Non–Decision Making in Occupational Health Policies in Developing Countries

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Developing countries have no significant policies for occupational health. This analysis identifies four broad mechanisms through which state- and enterprise-level decision makers in developing countries diffuse attemps to instigate improvements in occupational health: inaction or stifling of such efforts during policy implementation; exercise of power; appeal to the existing bias (norms, rules, procedures) of the system; and prevailing dominant ideology. Addressing these limiting factors requires initiating a process of raising the occupational health policy profile that recognizes the importance of empowering workers' organizations, and enabling professionals to play an active role in the generation of occupational health knowledge required to improve occupational health in the developing countries. *Key words*: occupational health; policy analysis; policy implementation; non–decision making; developing countries.

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During the 1980s and 1990s, occupational health scholars raised concerns about the lack of attention to occupational health that was evident in developing countries,[1–7] which had inadequate or no policies for protecting their workers. A recent study of occupational health in Latin America and the Caribbean provides evidence that occupational health still has low priority on these countries' governments' policy agendas.[8]

In order to begin to deal with this problem, it is necessary first to identify the factors that have contributed to it. The author examined existing policies governing occupational health in developing countries to determine how they had evolved and how they were being implemented, using a policy-analysis approach[9] and engaging the "non–decision making" concept to explain how various mechanisms have played roles in suppressing implementation. The data came mainly from documentary sources, particularly publications on occupational health in developing countries, and from a study in which the author used focus-group discussions, in-depth interviews, and documentary analysis to investigate state and workplace responses to workers' health needs in Tanzania.

The concept of non–decision making and the theoretical framework guiding the policy analysis are explained in this article. Four analyses then show how various factors keep occupational health off the policy agendas of developing countries.

WHAT IS NON–DECISION MAKING?

The concept of non–decision making emerged through attempts to theorize power relations in society. We can trace the roots of this concept in the theories of the state, where three contrasting theoretical perspectives—pluralist, elitist, and structuralist—feature prominently to explain power relations issues.

The pluralist perspective, rooted in the liberal democracy view, assumes power to be widely distributed, and that public demands and opinions essentially drive the policy process.[10]

The elitist perspective challenges this view, and sees power as concentrated in the hands of unrepresentative groups working in collaboration to confine the agenda and limit the area of public participation.[11,12] In this regard, elitist theorists have advocated two arguments: first, that not all people, particularly those with the greatest needs, participate in policy making, because there is a bias that operates in favor of some and against others,[11] and second, that there is another side of power reflected in constriction or containment of decision making achieved through ". . . manipulating the dominant community values, myths, and political institutions and procedures."[12] They further contend that power is not simply about the control of observable behaviors and decisions, but also manifests in the non-observable realm of non–decision making:

> . . . a means by which demands for change in the existing allocation of benefits and privileges in the community can be suffocated before they are even voiced; or kept covert; or killed before they gain access to the relevant decision-making arena; or, failing all these things, maimed or destroyed in the decision implementing stage of the policy process.[13]

Thus, the main argument of elitist theorists is that actors in the policy process have a capacity to keep issues off the agenda that they control.[14] This gets reflected in "involuntary failures to act and deliberate

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decisions not to act"[15–17] or "what is not being done" by leaders or institutions.[18]

The structuralist perspective appears most clearly in Marxist theory. It sees economic imperatives as paramount, limiting the scope for political intervention.[19] Structuralists also argue that the state, driven by economic imperatives, always plays a role of protecting economic interests.

WHY DEVELOPING COUNTRIES LACK SIGNIFICANT OCCUPATIONAL HEALTH POLICIES

Governments in developing countries claim to have policies that are responsive to workers' health needs. However, available evidence indicates that many such governments have afforded occupational health only cursory treatment.

The elitist and structuralist theories appear to explain why developing countries lack significant policies for protecting occupational health. The elitist theory appears most relevant because it provides a model for analyzing policies,[14,20] and shows the ways in which actors in the policy process have control of the agenda and events.[19] Structuralist theory can help to explain how economic preoccupations prevent developing countries from having significant policies for protecting occupational health.

Non–decision making fosters the assigning of low priority to occupational health in developing countries, reflected in attempts made by actors in governments and production enterprises to thwart demands to advance occupational health measures. In this respect non–decision making manifests in four broad forms: inaction or quashing of such initiatives; exercise of power; appeal to the existing bias of the system; and prevailing dominant ideology.

