Workforce Health Practices in Europe, USA & China: Towards Convergence?

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The Covid-19 pandemic has exposed fundamental differences around the world in approaches to protecting our population's health and wellbeing. Many of these reflect existing differences which the crisis has amplified and others are new areas where division and difference have emerged and dominated public discourse and polarised social media 'debate'. These include a number of questions:

- Are the findings of medical science fixed, open to interpretation, or can they evolve as new evidence emerges? Is the politicisation of medicine good for public health outcomes? Are the divisions between neo-liberal and communitarian interpretations of medical research here to stay?
- Are basic (and previously uncontroversial) public health measures acts of oppression or signs of social solidarity?
- Is health a private concern or a matter of community responsibility under which we all have collective obligations?
- Is the health of the working age population and the employed workforce given enough priority by employers given the impact of ill-health on business continuity and labour productivity? Do current labour standards relating to safety at work represent a sufficient and sustainable framework to protect workers from the wide range of workplace health risks to which they are now exposed?

Perhaps it should not surprise us that State responses to the pandemic should have become so politicised and polarised. We have seen controversy, anger and public protests over vaccinations, mask-wearing and 'lockdowns' in the USA, Europe, Australasia and China as both experts and populations struggle to find the right balance between the protection of public health and the preservation of individual and economic liberty.

Who is responsible for worker health?

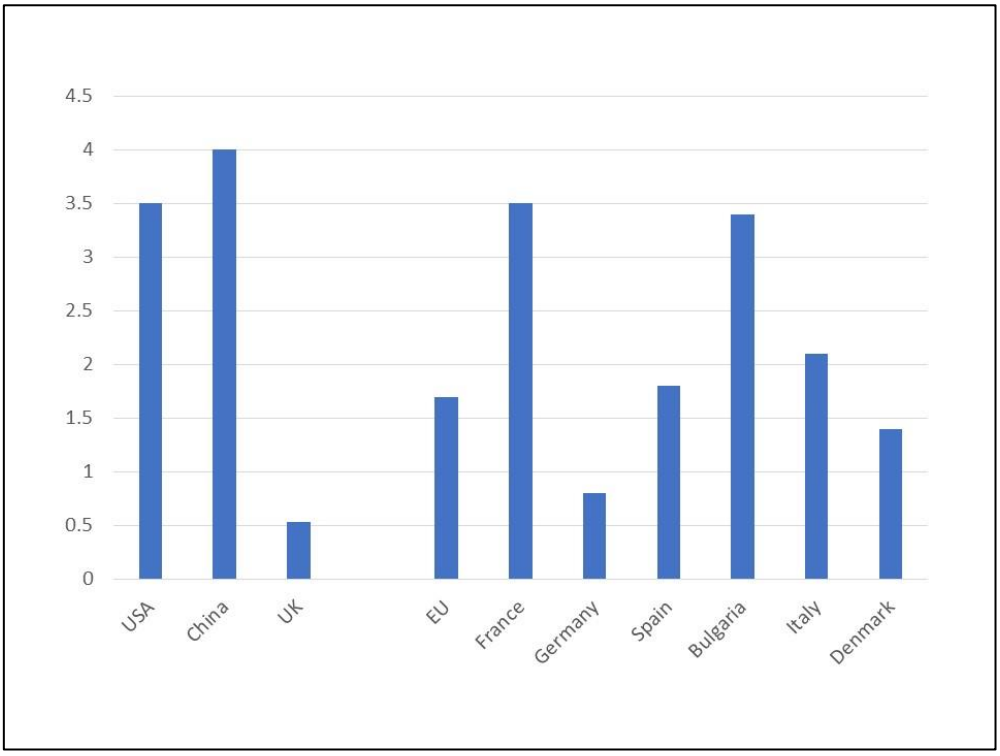
For employers, too, the pandemic has required very rapid and agile responses to a commercial and human crisis. This has raised questions about the limit of a business's legal and moral duty of care towards its employees and the social responsibility obligations they have to preserve and promote both the physical and psychological wellbeing of employees.

