

Macro Drivers of Health Equity: Discussion Paper for the Expert Forum



Linden Farrer & Stecy Yghemonos (EuroHealthNet)
Régine Kiasuwa, Bart Vanhercke (European Social Observatory)



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European Social Observatory is a centre for research, study and other activities in the field of social policy and employment in Europe. It analyses the impact of European policies on the social sphere at national and European level, and formulates proposals, carries out research and produces training tools so as to reflect on the social dimension of the European Union.

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EuroHealthNet is a not-for-profit network of regional and national agencies responsible for health promotion, public health and disease prevention in Europe. Its aim is to help improve health and health equity within and between EU member states by exchanging information inside and outside the network, and by supporting projects and policy developments with members and EU institutions. EuroHealthNet currently has 35 members or partner agencies in 27 European countries.

For more information, see <http://eurohealthnet.eu>.

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Introduction

This Discussion Paper has two main objectives. The first is to frame an understanding of the relationships between employment and health inequalities in European Union (EU) member states. Starting with some key concepts and an outline of the general linkages between employment and health inequalities, it then presents the roles played by the EU and international organisations in regulating health, labour markets and globalisation and their effects on the social determinants of health. The second objective is to stimulate discussion on macro drivers for a meeting organised by the "Working for Equity in Health" project, for which this Paper has been produced. For this reason, there is no concluding section to this paper, though implied and explicit pointers to policies that may work to reduce health inequalities are scattered throughout.

A lot of ground is covered: the social determinants of health, the social gradient in health, welfare state typologies, EU socio-economic strategies, regulation of the internal market, the effects of economic globalisation on health and the roles played by key international institutions. Although we refer to peer-reviewed scientific research in reputable journals, there is clearly much more that could be said on each of these subjects. As such, the aim of this paper is to provide a platform for discussion and some relevant analysis and pointers for further research rather than a comprehensive overview of any of these issues – something that would be well beyond the scope of a paper such as this.

Discussion on these issues comes at a historic juncture, as countries struggle with a crisis that has seen vulnerable people in particular lose their jobs, with resultant increases in stress and uncertainty and threats to public health. In 2008 the WHO's director-general Margaret Chan warned that health problems would increase as people struggled with unemployment and poverty: "It should not come as a surprise that we continue to see more stresses, suicides and mental disorders"¹. Indeed, recent data from one of the countries hardest hit - Greece - shows that it has seen a 36% increase in people attempting suicide attempts in 2011 compared to 2009 (Economou, 2011), and a 20% rise in heroin use in 2009 alone alongside a host of other disturbing statistics (Kentikelenis, 2011), demonstrating just how detrimental such crises can be to public health.

As we shall see, despite increased pressures on public safety nets, the most common response so far has been to accelerate a two-decade-old trend in the rolling back of state welfare provision, leaving ever more European citizens in precarious situations in society. As such, we hope that this paper provokes fruitful discussion and helps build towards more suitable policy responses to the current economic and political situation that we find ourselves in today.

¹ As reported on "The human factor" (Irish Medical Times), <http://www.imt.ie/features-opinion/2011/10/the-human-factor.html>.

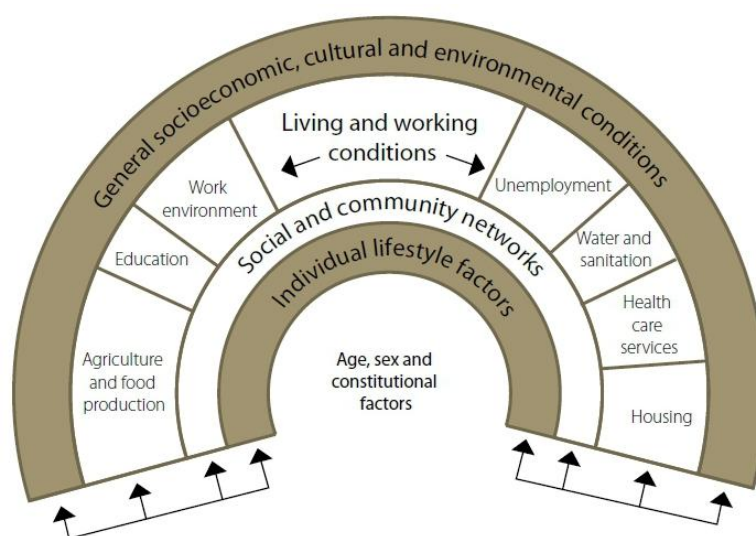
1. Conceptual Framework

A European Commission (EC) report on health inequalities published in 2006 noted that "At the start of the 21st century, all European countries are faced with substantial inequalities in health within their populations, particularly between people with higher and lower socio-economic positions. People with a lower level of education, a lower occupational class, or a lower level of income tend to die at a younger age, and to have, within their shorter lives, a higher prevalence of all kinds of health problems" (Mackenbach, 2006: 41). Noting that health inequalities are widening and deeply rooted in the social stratification systems of modern societies, it warned that effective action will take time and require considerable concerted efforts. Yet, calls to make reducing inequalities in health a priority - whether for moral or economic reasons - are backed up by firm scientific data.

This first section outlines the social determinants of health, the social gradient in health, and an overview of the linkages between welfare state regimes and inequalities in health.

1.1 The Social Determinants of Health

Dahlgren & Whitehead proposed the Health Determinants Model in 1991, illustrating how the conditions into which people are born, grow, live, work and age - the social determinants of health - are interlinked. Although health care services do play a role in determining health, more important are the social and economic conditions that make people ill and in need of medical care in the first place. These conditions have a cumulative effect throughout the life-course, though conditions before birth and during early childhood are particularly important in determining future health (Wilkinson & Marmot, 2003; Blane, 2006).



Source: European Commission (2011a), adapted from Dahlgren & Whitehead (1991)

Through their legislative work, national governments have a strong influence on each of the layers in the model; their policies directly influence socio-economic and living and working conditions, they

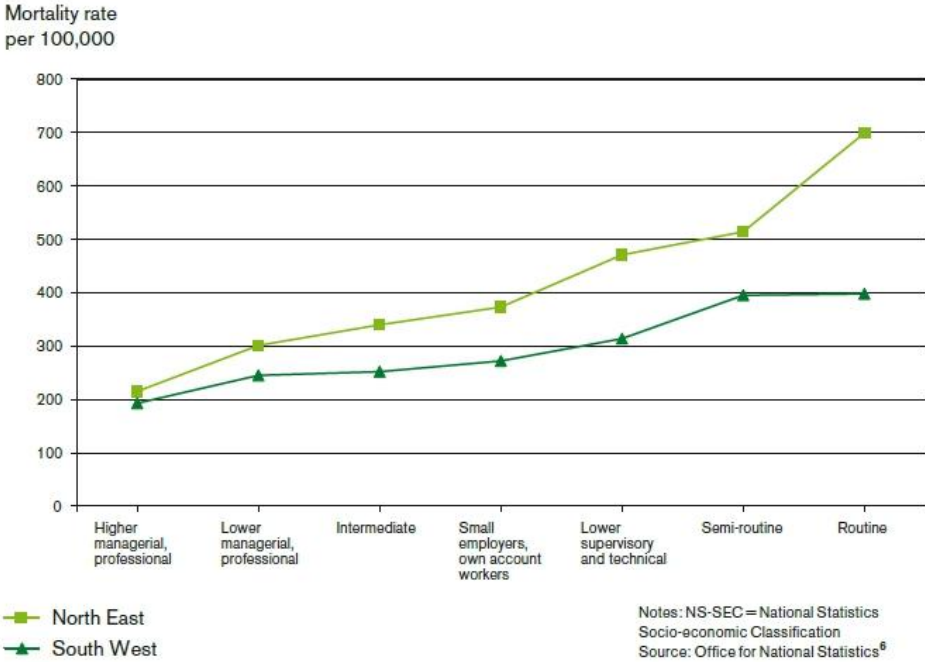
play a role in supporting social and community networks, and they (can) take actions on specific lifestyle factors. On the innermost layer - age, sex and constitutional factors - governments have considerable potential influence through gender equality, family, discrimination and immigration policies. International organisations also play a role in determining health and health inequalities, by shaping the context within which member states and the EU legislate.