Inaction or Destruction of Demands

Non–decision making may take place through inaction or destruction of demands. That is, ". . . the powerful may not attend to, may not listen to, or may not hear demands as articulated by the less powerful."[21] If such demands gain admission into the political agenda, they are destroyed in the implementation stage of the policy process.[13] This may happen through, for example, bureaucratic and procedural delays, or passing laws but not implementing them.

Two situations illustrate such inaction and destruction of demands: 1) killing initiatives geared towards improving occupational health through under-funding of programs; and 2) failures to implement health and safety improvement agreements reached by managers and trade unions at workplaces.

Under-funding of occupational health programs. Many developing countries have taken occupational health on board by enacting legislation and creating structures for its implementation. However, in most cases budget allocations are inadequate to support occupational health activities by governments and enterprises, which tends to kill occupational health in its implementation stage, as exemplified in Latin America and the Caribbean region[8] and in African countries.[22,23] For instance, Tanzania's occupational health expenditure trends reflect this situation. During the 1980s and 1990s the Labor Department allocated less than 1% of its budget to occupational health activities each year.[30]

The many effects of under-funding include:

- Shortages of equipment required for risk management and monitoring of occupational health practices and outcomes[24]
- Failures to recruit qualified occupational health personnel, including inspectors, leading to inadequate surveillance and poor provision of occupational health services[5,7,23–28]
- Weak occupational health legislation enforcement[7,8,28]
- Weak inspection services[23]
- Lack of investment in research, training, and development of occupational health professionals, a necessary condition for risk identification and collection of data on occupational health problems[7,8,23]

The main reason for under-funding is lack of political will[5,8,29] rather than lack of funds, as the following observation indicates:

> The second constraint to Occupational Health and Primary Health Care for workers in Africa is lack of resources. Resources include money, manpower, equipment, managerial skills and political will. Money can be allocated or appropriated; manpower can be recruited, trained or retrained. The most precarious resource is political will, at all levels. I have known situations when Labour Day celebrations in one year could cost the equivalent of a number of vehicles when factory inspectors cannot visit factories due to lack of funds to buy vehicles. . . . Manpower development requires money and training institutions. The availability of money or starting of a relevant course in any health training institution are purely political decisions, whether in the Government Cabinet or in the University Senate/Council. In other words, resources per se are not a problem, but the problem is the release of resources for appropriate use.[29]

This observation demonstrates what scholars see as inaction in policy implementation: ". . . if Parliament enacts a law but provides insufficient resources and generally does little to enforce it, then we are entitled to say that the Government policy is not to implement its own law."[17]

The other reason for under-funding of occupational health is that employers do not have sufficient economic incentives to improve worker protections because the total social burden of occupational injuries and diseases is distributed across other groups in society.[8] Research conducted in Tanzania supports this observation. As is evident in one example below, although companies make profits from production activities, they do not make the requisite investment in occupational health services.

Failure to implement health and safety improvement agreements. The other tactic employed to diffuse conflicts surrounding occupational health is to seem to agree with trade union demands but fail to follow through with implementation. An example demonstrating this tactic comes from Tanzania's sugar industry, where managers of a sugar-industry holding parastatal, the Sugar Development Corporation (SUDECO), signed a negotiated agreement with trade unions obligating the companies to provide personal protective equipment to every worker. However, this agreement remained on paper only, as the companies then provided only a few workers with the equipment.[30]

Exercise of Power

Demands also get suffocated through exercise of power. The powerful may exercise power through threat of sanctions against the initiator of a threatening demand.[13] Threats of sanctions may be positive or negative, ranging from intimidation (potential deprivation of valued things) to cooptation (potential rewards).

Governments and company managers have exercised power to suffocate occupational health measures through mechanisms such as centralization and monopolization of decision making power and weakening of organized groups through cooptation.

Centralization and monopolization of decision-making power. Centralized political structures that developed in tandem with monolithic political systems in African countries and dictatorial regimes in Latin America after independence discouraged particularistic interests, and created a situation whereby decision making became centralized and monopolized by a few powerful leaders.[31] Monopolization of decision making also became a reality at the enterprise level. This had three implications for occupational health.

First, it isolated workers' leaders in decision making over health and safety issues at workplaces. Although evidence shows that occupational health improved in developed countries that fostered democratization of industrial relations and open social and political dialogue about occupational health,[8,32] domination of decision making by the state did not allow this to happen in developing countries. Severe repression of trade unions under military and dictatorial regimes in Latin America and the Caribbean countries,[8] and the subordination of trade unions to the interests of the state in post-colonial Africa,[33] crippled trade union contributions to the advancement of occupational health.