Their ability to do this, of course, is conditioned partly by the effectiveness and accessibility of the health system within which each operates. It is also affected by social attitudes, the extent of social dialogue, the persistence of social, economic and health inequalities and the labour market conditions which prevail at any time.

HR policies and practices globally relating to workforce health are affected by the competitive environment, the extent to which employers bear some of the costs of worker ill-health and the prevailing labour regulation regime. With respect to health and safety regulations, for example, these are usually intended to reduce the risk and incidence of workplace fatalities and injuries, to eliminate exposure to hazardous substances and materials at work and to lower the risk of accidents. By far the greatest emphasis is on protecting the physical health of workers and recent data suggests that – over the last three decades – they have contributed to a significant reduction in the number of fatalities at

work. Compositional changes in many economies around the world (eg the growth of the service sector) have also played their part. Figure 1 shows, however, that considerable variation in fatality rates internationally (per 100k workers) persist (although data quality here can be variable).

Figure 1 Workplace Fatalities Per 100, 000 workers – Selected Countries, 2019



Source: Eurostat; Bevan & Cooper, 2022

Some of these differences can be explained by the relative importance of some industrial sectors in difference countries. For example, mining, manufacturing, agriculture, forestry and fishing all have higher rates of accidents, injury and death than banking, professional services or public administration. Another set of explanations may help us understand how different philosophies, cultural norms, systems of power and approaches to the way worker health is valued and measured need to be understood and accommodated as we seek to understand whether large economic blocs such as the USA, the EU and China are converging or diverging in their approaches.

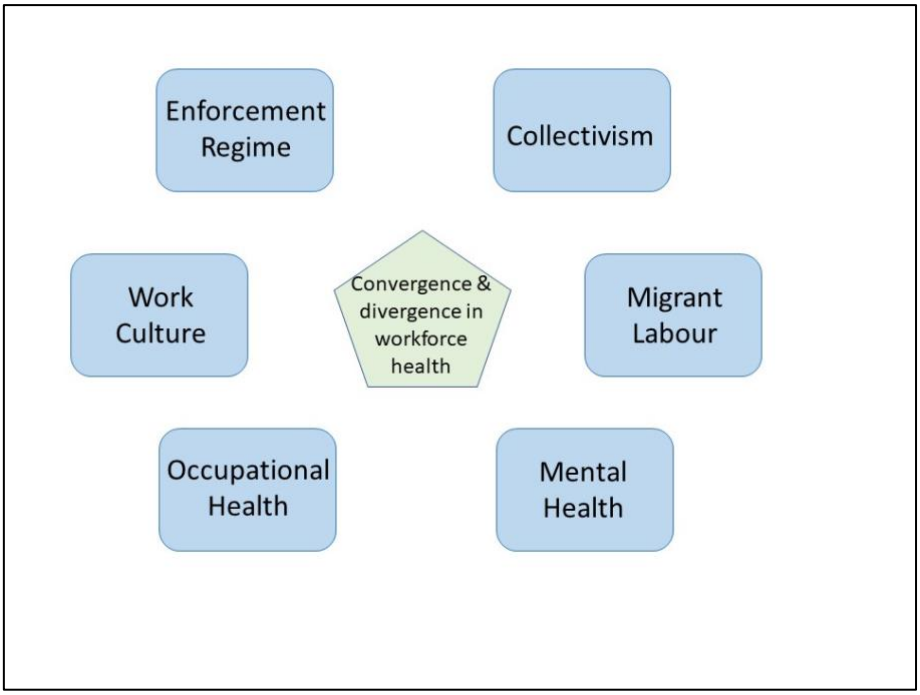
In what follows we will examine briefly some of the similarities and differences which exist in the ways that employers manage the HR and occupational health implications of wellbeing in their respective workforces. It includes observations from an interview conducted with Dr Yi Mein Koh, a public health doctor who has held senior clinical positions in the UK (including as COE of the Whittington Hospital in London, Hong Kong and China. She currently works for AXA PPP in Hong Kong and works with many Chinese employers on this topic.

