Thailand’s work and health transition

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Abstract. Thailand has experienced a rapid economic transition from agriculture to manufacturing and services, and to more formal employment. Its labour market regulation and worker representation, however, are much weaker than they are in developed countries, which underwent these transitions more slowly and sequentially, decades earlier. The authors examine the strengthening of Thailand’s policy and legislation on occupational safety and health in response to international standards, a new democratic Constitution, fear of foreign trade embargoes, and fatal workplace disasters. In concluding, they identify key challenges remaining for policy-makers, including enforcement of legislation and measurement of new mental and physical health effects.

How people work and the conditions in which they work are critical determinants of population health. Yet, while much attention has been devoted to interconnections between work and health in affluent developed countries, far less is known about this topic in transitional economies (CSDH, 2008). This case study of Thailand illustrates a contemporary work and health transition in a middle-income country. It occasionally uses data from Australia for

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comparison, to contrast the situations in transitional and developed economies. In concluding, the paper identifies the challenges confronting Thailand as it strives for a healthy and productive workforce.

**Economic transitions, work and health**

As traditional rural occupations give way to manufacturing, service and knowledge jobs, population health is affected by rising incomes, changing safety risks and working conditions, and employment insecurity (Benach, Muntaner and Santana, 2007). The resulting health transition is marked by shifts in environmental risks and human ecology (McMichael, 2001), diet and nutrition (Drewnowski and Popkin, 1997), and morbidity and longevity (Caldwell and Caldwell, 1991; Frenk et al., 1991; Caldwell, 1993; Jamison et al., 1993).

Jobs affect health through exposure to occupational hazards. The greatest risks occur in construction, manufacturing, and industrialized agriculture owing to atmospheric pollutants, heart diseases caused by emissions or stress, and injuries due to noise and poor ergonomics. Workers in the service sector, particularly office environments, generally face the lowest risk of injury or disease (Ezzati et al., 2004). The service and knowledge sectors, however, also pose health risks—especially to mental health—as a result of work organization, job insecurity, work pressures and shift work.

In affluent countries, the transition to a service and knowledge economy widened wage inequality (Goos and Manning, 2007)—a factor which may also affect health outcomes. In these countries, the transition has been sequential and relatively gradual, accompanied by a process of state regulation of working conditions and worker representation. Developing and transitional economies, by contrast, are changing at a faster pace without any tradition of worker representation, which limits capacity for regulation to protect workers' health. Furthermore, the context of accelerating globalization—with capital moving freely across borders and labour markets competing globally—is placing downward pressure on wages and conditions (Slaughter and Swagel, 1997). In other words, the pace and context of change in developing and transitional countries differ from what today's developed economies experienced previously; and it is not clear whether these countries will reap the same health benefits from development.

**Thailand's labour market and health transition**

When Thailand entered its transformative stage, its state regulation of working conditions, social security and employment policies were obviously much less advanced than those of developed countries. And such regulations and policies as were in place applied only to specific segments of the labour force (e.g. civil servants). To this day, most Thai workers are still employed in the informal economy, where work is contingent and conditions largely unregulated. Concurrently, unionization rates are low, and few workers are aware of their rights.
Although Thailand’s speedy economic transition has created a “modern” sector of service and knowledge industries, a sizeable proportion of the labour force continues to work in the traditional sectors of agriculture and industry. In today’s developed countries, by contrast, there was a more sequential shift from one dominant sector to the next over centuries. Thailand’s health transition is thus characterized by the coexistence of modern and traditional sectors with different work-related hazards, pay and working conditions.

In the course of Thailand’s transition over the past 50 years, many of its health indicators have shown improvement: life expectancy has increased, while mortality and the incidence of communicable diseases and malnutrition have decreased. From 1964 to 2006, for example, life expectancy increased from 56 to 70 years for males and 62 to 78 for females. From 1962 to 2006, the maternal mortality ratio fell from 374.3 to 9.8 per 100,000 live births. And from 1980 to 2004, the infant mortality rate fell from 49 to 21 per 1,000 live births (Wibulpolprasert, 2008).

Over the past 20 years, however, Thais have begun to experience many of the health problems prevalent in developed economies, including cardiovascular disorders, diabetes, obesity, cancer and traffic injuries. This health transition is quite advanced, with the incidence of, say, obesity and other nutrition-related diseases approaching developed-country levels (Banwell et al., 2008). By 2005, eight of the top ten causes of death in Thailand were strongly linked to aspects of modern work and life (ESCAP, 2008).