Although in some countries there were attempts to involve workers' leaders or representatives in decision making through "workers' participation" mechanisms,[34–36] these attempts did not improve working conditions and workers' health and safety. Conservative forces developed counter-strategies that rendered such participation structures weak.[37] In Tanzania, for example, the state and enterprise managers manipulated the structures, killing the workers' participation initiative.[38,39]

Second, monopolization of decision-making power instilled fear among trade union leaders and workers' representatives, preventing articulation of their demands. In Tanzania, for example, this fear among trade union leaders surfaced during focus-group discussions in one of the public firms, when one of the leaders commented: "One would be in trouble to put forward demands such as occupational health improvement to the state. It is the state that can initiate such improvement and not workers or workers' leaders."[30]

Chambua documents this fear instilled by enterprise managers as follows:

> Despite management's assurances that workers are free to air their opinions, some workers have expressed fears of dismissal if they speak out in the participatory process. Indeed, the presence of workers' representatives and their heads of departments and/or sections at the same meeting makes it difficult for the former to air their views freely. This is particularly so if and when they are called upon to give their opinions or criticisms related to the running of departments or sections. Consequently, the workers' representatives have developed their own tactics to avoid victimization.[39]

Third, the centralized decision-making structure created loopholes for neglecting health and safety needs and problems by not giving public-sector companies sufficient decision-making power over social expenditures. The case of the World Bank proposal to the Tanzanian government, made through the managers and Board of Directors, to change the old machinery in the loom sheds to reduce high noise levels causing auditory problems at one of the public textile firms is a good example of adverse effects of centralization of decision making on occupational health. The government unilaterally rejected the proposal without consulting the Board, managers, and workers, leaving auditory problems unsolved at the firm.[30]

Furthermore, in Tanzania, for example, taking advantage of the loophole of not having sufficient powers over social spending, public-sector enterprise managers often avoided taking decisions over certain issues, thereby diffusing occupational health-related demands.

Weakening of organized groups through cooptation strategies. States in developing countries have exercised power to diffuse occupational health and safety demands by reducing the potential power of trade unions through cooptation strategies. For example, trade unions in Latin America are not independent organizations,[40] as they ". . . have been co-opted to serve political interests that do not necessarily reflect the best interest of their membership."[8]

Before embarking on economic and political liberalization in the 1990s, some African states also adopted cooptation strategies by creating corporatist organizations linked to the state. For example, during the single-party rule in Tanzania, the state created structural arrangements in which civil society organization—including the trade union movement—became affiliated with the ruling party. The executive leaders of these organizations also came from the government and party leaders through presidential appointment.

This was an attempt by the political leadership to structure representation of the affiliated organizations' interests and to obstruct any demands from those organizations directed towards challenging the status quo, a move that destroyed the power base of peoples' organizations.[41] One of the scholars of state-civil society relations in Tanzania has observed that:

> Mass organizations were indeed captured and immobilized organizations which worked for the state . . . to erode the influence of civil society and to destroy the roots of opposing economic and political organizations.[42]

Within such structural arrangements, trade unions could not effectively articulate workers' demands seeking to improve occupational health.

With the current economic and political liberalization emphasizing democratic traditions in conducting socioeconomic life, the state-civil society relationship has been restructured, resulting in independent trade unions.[8,38,43] However, political liberalization has not given workers decision-making power. Governments and employers have decided to operate in a neo-liberal ideological framework provided by international organizations that reject the idea of giving workers decision-making power.[43]

Appeal to the Existing Bias of the System

Another form through which non–decision making manifests itself is appeal to the existing bias of the system.[13] By making reference to the existing norms, precedents, rules, and procedures of the system, authorities are able to deflect threatening demands. In other words, the powerful may dismiss a demand for change on the grounds that if it gets articulated it violates an established rule or procedure.

The tendency to appeal to the existing bias manifests in three ways: insistence on the use of proper bureaucratic channels; appeals to adherence to existing rules; and decentralization of occupational health responsibilities.