The EU, USA & China – More Similar than Different?

Dr Koh is quick to emphasise that China is both large and regionally very diverse. This may appear obvious to European or US eyes, but she is convinced that the scale and complexity of the Chinese

economy, it's population and the institutions of civil society are too often over-simplified when Western observers attempt to understand or summarise trends and patterns of government, business or workforce behaviour and activity. In our conversation we identified six areas of potential convergence and divergence which may be observed (see Figure 2) when examining the ways that HR policy and practice may develop over the next decade:

Figure 2 Worker Health: Potential Areas of EU/US/China Convergence & Divergence



Enforcement of Health & Safety Regulations

China has a workforce of approximately 800 million and the majority spend half of their lives working. The SME sector in China is dominant, with an estimated 43m SMEs in 2020 – 99.8% of all businesses and accounting for 80% of all non-Govt employment. The Chinese government has grown increasingly concerned about rates of occupational injury and illness and its own analysis indicates that at least 12m Chinese businesses have work environments where up to 200m workers have exposure to a range of risks, including dust, chemicals, poisons, machinery and heights. In the latest 'Healthy China 2030' plan, occupational health was included as one of China's 15 major health priorities. This now means that, by 2025, 95% of workers with such health exposures at work are required to have health risks and 80% of workers in mining, metal working industries and construction will be required to have work-related injury insurance.

On paper, these regulations, and the priority given to them by the government echo the actions of EU Member States (supported by oversight and resources from the EUOSHA) and the work conducted by OSHA in the USA. It will be no surprise, however, that such a SME-dominated economy has real challenges with the inspection of workplaces to monitor compliance with these regulations and with enforcement if employers do not comply. Dr Koh explained that there are very considerable variations in business practice by size of company, the sector within which it operates and across the many diverse regions of China. Larger businesses in urban settings (especially in the technology sector and among multinationals) and public sector employers are more likely to comply with regulations and to see the

business and operational benefits of healthy workers who have low sickness absence and who can sustain their contribution to productive working. While not popular, regulation in the field of health and safety can be viewed as promoting better standards and having business benefits. This is less the case in SMEs, in rural settings and in businesses employing migrant workers.

But is the situation in China that much different from the practices which prevail in either the EU or in the USA? In the EU many member states have reduced the resources given to labour inspectorates and have tried to reduce the burden on employers by cutting back on workplace inspections and even on investigations. In Bulgaria and Romania, for example, workplace accidents and fatalities remain high by EU standards and the enforcement of regulations (especially in SMEs and in rural areas) is almost non-existent. In the USA the OSHA has been starved of resources during the Trump Presidency (to reduce burden on business) and it has recently been estimated that it would take 165 years to inspect all US workplaces. Even employers found to be in breach of the regulations can view sanctions as just another cost of doing business as they are only rarely truly punitive. The average fine for workplaces with life-threatening hazards is $3,700. In the US Meatpacking sector, one body part lost every other day. It seems that China is not so different from prevailing practice in the West as it might first appear.

Collectivism or Individualism?

One area where Dr Koh and other commentators believe there are more deep-rooted practical and philosophical differences between China and the EU. At a practical level, worker health and safety is commonly one of the main components of collective agreements between Trades Unions and employers. It is an area where most unions have considerable expertise and where they provide training for local representatives and, increasingly, require union members to be consulted on and involved in the design and evaluation of policies and the conduct of risk assessments and hazard reporting. This does not guarantee that all workplaces in each member state are safe and healthy, but the principle that 'each worker should have the right to go home healthy each day' is now uncontroversial. In the EU, therefore, collectivism is one of the drivers of good practice and enforcement. Despite this, many employers in the EU (and in the USA) also believe that employees themselves bear responsibility for their own health. This is not just about being vigilant and alert to the risks of workplace accidents, but also that employees should play a role in making healthy lifestyle choices, avoiding behaviours which might make them unwell and engaging in 'self-management' of health conditions and their own recovery from illness or injury. In general, the regulatory approach and the 'individual responsibility' philosophy co-exist well, especially where employers invest in measures to support workers to eat healthily, to take exercise or to avoid or manage stress at work.