**Structural drivers of Thailand’s labour market transition**

**Trends in workforce composition**

Thailand’s sectoral employment trends illustrate the speed of its economic transformation (see figure 1). In 1960, agriculture occupied 82 per cent of the labour force; in 1980, just before Thailand’s economic transformation took off, the proportion was still over 70 per cent, but by 2008 it had fallen to around 35 per cent (NSO, 2008a and 2005a). By way of comparison, Australia’s agricultural employment had already fallen below 20 per cent in 1948 (figure 2). This reflects the different structural factors facing policy-makers in the two countries: unlike Australia, where employment has long been dominated by one sector, Thailand shows a fairly even distribution of employment across sectors (figures 1 and 2). Indeed, while its agricultural workforce shrank between 1980 and 2008, the proportion of Thai workers employed in the manufacturing and service sectors more than doubled, from 11 to 24 per cent and from 19 to 41 per cent, respectively (NSO, 2008a).

**The informal sector**

Thailand’s National Statistics Office (NSO) defines informal workers as those, primarily self-employed, who are not covered by existing workplace laws, regulations and protections (NSO, 1994). Informal workers operate at a low level of
organization, [... with labour relations] based mostly on casual employment, kinship or personal or social relations rather than contractual arrangements with formal guarantees” (ILO, 1993, art. 5(1)). In other words, informal-sector employment is insecure, unregulated and low-paid, and it generates more stress, workplace injuries and related ill health than work in the formal sector (Florey, Galea and Wilson, 2007). Furthermore, when a large proportion of the labour

Figure 1. Employment in Thailand, by sector (%)

Source: NSO, 2008a.

Figure 2. Employment in Australia, by sector (%)

Source: OECD, 2008.
force is informally employed, government tax revenues are substantially reduced, constraining investment in health infrastructure (Sujjapongse, 2005).

From 80 per cent two decades ago, the proportion of Thailand’s labour force in informal employment fell to 71 per cent in 2000, and 62.7 per cent in 2007 (NSO, 2007). A little over half of these informal workers were employed in agriculture, with the remainder running small businesses or market stalls, or working in factories or construction. Although the proportion of the labour force employed informally is still high, it is falling rapidly with modernization and development, particularly in Bangkok, where it was only 31.7 per cent in 2007 (NSO, 1994, 2005b and 2007). For the foreseeable future, however, informal employment will remain an important mechanism for absorbing excess labour in economic downturns and providing jobs for new urban migrants.

Inequity in the labour market
Life expectancy, infant mortality and other health indicators improve as incomes increase, but socio-economic inequalities mean that not all people experience the same health benefits (Kawachi, 2000; Coburn, 2000). A concomitant of Thailand’s labour market transition and rapid economic growth has been an increase in income inequality. Measured by the Gini coefficient, Thailand’s income inequality rose from 0.410 in 1962 to a peak of 0.525 in 2000, before falling back to 0.499 in 2007 (UNPAN, 2003; Thailand, 2007b). By comparison, in Australia where the work transition occurred earlier, the Gini coefficient has hovered around 0.448 in recent years (ABS, 2003).

Higher wages and safer working conditions in the growing service sector can also improve social cohesion and equity – including gender equality. Thailand differs from many countries at a similar stage of development in that its female labour force participation rate has always been relatively high (Ton Guthai, 2002). At over 60 per cent, it is comparable with the rates found in developed countries (NSO, 2009). Most women in Thailand enjoy the opportunity to work for pay, but they are more likely than men to be employed in the lowest-paid and most hazardous jobs created by economic development, or to be in insecure, informal and home-based employment (Ton Guthai, 2002). In 2005, for example, 76.3 per cent of home-based workers in Thailand were women (NSO, 2005).

