Annals of Work Exposures and Health, 2021, 1–5
doi: 10.1093/annweh/wxaa127
Editorial

BOHS The Chartered Society for Worker Health Protection

OXFORD

Editorial

COVID-19, Health and Vulnerable Societies

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This issue of the *Annals of Work Exposure and Health* contains a paper by Peter Smith, John Oudyk, Guy Potter, and Cameron Mustard on workplace infection control procedures and mental health amongst Canadian non-healthcare workers during the COVID-19 pandemic. The study finds that adequate design and implementation of employer based infection controls has implications for the mental health of site-based workers. This is an important finding as the authors recognize with wider implications for managing worker and community health during the pandemic. It adds to a growing body of research on the pandemic's impacts on worker health, including governments' compromising the rights and protections of frontline health and essential service workers because they failed to plan for and mitigate the effects of something predicted by public health researchers and agencies like the WHO for decades (Lippel, 2020; Watterson, 2020a,b). In many countries, protections for healthcare workers were compromised by belated government responses, local manufacturing inadequacies/supply chain failures. Where poorly controlled, the level of infection has placed long-term strains on if not overwhelmed healthcare infrastructure (including primary healthcare), in too many instances weakened by decades of short-sighted cost cutting. Tens of thousands of healthcare workers were arguably sacrificed to the infection, with an as yet untallied global death toll (Ministry of Health, 2020).

Peter Smith and colleagues highlight less-heralded effects on non-healthcare workers, many performing essential tasks in areas like transport, food production, and distribution, not just in terms of the risk of infection but the mental anguish of putting them and their families' health and life at risk (Fellows of the Collegium Ramazzini, 2020; Larochelle, 2020). Unlike healthcare workers they were neither trained for nor expecting to deal with a highly infectious disease. Nor were their workplaces designed or managed with this risk in mind. The risks of workplace transmission, especially in workplaces like abattoirs, aged care facilities, large warehouses and food distribution centres, supermarkets and ships (both passenger and freight) is now all too apparent (Bui *et al.*, 2020; Donahue *et al.*, 2020). Some of these workers like seafarers already experienced poor mental health indices (due to isolation, precariousness, and poor working conditions) which the pandemic served to intensify by increasing service periods and isolation as shipping lines sought to maintain supply lines as borders became increasingly closed (Kirkby, 2020).

What is important to note is that these non-healthcare workplaces were just as essential as healthcare to maintaining human health and had to continue operating even during lockdowns. These and other workers (like those collecting waste) were essential workers notwithstanding the irony that many were low paid, their jobs insecure and in places like North America, Western Europe, and Australasia, included recent immigrants and other vulnerable groups.

The pandemic has understandably sparked a flood of research and publications, some seeking to better understand the disease and preventative measures (including future pandemic risk and vaccines) while other have examined the economic and policy implications. Taking a longer term perspective, the pandemic's

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dire consequences were not the result of accidental oversight but magnified by conscious decisions and organizational/policy choices. Neoliberal policies that became globally dominant after 1975 favouring market-driven rules and decision-making, curbing government involvement in setting social objectives/policy parameters, corroding international agencies like WHO and ILO and consequent growing economic inequality undermined community health and created more vulnerable societies (Labonté and Schrecker, 2009; Schrecker 2016; LaDou, 2020; O'Neil, 2020). Neoliberalism was associated with a reduction in long-term planning by many governments, compounded by downsizing, privatization, and other cost-cutting measures with regard to healthcare and other essential infrastructure like aged care staffing levels (van Barneveld *et al.*, 2020). These and other changes like increased reliance on both local and global supply chains, the concentration of food production and processing (such as fewer but larger abattoirs), more concentrated population densities and growing economic inequality (and with it increased comorbidities amongst the poor) increased the vulnerability of societies to pandemics. The pandemic exposed the acute vulnerability if not unsustainability of neoliberal-guided social organization with some evidence those countries most wedded to it and with higher levels of inequality were faring worst (Barrera-Algarín *et al.*, 2020; Navarro, 2020).