Insistence on use of bureaucratic channels. Use of laid-down bureaucratic procedures relates to demand presentation. One example can be drawn from an experience with a sugar-producing firm in Tanzania, where managers used such tactics to deflect workers' demands for better occupational health protection. One of the firm's tractor workshop workers had written a letter to the managers, through the trade union office, demanding an explanation why the company had failed to provide personal protective equipment. The managers regarded the worker's demand as illegitimate and refused to attend to it on a simple technicality that the worker had violated the laid-down company procedure for presenting issues by submitting the letter through the wrong channel. They insisted that workers must channel any such demands through their department heads only.[30]

Appeal to adherence to existing rules. The tendency to appeal to adherence to the rules of the system featured in one of the textile enterprises studied in Tanzania, where conflicts had broken out over the handling of occupational health information resulting from workplace inspection. Trade union leaders complained that the managers, who exclusively accessed information contained in labor inspection reports, alienated them in matters regarding access to information revealing the state of occupational health and safety at the workplace.

According to the rule, state inspectors are not obliged to make inspection reports available to trade union leaders, but are required to provide employers/managers with inspection reports showing which occupational health and safety problems need attention. Scholars acknowledge that access to occupational health and safety information by various stakeholders, including workers, is very important in improving occupational health policy in developing countries.[8] Yet restrictive rules prevent trade union leaders from accessing information they would need to push through demands relating to occupational health improvements at their workplaces.

Decentralization of occupational health responsibilities. There has been a tendency by states in the developing countries to decentralize occupational health responsibilities to employers and nongovernmental organizations (NGOs).[30,44] This has occurred through, for example, implementation of the "employer liability" principle enshrined in labor legislation, particularly that of ex-British colonial countries. According to various scholars,[8,23,27,30,44] this decentralization policy led to:

- lack of the necessary state facilitation of occupational health and safety measures expected by employers;

- little state involvement in occupational health activities, leading to poor service provision;
- lack of ensuring an occupational health service orientation (prevention) in services provided by employers; and
- limited occupational health service coverage (particularly lack of services for informal-sector workers).

At the enterprise level, a tendency to decentralize occupational health responsibilities ensues as well. In Tanzania, for example, enterprise managers decentralized these responsibilities to powerless health and safety committees. Through this mechanism they suffocated occupational health, as the committees were unable to implement their decisions without support and resources from the authorities.[30]

Prevailing Dominant Ideology

Non–decision making also occurs through ideology maintained in an organization or community. Dominant interests may exert control over the values, beliefs, and opinions of less powerful groups[45] in such a way that the less powerful are unable to transform diffuse discontent into explicit demands.[15,19] In other words, powerful opinion formers mold the values, beliefs, and opinions of the less powerful groups to the extent that these groups do not become conscious of the problems affecting them.

The views that have dominated the beliefs of actors in occupational health in developing countries stem from economism,[46] an ideology rooted in modernization theory[20,47] and perpetuated through economic globalization.[48] The meaning of economism derives from the logic of "economic growth model" arguments, summarized as follows:

> The justification for not interfering with this markedly accelerated "the rich-get-richer" tendency in lower-income countries is the belief that societies can break out of the vicious cycle of poverty and underdevelopment only by placing the highest priority on short-term efficiency and overall economic growth, at the expense of social spending. The reasoning is that when adequate rates of growth are achieved the benefits will "trickle down" to all; according to this perspective, too much emphasis on equity now will jeopardize economic growth and perpetuate poverty and deprivation.[48]

Let us see how these views dominating state, enterprise management, and workers' consciousness levels have prevented improvement of occupational health in developing countries.

Dominant views at the state level. The three cases described below, from a research project in Tanzania, reveal the dominant economistic views upheld by state policymakers that workers' health protection is not affordable because developing countries like Tanzania are economically undeveloped. All the three cases involved state-owned firms, two of which were industrial firms, a textile mill and an asbestos manufacturing plant (first and third cases respectively), whose production processes caused alarming damage to workers' health that attracted outsiders' attention. In the second case, an agro-industrial enterprise accumulated huge profits but, due to state restrictions on social spending in public enterprises, failed to expend an appropriate portion of its accrued profit for occupational health improvement.