Work and family
Change from a rural, agriculture-based economy to a rapidly urbanizing one has affected family life, as work has moved away from the village and the extended family, while few alternative childcare options are available (Heymann, 2003). In rural Thailand, as men tend to work in urban areas, women have to look after agricultural production as well as the household and children (Coyle and Kwong, 2000). This extra workload is likely to have a damaging effect on the physical and mental health of mothers and children. Furthermore, women’s long working hours have increased marital instability (Edwards et al., 1992) – a further cause of psychological distress and related illness among parents and children.
Working conditions in Thailand

Hours of work and productivity
Thailand’s economic transition is characterized by persistently low labour productivity, rooted in generally low levels of educational attainment among the labour force. At present, around 57 per cent of the Thai labour force have primary-school education at best (NSO, 2008a). In the period of rapid growth that was largely driven by manufacturing, an uneducated labour force was not a hindrance to the country’s economic success. But jobs are now becoming increasingly skilled, service-oriented and knowledge-based, leaving Thailand with both a shortage of skilled workers and a large pool of unskilled labourers who cannot get good-quality jobs.

The Government has responded by increasing spending on education and promulgating the 1999 National Education Act, which provides for 12 years of free education. The number of students proceeding beyond the primary level has increased sharply in recent years: in 2006, approximately 59 per cent of students completed upper secondary school and 24 per cent went on to tertiary education (NSO, 2008b). However, the labour market effects of this trend are likely to occur with a persistent time-lag because of the large share of the labour force still having only primary education (Khoman, 2005).

Meanwhile, Thailand’s low labour productivity generates its own health risks, as employers demand longer hours and pay lower rates. The average working week is 48 hours in manufacturing, and up to 54 hours in trade and service industries. Almost 70 per cent of the labour force spend more than 40 hours a week at work (NSO, 2008a), compared with only 30 per cent in Australia, which is among the developed countries with the longest working hours (ABS, 2007). Such long hours clearly exacerbate the health risks facing workers, particularly women, who have to combine long hours at work with family responsibilities.

Social security systems
Social security is also important for workers’ health. Several schemes operate in Thailand, namely:

- the Civil Servants’ Medical Benefit Scheme and Government Officials’ Pension Act of 1951, which provide generous benefits for government workers and their dependants (Reisman, 1999);

- the Workman’s Compensation Scheme – an employer-funded scheme providing benefits for work-related sickness (ibid.);

- the Social Security Scheme, which provides sickness benefits for conditions unrelated to work, old-age pension and unemployment benefits (ibid.; Kanjanaphoomin, 2004);

- the Universal Coverage Scheme, which, since 2002, has been providing free medical care for a wide range of treatments, based on a capitation model for the whole population (Tangcharoensathien and Jongudomsuk, 2004).
Thailand’s social security system has thus progressed towards a universal safety net providing free health care to workers and their dependants, thereby greatly reducing inequities in access to health care. Legally registered foreign workers can also be covered by this scheme for a small fee. Although informal workers are still excluded from other social security benefits – e.g. paid sick leave and unemployment benefits – a universal pension of 500 baht per month covering even informal workers was recently introduced.

Unionization
Trade unions play a pivotal role in securing both statutory labour protection and rights – including on occupational safety and health, overtime and family/sick leave – and in the enforcement of those rights at the workplace (Mishel and Walters, 2003). Averaging less than 4 per cent in 2006, Thailand’s overall rate of unionization is very low, though it was more than 50 per cent among state-enterprise workers. Likely reasons include the large percentage of workers informally employed (particularly casual migrant labourers), cultural factors, and the lack of political support for unionization among the country’s leadership (Brown, 2001). Besides, many Thai workers are also reluctant to upset the traditional family relationships typically found within workplaces because they provide them with protection.

Until the mid-1970s, unionization was actively suppressed. Since then, there have been improvements in freedom of association, and trade unions now enjoy some statutory rights. The 1975 Labour Relations Act regulates the registration of unions and establishes labour-dispute resolution procedures. It favours enterprise-level unions and limits industry-wide organization (Lawler and Suttawet, 2000). However, despite improved statutory rights during Thailand’s rapid economic transition, union strength may have actually declined because of a combination of poor enforcement of the right to organize and private-sector employers’ active suppression of unionism (Brown, 2001).

In developed countries, trade unions have been key players in setting hours of work and minimum wages, reducing exposure to occupational hazards, and securing paid sick leave and holidays and other benefits for workers. The weakness of trade unions may thus be another reason for Thailand’s long hours of work and low wages. It has been estimated that up to 40 per cent of factories do not honour their minimum-wage obligations (Charoenloet, 1998).

National planning for labour and workplace safety
Changes in labour policy
The past 15 years have brought unprecedented openness in Thai politics, together with stronger government policy on workplace conditions and workers’ health and safety. Partly driven by a newly empowered civil society, a “People’s Constitution” was promulgated in 1997. This new Constitution’s numerous provisions for individual and collective rights led to the establishment of a National
Human Rights Commission (Baker and Phongpaichit, 2005). Reform of labour legislation can be seen as part of this process.