In China the practical impact of Trades Unions in the formulation, monitoring and enforcement of health and safety regulations is far less clear. This is not to say that workplace consultation does not happen and that co-design of ergonomic changes to work design, or workplace accommodations is not practiced. Some observers have argued, however, that there are occasions when the collective good can explicitly outweigh the needs of individual workers. This is not as harsh as it seems, but the effect of having such a large population and very significant labour surpluses in some regions or sectors, means that the collective contribution to the productive capacity of the Chinese economy can sometimes mean that the priorities of individual workers in routine work can feel subordinated.

Migrant Workers

It is estimated that there are about 280 migrant workers in China. The majority have moved from rural areas of the country into the large and rapidly growing urban and City areas. This feature of life in China has implications for social infrastructure, healthcare, housing and employment. The so-called 'Hukou'

system of population registration plays a major part in making workforce health disparities in China especially visible. This system means, among other things, that migrant workers cannot claim for welfare support or healthcare benefits in the cities where they work. As coverage is less generous or comprehensive in rural areas, or just too expensive, this means that the majority of migrant workers are likely to experience more accidents and illnesses at work because they are not covered by regulations, work many more unregulated hours, have no access to OH treatment or support, have no representation from Trades Unions and suffer from worse mental health problems than the general workforce. In these ways, China has a genuinely two-tier workforce which some have described as openly discriminatory. One consequence is that migrant workers are often working in hazardous jobs which escape regulatory oversight. While the Chinese government has made tentative steps towards reform of the system, it remains a powerful feature of the Chinese labour market and undermines attempts to improve labour standards and wellbeing for all workers. Although the EU has had, on a much smaller scale, its own experience of labour migration and has taken steps to outlaw exploitation, so-called 'modern slavery' and other abuses it will take many years for EU and Chinese practices in this respect to converge in any meaningful way.

Mental Health

In Dr Koh's view, an important area where there is divergence between the EU, USA and China is in the domain of mental health at work. While the dominant global focus of health and safety regulations and corporate practice in the last 40 years has been physical health, in the last decade most EU member states have introduced new regulations to ensure that so-called psychosocial risks at work are identified and mitigated. The 1989 EU Framework Directive which focuses on workplace mental health required all member states to adopt their own approaches to conducting stress audits at work. This means that European employers have a duty to promote psychologically healthy workplaces and many tools to help them to do this. Despite this, there remains a significant (but diminishing) stigma relating to mental health in wider society and at work. This particularly affects industries employing, for example, younger, unskilled and male workers (eg construction). There is also diversity across Europe in the enforcement of these regulations – in 2015 Denmark's labour inspectorate brought 1400 enforcement actions against employers and the UK's Health & Safety Executive (HSE, 2021) brought only four. It should be noted that the USA's OSHA places no such statutory obligations on US employers, although the CDC now has a Workplace Health Model which includes mental health resources (CDC, 2016).

By contrast, in China, health and safety regulations have only recently acknowledged that mental health at work should be a concern for employers. Stigma and even shame about mental illness in China remains a barrier to citizens and workers receiving medical and other support. Few feel confident to disclose details of mental illness with medical professionals and employers and, in the work context, there is an expectation that workers will be individually resilient and accept intense work conditions, long hours working and stress at work as 'normal'. Studies examining the mental health of Chinese migrant workers have shown that almost 60% of those surveyed suffered from depression, 17% from anxiety and 4.6% had considered the idea of suicide. Most bear a heavy financial and emotional burden as they have left behind aging parents or young children. They often feel guilty for being unable to care for them and, at the same time, feel pressure to provide for their families. The effects of poor mental health in the Chinese workforce are mainly hidden because there is no obligation to measure or report on it. It is hard to see circumstances in which any significant progress by China towards the relative sophistication of the European model of managing workforce mental health in the next decade.