1.2 The Social Gradient in Health

Unequal distributions of power, social status and resources (e.g. income) at global, national and local levels, are responsible for most of the health inequities - the unfair and avoidable differences in health status - seen between and within countries (WHO, 2010). Although socially excluded and minority groups are particularly vulnerable to poorer health, differences in rates of illness and health affect everyone: an individual’s health status diminishes together with their socio-economic status at each point along the gradient. This is referred to as the social gradient in health.

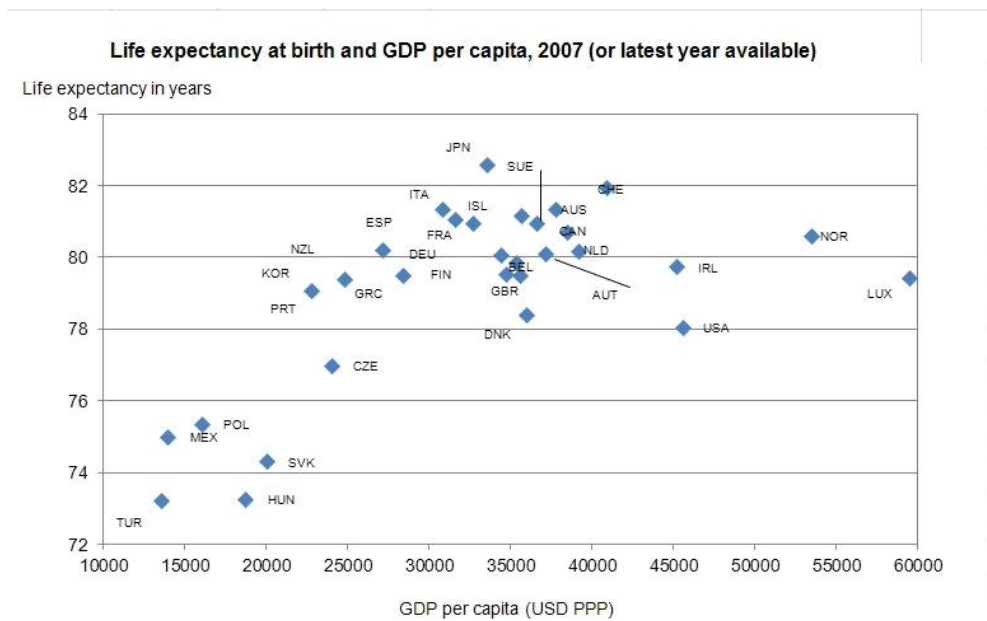
The following figure shows mortality rates by socio-economic classification in two regions of the UK, illustrating just one of many examples of this social gradients in health.

Figure 2 Age standardised mortality rates by socioeconomic classification (NS-SEC) in the North East and South West regions, men aged 25–64, 2001–2003



Source: Marmot (2010)

In general, richer countries (as measured by GDP) have more positive health outcomes than poorer ones. But beyond a certain point increases in GDP appear to make very little (or no) difference.

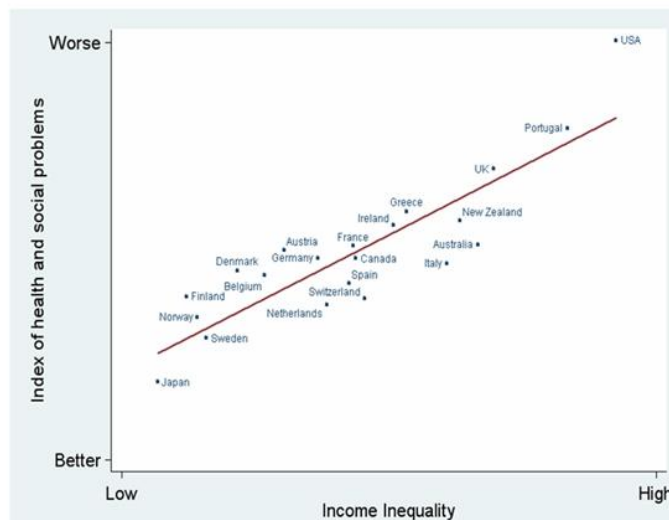


Source: OECD Health Data (2009)²

In fact, richer countries exhibit a relationship between inequality and health and social problems, illustrated as follows:

Health and Social Problems are Worse in More Unequal Countries

- Index of:**
- Life expectancy
 - Math & Literacy
 - Infant mortality
 - Homicides
 - Imprisonment
 - Teenage births
 - Trust
 - Obesity
 - Mental illness – incl. drug & alcohol addiction
 - Social mobility



Source: Wilkinson & Pickett (2009)

Relationships between increased income inequality and health and social outcomes have been heavily contested, though recent analysis does find evidence of an adverse effect of income inequality on health, and support for the 'threshold effect hypothesis' that posits the existence of a threshold of income inequality beyond which adverse impacts on health begins to emerge (Kondo *et al.*, 2009). Furthermore, research demonstrates that "the association between income inequality and mortality is considerably stronger than can be accounted for by statistical artifact... research underpinning public health policy should therefore take a broad view of the importance of the social milieu as a fundamental determinant of health" (Wolfeson *et al.*, 1999).

² Figure created using OECD data available at <http://tinyurl.com/6efmlvz>.

1.3 Welfare State Regimes & Health

Work plays a fundamental role in determining inequalities in morbidity and mortality. The relationship between work, worklessness and health inequalities is influenced by the broader political and economic context of welfare state regimes: states determine levels and the methods by which they (re)distribute resources, and also play a role in determining how socially mobile an individual may be in society. Significant inter-generational transfers of educational level and salary³ (Johansson, 2010) mean that the labour market not only reflects socio-economic inequalities but also helps reproduce them.

The first serious typology of welfare states was proposed by Esping-Andersen (1990), who based it on three principles: decommodification (the extent to which an individual's welfare is reliant upon the market), social stratification (the roles welfare states play in maintaining or breaking down social stratification), and the public-private mix (the relative roles of the state, family and market in welfare provision). Applying these principles to welfare regimes, Esping-Andersen identified three ideal regime types (exemplified by a particular country): Liberal (USA), Conservative (Germany) and Social Democratic (Sweden). Following widespread debate amongst scholars, consensus emerged on the addition of two categories to the typology, Southern and Eastern regimes⁴.

Welfare regime	Countries	Description
Scandinavian	Denmark Finland Norway Sweden	Characterized by universalism, comparatively generous social transfers, a commitment to full employment and income protection and a strongly interventionist state. The state is used to promote social equality through a redistributive social security system.
Anglo-saxon	United Kingdom Ireland	Characterized by its basic and minimal levels of provision: social transfers are modest and often attract strict entitlement criteria; recipients are usually means-tested and stigmatized; the dominance of the market is encouraged both passively, by guaranteeing only a minimum, and actively, by subsidizing private welfare schemes.
Bismarckian	Germany France Austria Belgium (Netherlands)	Distinguished by its 'status differentiating' welfare programmes in which benefits are often earnings related, administered through the employer and geared toward maintaining existing social patterns. The role of the family is also emphasized and the redistributive impact is minimal. However, the role of the market is marginalized.
Southern	Greece Italy Portugal Spain	Characterized by a fragmented system of welfare provision which consists of diverse income maintenance schemes that range from the meagre to the generous and a health care system that provides only limited and partial coverage. There is also a strong reliance on the family and charitable sector.
Eastern	Czech Republic Estonia Hungary Poland Slovakia Slovenia	Clearly the most under defined and understudied region in terms of welfare state development. The formerly Communist countries of East Europe have experienced extensive economic upheaval and have undertaken extensive social reforms throughout the 1990s. These have seen the demise of the universalism of the Communist welfare state and a shift toward policies associated more with the liberal welfare state regime notably marketization and decentralization. In comparison with the other member states of the European Union, they have limited health service provision.

³It should be noted that these are generalized descriptions of ideal type regimes; no single country will have all the characteristics of a specific regime.

Source: Eikemo *et al.* (2008a)

Numerous studies have examined the relationship between welfare regime types and health outcomes. Navarro *et al.* (2006) find a clear relationship between long periods of governments led by

³ For example, the wage premium for having a father with high education relative to having a father with medium education (men aged 35-44) is close 80% in Portugal and 30% in the UK (Johansson, 2010: slide 10).