Two other reasons may explain policy interest in workplace health and safety. The first was the series of industrial accidents that occurred in the 1990s, notably the 1993 fire at the Kader toy factory, where 188 workers were killed and some 500 injured. This drew the attention of the media, non-governmental organizations and public to the issue of worker safety, putting pressure on policy-makers to take action (Brown, 2001). Just like the 1911 Triangle Shirtwaist Factory fire that killed 146 garment workers in New York and led to a raft of new legislation aimed at protecting workers in the United States (McEvoy, 1995), these industrial accidents appear to have marked a turning point in national attitudes towards worker safety in Thailand.

The second, related reason was the fear of embargoes on Thai exports that might result from international condemnation of Thailand’s labour standards (Brown, 2001). Besides, Thailand has been a member of the ILO since 1919, and although it has cautiously ratified only a few of the ILO’s more than 180 Conventions, it hosts the Organization’s Regional Office for Asia and the Pacific, with which its Ministry of Labour and Social Welfare has developed a close working relationship.

An important channel for the implementation of Thailand’s new policy direction on labour has been its five-year National Economic and Social Development Plans, formulated by the powerful National Economic and Social Development Board (NESDB). Since the eighth such plan, spanning 1997–2001, policy guidelines have consistently emphasized reduction of the incidence of occupational injuries and illnesses. The plans now set incidence targets and prescribe the measures to be implemented in order to achieve them. They also promote the registration of informal workers, especially home-based workers, and recognition of informal workers’ organizations, thus providing them with greater protection and security. NESDB policy has also been aimed at providing informal workers with social security benefits similar to those enjoyed by the formal workforce (Thailand, 2004).

Since 1997, these issues have been specifically addressed through the NESDB’s Labour Development and Welfare Plans, which also open up avenues for collective bargaining on workplace conditions (Ruphan, 1999). These plans have provided for new safety regulations, a national safety culture campaign, better inspection systems, embedded safety management systems, improved reporting, and participatory training. These measures address both well-known occupational hazards and newly recognized biological, psychosocial and musculoskeletal risks (Chavalitnitikul, 2005).

Another channel for change was the 1998 Labour Protection Act, which required all (formal) workplaces to set up an occupational safety committee, made up of management and worker representatives trained in workplace health and safety. This legislation also established a reporting system for employees to notify suspected breaches of safety rules, which the Ministry is then obliged to investigate, and rendered the general workplace inspection
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process more rigorous (Seehavong, 2006; Thailand, 2007a). In addition, the 1998 Act addressed working conditions and conditions of employment (e.g. maximum working hours and minimum wages) and set up a separate reporting process for employees to report breaches of these conditions. Penalties for breaches were increased and independent third parties were allowed to investigate disputes (Suthamas and Buayaem, 2001).

Since 2005, the Ministry of Labour and Social Welfare has openly supported regulation to require organizations employing 50 or more workers to develop an occupational safety and health management system (Chavalitnikul, 2005). The prerequisite reforms and training procedures are still under way; if successful, they too should contribute to improved worker safety.

Alongside the above measures, the Ministry of Public Health has also conducted several nationwide campaigns and an active epidemiological surveillance programme. The latter is part of a joint effort to set up a comprehensive occupational health and safety surveillance system pooling the resources of the Ministry of Public Health, the Ministry of Labour and Social Welfare and the Ministry of Industry with a view to monitoring the incidence of target diseases (e.g. silicosis), identifying high-risk groups and developing policy interventions (Siriruttanapruk and Anantagulnathi, 2004).

Workplace health and safety

The Ministries of Health and of Labour and Social Welfare have addressed industrial health risks such as hazardous chemicals and unsafe manufacturing practices, but there are new hazards that remain unregulated. Indeed, poor ergonomics and workplace design, human resource practices and repetitive work also expose many unskilled or poorly educated workers to the risk of lifelong health problems (Tonguthai, 2002; Yingratanasuk, Keifer and Barnhart, 1998). But again, the size and nature of the informal labour market limit the Government’s ability to improve overall standards of occupational health and safety. In particular, the disease and injury rates reported for informal workers are most probably inaccurate because of under-reporting (Chavalitsakulchai and Shahnavaz, 1993).