In the first case, the government by inaction encouraged the creation of wealth at the expense of workers' health by its response to the World Bank proposal to consider rehabilitation of the manufacturing process to reduce noise levels, which had caused hearing impairment in workers in one of the state-owned textile industry firms (already cited above). The government defended its inaction by maintaining that it could not afford industrial rehabilitation programs involving large expenditures.[30]

The second case relates to the government's decision to boost investments in the sugar industry, indicating interest in increased economic investment to generate more wealth rather than boosting social investment to sustain workers' health and welfare. As already indicated above, although managers in the profit-making sugar companies denied the workers health protection on the grounds that the companies were not making profits, the government (before privatization of Tanzania's sugar industry in the late 1990s), through the holding parastatal (SUDECO), had been transferring funds from one of the profit-making firms to low-capital-investment companies in the sugar industry.[30]

The third case that illustrates the concern of the Tanzanian state with economic growth rather than workers' health and safety is reflected in its response to the request to close down the now-defunct Dar-es-salaam-based asbestos-sheets-manufacturing plant, which posed a grave danger to workers' health. The government became adamant when the press unveiled the health hazards of the plant, and the then-Minister for Industries was quoted responding: "At present we need the asbestos factory. We can try to clean it up, but we can't close it down until an alternative is found."[49]

Dominant views at the enterprise-management level. At the enterprise level, two cases in point indicate the dominance of economistic views. First, firm managers shared the views upheld by state policymakers that the undeveloped nature of developing countries precludes occupational health improvement. In one firm studied in Tanzania, for example, seemingly supporting the reason given by the government to shelve the World Bank proposal for rehabilitating the textile firm's loom

sheds to reduce noise levels (cited above), one of the managers had this to say:

> Redesigning of the production process may mean a complete installation of new machines to replace those currently in use and with the present worldwide inflation it is something that cannot be expected in the near future, particularly in the developing countries.[50]

Second, evidence from a number of developing countries indicates that profitability takes precedence over the improvement of workers' health and working conditions.[51–53] A Tanzanian experience illustrates this point.

Since the colonial period, employers in Tanzania have believed that the provision of social services to workers erodes their profits,[30] and as such, workers' attempts to put occupational health on the agenda have always met resistance. For example, there is a firm that had accumulated a profit of around Tsh 2.3bn (US$10 million) in the period 1986–87 to 1990–91. However, in one of its board of directors' meetings an occupational health item was postponed, ostensibly based on the bad financial situation of the firm.[30] In another firm, workers' leaders did not even receive any feedback from their managers when they suggested occupational health be one of the items on the agenda in a management meeting, on the pretext that the firm was not making any profit.

Dominant views at the workers' consciousness level. Economistic views propagated by state and enterprise policymakers have been a powerful force in molding workers' opinions. Whenever workers put forward demands to improve occupational health, they are told to wait until the financial situations of their companies improve. Such responses make workers believe that their firms are not generating sufficient profits to permit the provision of effective health and safety services. This is exemplified by the following minute of one of the health and safety committee meetings in one of Tanzania's sugar industry enterprises.

> The management had intended to provide the cane cutters with pairs of shorts but due to prohibitive financial situation it was not fulfilled. The management should take this issue seriously this time to provide them with sandals and pairs of shorts.[30]

Instead of sympathizing with the managers, as reflected in the foregoing observation by the health and safety committee, one would have expected workers and their leaders to vigilantly question this kind of argument put across to them every time they asked for health protection.

However, we acknowledge that workers have sometimes failed to effectively address work practices that jeopardize occupational health and safety at the workplaces due to job insecurity. This is a challenge that workers have to face.

CONCLUSION

The Way Forward to Address Non–Decision Making

This article has analyzed how decisions and actions of states and enterprise policymakers have prevented developing countries from adopting significant occupational health policies. This situation has arisen through four non–decision making strategies: inaction or destruction of demands, exercise of power, appeal to the existing bias of the system, and control over workers' beliefs through a prevailing dominant ideology.

To raise the occupational health policy profile in developing countries, therefore, it is important to address the factors killing occupational health. The struggle to improve occupational health requires strengthened organization and leadership in trade unions, conscious workers who are able to control the work process, and generation of unbiased information about occupational health risks.[8,27,54] This will happen through:

- raising workers' awareness of the factors hindering measures to protect their health and of the need to empower themselves;
- empowering trade unions so that they can play a key role in demanding occupational health improvements;
- making professionals available through training and development; and enabling them to play an active role in the generation of information and knowledge through occupational health monitoring and research.

The struggle for improvement of occupational health should also focus on the need to enable workers to demand decent jobs and to work in environments that do not imperil their health.

The article also points to the need for policymakers to change their attitude towards occupational health. They should recognize that occupational health improvement is a vehicle for socioeconomic development. They should, therefore, create participatory mechanisms to allow workers' representatives and trade union leaders to effectively participate in decision making about occupational health issues.

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