⁴ See Eikemo *et al.* (2008b) for development of welfare typologies, and Blum & Rille-Pfeiffer (2010) for recent analysis.

pro-redistributive parties and low infant mortality; Bambra (2005) finds that countries with more socially redistributive-oriented political parties in power for longer tend to have better health outcomes; Eikemo *et al.* (2008a) find that countries with the least extensive welfare states have the largest income-related health inequalities, suggesting that a 'minimal approach' to welfare exacerbates health inequalities. Moreover, studies of individual 'components' of welfare regimes, such as Swedish paternity leave - showing that fathers who take paternity leave have a 16% reduced risk of death compared to those who do not -, give further credence to the notion that more 'maximal' welfare regimes favour more positive health outcomes (Månsdotter *et al.*, 2007).

1.4 Working Conditions: Physical Work Environment

Successive studies since the Black Report (Department of Health, 1980) have found that wage differentials have a greater overall impact on health than actual working conditions. Hours and patterns of work, and the type of work itself do, however, make a contribution to the social gradient in health. Data shows that professionals have much less exposure to the major physical hazards (dangerous chemicals, noise, vibrations, repetitive work, shift work and heavy lifting) than lower occupational groups.

Figure 3.6: Type of exposure to ergonomic risk factors, by sector and occupation (average standardised (z) score)

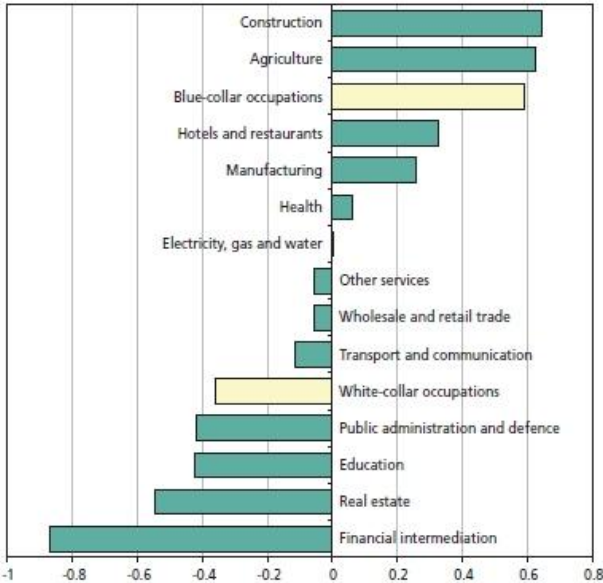
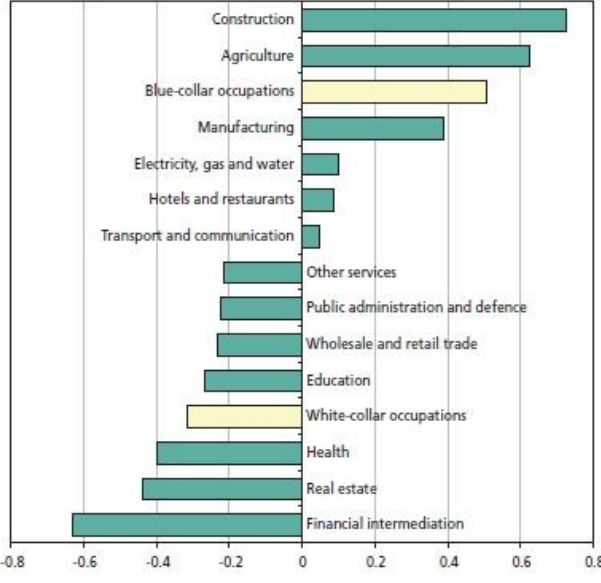


Figure 3.8: Exposure to noise/temperatures, by sector and type of occupation (average standardised (z) score)



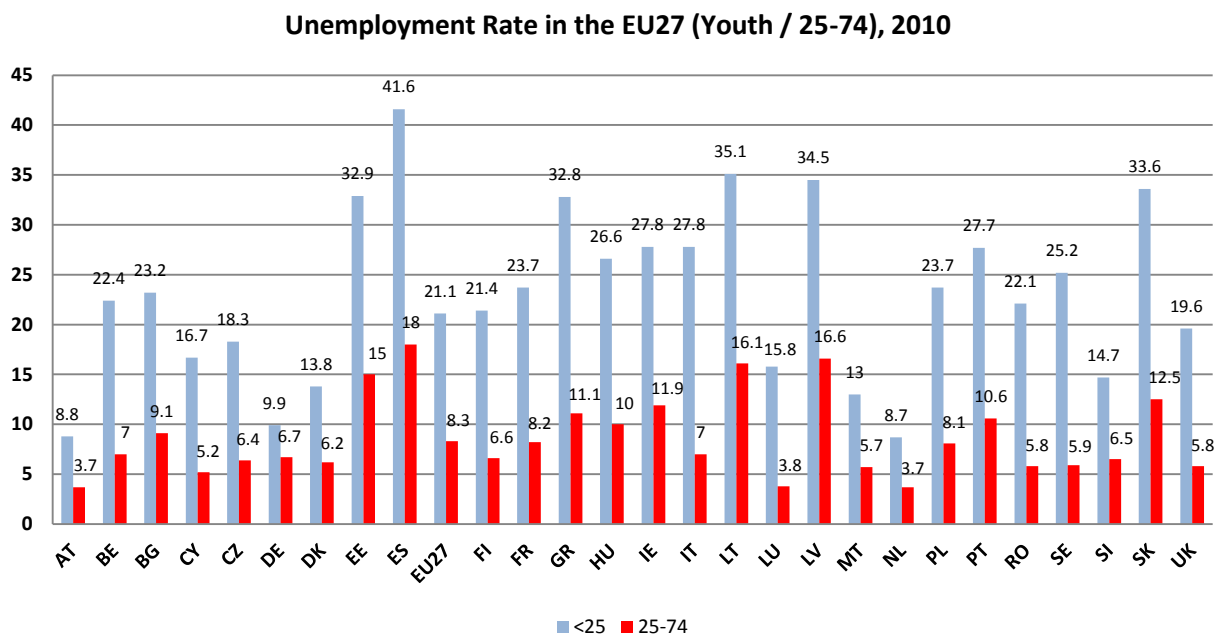
Source: Eurofound (2007)

Some risk factors, such as heavy workloads and vibrations, have barely changed over the last 20 years. Others, such as exposure to tobacco smoke and health and safety legislation, have changed radically for the better (Eurofound, 2010b). Even when employers do uphold their legislative responsibilities in terms of health and safety, however, accidents still happen: in the EU15, in 2007,

3.6% of workers had a non-fatal accident at work and 2.1 per 100,000 workers had a fatal accident⁵.

1.5 Unemployment, Poverty & Social Exclusion

In August 2011 9.5% of EU27 citizens were unemployed, representing 22.5 million people. The youth unemployment rate was more than double this, standing at 21%⁶.



Source: Eurostat⁷

In terms of the prevalence of self-related poor health, evidence shows that unemployment accounts for up to 81% of the inequalities between the most and the least affluent socio-economic classes in the English working-age population (Bambra, 2010). In the EU27, 25.4% of inactive and unemployed people reported “very bad” or “bad” health compared to 3.1% of employed; job losses due to ill health are also more prevalent in lower than higher economic classes (Eurostat, 2010).

Unemployment can lead to social exclusion and contributes to poverty, particularly where welfare state regimes are less developed or active. In 2010, 79 million Europeans lived below the poverty line, representing 16% of the EU27 population⁸. Some groups exhibit a higher than average risk of exposure to poverty: unemployed people (43%), immigrants from outside the EU (30-45%), children in single parent households (34%), large families (25%), single person households (25%), persons with low levels of educational qualifications (23%), elderly women (22%), young adults aged 16-24

⁵ See “Statistics of workplace fatalities and injuries across the European Union”, <http://www.hse.gov.uk/statistics/european/index.htm>.

⁶ See http://epp.eurostat.ec.europa.eu/statistics_explained/index.php/Unemployment_statistics.

