergonomic conditions* at work include exposures to heavy lifting, repetitive work and shift work. Manually lifting heavy loads and repetitive work are both strongly associated with musculoskeletal disease such as lower back pain. Shift work is associated with a variety of adverse health outcomes including gastrointestinal disease, heart disease, fatigue and increased risk of injury.

4.1.5 The European Survey of Working Conditions estimates that 15% to 33% of workers across the EU-15 countries (including the UK) are regularly exposed to potentially harmful physical working conditions: 16% for chemical hazards, 28% for high noise levels, 22% vibrations, 33% heavy lifting, 31% repetitive work, 16% shift work.

4.1.6 On average, workers in jobs that require exposure to these adverse physical conditions will have worse health outcomes.

4.2 The health effects of low quality psychosocial working conditions:[2]

[1] Bambra, C. (2011) Chapter 3 (pages 47-73).

4.2.1 There is a strong epidemiological evidence base which shows that adverse psychosocial working conditions – particularly the combination of low levels of job control and high levels of job demand (the job strain model) – increase chronic stress levels and thereby lead to poorer health and wellbeing outcomes.

4.2.2 Low quality work is defined as jobs that combine low levels of control with high psychological demands. High quality work is where there is high levels of control.

4.2.3 Demands include time pressure, high work pace, high work load and conflicting demands. Control includes control over workload, a variety of work tasks, regular skills development and use of different skills.

4.2.4 These psychosocial risk factors result in poorer health outcomes by means of increasing chronic stress levels. Stress at work results in poor health by suppressing the immune system, raising the heart rate, increasing blood pressure, increasing the release of hormones such as cortisol, which over the long term lead to reduced biological resistance and impaired homeostasis.

4.2.5 According to the European Survey of Working Conditions, 30% of workers across the EU-27 countries (including the UK) report high levels of job strain.

4.2.6 On average, workers with low quality psychosocial working conditions are more likely to develop musculoskeletal conditions, heart disease (and mortality), hypertension, obesity, and mental illness.

4.3 The health effects of low quality contractual working conditions[3]

4.3.1 Over the past few decades there has been a decline in the standard, permanent, full time contract with benefits and a rise in flexible, insecure or precarious employment: increasing numbers of people are working on either temporary contracts or no contracts (‘zero hours’), with limited or no employment, pension or welfare rights. These jobs are also often characterised by low pay levels.

4.3.2 There is an emerging evidence base which shows that insecurity at work has adverse effects on physical and psychological health and wellbeing.

4.3.3 Studies have also found that insecure work is as ‘bad’ for health as unemployment: jobs with low quality terms and conditions do not protect against physical or mental ill health.

4.3.4 There is a longstanding evidence base which shows that those in receipt of lower pay are more likely to experience adverse health outcomes (physical, mental and behavioural) as well as lower life expectancy and higher mortality rates.

4.3.5 The European Survey of Working Conditions estimates that 16% of workers across the EU-15 countries (including the UK) are on temporary (including zero hour) contracts. Women (17.5%) are slightly more likely than men (15.5%) to experience such working conditions as are immigrants, the young and those with lower skills.

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[2] Bambra, C. (2011) Chapter 4 (pages 74-99).

[3] Bambra, C. (2011) Chapter 5, section 5.2.5 (pages 113-117).

4.3.6 On average, workers with low quality contractual working conditions are more likely to develop stress, fatigue, musculoskeletal pain, hypertension, and mental illness (such as anxiety and depression). They are also more likely to engage in unhealthy behaviours (e.g. alcohol consumption). There is also evidence that associates temporary working with higher rates of mortality.

4.4 Low quality jobs, multiple exposures and health inequalities [4]

4.4.1 The three health-damaging aspects of low quality work (physical, psychosocial and contractual conditions) are often clustered and experienced at the same time, by the same workers.

4.4.2 For example, workers on insecure or low paid contracts are more likely to also experience adverse physical and psychosocial working conditions.

4.4.3 Lower skilled workers are more likely to be exposed to adverse physical working conditions. For example, in the UK, injury rates are more than 6 times higher amongst elementary workers than amongst managers or those in professional occupations, whilst repetitious or monotonous tasks are 60% higher.

4.4.4 Stressful psychosocial working conditions are also more prevalent amongst lower skilled workers with 85% of professionals reporting that they have control over their work compared to only 55% of elementary occupations (EU working conditions survey). Health Survey for England data suggests a three-fold difference in levels of control between these occupational groups.

4.4.5 Low skilled workers are also more likely to experience low pay and poorer terms and conditions.

4.4.6 As such, working conditions contribute greatly to health inequalities

5.0 What can the Scottish Government and public policy makers do to improve job quality in Scotland?[5]

5.1 There is extensive existing health and safety legislation around minimising exposure to health-damaging noise, vibrations, or chemical exposures. The Scottish Government could ensure the better enforcement of this legislation by increasing the number and frequency of inspections in Scotland, especially in the most high risk workplaces. Research conducted in the construction industry suggests that companies subject to recent inspections have better working conditions and lower injury rates.

5.2 In terms of repetitive tasks or heavy lifting, there is existing best practice guidance from the Health and Safety Executive outlining measures that employers can take to minimise the adverse health effects on their employees (such as rotating tasks, regular short breaks). The Scottish Government could revisit this guidance and further publicise it amongst Scottish employers and/or examine whether legislation (e.g. around break frequency) could be effective.

[4] Bambra, C. (2011) Chapter 3, section 3.4 (pages 66-70),Chapter 4, section 4.3 (pages 91-95), and Chapter 5, section 5.2.5 (pages 113-117).
[5] Bambra, C. (2011) Chapter 7, section 7.1 (pages 163-170) and section 7.2 (pages 170-174).

5.3 In terms of shift work, the evidence suggests that some shift working patterns are less harmful to the health and wellbeing of workers than others (more ergonomic patters), that having some employee control of when their shifts are scheduled, decreasing the lengths of shifts (especially for night shifts) or providing nap breaks, education or other forms of support, can help mitigate the ill health effects of shift working. The Scottish Government could examine this evidence base and develop advice and guidance for employers as well as examining the feasibility of legislative routes.

5.4 In terms of the psychosocial work environment, evidence suggests that micro-organisational changes that increase task variety or team working and macro-organisational changes such as increasing the role of employees in decision-making practices about their work place (e.g. German workers councils), increase employee control and thereby improve health. The Scottish Government could consider interventions to increase employee control at work as well as consider the wider regulation of the psychosocial work environment (as is the case in Sweden and Norway).

5.5 In terms of improving the quality of contractual working conditions, the Scottish Government could examine the feasibility of banning zero-hours contracts, regulating other forms of insecure work, implementing a living wage and/or re-examining the contribution basis of work-related benefit and pension entitlements.

6.0 Relevant Publications

C. Bambra (2011) *Work, Worklessness and the Political Economy of Health*, Oxford, Oxford University Press. http://ukcatalogue.oup.com/product/9780199588299.do

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