This editorial cannot even begin to explore all the issues just raised. Rather, it focuses on one aspect of neoliberalism, namely the changing world of work that has long-term health implications and has, with exceptions, largely escaped serious attention in the COVID-19 debate (Cook *et al.*, 2020).

Since the mid-1970s, there has been a significant global shift in work arrangements away from full-time and relatively secure work, with a growing number of workers—especially the young, old, and immigrants/minority groups—being engaged in short-tenure/insecure jobs (including multiple jobholding) and self-employment in the old rich countries. Terms like the gig economy, at will employment, zero hour contracts and worker misclassification all fall within this wider rubric of change and those retaining nominally permanent jobs have experienced insecurity as a result of repeated rounds of downsizing, offshoring, and privatization. Paralleling this in poor/middle income countries like India, Nigeria, and Brazil the informal sector (insecure work subject to no regulation) has expanded to make up 70% or more of the workforce.

The pandemic graphically revealed the acute vulnerability created by this shift because it meant many workers had to keep working to feed themselves and their families and were thereby reluctant to either report infection, stop working, or to isolate themselves if they or someone in their household was symptomatic/ill. In countries like India and Brazil governments shied away from lockdowns to control the virus, in part because without work many workers and their families would literally starve unless the government provided food relief and other supports (which with some notable exceptions they didn't). India's short-term lockdown had catastrophic effects on informal workers many left stranded far from their home.

Even with social welfare supports rich countries struggled. Some governments provided job-protection payments and increased unemployment benefits. A few covered the sick leave entitlements of precarious workers (something many would have been excluded from otherwise) when in isolation as a result of testing protocols or infection. Some governments also provided support to temporary migrant workers (now a global workforce numbering many millions) not usually entitled to welfare—others didn't. The operation of a number of industries heavily dependent on precarious workers like tourism, hospitality, and retailing were heavily curtailed. Other industries deemed essential kept operating even during lockdowns, including abattoirs, other food processing, food distribution, and aged care. These also often relied heavily on precarious workers (many drawn from widely geographically dispersed areas) increasing the risk of the disease rapidly spreading as well as helping to account for the high death toll in aged care facilities. In Canada and other countries, it was common for aged care employees to work in several different facilities simultaneously (to boost their income), to move between facilities because they were temporary agency workers (Lippel, 2020), or to travel large distances as part of a growing mobile workforce (Neis *et al.*, 2020). This, together with pre-existing low staffing levels and inadequate skill mixes both increased the risk of virus spread and made infections amongst a very vulnerable population extremely difficult to manage (Royal Commission into Aged Care Quality and Safety, 2019).

In sum, the new world of flexible work made disease prevention and suppression more difficult. While temporary work arrangements have always existed (e.g. with regard to harvest work) this shift was not preordained or unavoidable—it was the outcome of decisions made by employers and governments and endorsed if not actively reinforced by international agencies like the IMF and OECD.

Three important additional observations need to be made. First, even prior to the pandemic it was known

that precarious and informal work had serious health damaging effects incompatible with enhancing occupational and public health. Since the 1980s, there has been a growing body of research (hundreds if not thousands of studies) into the health effects of precarious work, job insecurity, and the informal sector. The vast majority of these studies, using an array of methods, have found these work arrangements are associated with worse health outcomes including increased injury frequency rates, adverse physical health/hazard exposures and poor mental health as well as inferior protection under occupational health and safe and workers' compensation/social security laws (Quinlan, 2015; O'Connor *et al.*, 2020). Subcontracting and the precarious work it entails also contributed to disasters in mines and factories, refineries, and oil rigs (Quinlan, 2014). Last but not least, those researching precarious work identified important interactions between precarious work and public health including drug-use, poor diet, accommodation, life-style, and children's education/prospects (Muntaner *et al.*, 2011). In short, the pandemic exposed additional health risks of work arrangements already known to be damaging and its wider dislocating effects on the precarious are likely to prove long term (Spurk and Straub, 2020).