⁷ Figure created using Eurostat 2010 data (Seasonally Adjusted Figures), available at:

http://epp.eurostat.ec.europa.eu/portal/page/portal/product_details/dataset?p_product_code=UNE_RT_A.

⁸ Where poverty is defined as 60% of a country’s median income. See “Poverty and Inequality in the European Union”, <http://www.poverty.org.uk/summary/eapn.shtml>, Nolan & Whelan (2011) and “European Year for Combating Poverty and Social Exclusion”, <http://ec.europa.eu/social/main.jsp?langId=en&catId=637>.

(20%) and children (20%); children in lone-parent, large or ethnic-minority families, and those with unemployed or disabled parents were at particular risk of poverty (Wall *et al.*, 2010a). Although work is one of the key routes out of poverty, in the EU27 8% of those holding a job (13% of those employed on temporary contracts) in 2008 were at risk of poverty (Wolff, 2010).

In a society where children's well-being is largely determined by the socio-economic status of their parents, and where social inequalities and social advantages and disadvantages are transmitted across generations, investing in children's well-being "is not only a moral obligation but also an economic priority" and "probably the most effective route towards sustainable social, economic and political progress in Europe"⁹. Because unemployment, poverty and social exclusion are associated with poorer health and premature mortality (Bambra, 2010), "the fight against poverty and social exclusion is crucial for tackling health inequalities" (Judge *et al.*, 2006).

1.6 Welfare Reform

Welfare regimes play a key role in determining inequalities in health between employed and unemployed people, and their extensiveness helps shape inequalities more generally. Social transfers have a significant impact on reducing poverty among children (39.4%) and adults (9%) (Eurostat, 2010), and as we have seen, more 'maximal' approaches to welfare result in better health outcomes.

Positive future reforms might include adequate and timely support to meet basic needs (for example nutrition, physical activity, housing, psychosocial interactions, transport, medical care and hygiene), minimum income schemes¹⁰, various back to work, training and social inclusion projects and programmes (as some people may not be able to (re-)enter the labour market), and "proportionate universality" (Marmot, 2010) without recourse to means testing. Practical grassroots experience shows that families require a package of welfare, balancing provision of time, services and resources (COFACE, 2001), and children would benefit from more comprehensive after-school services, affordable, accessible and high-quality child care and targeted support for vulnerable families (Eurochild, 2011). Given that income and inequality affects health and lessens or worsens social problems, it makes sense to tackle both; a "range of policy levers can be used to do this: from redistribution through the tax/benefit system, to original income and wealth policies, to stronger public services to a greater focus on equal opportunities" (Rowlingson, 2011).

Yet following the 'golden age of welfare state development' in Europe from 1945-1974, welfare has more recently been subject to a series of reforms - sometimes termed 'neo-liberal' - that have emphasised retrenchment, privatisation and personal rather than collective responsibility. Analysis of changes in European welfare regimes finds a 6% increase in commodification between 1980 and 1998 (Bambra, 2005), with income inequality increases "particularly pronounced in those nations

⁹ See "Child Poverty in the EU", <http://www.eurochild.org/en/policy-action/child-poverty-in-the-eu/index.html>.

¹⁰ Moves are afoot at the EU level on minimum income schemes, but are many years away from possible fruition.

adopting more stringent neo-liberal or market-oriented politics and policies” (Coburn, 2004). Such reforms, based upon the belief that 1) markets are the best and most efficient allocators of resources in production and distribution, 2) societies are composed of autonomous individuals motivated by material and economic considerations, and 3) competition is the major vehicle for innovation, have undermined the welfare state and existing class structures leading to greater inequality, lower social cohesion and lowered health statuses (Coburn, 2000; Coburn, 2004).

Given that most Europeans’ basic needs are already met, reforms such as these may have stimulated what Marmot (2004) terms “Status Syndrome”, where perceptions about relative status produce negative emotions such as shame and distrust, resulting in anti-social behaviour, reduced civil participation and cohesion in communities, and ultimately impacting negatively on health. But despite the increased public emphasis on personal responsibility and competition rather than collective responsibility and solidarity, social mobility is higher in more equal countries¹¹. And as noted by the Marmot Commission, such psychosocial effects of relative deprivation remain untouched by material economic interventions (WHO, 2008).

One might assume that recent welfare reforms have taken place with the tacit - or even explicit - consent of European electorates, and that public opinion therefore has a negative effect on the social determinants of health. Research indicates that across the EU27 individuals with strong negative perceptions of social welfare spending generally have a lower educational level, no personal experience of welfare and a rightist and conservative political stance, whilst individuals with a positive perception are more satisfied with their position in society, trust government more and hold more ‘leftist’ political positions. However, this same research indicates that in only three European countries (the United Kingdom, Slovakia and Hungary) does public opinion perceive welfare more negatively than positively (Oorschot, 2010), indicating that reforms of welfare regimes might not always have been carried out with the explicit consent of European electorates. Regardless, for welfare reform to be implemented which favours effective action on inequalities in health (and hence inequalities in power, social status and resources), the right conditions at the level of public opinion have to be fostered to enable this to take place.

¹¹ See “Evidence: Social Mobility”, <http://www.equalitytrust.org.uk/why/evidence/social-mobility>.

2. Role and Influence of the EU in Shaping the Relationship Between Employment and Health Inequalities

Although the primary responsibility for health-related policies in the EU lies with member states - the EU having only limited direct legislative competence on health systems themselves (Hervey, 2008) - the EU does have competence in health promotion and disease prevention, and a role to play in co-ordinating and providing support to member states in order to attain 'a high level of human health protection'. In addition, the EU has competence in areas affecting the social determinants of health, such as health and safety, agricultural policy (as part of which public health has recently been treated more prominently), environment, transport, employment and consumer protection. Its role in shaping the single market and regulating trade within and without the bloc, in particular, has considerable potential impact on the social determinants of health.

2.1 Health & Safety and Employment

Improving health and safety at work was an early objective of the European Union. It became a competence after the Single European Act (1986), and was legislated on with the Framework Directive on Health and Safety (1989)¹². It now represents "one of the most important advanced fields of the social policy of the European Union"¹³. On-going work includes EC proposals for improving protection of workers from harmful electromagnetic fields¹⁴, and improving legislation on work-related musculoskeletal disorders, which affect 40 million workers in the EU and account for 49% of workplace absences and 60% of permanent incapacity to work (Bevan *et al.*, 2009).

In others fields of employment policy, the EU is constrained by limitations on its powers, the continuing influence of internal market considerations, and the need for political consent. In this policy area - which does not fall within its exclusive competence - the EU can only act "in so far as the objectives of the proposed action cannot be sufficiently achieved by the Member States, either at central level or at regional and local level, but can rather, by reason of the scale or effects of the proposed action, be better achieved at Union level"¹⁵. As such, its main role is to co-ordinate actions (for example through the European Social Fund and PROGRESS¹⁶), monitor and analyse employment issues, and recommend action so as to ensure progress towards agreed European goals. Its

¹² Directive 89/391, see "Health and safety", <http://www.eurofound.europa.eu/areas/industrialrelations/dictionary/dictionary8.htm>.

¹³ See "Health and safety at work", <http://ec.europa.eu/social/main.jsp?catId=148> & <http://osha.europa.eu/en/legislation/index.html> for a full list of EU legislation in this field.

¹⁴ See "Commission proposes to revamp rules to protect EU workers from harmful electromagnetic fields", <http://europa.eu/rapid/pressReleasesAction.do?reference=IP/11/704&format=HTML&aged=0&language=en>.

¹⁵ See "Competences of the European Union", <http://www.eurofound.europa.eu/areas/industrialrelations/dictionary/definitions/competencesoftheeuropeanunion.htm>.

¹⁶ See example projects funded by PROGRESS at <http://ec.europa.eu/social/BlobServlet?docId=6325&langId=en>.

overriding aim is to promote 'flexicurity' ('flexible but reliable contractual arrangements'), increase the employability and adaptability of the workforce, and promote effective labour market policies to help workers cope with labour market change and modern social security systems to provide adequate income support (European Commission, 2011b). The EC recently argued that boosting employment, ensuring healthy and safe working environments, tackling long-term unemployment, and striving to provide adequate and accessible social protection systems were key means of tackling inequalities in health (European Commission, 2011a).