Nevertheless, after peaking in 1990, the numbers of recorded workplace injuries and deaths have been falling in recent years, as has the incidence of occupational disease. Indeed, statistics from the Office of the Workmen’s Compensation Fund reflect a downward trend in death and injury rates since 1994: reported deaths per 100,000 workers fell from 19.2 in 1994 to 17.7 in 1997, 11.6 in 2004, and 9.5 in 2006; similar declines were reported in injury rates per 1,000 workers: from 43.8 in 1994 to 29.2 in 2004, and 24 in 2007 (see also Chavalitnikul, 2005; Wilbulpolprasert, 2008; Seehavong, 2006; Thailand, 2007a).

The role of globalization in Thailand’s transition

As from 1987 rapid economic expansion was fuelled by massive growth in foreign direct investment. Concomitantly, the Thai Government’s economic policies
promoted export-oriented development, reduced trade barriers, and privatized state enterprises in order to maximize international trade and the country’s competitiveness. Thailand’s growing reliance on foreign investment and trade culminated in the Asian financial crisis of 1997, triggered by a massive outflow of foreign capital (Warr, 1993, 1999 and 2005). The country has since tried to strike a better balance in its economic development by reducing its dependence on foreign capital and exports.

This “encounter” with globalization occurred at a time when Thailand had neither policies nor structures in place to ensure that workplace health and safety rules were followed by international companies on its soil. Nor did it yet have the economic capacity to protect workers (especially agricultural workers) from new pressures to produce for powerful global buyers. On the positive side, the Thai Government has been quite quick to adopt international standards of workplace safety refined over long years of industrial development in more advanced countries. In contrast to the deregulation of many developed economies, the Thai bureaucracy is thus demanding increased workplace safety based on the standards stipulated by the ILO.

Indeed, Thailand has not adopted neoliberal ideas uncritically and in full. Since the 1980s, a Buddhist model of economics has emerged, notably under the influence of P.A. Payutto. This approach emphasizes well-being, moderation and self-reliance. It has led to the concept of a “sufficiency economy”, advocated by King Bhumiphol Adulyadej and now enshrined in the last two national economic development plans (Thailand, UNEP and TEI, 2008). What this actually means for the interaction between work and health in Thailand is unclear. In rural Thailand, at least, there is a movement towards community rights over resources and empowerment, along with emphasis on self-reliance and distrust of financial markets and industrialization (Hewison, 2000; Reynolds, 2001).

**Implications for a healthy and productive labour force**

Thailand is progressing towards a modern, well-regulated labour market as employment moves steadily from agriculture towards the manufacturing and service sectors. The labour force is formalizing, workplace health and safety are improving, and workers enjoy more rights than before. These developments have coincided with globalization, which has strengthened external influence on Thai policy-making. This is particularly obvious in regard to workplace health and safety. What is more, growing openness and civil-society participation in politics have led to improved legislation, protecting workers and granting them rights in accordance with international standards.

Over the past few decades, Thailand has experienced a health transition closely bound to its labour market transition. Indicators linked to poverty, such as infant mortality and life expectancy, have shown improvements and recorded rates of workplace injuries and deaths and occupational disease have declined. However, Thai health statistics do not yet enable us clearly to correlate changes in injuries and diseases to changes in the nature of workplace hazards, and given
the low unionization rates and large informal workforce, occupational diseases are likely to continue to be a major public health burden. Another unknown is the way changes in work organization, workloads, autonomy and job insecurity may affect the mental health of the Thai labour force, both formal and informal. In the developed world, mental health problems such as depression – in which working conditions play an important role – are now one of the leading causes of morbidity (Stansfeld and Candy, 2006).

Changes in government policy on workplace health and safety are relatively recent, with little research on their benefits to workers’ health. But new academic journals are being launched and new research alliances are being formed which may provide the evidence base needed by policy-makers in Thailand and other transitional economies. Indeed, the bulk of the world’s working population lives in transitional and developing countries. Hence the need for further research on the impact of heavy workloads, work intensification, low autonomy, job insecurity and low work rewards in these countries. Indeed, in the context of economic downturns and frequent recourse to offshoring, such working conditions may become even more widespread and important for public health in middle-income countries such as Thailand. Developing this evidence base requires large-scale national monitoring arrangements as well as research on representative cohorts of workers and their families. Given the impact of work on health, investment in this research is urgent.

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