Second, widespread precarious work is not a new phenomenon. It was the norm prior to world war two and knowledge of its health damaging effects and difficulties it posed for managing infectious disease is also not new. In 1876, the *Lancet* editorialized on the connection between outwork/sweating in the garment trade and the spread of infectious disease via tainted clothing, acknowledging that the link had been identified by public health pioneer Benjamin Ward Richardson years earlier (Anonymous, 1876). Poor and closely interlinked working and living conditions encouraged disease and its spread and discouraged disease reporting by both workers afraid to lose their livelihood and economically motivated landlords. Between 1870 and 1925 a series of independent investigations by the Lancet, Florence Kelley, and others, a string of government inquiries and published research identified the health damaging effects of insecure and precarious employment (and it was often labelled precisely that) in terms of increased risk of injury, poor physical and mental health (including suicide), hazard exposures, the spread of infectious disease, and the cascading community health effects associated with poverty/irregular income, under-nourishment and the like in Europe, Canada, the USA, Australia, and New Zealand (Gregson and Quinlan, 2020). In short, we are re-discovering what was widely known a century ago about precarious work, including the increased risk of infectious disease spread related to insecure work and crowded working and living conditions, especially amongst immigrants and vulnerable communities with existing comorbidities.

Third, the pandemic provides further evidence of the intimate interconnection between occupational health and public health and the need for both practice and policies to be shaped with these interactions in mind. Widespread precarious work and the informal sector are incompatible with maintaining let alone improving community health and other aspects of social welfare. The concentration of already vulnerable groups in precarious and informal work (which exists in rich countries too) reinforces health disparities along lines of race, ethnicity, caste, and immigrant status further fomenting social division and dislocation.

So is there any learning? In June–October (winter) 2020 the Australian state of Victoria (population 6.4 million) experienced a second wave of the virus originating from a breach in hotel quarantine arising from relying on subcontracted private security firms using poorly paid/trained guards. The state now accounts for 73% of the country's total of almost 28 000 infections and 90% of its 907 death toll. The wave was crushed by a prolonged lock down, science driven controls including mandated mask wearing, curfews/travel restrictions, social distancing and COVID-safe plans, closure of non-essential high-risk workplaces like gyms, encouraging working from home, regular sentinel testing of essential workplaces like abattoirs, and vigorous contact-tracing. Importantly, the control strategy also entailed significant financial support for affected families, including sick leave payments to all workers required to self-isolate including precarious workers normally excluded from such entitlements. In the midst of this wave Victoria's premier (similar to a US state governor) Daniel Andrews publicly pointed to the wider significance of insecure work:

> Insecure work is toxic. There is nothing good about insecure work, and when this is done, when this virus has been beaten, we will need to commit ourselves to do something really significant about it. It is no good for anything, for families, for a sense of security [and] for public health, for any purpose. We have a lot of people who work very hard but have no safety net to fall back on and that is just not something we should settle for (Guardian, 2020).

Notwithstanding abundant evidence, such a public condemnation of precarious work by a government leader is rare. Indeed, the contribution of precarious work and the informal sector to exacerbating the pandemic and

rendering societies more vulnerable has largely escaped detailed scrutiny or policy debate globally. COVID-19 has highlighted a number of structural problems as well as the need to learn from the past. It affords an opportunity for an evidence-driven policy re-set with regard to the primacy of health infrastructure/goals, reintegrating work and public health, and policies to reshape work arrangements. The pandemic is also a warning signal as it is unlikely to be the last major global disaster/catastrophe experienced in coming decades. Climate change, environmental degradation, and habitat loss interacting with rising economic inequality and ongoing structural racism will see to that.

Conflict of interest

The author states that he had no conflicts of interest to disclose in the preparation of this paper.

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