2.2 Important 'Shapers' of EU Health Inequalities

2.2.1 The Single Market

One of the first concerns of the (then) European Economic Community/Common Market was the integration of economic markets by simplification of existing rules and removal of barriers to trade. Since 1950, more than a thousand directives have been adopted in order to regulate the internal market¹⁷ with the stated aim of enabling everyone in the EU - individuals, consumers and businesses - to make the most of direct access to 27 countries and 480 million people¹⁸. The cornerstones of the single market are said to be the 'four freedoms' - the free movement of people, goods, services and capital¹⁹.

The principal rationale behind this strategy is the argument that increased market competition between member states leads to lower prices for consumers. However, pressure on industries to compete has a direct impact on working environments and critics claim it undermines workers' pay and conditions. The tension between increasing competition by removing barriers to trade and protecting jobs and working conditions has long stood at the heart of political struggles and internal contradictions within the European project.

2.2.2 Lisbon Strategy (2000-2010)

The Lisbon Strategy was launched in 2000 as a response to the challenges of globalisation, with the overall aim of becoming "the most dynamic and competitive knowledge-based economy in the world by 2010 capable of sustainable economic growth with more and better jobs and greater social cohesion and respect for the environment"²⁰. It had three main objectives: 1) to increase employment, 2) to reduce the risk of social exclusion and poverty, and 3) to help the most vulnerable (Judge *et al.*, 2006).

The official evaluation of the Lisbon Strategy found it had a generally positive effect on employment

¹⁷ See http://ec.europa.eu/internal_market/score/docs/relateddocs/list-dir/im-directives_en.pdf.

¹⁸ See "The Single Market Act", <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:52011DC0206:EN:NOT>.

¹⁹ See "General policy framework", http://ec.europa.eu/internal_market/top_layer/index_1_en.htm.

²⁰ See "Communication to the Spring European Council - Working together for growth and jobs - A new start for the Lisbon Strategy - Communication from President Barroso in agreement with Vice-President Verheugen {SEC(2005) 192} {SEC(2005) 193}", <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:52005DC0024:EN:NOT>.

(increasing it from 62% in 2000 to 66% in 2008) and on internal competitiveness, though it did not always succeed in lifting people out of poverty, with high levels of child poverty persisting in some member states. Social stakeholders were much more critical, questioning the very basis of the strategy: "Growth and jobs have been prioritized as the necessary pre-condition for social cohesion, assuming a "trickle down" effect on addressing social exclusion and poverty. However, this assumption has clearly not been justified by the results" (EAPN, 2007). Indeed, it could be argued that although the strategy acknowledged the importance of reducing poverty and social exclusion, it did not tackle causes of economic inequality, and was far too passive on the issue of economic globalisation, focusing on responding to it rather than trying to shape it.

2.2.3 The Directive on Services in the Internal Market (2006)

The Directive on Services in the Internal Market (commonly known as the 'Bolkenstein Directive') was an important method of furthering the goals of the Lisbon Agenda by opening up services to the free market. It was harshly criticised by the European left, who stated that it would lead to competition between workers in different parts of Europe resulting in 'social dumping', 'capital flight', and increased 'price competition' between workers in the services sector²¹. As a result of opposition, it was only passed after substantial amendment, including the exclusion of public health and social services from its scope²².

2.2.4 The European Health Strategy (2008-2013)

A White Paper titled "Together for Health: A Strategic Approach for the EU 2008-2013" declared that the role of the EU was to undertake measures to supplement the work of member states on major health threats and issues that have cross-border or international impact. It made reference to the difficulties separating "national or EU-wide actions from global policy, as global health issues have an impact in internal Community health policy and vice versa", though "the EU's contribution to global health... will enhance the EU's voice in global health and increases its influence and visibility to match its economic and political weight"²³. The eventual Health Strategy (2008-2013) outlined three broad areas for action:

- 1) Protecting citizens from health threats such as bioterrorism, global pandemics and the influence of climate change on diseases.
- 2) Fostering good health in an ageing Europe, by anticipating increased pressures on health care spending, and developing measures concerning tobacco, nutrition, alcohol, cancer screening, etc.
- 3) Supporting dynamic health systems and new technologies, by developing a community

²¹ Le Figaro (2007) - Villiers : «La nouvelle directive Bolkestein est un mensonge». Published 15/10/2007, available at: <http://www.lefigaro.fr/politique/20060216.FIG0011.html?104859>.

²² Finally adopted as the Directive 2006/123/EC. See <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:L:2006:376:0036:0068:en:PDF>.

²³ See COM (2007) 630, http://ec.europa.eu/health/ph_overview/Documents/strategy_wp_en.pdf.

framework for safe and high quality health services and managing innovation in health systems²⁴.

The EU Health Programme is the main tool for implementing the health strategy, doing so by co-financing projects and operating costs of non-governmental organisations, jointly financing public bodies in the EU and in joint actions with other EU programmes. It has the objectives of improving citizens' health security, promoting health, reducing health inequalities, and generating and disseminating health information and knowledge²⁵.

The next EU Public Health Programme (2014-2020) - entitled "Health for Growth" - should build on previous objectives, and seek to instate health as a driver of growth. Initial discussions indicate that the next programme will aim to encourage innovation in healthcare, increase the sustainability of health systems, improve the health of the EU citizens and protect them from cross-border health threats²⁶.

2.2.5 Solidarity in Health: Reducing Health Inequalities in the EU (2009)

This EC Communication declared that the increased levels of unemployment and uncertainty caused by the economic crisis were increasing health inequalities between and within EU member states. Establishing a clear relationship between employment, socio-economic status and health inequalities, it stated that "health inequalities are not simply a matter of chance but are strongly influenced by actions of individuals... they are not inevitable"²⁷.

Five key objectives were outlined:

1. Ensuring an equitable distribution of health as part of overall social and economic development.
2. Improving the knowledge base and mechanisms for measuring, monitoring, evaluating and reporting data.
3. Building commitment across society.
4. Meeting the needs of vulnerable groups.
5. Developing the contribution of EU policies.

Responding to these recommendations, the Social Protection Committee declared that the Open Method of Co-ordination (an EU form of 'soft law'²⁸) on Social Protection and Social Inclusion "has a crucial role to play in this context" to ensure access for all to health care services, guarantee

²⁴ See http://ec.europa.eu/health/strategy/policy/index_en.htm.

²⁵ See http://ec.europa.eu/health/programme/policy/2008-2013/index_en.htm.

²⁶ See http://ec.europa.eu/health/programme/policy/proposal2014_en.htm.

²⁷ See COM (2009) 567, http://ec.europa.eu/health/ph_determinants/socio_economics/documents/com2009_en.pdf.

²⁸ See "Open method of coordination",

<http://www.eurofound.europa.eu/areas/industrialrelations/dictionary/definitions/openmethodofcoordination.htm>.

coverage of citizens from all backgrounds and to improve health outcomes for vulnerable groups²⁹. While some would argue that 'hard law' mechanisms are needed for such crucial matters, the Social OMC does provide a platform for the exchange and evaluation of policies related to issues for which the EU has no formal competency, according to the principle of subsidiarity.

2.2.6 The 2020 Strategy (2010-2020)

The 2020 Strategy follows on from the Lisbon Strategy, outlining the EU's strategy for the coming decade. Aiming for 'smart, sustainable and inclusive growth'³⁰, 2020 has targets in five headline areas:

1. Employment: For 75% of 20-64 year-olds to be employed and to reduce youth unemployment.
2. Research, Development & Innovation (RDI): For 3% of the EU's GDP (public and private combined) to be invested in RDI.
3. Climate Change & Energy: To cut greenhouse gas emissions to 20% (or even 30%, if the conditions are right) of 1990 levels, for 20% of energy from to come from renewable sources, and for a 20% increase in energy efficiency.
4. Education: To reduce the early school leaver rate to below 10%, and for at least 40% of 30-34 year olds to have completed third level education.
5. Poverty/Social Exclusion: For 20 million fewer people to be at risk of poverty and social exclusion.

The EU2020 Strategy's relevance to health includes the economic benefits of keeping people active and healthy for longer, the importance of innovation in healthcare, the importance of the healthcare sector in improving skills and creating jobs (employing 1 in 10 of the most qualified workers in the EU), and finding alternative sustainable social models in the context of an ageing population.