Occupational Health (OH)

Primary care in China is, at best, under-developed and, at worst, non-existent. Healthcare in cities can be of high quality but is delivered by hospitals – with a strong focus on administering treatment and far less emphasis on preventative medicine. There are big regional (and urban-rural) variations in healthcare coverage and, for some citizens, the cost of comprehensive healthcare insurance can be prohibitive (although over 95% of the Chinese population have basis coverage and, for comparison, 17m or 9% of US workers have no healthcare at all.). Occupational medicine as a clinical specialism is not well-developed in China and, where it exists, its focus is exclusively on physical hazards, occupational diseases and exposure to dangerous substances. This means that, from an HR perspective, the partnership with OH which is more routine in larger enterprises and public sector organisations in Europe and the USA is absent. One lesson from the way that Covid-19 has affected western employers is that the C-suite has needed high-level clinical advice to CEOs and other executives. This has raised the profile of OH professionals and has demonstrated the value of a Chief Medical Officer.

Work Culture

The so-called '996' work culture in many Chinese businesses (start at 9am, finish at 9pm for 6 days a week) echoes similar informal work norms in Japan and South Korea. Other parallels include the expectation in some sectors is that workers will attend drinking sessions after work, as a signal of their commitment to the business but with sometimes damaging consequences for mental health and family life. Theoretically, there is a cap to working time in China. Its labour law states that workers should not work more than eight hours a day, or 44 hours a week, and that anything more than this should be classed as overtime, which can only be imposed after consultation with worker representatives. However, Dr Koh notes that it is often impossible to determine whether the overtime hours being worked by many Chinese workers are genuinely voluntary. Some studies show that 85 per cent of white-collar workers in China have to work overtime, with more than 45 per cent reporting overtime of more than 10 hours a week. Although Chinese law requires overtime work to be compensated at 1.5 times ordinary pay, many workers report in surveys that they do not generally receive such payments, because the work was classified as "voluntary" by their employer, meaning it falls outside the official definition of overtime. There is considerable research evidence that long-hours working is associated with cardiovascular disease, obesity, depression and anxiety, which can lead to disturbed sleep, fatigue and an elevated risk of accidents through poor concentration. In many ways the USA has a similar approach to China – with 1 in4 workers in the US receiving no paid time off, no cap on working hours & no statutory rights to overtime payments or to rest breaks. This is a legacy of the 1938 Fair Labor Standards Act which has not been superseded by subsequent OSH regulations because their safety implications are considered less important than their potential to constraint business agility. While the EU's Working Time Directive is by no means a perfect legislative instrument, and its application has not been universal, the rate of long-hours working in most member states has reduced and several have also introduced regulations to give employees the 'right to disconnect' from work emails at weekends and during holidays.

Conclusions[1]

EU, USA and China comparisons of HR policy and practices in the domain of worker health can be simplistic and lack nuance. They can assume that Chines practices are universally less advanced and focus too much on differences rather than on similarities. However, in many respects EU & US employers are struggling with the same problems as their counterparts in China and (while labour

[1] *The author is grateful to Dr Yi Mein Koh for being interviewed for this paper. However, the views expressed in the paper are the authors alone.*

standards and regulation in the EU appear more comprehensive) it appears that the challenges of compliance and enforcement do not respect national borders. It is clear that the Chinese government recognises that investment in better healthcare will bring social and economic benefits and that it knows that sustained economic growth will not be delivered if a high proportion of the workforce is unwell and unproductive. Its recent programme of investment in healthcare indicate that change is happening, and the influence of multinational business practice in the area of wellbeing is also gradually improving awareness and the adoption of good practice.

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