According to the Directorate General for Health & Consumers, the main instruments dealing with health are the Innovation Union (including the Pilot European Innovation Partnership on Active and Healthy Ageing³¹), the Digital Agenda for Europe, the Agenda for New Skills and Jobs, and the European Platform Against Poverty³². Although not part of the EU2020 Strategy, the 2012 Year of Active Ageing and Intergenerational Solidarity should also be mentioned, as it is a means of promoting active ageing and enhancing solidarity between generations³³.

²⁹ See SPC/2010/5/4, <http://ec.europa.eu/social/BlobServlet?docId=5363&langId=en>.

³⁰ See "Europe 2020", http://ec.europa.eu/europe2020/index_en.htm.

³¹ Which has the objective of increasing the average healthy lifespan by two years by 2020. See http://ec.europa.eu/research/innovation-union/index_en.cfm?section=active-healthy-ageing.

³² See "Europe 2020 – for a healthier EU", http://ec.europa.eu/health/europe_2020_en.htm.

³³ See <http://www.age-platform.eu/en/age-policy-work/solidarity-between-generations/latest-news/1231-2012-european-year-on-active-ageing-and-intergenerational-solidarity/>.

It is not possible to evaluate the effectiveness of the 2020 Strategy, but it clearly builds on the Lisbon Agenda, with more specific objectives and targets thereby attempting to combine different economic and social visions of Europe and 'different models of capitalism' (Vilpišauskas, 2011). The introduction of an EU poverty target is significant, as it is "a major development in the role accorded to social inclusion in the EU" (Nolan & Whelan, 2011); some other initiatives may also be regarded as positive in terms of tackling health inequalities. Overall however, some important social stakeholders argue 'the balance of policies is still dominated by a neo-liberal approach with priority given to growth' (EAPN, 2011) which 'does not depart significantly from the previous growth and jobs paradigm' (Eurochild, 2010).

3. Effects of Globalisation on Employment and Health Inequalities

The last 25 years have seen the abrupt end of the cold war due to the collapse of communism and the institution of democracy in a number of countries. As recent events have shown in the so-called “Arab Spring”, upheavals are still sweeping the world. These have been accompanied - and in some cases aided - not only by advances in information communications technology (ICT) and increased migration, but also by the spread of an economic paradigm emphasising domestic liberalisation, privatisation of state-owned enterprises and public utilities, and the removal of barriers to international trade and finance in the belief that market-based solutions hold more promise than the national and publicly owned systems of the past. As such, globalisation is a key context for studying a number of different pathways affecting the social determinants of health³⁴.

3.1 Trade Liberalisation

Proponents of economic globalisation argue that competition increases growth, leading to improved health. Where: (1) domestic and global markets are complete, competitive and non-exclusionary, (2) regulatory institutions are strong, (3) asset concentration is moderate, and (4) access to health services is universal and social safety nets are in place, economic globalisation may be desirable from an efficiency, equity and health perspective.

Critics point out, however, that these conditions are rarely in place and the results are marked by ‘asymmetry’, creating winners and losers and growing inequalities between the two. Not only does it work “less well for the currently poor countries and for poor households within developing countries” (Birdsall, 2006), it also ‘shrinks national policy space’ for dealing with public health issues (Labonté, 2007). Pressure to appear ‘business friendly’ may have limited governments’ abilities to implement labour standards, health and safety regulations and redistributive social policy measures (Labonté & Schrecker, 2007). ‘Business-friendly’ international trade agreements are identified as reducing options for dealing with public health issues such as water, sanitation, tobacco, alcohol, firearms, pricing of medication, health practitioner registration, privacy rules, distribution of services based on needs and occupational health and safety standards (PHAA, 2008).

Trade liberalisation has had a substantial impact on food security, producers’ income and food consumption, for example shifting demand from locally produced foods to mass-produced processed foods with negative dietary impacts (Labonté, 2007). More recently, ‘excessive’ financial speculation has contributed to increasing price volatility and higher food prices, exacerbating global hunger and

³⁴ In the following sections, we refer to pathways outlined by Labonté & Schrecker (2007), based on “many years of research on how policies adopted by the Group of 8 (G8) countries affect population health outside the industrialized world, and on a review of the relevant literature”.

poverty and thereby negatively influencing public health³⁵.

Recent research examining the relationship between economic globalisation and three key determinants of health (GDP per capita, volatility of GDP per capita and income inequality) shows that economic globalisation 'unexpectedly' contributed to a slowdown in the pace of improvement of the social determinants of health between 1980-2000 (relative to trends observed between 1960-1980), and therefore to a corresponding deceleration in global health gains. Identified causal pathways include reduced growth, higher rates of inequality, increased instability, reduced access to health care, increased out-of-pocket expenditures on health care, a weakening of the ability of states to provide basic services, and reduced potential for medical knowledge transfer due to international intellectual property rights legislation (Cornia *et al.*, 2007). Although figures show that the number of people in the world living on \$1/day or less fell by 392 million between 1981 and 2001, the number of people living on \$2/day or less rose by 285 million (Labonté & Schrecker, 2007). In short, even where economic globalisation has led to periods of sustained economic growth, its benefits have not been spread evenly and it has contributed to an increase in inequalities.

3.2 Global Reorganisation of Production and Migration

Livelihoods have been lost as countries have opened up to imports and implemented liberalising trade agreements. Social protection measures have only been partly able to compensate, due to the loss of tariff revenues in advance of possible alternative sources (Öslin *et al.*, 2011). Increased competition between countries has intensified competition between low-income workers, often leading to an increase in 'flexible' contracts and insecure employment. Where jobs have been created, these have often been 'bad jobs' with below average wages. Recent examination of the relationship between trade liberalisation and the labour market finds that as many as one quarter of existing 'good jobs' (those with above average wage) may be lost as a result of liberalisation (Davis & Harrigan, 2007).

While new trade agreements have dismantled barriers to capital transfer, they have generally not been accompanied by dismantling of barriers to free movement of people³⁶. Inter-EU migration is a notable exception to this trend, though only 2.3% (11.3 million people) reside in a member state other than their own³⁷ compared to almost 4% (20 million people) of the total EU27 population who come from outside the EU. Without net migration, however, the EU working-age population would shrink by 12% in 2030 and by 33% in 2060 compared with 2009³⁸. As a result, richer countries increasingly 'cherry pick' their migrants, and certain professions such as health workers have left

³⁵ See "450 economists tell the G20: regulate speculation on food prices", <http://www.wdm.org.uk/stop-bankers-betting-food/hundreds-economists-tell-g20-regulate-speculation-food-prices>.

³⁶ For more information see "Free movement of workers", <http://www.eurofound.europa.eu/areas/industrialrelations/dictionary/dictionary6.htm>.

³⁷ See 'Free movement rights for workers and Eurobarometer survey on labour mobility', <http://europa.eu/rapid/pressReleasesAction.do?reference=MEMO/10/322>.

³⁸ See "An Agenda for new skills and jobs: A European contribution towards full employment", http://ec.europa.eu/education/news/news2675_en.htm.

developing countries in such large numbers that the WHO has termed it a 'brain drain', undermining embryonic healthcare systems and 'threatening to precipitate a complete collapse of health systems already stretched to the breaking point by financial constraints and the impacts of HIV and AIDS' (Östlin *et al.*, 2011).

In the EU, the 'feminisation of migration' due to reduced wages and labour rights and increasing pressure on women to migrate (European Women's Lobby, 2000) has resulted not only in an estimated 250,000 females being trafficked every year in Europe alone (United Nations Office on Drugs and Crime, 2009), but in 'large numbers of children being left behind by parents who migrate for employment, with long-term consequences for their children's well-being and social integration' (Eurochild, 2010). Non-EU families who do stay together face "extreme vulnerability... in comparison with other families and EU migrant families" (Wall *et al.*, 2010b).

New jobs have opened up to women, enabling them to participate in the labour market, and having the concomitant potential to reduce gender inequalities, though figures from 2007 show that females earned 17.6% less than men in the EU27 (as high as 30% in Estonia) (Eurofound, 2010a) and similar seemingly intractable differences in earnings are also found at the global level (Weichselbaumer & Winter-Ebmer, 2003). Increased levels of female employment should be accompanied by provision of adequate childcare provision, but despite the Barcelona Targets³⁹, use of formal childcare arrangements varies from 73% in Denmark to only 2% in the Czech Republic and Poland (Jokinen *et al.*, 2010). In the face of such conditions it is not surprising that the typical female multiple role, combining paid and unpaid work, may be a factor in triggering a variety of adverse health outcomes (Härenstam *et al.*, 2001).

3.3 Financial Liberalisation and Financial Crises

Financial crises, such as Mexico (1994), Asia (1997) and Russia (1998), have increased in frequency since the late 1970s. Although the specific causes of each crisis varies, they are usually associated with volatile speculative flows of short-term investments in shares and government bonds and sudden mass panics on globalised markets. The current crisis may be attributed to deregulation of the banking and lending sectors, the shifting of vast amounts of capital in financial derivatives holding little meaningful value, low interest rates permitting easy lending to risky investments, an overreliance on the financial sector, and an overconcentration of capital in the hands of the very few resulting in massive global imbalances⁴⁰. It is but the latest example of a series of crises undermining the health and well-being of people, particularly those who are already vulnerable.

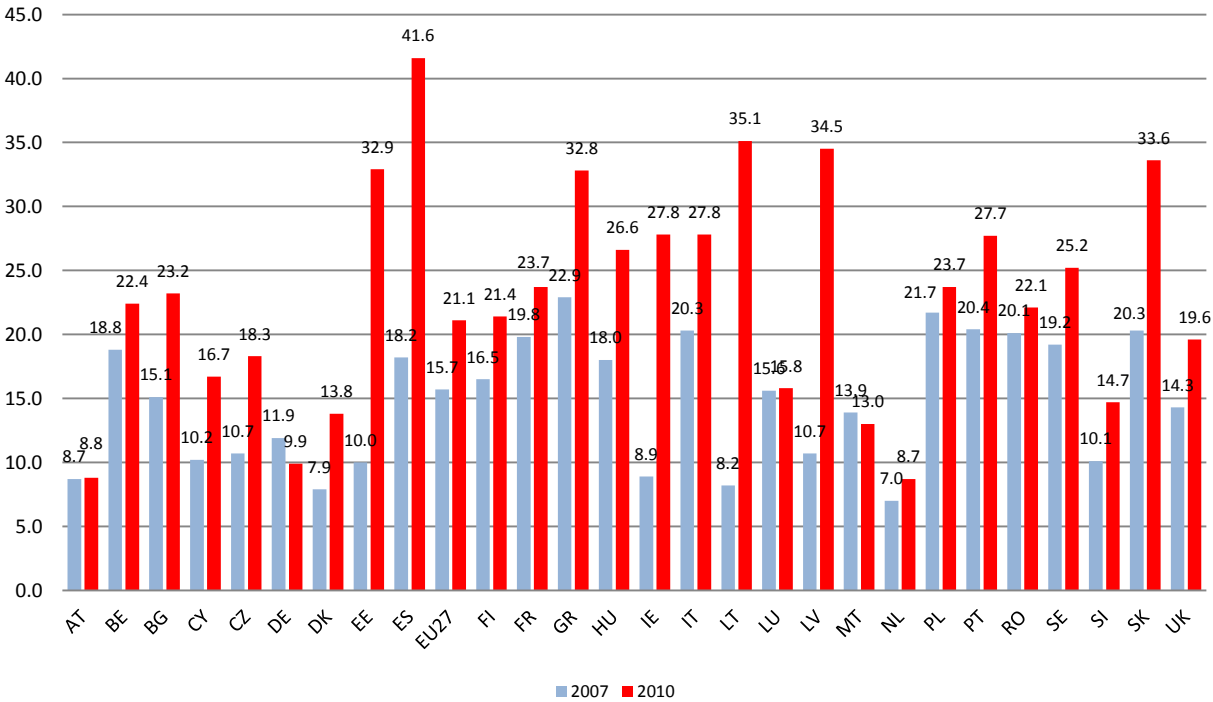
Financial crises lead to losses on stock markets, reduced public and consumer spending, public and

³⁹ See "Childcare services in the EU", <http://europa.eu/rapid/pressReleasesAction.do?reference=MEMO/08/592>.

⁴⁰ See for example "Late-2000s financial crisis", http://en.wikipedia.org/wiki/Late-2000s_financial_crisis.

private debt, cutbacks in public services and unemployment. Countries, particularly those without adequate labour protection laws and safety nets, see vast numbers of people (particularly those on temporary contracts) facing unemployment. Evidence from France, Spain and Sweden illustrate how temporary workers functioned as an 'employment buffer' in the crisis: in Spain, for example, close to 90% of those made redundant had been employed on temporary contracts (OECD, 2011). Job losses are exacerbated by employment levels recovering much more slowly from a crisis than 'growth', and by increased levels of debt limiting the ability of many economies to meet the basic needs of their populations. In addition to the negative effects of unemployment on health, crises are accompanied by increased levels of crime, alcoholism, domestic violence and stress-related deaths (Stuckler *et al.*, 2011).

Youth (<25) unemployment rate, annual average, 2007 & 2010



Source: Eurostat

Even countries with relatively developed safety nets are not immune: recent research shows that the health of Greek citizens has deteriorated since 2007, with people visiting doctors less and going to public hospital more (despite cuts to hospital budgets of 40%), and suicides increasing by 17-25%. Vulnerable people are particularly badly hit, reminding us that "in an effort to finance debts, ordinary people are paying the ultimate price: losing access to care and preventive services, facing higher risks of HIV and sexually transmitted diseases, and in the worst cases losing their lives" (Kentikelenis *et al.*, 2011).

3.4 Globalisation and Income Distribution

The elimination of import tariffs and export taxes reduces revenue for national industries. In a

world of mobile capital (and much less mobile labour), developing countries wishing to attract foreign capital often engage in 'downward bidding'. This can lead to a reduction in taxation progressivity, the granting of tax concessions and an overall decrease in taxation revenue, and therefore to a reduced ability to pay for and provide health services and social security. Such policies have often been pursued with the aim of increasing growth, but if this is not accompanied by measures to (re)distribute income more fairly then poverty reduction may itself be endangered by increased wealth inequality (Bourguignon, 2004). Indeed, the EUREQUAL project found that more egalitarian states exhibit higher economic growth and are more democratic than less egalitarian ones (European Commission, 2010b).

Globalisation has also led to an informalisation of the economy through outsourcing and subcontracting by large corporations, rendering revenue collection more difficult. In terms of vulnerability, this is a step beyond precarious or 'flexible' employment (Klein, 2000; WHO, 2007). Although informal employment exists (and may well be growing) in developed countries, it is not yet a defining feature as it is in developing countries. Economic pressures, social disadvantages and disorganisation surrounding much informal economic work exposes workers to an array of heightened risks, including poor mental health, physical over-exertion, and exposure to sexual harassment and violence.

3.5 Globalisation and Social Instability

Proponents of globalisation argue that it positively influences social solidarity by bridging physical distances between people through use of ICT and tourism; the digital divide between the rich and the poor, a new form of social exclusion from 'global civil society', is something temporary, to be bridged and overcome.

Critics of globalisation respond by arguing that in societies with latent ethnic, class, religious or regional tensions, the economic upheavals brought about by globalisation actually lead to increased political instability, the delegitimisation of the state and the rule of law and increased organised crime. Material deprivation leads to humiliation, rage and hopelessness, and to the perception that elites benefiting from liberalisation have reached their position through corrupt practices. Olivier Roy (2004) ascribes the rise of populism and religious fundamentalism to the changes inflicted by globalisation, often reacting to the unidirectional movement of culture emanating from the USA. Daniele Conversi asserts simply that "one of the long-term legacies of the era of globalization is the global spread of oppositional ethnic and religious conflict" (Conversi, 2010: 361).

3.6 Global Governance: Key International Organisations

A number of key international organisations regulate global activities governing international trade, health, and labour. Although it would be beyond the scope of this document to go into detail about

their activities, they are presented below to give an overview of how they govern and behave as regards health.

3.6.1 World Trade Organization (WTO)

The World Trade Organization (formerly GATT) oversees implementation, administration and operation of trade agreements, provides a forum for negotiation and settling of disputes, and reviews national trade policies to ensure coherence and transparency for its 153 members⁴¹. Its activities have an immense impact on global health, by determining which (health) issues are part of trade agreements and by setting the scope for trade among WTO members (Ervik *et al.*, 2009). Two agreements, in particular, shape national provision of health care:

1. Agreements on Technical Barriers to Trade: covers issues such as trade in biotechnological and pharmaceutical products, and equal access to - and sharing the benefits of - health resources.
2. Trade-Related aspects of Intellectual and Property Rights (TRIPS): agreements decisive to issues of medical patenting.

Lee *et al.* (2009) outline three main concerns about the WTO's role in health. The first is that the major trading partners (the EU, USA, Japan, and Canada) dominate restricted bilateral meetings, with many low and middle income countries lacking the resources to sufficiently monitor or influence negotiations. Whilst the average size of a delegation from a low-income country consists of two representatives, the EU sends over 140 in addition to capital-city based officials. As a consequence, the priorities of those with the most resources dominate proceedings. A second concern is about the settlement dispute process, which is central to the WTO's rules-based trading system. On this, Lee *et al.* claim that it fails to adequately balance commercial and health interests and doesn't permit sufficient public health measures based on the precautionary principle. The third main concern relates to the low status accorded to health policy in comparison to commercial interests. For example, health representatives only sit in on two of the 16 advisory committees, and 93% of the 742 advisors represent commercial interests.

Given that, the WTO is criticised for subsidising richer countries at the expense of developing ones, favouring richer countries in trade agreements over poorer ones, creating barriers to the use of drugs and medicines in the name of intellectual property rights, having an overly complex and expensive legal system favouring richer litigants and deterring poorer ones, and failing to respond swiftly with trade concessions to countries hit by natural disasters⁴².

⁴¹ See "What is the WTO?", http://www.wto.org/english/thewto_e/whatis_e/whatis_e.htm.

⁴² See "The WTO has failed developing nations", <http://www.guardian.co.uk/global-development/poverty-matters/2011/nov/14/wto-fails-developing-countries> (and links therefrom).

3.6.2 The World Health Organization (WHO)

The WHO is the public health arm of the UN, responsible for providing leadership on global health matters. As such, it helps shape the health research agenda, sets norms and standards, articulates evidence-based policy options, provides technical support to countries and monitors and assesses health trends.

For many decades GATT/WTO and the WHO operated in isolation, co-operating infrequently. The growth and expansion of world trade and economic globalisation increased the importance of health issues, bringing the two into more frequent contact (Lee *et al.*, 2009). In 1997 the WHO reacted to the potential effect of the TRIPS agreement on access to drugs, noting that negotiations were largely dominated by industrialised countries, sometimes forcing developing countries to accept commitments running counter to their economic and social development (WHO, 1998). Essentially a defence of public-health over free-trade principles, this initial dispute prompted the WHO to strengthen its engagement and show leadership on trade issues. The WHO currently has observer status at the WTO in the committees on sanitary and phytosanitary measures and technical barriers to trade, and *ad hoc* observer status on the TRIPS Council and the Council for Trade in Services, allowing it to contribute to discussions even though it does not enjoy official decision-making authority.

The WHO has been increasingly active on the social determinants of health, establishing the Commission on Social Determinants of Health in 2005 in response to worldwide persistent and increasing health inequalities. The Commission's final report (WHO, 2008) argued that "social justice is a matter of life and death", and proposed actions in three main areas: 1) improving daily living conditions, 2) tackling the inequitable distribution of power, money and resources, and 3) measuring and understanding the problem and assessing the impact of action. Work is currently on-going into a review of health inequalities in the European Region⁴³, which is due to report in 2012 and will inform the WHO's Health 2020 Strategy⁴⁴.

Most EU member states have endorsed the equity principles and values articulated by the WHO, and the EU and WHO generally co-operate with each other on issues relating to public health, though the role of the EU is growing in this respect.

3.6.3 International Monetary Fund (IMF)

The International Monetary Fund (IMF) works to provide financial assistance to countries experiencing serious financial and economic difficulties. It claims that low-income countries which borrow from the IMF under its Poverty Reduction and Growth Facility generally increase

⁴³ See <http://www.marmotreview.org/reviews/european-review-of-hi/consultation.aspx>.

⁴⁴ See <http://www.euro.who.int/en/what-we-do/event/first-meeting-of-the-european-health-policy-forum/health-2020>.

spending on health and other social programmes⁴⁵. However, research demonstrates that countries participating in an IMF programme experience a 16.6% increase in tuberculosis deaths, with each additional year of participation in an IMF programme associated with an increased tuberculosis mortality rate of 4.1% (Stuckler *et al.*, 2008) though it should be noted that countries in receipt of IMF assistance already have difficulties financing their health and welfare systems.

The IMF has been widely criticised for advocating austerity programmes, supporting military regimes, and for impoverishing countries, and as a result has been the subject of numerous protests and demonstrations around the world. A recent book by Rick Rowden (2009) argued that the IMF's approach stopped developing countries from increasing public investments, resulting in chronically underfunded health systems, dilapidated health infrastructures, inadequate training of health workers, and demoralising working conditions, helping contribute to the aforementioned 'brain drain'. Östlin *et al.* (2011) note that international institutions including the IMF have increased emphasis on market-based and privately-financed health care, and that research is needed on how to redesign institutions for global decision-making "so that these institutions address not only trade and economic crises, but other global issues... that have important social and health consequences".

3.6.4 The World Bank

The World Bank is an international financial institution with 186 members, providing low-interest loans to developing countries for public and private investments in education, health, administration, agriculture and environmental and natural resource management, alongside technical and financial assistance.

Although its stated intention is to reduce poverty, critics assert that it is dominated by richer countries, that its policies have actually increased poverty, and that it has been detrimental to the environment, public health and cultural diversity. Lumped alongside the WTO and the World Bank, critics such as George (1988) argue it promotes a neo-liberal agenda: an example being its demand that Bolivia privatise its water supply in 2000, resulting in massively increased water bills for local people and widespread social unrest⁴⁶. Worse, the World Bank's approach to health 'exacerbates poor health outcomes by reducing access to health services for those unable to pay for care in newly privatised systems... with recent programmes aiming to help the poorest actually ignoring structural deficiencies in social services' (Birn & Dmitrienko, 2005).

3.6.5 International Labour Organization (ILO)

The International Labour Organization (ILO) is the specialised agency of the United Nations (UN) responsible for drawing up and overseeing international labour standards⁴⁷. It is the only 'tripartite'

⁴⁵ See "IMF Helping Countries on Health, Social Spending Policies", <http://www.imf.org/external/pubs/ft/survey/so/2008/POL072508A.htm>.

⁴⁶ See http://en.wikipedia.org/wiki/2000_Cochabamba_protests.

⁴⁷ See "About the ILO", <http://www.ilo.org/global/about-the-ilo/lang--en/index.htm>.

UN agency bringing together representatives of government, business and labour to jointly shape policies and programmes concerning labour. The ILO's standards directly influence EU member states' policies on workplace health and safety, and ILO recommendations help determine the strategies of the European Agency for Safety and Health at Work⁴⁸.

In recent years the ILO has put forward a proposal for a Universal Social Protection Floor, which aims to provide a guaranteed minimum level of social security by combining income transfers, access to health, education and active labour market programmes to act as safeguards against the negative social and economic effects of unemployment, job insecurity and poverty⁴⁹. In addition, it promotes the Decent Work Agenda, which aims to create jobs, guarantee rights at work, extend social protection, and promote social dialogue as a means of paving the way for broader social and economic advancements, strengthening not just individuals and their families but communities as well⁵⁰.

⁴⁸ See "European Safety and Health Legislation", <http://osha.europa.eu/en/legislation>.

⁴⁹ See <http://www.ilo.org/gimi/gess/ShowTheme.do?tid=1321>.

⁵⁰ See <http://www.ilo.org/global/about-the-ilo/decent-work-agenda/lang--en/index.htm>.

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